Merit-Based Incentive Payment System (MIPS): Clinical Practice Improvement Activities (CPIA) Performance Category Overview
Wednesday, June 22, 2016, 12:00 – 1:00 pm EDT

On Wednesday, June 22, 2016, CMS hosted a webinar on the Clinical Practice Improvement Activities (CPIA) Performance Category of the Merit-Based Incentive Payment System (MIPS). CMS has hosted a few webinars on the performance categories, and the overview of MIPS and the alternative payment models (APMs). The recording and slides for these webinars can be found on the Quality Payment Program web site.

Quality Payment Program

The Quality Payment Program is the next step in actually putting the new system envisioned by The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) into place. It is the umbrella that houses MIPS and APMs. MACRA replaced a patchwork collection of programs with a single system where every Medicare physician and clinician has the opportunity to be paid more for high quality care and investments that support patients. One thing to note is that CMS now refers to providers as eligible clinicians, rather than eligible providers, or EPs. Through its stakeholder engagement, CMS has learned that the term clinicians is more meaningful to providers.

Eligible Participants

For the first and second years, those eligible to participate in MIPS include physicians, physician's assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists who bill under Medicare Part B. For the third and future years, CMS can expand those who are eligible to participate to include physical or occupation therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists, and dieticians/nutritional professionals. Those clinicians who are not eligible to participate in the MIPS during the first two years, particularly those who are currently participating in the Physician Quality Reporting Program (PQRS), but would like to gain experience under the program before they are actually required to dos so, can volunteer to report if they choose.

Excluded Participants

The three groups of clinicians that will not be subject to MIPS include the following:

1. Those that are in their first year of Medicare Part B participation;

2. Those that have a very low volume of patients (current proposal is Medicare billing charges less than or equal to $10,000, and provides care for 100 or fewer Medicare patients in a year);

3. Certain participants in advanced alternative payment models (APMs).

It is important to note that MIPS does not apply to hospitals or facilities. It applies to individual clinicians. Most participants will not likely be qualifying APM professionals, and will therefore not receive a bonus, but instead, will be subject to MIPS. The Quality Payment Program provides multiple ways for practitioners to be rewarded for responsible practice, and multiple incentives to participate in APMs. In order to avoid duplicate reporting across APMS and MIPS, while still holding APM participants accountable for MIP goals, CMS proposes unique reporting and scoring standards for APM participants who do not become qualified participants (QPs).

Current Quality Programs

The current quality and value reporting programs, including the Physician Quality Reporting System, the Value-Based Payment Modifier Program (VM), and the Medicare Electronic Health Records (EHR) Incentive Program will all sunset in 2018, and the MIPS payment adjustment will begin in 2019, for the proposed performance period of 2017.

MIPS Performance Categories

MIPS is a new program that streamlines the three current independent quality programs to work as one in order to ease clinical burden. It also provides clinicians flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance. Under MIPS, clinicians will be assessed under four weighted performance categories on a 0 to 100 point scale. These four categories will constitute a composite performance score (CPS) for each clinician:

- Quality
- Resource Use
- Clinical Practice Improvement Activities
- Advancing Care Information (deals with EHR usage, and will look similar, but different from the current Medicare EHR program). CMS has renamed this category from Usage of EHR to Advancing Care Information because as it listened to its conversations with physicians and other stakeholders throughout the past 18 months or so, it has found that the usage of the terms meaningful use in EHR isn't really meaningful. Thus, it has rephrased these terms and now refers to the functions included as Advancing Care Information. CMS feels this more accurately reflects what physicians will be doing under the MIPS program.

The CPIA category is new under the MIPS program. The focus here is on quality and resource use. It includes quality improvement activities, shared decision-making, safety checklists, providing after-hours access to care, and care coordination. These activities have occurred at the regional and local levels for years, but this is the first time they will be required under a national skilled program.

