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MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)
IMPROVEMENT ACTIVITIES CATEGORY

QUALITY PAYMENT PROGRAM FINAL RULE SUMMARY

Synopsis —

Under the Merit-Based Incentive Payment System (MIPS), activities identified as improving clinical practice or care delivery that, when effectively executed, are likely to result in improved outcomes. The Improvement Activities performance category (formerly referred to in the proposed rule as the Clinical Practice Improvement Activities category) will comprise 15 percent of a MIPS eligible clinician's performance. CMS has finalized more than 90 qualified activities that are weighted as "high" or "medium" that must be performed over a period of at least 90 consecutive days for MIPS credit. Activities weighted as "high" are recognized for their alignment with CMS national priorities and programs. MIPS eligible clinicians who participate in a certified patient-centered medical home or comparable specialty practice will automatically receive the highest potential Improvement Activities score. MIPS eligible clinicians who participate in a MIPS alternative payment model will automatically receive full or partial credit. CMS has finalized reporting exceptions for small groups, physicians in rural areas, non-patient-facing clinicians and others.

The list of final Improvement Activities for the 2017 performance year can be found at page 2,157 in Table H of the final rule *(pgs. 2157-2171)*. CMS' online interactive tool will assist eligible clinicians with identifying Improvement Activities. Sub-regulatory guidance from CMS is expected on Improvement Activity reporting and specific activities for earning credit.

Provisions for the Improvement Activities category start on page 617 of the final rule.

In Brief: What Do You Need to Do?

1. **Most participants:** Attest that you completed up to 4 improvement activities for a minimum of 90 days.

2. **Groups with fewer than 15 participants or if you are in a rural or health professional shortage area:** Attest that you completed up to 2 activities for a minimum of 90 days.

3. **Participants in certified patient-centered medical homes, comparable specialty practices, or an APM designated as a Medical Home Model:** You will automatically earn full credit.

4. **Groups in APMs qualifying for special scoring under MIPS, such as Shared Savings Program Track 1 or Oncology Care Model**: You will automatically receive points based on the requirements of participating in the APM. For all current APMs under the APM scoring standard, this assigned score will be full credit. For all future APMs under the APM scoring standard, the assigned score will be at least half credit.

5. **Participants in any other APM:** You will automatically earn half credit and may report additional activities to increase your score.

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PROPOSED RULE	FINAL RULE
CONTRIBUTION TO FINAL SCORE	
CMS proposed to weight the CPIA category as 15 percent of the eligible clinician's total score. The law stipulates that an eligible clinician or group that is certified as a patient-centered medical home or comparable specialty practice must be given the highest possible CPIA score. CMS proposed that a patient-centered medical home will be recognized if it is a nationally recognized accredited patient-centered medical home, a Medicaid Medical Home Model, or a Medical Home Model. The NCQA Patient-Centered Specialty Recognition will also be recognized, which qualifies as a comparable specialty practice. Nationally recognized accredited patient-centered medical homes are recognized if they are accredited by: (1) the Accreditation Association for Ambulatory Health Care; (2) the National Committee for Quality Assurance (NCQA) PCMH recognition; (3) The Joint Commission Designation; or (4) the Utilization Review Accreditation Commission (URAC). The law states that MIPS eligible clinicians or groups who are participating in an alternative payment model, must earn at least one half of the highest potential score for the CPIA performance category.	CMS has finalized the Improvement Activity category will account for 15 percent of the final MIPS score. CMS is finalizing an expanded definition of what is acceptable for recognition as a certified-patient centered medical home or comparable specialty practice. CMS is recognizing a MIPS eligible clinician or group as being a certified patient-centered medical home or comparable specialty practice if they have achieved certification or accreditation as such from a national program, or they have achieved certification or accreditation as such from a regional or state program, private payer or other body that certifies at least 500 or more practices for patient-centered medical home accreditation or comparable specialty practice certification. Practices may receive a patient-centered medical home designation at a practice level. Individual TINs may be composed of both undesignated practices and practices that have received a designation as a patient-centered medical home (for example, only one practice site has received patient-centered medical home designation in a TIN that includes five practice sites).

