Advancing Care Information (ACI) Requirements for 2017

Please Note: Hospital-based and non-patient facing clinicians are exempt from the ACI category. If exempt clinicians do not submit information for ACI, the category will be reweighted at 0% and the original 25% weight will be added to the quality category, reassigning the Quality weight to 85%. If applying for CMS's hardship exception for first time eligible participants for a payment adjustment in 2018, the deadline is October 1, 2017.

In the MIPS program, the Advancing Care Information (ACI) category replaces the Medicare EHR Incentive Program (Meaningful Use) and is intended to promote patient engagement and the electronic exchange of information using certified EHR technology. MIPS eligible clinicians may earn a maximum score of up to 155% but any score above 100% will be capped at 100%.

The score is combined total of the following three scores:
1. **50%:** Required Base Score
2. **90%:** Performance Score
3. **15%:** Bonus score (up to 15%)

The bonus and performance scores are added to the base score to get the total ACI performance score. The ACI total score will be multiplied by the 25% ACI 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% ACI score. When weighted by 25%, this would contribute 22.5 points to their overall MIPS final score (90 X .25 = 22.5).*

Clinicians must use CEHRT to report ACI information. These are the methods of submitting your CEHRT information:

Individual Reporting	**Group Reporting**
• Attestation	• Attestation
• QDCR	• QCDR
• Qualified Registry	• Qualified Registry
• EHR Vendor	• EHR Vendor
	• CMS Web Interface (groups of 25 or more)

If clinicians do not use CEHRT, then they will have to meet certain criteria to qualify for a reweighting of the performance category to 0% so the ACI category is not included in the total score. The following reasons qualify for a reweighting:

- Insufficient internet connectivity
- Extreme and uncontrollable circumstances
- Lack of control over the availability of CEHRT
- Clinicians that qualify for automatic reweighing:
  - Hospital based clinicians
  - Physician assistants
  - Nurse practitioners
  - Clinical nurse specialists
  - Certified registered nurse anesthetists
  - Non-patient facing clinicians

Clinicians must submit an application to CMS to reweigh the ACI category to 0 if they do not automatically qualify for a reweighting. Qualifying clinicians can choose to report ACI if they wish and CMS will score their performance and weigh their ACI performance. For both automatically-eligible clinicians and ones that submit an application, CMS will reweight the category to 0% and assign the 25% to the Quality performance category to allow participants to receive up to 100 points in the MIPS final score.

Options for ACI Reporting using CEHRT
There are two measure sets for reporting. Submission is based on your CEHRT edition:
1. Advancing Care Information Objectives and Measures
2. 2017 Advancing Care Information Transition Objectives and Measures

In 2017, clinicians can report the 2017 ACI **transition** objectives and measures if they have technology certified to the 2015 edition, technology certified to the 2014 edition, or a combination of both 2014 and 2015 editions.

Base Score Scoring for 2017 Transition Measures
Clinicians must fulfill the requirements of all the base score measures to receive the 50% base score; if they do not they will get a 0 in the overall ACI category. They must submit a "yes" for the security risk analysis measure, and **at least a 1** in the numerator for the numerator/denominator for the remaining measures:
- Security risk analysis
- E-Prescribing
- Provide patient access
- Health information exchange

Partial and Full Scoring will occur when submitting more than the base score (i.e. submitting performance and bonus scores). Some of the base score measures can also contribute towards the performance score.

Performance Score Scoring
Performance score is calculated by using the numerators and denominators submitted for measures included in the performance score, or for the Immunization Registry Reporting measure by the yes or no answer submitted (10 full percentage points for a yes). 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. Clinicians must report up to 7 2017 ACI Transition Measures.

