



Small and Rural
Practice Family
Physicians' Quality
Payment Program
Primer

California Academy of Family Physicians
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CALIFORNIA ACADEMY OF
FAMILY PHYSICIANS
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This primer has been developed by the CAFP's Medical Practice Affairs Committee as a means to assist Academy members who practice in small and/or rural settings address the requirements of the Centers for Medicare and Medicaid (CMS) Quality Payment Program, or MACRA.

Please feel free to contact Sonia Kantak, MPH, Manager of Medical Practice Affairs (skantak@familydocs.org or 415-345-8667 ext. 221) with questions. Thank you.

HIGHLIGHTS:

- MIPS Eligibility Look-Up Tool (Page 6)
- **FREE Technical Assistance** Available to Small and Rural Practice Physicians (Page 9)
- Special Considerations for Small and Rural Practices (Page 6)
- [Register for CAFP's Small and Rural Practices MACRA Webinar or watch the recorded webinar at www.familydocs.org/](http://www.familydocs.org/)

INTRODUCTION

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) created the Quality Payment Program that will change the way Medicare pays more than 600,000 clinicians. Though the Quality Payment Program affects California family physicians in many different practice settings and geographies, the California Academy of Family Physicians (CAFP) recognizes that California's solo, small and rural practice family physicians have particular needs when it comes to preparing for the Quality Payment Program. CAFP developed this guidance for small and rural practice family physicians to highlight applicable rules and opportunities for assistance.

The Quality Payment Program is designed to move Medicare payment away from fee-for-service and toward payment that rewards higher quality care provided at a lower cost. Changes to payment start in 2019, but are based on clinicians' performance in 2017. Most clinicians participating in the Quality Payment Program will be rewarded or penalized based on an overall performance score. The Quality Payment Program is required to be "budget neutral," so clinicians' Medicare payment will be based on their performance score relative to the performance scores of their peers.

CAFP'S MISSION

CAFP's mission is to ensure family physicians in all practice settings thrive in California. We recognize that solo, small (generally defined by MACRA as 15 or fewer clinicians practicing under a single Tax Identification Number) and rural practice family physicians face unique challenges when it comes to the shift toward value-based payment. The extensive reporting required by value-based payment programs is time-consuming and often demands additional staff and/or technology to complete.

Small and rural family physicians' practices are an essential part of our health system. CAFP fought hard to turn what we initially perceived as a program that harms small and rural practices into a program that works for small and rural practices. We advocated for a simplified program with a slower start and free assistance for small and rural practices to support their transition.

CAFP offers the following guidance on the Quality Payment Program, tailored to small and rural practices, as part of our ongoing effort to ensure these practices succeed in a future with value-based payment.

WHERE IN THE QUALITY PAYMENT PROGRAM DO I BELONG?

Clinicians will participate in one of two tracks in the Quality Payment Program:

1. The Merit-Based Incentive Payment System (MIPS); or
2. Advanced Alternative Payment models (APMs).

Most small and rural practice family physicians will participate in the MIPS program. This is not a choice or the result of any action. In the final rule, CMS narrowly defined those APMs that are exempt from MIPS and few California family physicians are in qualifying programs. CMS reports that the following are Advanced APMs in the 2017 performance year:

- Medicare Shared Savings Program (Track 2 and 3)
- Next Generation Accountable Care Organization Model
- Comprehensive End Stage Renal Disease Care – two-sided track
- Comprehensive Primary Care Plus
- Oncology Care Model (two-sided risk)
- Comprehensive Care for Joint Replacement Payment Model (Track 1)

**If you do not practice in one of these models,
you are required to report in the MIPS program.**

CMS intends to broaden opportunities for clinicians to participate in Advanced APMs by retrofitting existing models to qualify by using the CMS Innovation Center to create new models.