DATA SUBMISSION CRITERIA	
CMS proposed to allow for submission of data for the CPIA performance category using a qualified registry, EHR, Qualified Clinical Data Registry (QCDR), CMS Web Interface and attestation data submission mechanisms. If technically feasible, CMS proposed to use administrative claims data to supplement the CPIA submission. For the first year only of MIPS, all MIPS eligible clinicians or groups, or third party entities such as health IT vendors, QCDRs and qualified registries that submit on behalf of a MIPS eligible clinician or group, must designate a yes/no response for activities on the CPIA Inventory. In the case where a MIPS eligible clinician or group is using a health IT vendor, QCDR, or qualified registry for their data submission, the MIPS eligible clinician or group will certify all CPIAs have been performed and the health IT vendor, QCDR, or qualified registry will submit on their behalf.	CMS is finalizing submission of Improvement Activity data using the qualified registry, EHR, QCDR, CMS Web Interface, and attestation data submission mechanisms. All MIPS eligible clinicians or groups must select activities in Table H. For the transition year of MIPS, all MIPS eligible clinicians or groups, or third party intermediaries such as health IT vendors, QCDRs and qualified registries that submit on behalf of a MIPS eligible clinician or group, must designate a yes response for activities on the improvement activities inventory. In the case where a MIPS eligible clinician or group is using a health IT vendor, QCDR, or qualified registry for their data submission, the MIPS eligible clinician or group will certify all improvement activities have been performed and the health IT vendor, QCDR, or qualified registry will submit on their behalf. The vendor simply reports the MIPS eligible clinician's or group's attestation, on behalf of the clinician or group, that the improvement activities were performed. The vendor is not attesting on its own behalf that the improvement activities were performed. CMS is not finalizing the data submission method of administrative claims data to supplement the improvement activities. All MIPS eligible clinicians, reporting as a group, will receive the same score for the Improvement Activity category. If at least one clinician within the group is performing the activity for a continuous 90 days in the performance period, the group may report on that activity. CMS will provide technical assistance through sub-regulatory guidance to further explain how MIPS eligible clinicians will report on activities within the improvement activities performance category. This sub-regulatory guidance will also include how MIPS eligible clinicians will be able to identify a specific activity through some type of numbering or other similar convention. A MIPS eligible clinician must meet all requirements of the activity to receive credit for that activity.

	Many activities offer multiple options for how clinicians may successfully complete them and additional criteria for activities are included in the improvement activities inventory. CMS will verify data through the data validation and audit process as necessary. MIPS eligible clinicians may retain any documentation that is consistent with the actions they took to perform each activity.
WEIGHTED SCORING	
Patient-Centered Medical Home Participants: 100 percent (60 points) of the potential CPIA score APM Participants: 50 percent (30 points) of the potential CPIA score CMS proposed to weight other CPIAs as medium (10 points per activity) or high (20 points per activity). CMS proposed to compare the CPIA points associated with the reported activities against the highest number of points that are achievable under the CPIA performance category, which is 60 points. CMS recognizes that working with a QCDR could allow a MIPS eligible clinician or group to meet the measure and activity criteria for multiple CPIAs. For the first year of MIPS, there are several CPIAs in the inventory that incorporate QCDR participation. Each activity must be selected and achieved separately for the first year of MIPS.	Maximum achievable points are 40. CMS is finalizing Improvement Activity weights as medium (10 points per activity) or high (20 points per activity). While there are many QCDR-associated Improvement Activities, CMS has emphasized that participating in a QCDR is not sufficient for demonstrating performance of multiple improvement activities. The CAHPS for MIPS survey is included as a high-weighted activity under the activity called “Participation in the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS) or other Supplemental Questionnaire Items.”

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SUBMISSION CRITERIA	
To achieve the highest score of 100 percent, the eligible clinician would need to achieve 60 points and could do this through selecting and submitting data on a combination of CPIAs, or a combination of APM participation and other CPIAs. CMS proposed participation exceptions: MIPS small groups (consisting of 15 or fewer clinicians), MIPS eligible clinicians and groups located in rural areas, MIPS eligible clinicians and groups that are located in geographic HPSAs, non-patient-facing MIPS eligible clinicians or groups or MIPS eligible clinicians, or groups that participate in an APM and/or a patient- centered medical home submitting in MIPS. For these groups, to achieve the highest score of 100 percent, two CPIAs are required (medium or high). To achieve a 50 percent score, one CPIA (medium or high) is required.	CMS is reducing the maximum number of activities required to achieve the highest possible score in this performance category: 2 high-weighted improvement activities or 4 medium-weighted improvement activities, or some combination of high and medium-weighted improvement activities which will be less than 4 total number of activities for MIPS eligible clinicians participating as individuals or as groups. To achieve the highest score, MIPS eligible clinicians and groups that are small practices, practices located in rural areas or geographic HPSAs, or non-patient facing MIPS eligible clinicians or groups must report 1 high-weighted or 2 medium-weighted improvement activities. For these MIPS eligible clinicians and groups, to achieve one-half of the highest score, 1 medium-weighted improvement activity is required. Clinicians identified on the participation list of certain APMs will receive at least one-half of the highest score. (For 2017, these clinicians will full credit). To develop the improvement activities additional score assigned to all MIPS APMs, CMS will compare the requirements of the specific APM with the list of activities in the Improvement Activities Inventory in Table H. Should the MIPS APM not receive the maximum Improvement Activity score then the APM entity can submit additional improvement activities. All other MIPS eligible clinicians or groups that we identify as participating in APMs will need to select additional improvement activities to achieve the improvement activities highest score. For 2017, clinicians in any other APM will automatically earn half credit under the Improvement Activities category.