MIPS Category Weights

Under MIPS, each category has a specific weight defined by the MACRA law. For year 1, the performance category weights for MIPS will be:

- Quality – 50%
- Resource Use – 10%
- Clinical Practice Improvement Activities – 15%
- Advancing Care Information – 25%

CMS has converted all of the measures and activities to points based off of decile break marks which is based off of a 1 to 10 historical benchmark (if available). CMS will inform physicians of what the benchmarks are and what the overall MIPS performance threshold is prior to the beginning of the performance period. Partial credit will be provided where information and data is available. For all of the categories, CMS has not taken an "all or none" approach. Therefore, percentage points will be provided based off of the data received.

MIPS Scoring

Some of the CMS proposals related to scoring include the following:

- Each performance category has a specific weight;
- Scoring also factors in the availability and applicability of all measures, as well as activities for different types of clinicians for each of the categories;
- Special circumstances that small or solo practitioners face, as well as practices located in rural or underserved areas, and non-patient facing MIPS eligible clinicians and groups.

MIPS Performance Period, Payment Adjustment, and Incentive Payment Formula

The MIPS performance period is 2017 for payments that would be adjusted beginning in 2019. Thus, the first performance period would be from January 1, 2017, through December 31, 2017. A MIPS clinician's payment adjustment percentage is based on the relationship between the CPS and the MIPS performance thresholds. A clinician with a CPS that falls below the performance threshold, will receive a negative MIPS payment adjustment. The total amount of payments that are at risk for the first year is 4%, so the maximum that a clinician's negative adjustment could reach is -4%. A CPS that is less than or equal to 25% of the threshold will yield the maximum negative adjustment of -4%.

Both positive and negative adjustments would increase over time. A CPS that falls at or above the threshold will yield a payment adjustment of 0% upward to +12%, based on the degree to which the CPS exceeds the threshold, and the overall CPS distribution. The 12% comes from the 4% total amount of payment that is available, and the scaling factor of 3. When the 4% is multiplied by the scaling factor, that's how the 12% is reached. Clinicians that have exceptional performance, where the CPS is equal to or greater than an "additional performance threshold" (defined as the 25th percentile of possible values above the CPS performance threshold) can receive an additional bonus, not to exceed 10%.

Eligible clinicians with performance scores above the performance threshold will receive a positive payment adjustment factor. The performance threshold is defined as the level of performance that is established for a performance period at the CPS level. According to the proposed rule, for each year of the MIPS, the Secretary shall compute a performance threshold with respect to which the CPS of MIPS eligible clinicians are compared for purposes of determining the MIPS adjustment factors under section 1848(q)(6)(A) of the Act for a year. The performance threshold for a year must be either the mean or median (as selected by the Secretary, which may be reassessed every three years) of the CPS for all MIPS eligible clinicians for a prior period specified by the Secretary. For the 2019 MIPS payment year, CMS would set the performance threshold at a level where approximately half of the eligible clinicians would be below the performance threshold and half would be above the performance threshold.

Scores are determined based on a linear sliding scale relative to the threshold and the applicable percent. Eligible clinicians with exceptional performance where the CPS is equal to or greater than an "additional performance threshold," defined as the 25th quartile of possible values above the CPS performance threshold, will receive an additional positive adjustment factor. Those with performance scores below the performance threshold will receive a negative payment adjustment factor between zero and negative of the applicable percent. An eligible clinician with scores below a number equivalent to 25% of the performance threshold would receive the maximum reduction. MACRA allows for a potential three times upward adjustment, which is unlikely. Exceptional performers can receive an additional positive adjustment factor.

In the first five payment years of the program, the law allows for $500 million in additional performance bonus that is exempt from budget neutrality for exceptional performance. CMS emphasizes that MACRA is designed to be a budget neutral program, which means that the total upward and downward adjustments will balance each other so that the average change will be 0%. To keep MACRA budget neutral, the law allows for the scaling of the positive adjustment factor of up to three times, either upward or downward. The scaling process will only apply to positive adjustments, not negative.

