QUALITY PAYMENT PROGRAM — YEAR 2
CY 2018 PROPOSED RULE
Improvement Activities Component Reporting Requirements

Brief Synopsis: The Improvement Activities (IA) performance category will continue to comprise 15 percent of a MIPS eligible clinician's performance. Activities will continue to be 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. CMS is proposing to revise its policy to require at least 50 percent of the practice sites within the TIN be recognized as a patient-centered medical home or comparable specialty practice. This is an increase to the current requirement that only one practice site within a TIN needs to be certified as a patient-centered medical home, MIPS eligible clinicians who participate in a MIPS alternative payment model will automatically at least one-half of the highest IA Category score.

CY2017 Final Rule	**CY2018 Proposed Rule**
Contribution to the Final Score CMS has finalized the Improvement Activity category will account for 15 percent of the final MIPS score.	**Contribution to the Final Score** No change.

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Patient-Centered Medical Home or Comparable Specialty Practice The law stipulates that an eligible clinician or group that is certified as a patient-centered medical home (PCMH) or comparable specialty practice must be given the highest possible IA score. CMS finalized an expanded definition of what is acceptable for recognition as a certified PCMH or comparable specialty practice. CMS is recognizing a MIPS eligible clinician or group as being a certified PCMH 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 PCMH 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 PCMH (for example, only one practice site has received PCMH designation in a TIN that includes five practice sites).	**Patient-Centered Medical Home or Comparable Specialty Practice** CMS proposes to clarify the term “certified” PCMH. It has come to their attention that the common terminology utilized in the general medical community for “certified” PCMH is “recognized” patient-centered medical home. Therefore, to provide clarity CMS proposes the term “recognized” be accepted as equivalent to the term “certified” when referring to the requirements for a PCMH to receive full credit for the improvement activities performance category for MIPS (page 152). For the 2020 MIPS payment year and future years, CMS proposes that to receive full credit as a certified or recognized patient-centered medical home (PCMH) or comparable specialty practice, at least 50 percent of the practice sites within the TIN must be recognized as a PCMH or comparable specialty practice. This is an increase to the requirement that only one practice site within a TIN needs to be certified as a PCMH, but does not require every site be certified, which could be overly restrictive given that some sites within a TIN may be in the process of being certified as PCMHs (page 159).

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Data Submission Criteria	Data Submission Criteria
CMS finalized submission of Improvement Activity data using the qualified registry, EHR, QCDR, CMS Web Interface, and attestation data submission mechanisms. 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.	CMS proposes to extend current requirements to include future years, not just the transition year. CMS is also proposing to apply these policies to virtual groups. ***NEW*** For the 2020 MIPS payment year and future years, CMS is proposing to allow MIPS eligible clinicians and groups to submit measures and activities, as applicable, via as many submission mechanisms as necessary to meet the requirements of the quality, improvement activities, or advancing care information performance categories (pages 154-156).

Data Submission Criteria, Cont'd.	**Data Submission Criteria, Cont'd.**
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. 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.	

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Weighted Scoring Maximum achievable points are 40. CMS finalized 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."	**Weighted Scoring** ***NEW*** CMS is proposing 20 new, additional, medium and high-weighted activities in Table F in the Appendix of this proposed rule (Pages 1037-1043). CMS notes that high-weighting should be used for activities that directly address areas with the greatest impact on beneficiary care, safety, health, and well-being. The agency is not proposing changes to the approach in this proposed rule; however, it will take suggested additional criteria into consideration for designating high-weighted activities in future rulemaking (page 153).

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Submission Criteria	Submission Criteria
CMS finalized the maximum number of activities required to achieve the highest possible score in this performance category: 2 high-weighted improvement activities, 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. 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	CMS is proposing to extend current requirements to virtual groups.

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 IA category.	

Required Period of Time for Performing an Activity 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 (PCMH) 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 PCMH or comparable specialty practice cannot receive automatic credit as such for the improvement activities performance category.	**Required Period of Time for Performing an Activity** CMS is proposing to extend these policies to virtual groups. CMS is not proposing any changes to the required period of time for performing an activity for the improvement activities performance category (page 161).

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Application of Improvement Activities to Non-Patient Facing MIPS Eligible Clinicians and Groups 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.	**Application of Improvement Activities to Non-Patient Facing MIPS Eligible Clinicians and Groups** CMS is not proposing any changes to the application of improvement activities to non-patient facing individual MIPS eligible clinicians and groups for the improvement activities performance category (page 161).

Special Consideration for Small, Rural, or Health Professional Shortage Areas Practices CMS finalized 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. Rural area means clinicians in zip codes designated as rural, using the most recent HRSA Area Health Resource File data set available. CMS finalized 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.	**Special Consideration for Small, Rural, or Health Professional Shortage Areas Practices** CMS is not proposing any changes to the special consideration for small, rural, or health professional shortage areas practices for the improvement activities performance category (page 162).

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Improvement Activities Subcategories	**Improvement Activities Subcategories**
CMS finalized that MIPS eligible clinicians may select any activity across any improvement activities subcategory. 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 finalized the following additional subcategories: • Achieving Health Equity • Integrated Behavioral and Mental Health Emergency Preparedness and Response	CMS is not proposing any changes to the improvement activities subcategories for the improvement activities performance category in this proposed rule (page 162).

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Improvement Activities Inventory CMS approved 93 Improvement Activities for 2017. 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 did not propose 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.	**Improvement Activities Inventory** ***NEW*** The 2018 proposed new improvement activities and the 2018 proposed improvement activities with changes can be found in Tables F and G of the Appendix of this proposed rule and will be available on the CMS website. Table F, pages 1037-1043. Table G, pages 1044-1058.