Required Period of Time for Performing an Activity	
CMS proposed that an activity must be performed for at least 90 days during the performance period for CPIA credit. CMS proposed that activities, where applicable, may be continuing (that is, could have started prior to the performance period and are continuing) or be adopted in the performance period, as long as an activity is being performed for at least 90 days during the performance period.	CMS has finalized that each improvement activity be performed for a continuous 90-day period. Additionally, the continuous 90-day period must occur during the performance period. Activities, where applicable, may be continuing (that is, could have started prior to the performance period and are continuing) or be adopted in the performance period as long as an activity is being performed for at least 90 days during the performance period. MIPS eligible clinician or group must qualify as a certified patient-centered medical home or comparable specialty practice for at least a continuous 90 days during the performance period. Therefore, any MIPS eligible clinician or group that does not qualify by October 1st of the performance year as a certified patient-centered medical home or comparable specialty practice cannot receive automatic credit as such for the improvement activities performance category.
Application of Improvement Activities to Non-Patient Facing MIPS Eligible Clinicians and Groups	
CMS proposed allowing non-patient facing MIPS eligible clinicians and groups to report on a minimum of 1 activity to achieve partial credit or 2 activities to achieve full credit to meet the improvement activities submission criteria. These non-patient facing MIPS eligible clinicians and groups receive partial or full credit for submitting 1 or 2 activities irrespective of any type of weighting, medium or high (for example, two medium activities will qualify for full credit).	For non-patient facing MIPS eligible clinicians or groups, to achieve the highest score 1 high-weighted or 2 medium-weighted improvement activities are required. For these MIPS eligible clinicians and groups, in order to achieve one-half of the highest score, 1 medium-weighted improvement activity is required.

SPECIAL CONSIDERATION FOR SMALL, RURAL, OR HEALTH PROFESSIONALS SHORTAGE AREA PRACTICES	
CMS proposed to accommodate small practices and practices located in rural areas, or geographic HPSAs for CPIA category by allowing MIPS eligible clinicians or groups to submit a minimum of 1 activity to achieve partial credit or 2 activities to achieve full credit. These MIPS eligible clinicians or groups receive partial or full credit for submitting 2 activities of any type of weighting (for example, two medium activities will qualify for full credit).	CMS is finalizing that for MIPS eligible clinicians and groups that are small practices or located in rural areas, or geographic HPSAs, to achieve full credit, 1 high-weighted or 2 medium-weighted improvement activities are required. In addition, CMS is modifying its proposed definition of rural area to mean clinicians in zip codes designated as rural, using the most recent HRSA Area Health Resource File data set available. In addition, CMS is finalizing the following definitions, as proposed: (1) small practices means practices consisting of 15 or fewer clinicians and solo practitioners; and (2) Health Professional Shortage Areas (HPSA) means areas as designated under the Public Health Service Act. The Transforming Clinical Practice Initiative (TCPI) credit, which includes activities such as a Practice Transformation Network, is provided as a high-weighted activity for the transition year of MIPS.
IMPROVEMENT ACTIVITIES SUBCATEGORIES	
Subcategories explicitly included in the law: • Expanded Practice Access • Population Management • Care Coordination • Beneficiary Engagement • Patient Safety and Practice Assessment • Participation in an APM • Promoting Health Equity and Continuity • Social and Community Involvement In addition to the subcategories prescribed by law, CMS proposed to add the following subcategories: • Achieving Health Equity • Emergency Preparedness and Response • Integration of Primary Care and Behavioral Health	CMS is finalizing that MIPS eligible clinicians may select any activity across any improvement activities subcategory. CMS is finalizing the following additional subcategories: Achieving Health Equity; Integrated Behavioral and Mental Health; and Emergency Preparedness and Response.

IMPROVEMENT ACTIVITIES INVENTORY	
	CMS has approved 93 Improvement Activities for 2017. The improvement activities and weighting are provided in Table H. The activities and weighting are finalized as proposed with the exception of the following: one change for one activity in the Emergency Response and Preparedness Subcategory from a medium to a high-weighted activity; one change for one activity in the Population Management Subcategory from a medium to a high-weighted activity. Activities with an asterisk (*) in Table H also qualify for the advancing care information bonus. For the transition year of MIPS, CMS intends for MIPS eligible clinicians to focus on achievement of these activities; they do not need to show that the activity led to improvement. CMS has not proposed prescriptive thresholds for activities beyond an attestation that a certain percentage of patients were impacted by a given activity and that in establishing the improvement activities performance category CMS included activities that align with those patient-centered medical homes typically perform. CMS will provide MIPS eligible clinicians more information about documentation expectations for the transition year of MIPS in sub-regulatory guidance.