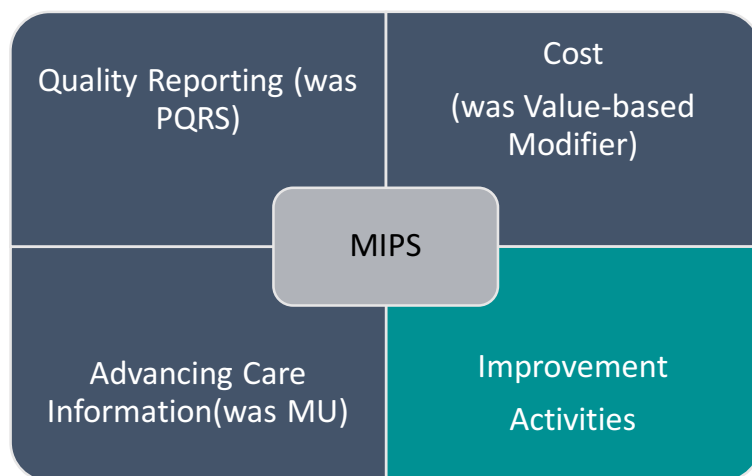
Merit-Based Incentive Payment System

MIPS evaluates physicians in four performance categories: Quality, Resource Use, Improvement Activities and Advancing Care Information (ACI); CMS decided not to evaluate Resource Use in the first year of the Program, however. MIPS combines these three (2017) or four (2018 and beyond) evaluations to create a Composite Performance Score. The weight of the various performance categories in the first year is illustrated here.

For 2017

Quality = 60 percent
 ACI = 25 percent
 IA = 15 percent
Cost = 0 percent

As a starting point to understand these performance categories, recognize that three of them draw from existing CMS programs: Quality is based on PQRS; Resource Use on the Value-Based Payment Modifier; and ACI is based on the Meaningful Use program.



MIPS evaluates "Eligible Clinicians" (ECs). ECs include physicians (MD/DO/DMD/DDS), physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists. Some physicians are excluded from MIPS, including newly enrolled physicians, physicians participating in Advanced APMs and physicians with billing charges less than \$30,000 OR who provide care for 100 or fewer Part B-

enrolled Medicare beneficiaries annually. **We describe the low-volume exemption, which may impact a higher proportion of small and rural practices, below.**

ECs can have their performance assessed as a group across all four performance categories. A "group" is defined as a single Medicare-billing Taxpayer Identification Number (TIN) with two or more individual ECs (including at least one MIPS eligible clinician), as identified by their individual National Provider Identifier (NPI), who have reassigned their billing rights to the TIN. A group will get one payment adjustment based on the group's performance.

Within the performance categories, ECs have a great deal of flexibility in the measures they choose. For example, most ECs will report on six quality measures containing more than 270. ECs are free to choose measures that are easiest for them to report.

The MIPS Composite Performance Score methodology is complicated. Suffice to say, after the transition year of 2017, payment may be adjusted (positively or negatively) based on whether an EC scores above

or below a performance threshold. CMS will use a sensitivity analysis to determine where the performance threshold is set annually, with approximately 50 percent of ECs above that threshold and 50 percent below. For payment years 2019 through 2024, an additional positive adjustment of \$500 million will be distributed each year to those ECs who meet the “exceptional performance” threshold.

Composite scores and performance scores will be published on the [Physician Compare website](#), as well as aggregate information on the range of MIPS composite scores and range of performance by category.

Alternative Payment Models

Between 2019 and 2025, those who participate in the Advanced APMs listed above will be excluded from the MIPS program and will be eligible to receive an annual lump sum incentive payment equal to five percent of their prior year’s payments for Part B-covered professional services. Starting in 2026, qualified participants will receive a higher annual fee schedule update than ECs participating in the MIPS program – a .75 percent increase rather than the standard .25 percent increase. CMS has established criteria for APMs and a threshold amount to be an Advanced APM.

MIPS Reporting Options

Small and rural practice physicians who have not yet implemented an EHR and are not using a registry should note that claims are a mechanism for reporting quality and improvement activity data.

CAFP encourages all small and rural practice physicians to at least test the program in 2017 to avoid a negative adjustment.

The Quality Payment Program changes Medicare payment in 2019, but those changes are based on 2017 performance. ECs must report on their 2017 data by March 2018. In response to CAFP and other advocates’ concerns about a January 1, 2017 start date, CMS created a more flexible option whereby physicians who submit ANY data in 2017 can avoid a penalty to their payment. Physicians who submit more data may get a bonus.