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Performance Rates for Each Measure Worth Up to 10%

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Performance Rate 1-10 = 1%	Performance Rate 51-60 = 6%
Performance Rate 11-20 = 2%	Performance Rate 61-70 = 7%
Performance Rate 21-30 = 3%	Performance Rate 71-80 = 8%
Performance Rate 31-40 = 4%	Performance Rate 81-90 = 9%
Performance Rate 41-50 = 5%	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.*

Bonus Score Scoring
Clinicians can earn bonus 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.**
  - Syndromic Surveillance Reporting
  - Specialized Registry Reporting (14)
  - Electronic Case Reporting (15)
  - Public Health Registry Reporting (15)
  - Clinical Data Registry Reporting (15)
- Reporting "yes" to the completion of at least 1 of the specified Improvement Activities using CEHRT will result in a **10% bonus.**

If clinicians meet both requirements, they will receive the full 15% bonus score.

Group Reporting ACI Scores
If doing group reporting, then the group would have to combine their performances under one TIN. Hospital based clinicians would not need to be included in the group calculation.

ACI Resources for ACR Members
- CMS's ACI Calculator
- Identify your EHR edition
- CMS QPP Fact Sheet
- CMS MIPS ACI Presentation
- Medisolv ACI Information

- Advocacy in Action: ACR Clarified ACI Options in MIPS
- CMS Hardship Exception Information

Performance Category: 2017 ACI Transition Objectives and Measures

Objective	*Measure*
Patient Electronic Access	Provide Patient Access*
Patient Electronic Access	View, Download and Transmit (VDT)
Patient-Specific Education	Patient-Specific Education
Secure Messaging	Secure Messaging
Health Information Exchange	Health Information Exchange*
Medication Reconciliation	Medication Reconciliation
Public Health Reporting	Immunization Registry Reporting

(*) = *Additional achievement on measures above the base score requirement*

Improvement Activities Eligible for the ACI Performance Category Bonus

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. The fukk

IA Performance Category Subcategory	Activity Name	Activity	Performance Category Weight	Related ACI Measures
Expanded Practice Area	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 (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	• Provide Patient Access • Secure Messaging • Send a Summary of Care • Request/Accept Summary of Care

IA Performance Category Subcategory	Activity Name	Activity	Performance Category Weight	Related ACI Measures
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 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.	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 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 patientspecific 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 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.
			High	• Patient Generated Health Data
				• Clinical Information Reconciliation
				• Clinical Decision Support, CCDS, Family Health History (CEHRT functions only)

IA Performance Category Subcategory	Activity Name	Activity	Performance Category Weight	Related ACI Measures
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; • 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.	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 • 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 Non-Clinical Setting • Send A Summary of Care • Request/Accept Summary of care • Clinical Information Reconciliation • Clinical Decision Support, CCDS, Family Health History, Patient List (CEHRT functions only)

IA Performance Category Subcategory	Activity Name	Activity	Performance Category Weight	Related ACI Measures
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 care settings and eligible clinicians or groups; • Integrate a pharmacist into the care team; and/or conduct periodic, structured medication reviews.	Medium	• Clinical Information Reconciliation • Clinical Decision Support • Computerized Physician Order Entry Electronic Prescribing (CEHRT functions only)
Care Coordination	Implementation or use of specialist reports back to the 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	• Provide Patient Access (formerly Patient Access) • View, Download, Transmit • Secure Messaging • Patient Generated health Data or Data from Non-Clinical Setting • Send A Summary of Care • Request/Accept Summary of care • Clinical Information Reconciliation

IA Performance Category Subcategory	Activity Name	Activity	Performance Category Weight	Related ACI Measures
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 alcohol use, etc.) or patient activation measures through use of CEHRT, containing this date in a separate queue for clinician recognition and review.	Medium	• Provide Patient Access • Patient-specific Education • 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 processes for screening	Participation in a QCDR, demonstrating performance of activities for use of standardized 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.	Medium	• Patient Generated Health Date or Data from a Non-Clinical Setting • Public Health and Clinical Data Registry Reporting

IA Performance Category Subcategory	Activity Name	Activity	Performance Category Weight	Related ACI Measures
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 through co-location of services when feasible.	High	• Provide Patient Access • Patient-Specific Education • Patient Generated health Data or Data from Non-Clinical Setting • View, Download, Transmit • Secure Messaging
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

For the ACR's full list of MIPS Improvement Activities, please **click here**.