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CMS STUDY ON IMPROVEMENT ACTIVITIES AND MEASUREMENT	
CMS proposed to conduct a study on CPIAs and measurement to examine clinical quality workflows and data capture using a simpler approach to quality measures. The lessons learned in this study on practice improvement and measurement may or may not influence changes to future MIPS data submission requirements. The study will allow a limited number of selected MIPS eligible clinicians and groups to receive full credit (60 points) for the CPIA category. For the 2017 performance period, the participating MIPS eligible clinicians or groups would submit their data and workflows for a minimum of three MIPS clinical quality measures that are relevant and prioritized by their practice. One of the measures must be an outcome measure, and one must be a patient experience measure. This test will be open to include up to 10 non-rural individual MIPS eligible clinicians or groups of less than three non-rural MIPS eligible clinician's, 10 rural individual MIPS eligible clinicians or groups of less than three rural MIPS eligible clinician's, 10 groups of three to eight MIPS eligible clinicians, five groups of nine to twenty MIPS eligible clinicians, three groups of 21 to 100 MIPS eligible clinicians, two groups of greater than 100 MIPS eligible clinicians, and two specialist groups of MIPS eligible clinicians. Eligible clinicians and groups will need to sign up from Jan. 1-31, 2017. Participants will be approved on a first come first served basis and must meet all the required criteria.	CMS is finalizing the study on improvement activities and measurement. MIPS eligible clinicians and groups in the CMS study on practice improvement and measurement will receive full credit (40 points) for the Improvement Activities category of MIPS after successfully electing, participating and submitting data to the study coordinators at CMS for the full calendar year. For CY 2017, the participating MIPS eligible clinicians or groups would submit their data and workflows for a minimum of three MIPS CQMs that are relevant and prioritized by their practice. One of the measures must be an outcome measure, and one must be a patient experience measure. The study will select 10 non-rural individual MIPS eligible clinicians or groups of less than three non-rural MIPS eligible clinicians, 10 rural individual MIPS eligible clinicians or groups of less than three rural MIPS eligible clinicians, 10 groups of three to eight MIPS eligible clinicians, five groups of nine to 20 MIPS eligible clinicians, three groups of 21 to 100 MIPS eligible clinicians, two groups of greater than 100 MIPS eligible clinicians, and two specialist groups of MIPS eligible clinicians. Participation would be open to a limited number of MIPS eligible clinicians in rural settings and non-rural settings. MIPS eligible clinicians and groups would need to sign up from Jan. 1, 2017, to Jan. 31, 2017. The sign up process will utilize a web-based interface. Participants would be approved on a first come first served basis and must meet all the required criteria.
REQUEST FOR COMMENTS ON CALL FOR MEASURES AND ACTIVITIES FOR ADDING NEW ACTIVITIES	
	MIPS eligible clinicians or groups would be able to nominate additional activities that we could consider adding to the improvement activities inventory. This nomination and acceptance process would, to the best extent possible, parallel the annual call for measures process already conducted by CMS for quality measures.

REQUEST FOR COMMENTS ON USE OF QCDRS FOR IDENTIFICATION AND TRACKING OF FUTURE ACTIVITIES	
In future years, CMS expects to learn more about CPIAs and how the inclusion of additional measures and activities captured by QCDRs could enhance the ability of MIPS eligible clinicians or groups to capture and report on more meaningful activities. This is especially true for specialty groups. CMS believes that for future years, QCDRs will be allowed to define specific CPIAs for specialty and non-patient-facing MIPS eligible clinicians or groups through the already-established QCDR approval process for measures and activities.	CMS did not receive any comments regarding the use of QCDRs for identification and tracking of future activities.
REQUEST FOR COMMENTS ON ACTIVITIES THAT WILL ADVANCE THE USAGE OF HEALTH IT	
	ONC certifies technology for additional emerging health IT capabilities which may also be important for enabling activities included in the improvement activities inventory, such as technology certified to capture social, psychological, and behavioral data and technology certified to generate and exchange an electronic care plan. In the future, CMS may consider including these emerging certified health IT capabilities as part of activities within the improvement activities inventory. By referencing these certified health IT capabilities in improvement activities, clinicians would be able to earn credit under the improvement activities performance category while gaining experience with certification criteria that may be reflected as part of the CEHRT definition at a later time.