Four options are available for physicians:

1. **Test the Program:** Submit a minimum amount of 2017 data and avoid a payment penalty. A minimum amount of data means one quality measure, one improvement activity OR four or five ACI measures.
2. **Participate for Part of the Calendar Year:** Submit 90 days of 2017 data and you may receive a small bonus. This means your first performance period could begin later than October 2, 2017 and your practice could still qualify for a small bonus.

3. **Participate for the Full Calendar Year:** Submit data to the program for a full 2017 calendar year and you may receive a bigger bonus. This means your first performance period began on January 1, 2017.
4. **Do Not Participate in the Quality Payment Program and Take the Payment Penalty:** If you are a MIPS-eligible clinician and you do not submit any 2017 data, then you receive a negative four percent penalty.

Special Considerations for Small and Rural Practices

Low-volume Providers

If you are a family physician who bills Medicare and you are not in an Advanced APM, you are by default in the MIPS program. Consider, however, the exemption for “Low-Volume” providers: those who bill Medicare \$30,000 or less in Part B-allowed charges a year OR provide care for 100 or fewer Medicare patients a year are exempt from MIPS.

Practices will get a MIPS Participation Status letter from the Medicare Administrative Contractor (MAC) that processes Medicare Part B claims in May of 2017. This letter will let practices know which clinicians need to take part in [MIPS](#) based on historic claims data or whether clinicians historically fit the category of low-volume providers and likely would be exempt from MIPS. **California’s MAC, Noridian Healthcare Solutions, should be distributing letters in May of 2017. Contact Noridian at (855) 609-9960 if you do not receive a letter and think that you should have.**

Physicians can also look up their MIPS eligibility on the new [MIPS eligibility section](#) of CMS’s QPP website. Physicians will need their 10-digit National Provider Identifier (NPI). Contact CMS with questions about the results at gpp@cms.hhs.gov or (866) 288-8292.

Reporting Options for 2017

If you are an eligible clinician in MIPS and do not fit into the low-volume exemption, consider your reporting options for 2017. Reporting options for 2017 allow small and rural practice physicians to build up to meet full QPP requirements for 2018 reporting without being penalized. **CAFP strongly urges you to submit one Quality measure, one Improvement Activity or four or five Advancing Care Information measures to avoid that penalty.**

You can explore Quality, Improvement Activity and ACI measures on CMS’s [QPP website](#). While we cannot tell you what measures would be best for you to report, as that depends on the unique characteristics of your practice, CAFP’s Medical Practice Affairs Committee suggests some achievable measures for your consideration, available in [Appendix A](#). If you participated in the Meaningful Use program in the past, ACI measures also may be a good option.

Reporting Mechanisms

Be aware of the variety of reporting mechanisms available to individual physicians and groups, as illustrated in the table below. While CAFPP urges small and rural practice family physicians to adopt an EHR if you have not already done so and we note that this will be required for the Advancing Care Information performance category after 2017, necessary data can be delivered to CMS in other ways as well.

Performance Category	Mechanism – Individual	Mechanism – Group
Quality		
	Claims	QCDR
	QCDR	Qualified Registry
	Qualified Registry	EHR
	EHR	CMS Web Interface
	Administrative Claims	CMS-approved survey vendor for Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS
Advancing Care Information		
	Attestation	Attestation
	QCDR	Qualified Registry
	Qualified Registry	EHR
	EHR	CMS Web Interface
Improvement Activities		
	Attestation	Attestation
	QCDR	Qualified Registry
	Qualified Registry	EHR
	EHR	CMS Web Interface
	Administrative Claims	Administrative Claims

Improvement Activity Requirements

A few accommodations are made to small and rural practices in the MIPS rules, including the creation of an easier standard in the Improvement Activity category. After the 2017 transition year, most MIPS clinicians are required to complete up to four Improvement Activities for a minimum of 90 days. **MIPS clinicians in practices with fewer than 15 providers or rural or health professional shortage areas, however, must complete only two Improvement Activities for a minimum of 90 days.**

Reweight Advancing Care Information

MIPS clinicians must use certified EHR technology (CEHRT) to satisfy the requirements of the Advancing Care Information performance category. There is, however, an exception for rural practices in areas of limited Internet connectivity. If you do not have a certified EHR, you can qualify for reweighting of the

ACI performance category to zero percent so that it is not included in your overall score if you meet certain criteria, listed below. Simply lacking a certified EHR is not sufficient to qualify for reweighting.