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CMS Study on Improvement Activities and Measurement	**CMS Study on Improvement Activities and Measurement**
CMS finalized 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.	CMS is modifying the name of the study to the “CMS study on burdens associated with reporting quality measures” to more accurately reflect the purpose of the study (page 167. CMS is proposing changes to the study participation credit and requirements sample size, how the study sample is categorized into groups, and the frequency of quality data submission, focus groups, and surveys. CMS is proposing a larger sample size for 2018 to conduct a more rigorous statistical analysis. CMS proposes to increase the sample size for the performance periods occurring in 2018 to a minimum of: ● 20 urban individual or groups of < 3 eligible clinicians - (broken down into 10 individuals & 10 groups). ● 20 rural individual or groups of < 3 eligible clinicians - (broken down into 10 individuals & 10 groups). ● 10 groups of 3-8 eligible clinicians. ● 10 groups of 8-20 eligible clinicians. ● 10 groups of 20-100 eligible clinicians. ● 10 groups of 100 or greater eligible clinicians. ● 6 groups of > 20 eligible clinicians reporting as individuals - (broken down into 3 urban & 3 rural). ● 6 specialty groups - (broken down into 3 reporting individually & 3 reporting as a group).

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.	● Up to 10 non-MIPS eligible clinicians reporting as a group or individual (any number of individuals and any group size).

CMS Study on Improvement Activities and Measurement Cont'd	**CMS Study on Improvement Activities and Measurement Cont'd** CMS is proposing that for Quality Payment Program Year 2 and future years: - Study participants would be required to attend as frequently as four monthly surveys and focus group sessions throughout the year, but certain study participants would be able to attend less frequently. - To offer study participants flexibility in their submissions so that they could submit once, as can occur in the MIPS program, and participate in study surveys and focus groups while still earning improvement activities credit (pages 167-171).

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Improvement Activities Inventory 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.	**Improvement Activities Inventory** <u>Proposed Approach on the Annual Call for Activities Process for Adding New Activities</u> For the QPP Year 3 and future years, CMS proposes to formalize an Annual Call for Activities process for adding possible new activities to the Improvement Activities Inventory (page 163). CMS proposes that individual MIPS eligible clinicians or groups and other relevant stakeholders may recommend activities for potential inclusion in the Improvement Activities Inventory via a similar nomination form utilized in the transition year of MIPS found on the QPP website. As part of the process, individual MIPS eligible clinicians, groups, and other relevant stakeholders would be able to nominate additional improvement activities that they may consider adding to the Improvement Activities Inventory. Individual MIPS eligible clinicians and groups and relevant stakeholders would be able to provide an explanation via the nomination form of how the improvement activity meets the criteria (page 163).

Improvement Activities Inventory, Cont'd.	**Improvement Activities Inventory, Cont'd.** <u>Criteria for Nominating New Improvement Activities for the Annual Call for Activities</u> CMS proposes for the QPP Year 2 and future years that stakeholders would apply one or more of the following criteria when submitting improvement activities in response to the Annual Call for Activities: ● Relevance to an existing improvement activities subcategory (or a proposed new subcategory); ● Importance of an activity toward achieving improved beneficiary health outcome; ● Importance of an activity that could lead to improvement in practice to reduce health care disparities; ● Aligned with patient-centered medical homes; ● Activities that may be considered for an advancing care information bonus; ● Representative of activities that multiple individual MIPS eligible clinicians or groups could perform (for example, primary care, specialty care); ● Feasible to implement, recognizing importance in minimizing burden, especially for small practices, practices in rural areas, or in areas designated as geographic HPSAs by HRSA; ● Evidence supports that an activity has a high probability of contributing to improved beneficiary health outcomes; or

	• CMS is able to validate the activity (page 164).

Improvement Activities Inventory, Cont'd.	**Improvement Activities Inventory, Cont'd.** <u>Submission Timeline for Nominating New Improvement Activities for the Annual Call for Activities</u> The intention of CMS is that the nomination and acceptance process will parallel the Annual Call for Measures process already conducted for MIPS quality measures. CMS proposes to accept submissions for prospective improvement activities at any time during the performance period for the Annual Call for Activities and create an Improvement Activities Under Review (IAUR) list. CMS proposes that for the Annual Call for Activities, only activities submitted by March 1 would be considered for inclusion in the Improvement Activities Inventory for the performance periods occurring in the following calendar year. This proposal is slightly different than the Call for Measures timeline. The Annual Call for Measures requires a 2-year implementation timeline because the measures being considered for inclusion in MIPS undergo the pre-rulemaking process with review by the Measures Application Partnership (MAP). CMS proposes to add new improvement activities to the inventory through notice-and comment rulemaking. In future years, CMS anticipates developing a process and establishing criteria for identifying activities for removal from the Improvement Activities Inventory through the Annual Call for Activities process. CMS is requesting comments on what

	criteria should be used to identify improvement activities for removal from the Improvement Activities Inventory (page 165).

Use of QCDRs for Identification and Tracking of Future Activities CMS did not receive any comments regarding the use of QCDRs for identification and tracking of future activities.	**Use of QCDRs for Identification and Tracking of Future Activities** No new information included.

Activities that will advance the usage of Health IT	**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.	CMS received comments in the final rule that using CEHRT could aid in improving clinical practices, however several noted concerns of health IT burdens and increased costs. In response to the comments, CMS will continue to focus on incentivizing the use of health IT, telehealth, and connection of patients to community-based services (page 151).

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