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

1. The clinician applies for reweighting, citing one of three specified reasons:

- Insufficient Internet connectivity
- Extreme and uncontrollable circumstances
- Lack of control over the availability of CEHRT.

2. The clinician is one of the following MIPS ECs who qualify for 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

CMS will reweight the category for these two groups of MIPS ECs to zero percent and reassign the 25 percent to the Quality performance category. Put another way, in 2017, ACI is 25 percent and Quality is 60 percent of most MIPS ECs' overall score, but for those who are reweighted, ACI is zero percent and Quality is 85 percent.

Virtual Groups and APMs

Under MIPS, clinicians will have the option to be assessed as a group across all four MIPS performance categories. The law provides that solo and small practices may join "virtual groups" and combine their MIPS reporting. CMS is not permitting virtual groups in the 2017 performance year, but watch for information from CAFPP on virtual groups in future years.

FREE Technical Assistance for Small and Rural Practice Physicians Available Now

CMS recently awarded \$20 million to 11 organizations to provide assistance with the Quality Payment Program to clinicians in small, rural and Health Professional Shortage Area (HPSA) practices. CMS intends to invest an additional \$80 million in this technical assistance program over the next four years.

[Health Services Advisory Group](#) (HSAG) was awarded the contract in California. HSAG's assistance is available immediately and will be provided at no cost. California family physicians should contact HSAG using the information below:

California's Technical Assistance Provider:

Health Services Advisory Group (HSAG)

Enrollment: <https://hsag.com/qpp>

Phone: (844) 472-4227. This support line is open from 5 am to 5 pm.

HSAG will return all emails calls within 24 hours.

CAFP encourages small and rural practice family physicians to visit [HSAG's website](#), click "enroll," and complete the brief form. HSAG will tailor programming for clinicians based on the enrollment information collected.

HSAG will help clinicians:

- Select and report on appropriate measures and activities to satisfy the requirements of each performance category under MIPS;
- Design a quality-improvement strategy that satisfies the performance categories; and
- Optimize the use of health information technology (HIT).

HSAG will provide most assistance virtually and one-on-one, and later plans to create learning networks. In rare cases, HSAG may also provide in-person assistance.

For additional assistance, CMS has also launched a helpline for clinicians with questions or concerns about the Quality Payment Program. The helpline can be reached by calling (866) 288-8292 from 8 am to 8 pm Eastern Standard Time or emailing qpp@gms.hhs.gov.

Practice Transformation Networks (PTNs) continue to work with physicians on delivery system transformation and quality improvement efforts that ready practices for Quality Payment Program reporting. The [National Rural Accountable Care Consortium](#), in particular, is assisting small and rural California practices ready themselves for Quality Payment Program measurement and reporting.

Library of Resources Available for Small and Rural Practices

For small and rural practice physicians seeking additional information about the Quality program, CMS's [Quality Payment Program website](#) is a great place to start. The QPP website is designed to help providers understand the Program and “shop” for metrics in each performance category. CMS's [Quality Payment Program Overview Fact Sheet](#), is also a terrific starting point for physicians interested in learning more. Finally, [CAFP's Quality Payment Program Playbook](#) includes information tailored to California's family physicians and action steps to take now.

Other resources available to small and rural practices are as follows:

- [CMS fact sheet](#) for small practices
- [CMS FAQ](#) on technical assistance for small/rural practices
- [Government Accounting Office Report](#) on participation challenges for small and rural practices
- [AMA Podcast](#): MACRA Issues for Physicians in Small Practices (primarily about advocacy)
- [PCPCC Presentation](#) for small practices
- [PCPI Presentation](#) for small practices
- [MGMA article and podcast](#)

Conclusion

CAFP encourages our small and rural practices to think strategically about the Quality Payment Program and start planning now. Once again, we want to emphasize that **physicians who submit ANY data in 2017 can avoid a payment penalty and we urge all MIPS-eligible family physicians to participate in this first transition year**. As always, we are here to help. CAFP will continue to provide educational programming and [news updates](#) on MACRA, payment reform and related topics. We will continue to be your advocate with CMS. Please contact CAFP's Director of Health Policy, Conrad Amenta, or Manager of Medical Practice Affairs, Sonia Kantak, MPH by email or by calling (415) 345-8667 with any questions.

Appendix A

Improvement Activities Measures

Activity Name	Activity Description	Activity ID	Subcategory Name	Activity Weighting
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.	IA_BMH_4	Behavioral and Mental Health	Medium
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.	IA_BE_4	Beneficiary Engagement	Medium
Glycemic management services	For outpatient Medicare beneficiaries with diabetes and who are prescribed anti-diabetic agents (e.g., insulin, sulfonylureas), MIPS eligible clinicians and groups must attest to having: For the first performance year, 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,	IA_PM_4	Population Management	High

	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.			
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.	IA_PM_15	Population Management	Medium
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.	IA_CC_2	Care Coordination	Medium
Improved practices that engage patients pre-visit	Provide a pre-visit development of a shared visit agenda with the patient.	IA_BE_22	Beneficiary Engagement	Medium

<p>Participation in MOC Part IV</p>	<p>Participation in Maintenance of Certification (MOC) Part IV for improving professional practice including participation in a local, regional or national outcomes registry or quality assessment program. Performance of monthly activities across practice to regularly assess performance in practice, by reviewing outcomes addressing identified areas for improvement and evaluating the results.</p>	<p>IA_PSPA_2</p>	<p>Patient Safety & Practice Assessment</p>	<p>Medium</p>
<p>Population empanelment</p>	<p>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,</p>	<p>IA_PM_12</p>	<p>Population Management</p>	<p>Medium</p>

	allowing inclusion of younger patients who have minimal acute or preventive health care.			
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.	IA_CC_13	Care Coordination	Medium
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 (e.g., eligible clinician and care team access to medical record, cross-coverage with access to medical record, or protocol-driven nurse line with access to medical record) that could include one or more of the following: Expanded hours in evenings and weekends with access to the patient medical record (e.g., coordinate with small practices to provide alternate hour office visits and urgent care); Use of alternatives to increase access to care team by MIPS eligible clinicians and groups, such as e-visits, phone visits, group visits, home visits and alternate locations (e.g., senior centers and assisted living centers); and/or Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management	IA_EPA_1	Expanded Practice Access	High
Tobacco use	Tobacco use: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and	IA_BMH_2	Behavioral and Mental Health	Medium

	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.			
Use evidence-based decision aids to support shared decision-making.	Use evidence-based decision aids to support shared decision-making.	IA_BE_12	Beneficiary Engagement	Medium
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.	IA_PSPA_16	Patient Safety & Practice Assessment	Medium
Use of QCDR data for quality improvement such as comparative analysis reports across patient populations	Participation in a QCDR, clinical data registries, or other registries run by other government agencies such as FDA, or private entities such as a hospital or medical or surgical society. Activity must include use of QCDR data for quality improvement (e.g., comparative analysis across specific patient populations for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcome).	IA_PM_10	Population Management	Medium

Quality Measures

eMeasure ID	eMeasure NQF	NQF	Quality ID	NQF Domain	Measure Type	High Priority Measure	Data Submission Method	Specialty Measure Set	Primary Measure Steward <i>Abbreviation descriptions below</i>
Breast Cancer Screening: Percentage of women 50-74 years of age who have had a mammogram to screen for breast cancer.									
CMS125v5	N/A	2372	112	Effective Clinical Care	Process	No	Claims, CMS Web Interface, EHR, Registry	Internal medicine, Obstetrics-gynecology, Preventive medicine, General Practice, Family medicine	NCQA
Cervical Cancer Screening: Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: <ul style="list-style-type: none"> ▪ Women age 21-64 who had cervical cytology performed every 3 years ▪ Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years 									
CMS124v5	N/A	32	309	Effective Clinical Care	Process	No	EHR	Obstetrics-gynecology, General practice, Family medicine	NCQA
Colorectal Cancer Screening: Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.									
CMS130v5	N/A	34	113	Effective Clinical Care	Process	No	Claims, CMS Web Interface, EHR, Registry	Internal medicine, General practice, Family medicine	NCQA
Controlling High Blood Pressure: Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.									

CMS165v5	N/A	18	236	Effective Clinical Care	Intermediate Outcome	Yes	Claims, CMS Web Interface, EHR, Registry	Internal medicine, Cardiology, Obstetrics-gynecology, Preventive medicine, Thoracic surgery, Vascular surgery, General practice, Family medicine	NCQA
<p>Depression Remission at 12 Months: Patients age 18 and older with major depression or dysthymia and an initial Patient Health Questionnaire (PHQ-9) score >9 who demonstrate remission at 12 months (+/- 30 days after an index visit) defined as a PHQ-9 score <5. This measure applies to both patients newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.</p>									
CMS159v5	N/A	710	370	Effective Clinical Care	Outcome	Yes	CME Web Interface, EHR, Registry	Mental-behavioral health, General practice, Family medicine	MCM
<p>Diabetes-Hemoglobin A1C (HbA1c) Poor control (>9%): Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c>9% during the measurement period.</p>									
CMS122v5	N/A	59	1	Effective Clinical Care	Intermediate Outcome	Yes	Claims, CMS Web Interface, EHR, Registry	Internal medicine, Preventive medicine, General practice, Family medicine	NCQA
<p>Documentation of Current Medications in the Medical Record: Percentage Hemoglobin A1c (HbA1c) of visits for patients ages 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' names, dosages, frequencies and routes of administration.</p>									
CMS68v5	N/A	419	130	Patient Safety	Process	Yes	Claims, EHR, Registry	Allergy-immunology, Internal medicine, Anesthesiology, Cardiology, Dermatology,	CMMS

								Emergency medicine, gastroenterology, General surgery, Oncology, Hospitalists, Neurology, Obstetrics-gynecology, Ophthalmology, Orthopedic surgery, Otolaryngology, Physical medicine, Preventive medicine, Rheumatology, Thoracic surgery, Urology, Vascular surgery, Mental-behavioral health, Plastic surgery, General practice, Family medicine	
HIV Viral Load Suppression: The percentage of patients, regardless of age, with a diagnosis of HIV with an HIV viral load <200 copies/mL at last HIV viral load test during the measurement year.									
N/A	N/A	2082	338	Effective Clinical Care	Outcome	Yes	Registry	General practice, Family medicine	HRSA
One-Time Screening for Hepatitis C (HVC) for patients at risk: Percentage of patients 18 years and older with one or more of the following: <ul style="list-style-type: none"> ▪ A history of injection drug use; ▪ Recipient of a blood transfusion prior to 1992; ▪ Receiving maintenance hemodialysis; OR ▪ Birthdate in the years 1945-1965 who received one-time screening for hepatitis C virus (HCV) infection 									

N/A	N/A	N/A	400	Effective Clinical Care	Process	No	Registry	Internal medicine, General practice, Family medicine	PCPI
Preventive Care and Screening Influenza Immunization: Percentage of patients ages 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.									
CMS147v5	N/A	41	110	Community-Population Health	Process	No	Claims, CMS Web Interface, EHR, Registry	Allergy-immunology, Internal medicine, Obstetrics-gynecology, Preventive medicine, General practice, Family medicine, Pediatrics	PCPI
Preventive Care and Screening Screening for clinical depression and follow-up plan: Percentage of patients ages 12 years and older screened for depression on the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screening.									
CMS2v5	N/A	418	134	Community-population Health	Process	No	Claims, CMS Web Interface, EHR, Registry	Internal medicine, Mental-behavioral health, General practice, Family medicine, Pediatrics	CMMS

NCQA = National Committee for Quality Assurance

MCM = Minnesota Community Measurement

CMMS = Centers for Medicare and Medicaid Services

HRSA = Health Resources and Services Administration

PCPI = Physician Consortium for Performance Improvement