What Does This Mean for You?

The fee schedule updates are occurring now, and there is currently a 0.5% payment adjustment through 2019. There is no payment adjustment for years 2020 through 2025, and in 2026 onward, if you are part of an APM, you would get a 0.75% payment adjustment. If you are not part of an APM, you would get a 0.25% payment adjustment. Under MIPS, the total amount of payment increases over time. Beginning in 2019, the maximum adjustment is 4%, but it increases to 5% in 2020, 7% in 2021, and 9% from 2022 to 2026 and onward. There is a 5% lump sum incentive bonus associated with being a qualified participant in an advanced APM.

Clinical Practice Improvement Activities Performance Category

This category, in which both individuals and groups can participate, focuses on one of CMS's MIPS strategic goals to use a patient-centered approach to program development that leads to better, smarter, and healthier care. It also fulfills another of its goals, which is to design incentives that drive movement towards delivery system reform principles in APMs. For the CPI category, the menu of proposed activities will be published in an annual list. Clinicians will be able to choose from a variety of activities that best fit their practices. *To view this proposed list of activities, refer to* ***Table H of the***

proposed rule, which is located in the Appendix on page 410 of the pdf, or page 28570 of the hard copy.

Category Specifics

CMS proposes that clinicians complete at least one activity from a proposed set consisting of a little over 90. Completion of more activities can potentially increase the performance score under this category. Activities categorized as "high" or "medium" can earn clinicians 20 or 10 points, respectively. The achievement of 60 points is considered full credit. Clinicians that are part of a nationally recognized certified patient centered medical home, Medical Home, or comparable specialty practice will automatically get the full percentage points available. Those that are part of an APM would get half of the percentage points available, with the opportunity to select additional activities for full credit.

Subcategories of CPIA

Six subcategories are specified by MACRA		Three additional subcategories proposed by the notice of proposed rule making
Expanded Practice Access	Beneficiary Engagement	Achieving Health Equity
Population management	Patient Safety and Practice Assessment	Emergency Preparedness and Response
Care Coordination	Participation in an APM, Including Medical Home Model	Integrated Behavioral and Mental Health

The following table lists the data submission options available when reporting as an individual or as a group.

MIPS Data Submission Options for CPIA Performance Category

Individual Reporting	Group Reporting
Attestation	Attestation
QCDR	QCDR
Qualified Registry	Qualified Registry
EHR	EHR
Administrative claims) if technically feasible, no submission required)	CMS Web Interface (groups of 25 or more)
	Administrative claims) if technically feasible, no submission required)

Data Submission Requirements for CPIA

For the first year, all MIPS eligible clinicians, groups, or third party entities must designate a yes/no response for activities on the CPIA inventory. For third party submissions, MIPS eligible clinicians or groups will certify all CPIAs have been performed, and the health information technology vendor, QCDR, or qualified registry will submit on their behalf. The administrative claims method proposed, if technically feasible, to supplement CPIA submissions. MIPS eligible clinicians or groups, using the telehealth modifier GT, could get automatic credit for this activity.

Scoring Overview

This scoring overview applies to clinicians in groups who are not part of an APM, a patient-centered medical home, or comparable specialty practice, or for a small, rural health professional shortage area (HPSA) and non-patient facing eligible clinicians and groups. To get maximum credit, the total points needed are 60. This can be achieved by selecting a combination of activities. All high-weight activities can be selected, which are worth 20 points each; all medium-weight activities can be selected, which are 10 points each, or a combination of each can be selected to reach 60 points. There will be special scoring considerations for specific types of eligible clinicians and groups.

Scoring Process Summary

CMS provided the following example of how a clinician would calculate a CPIA score if it chose to report a mix of high and low activities:

In order to calculate the CPIA score, the clinician would take the total points for any high-weight activities, and add them to the total points of any medium-weight activities, resulting in the total CPIA points. The clinician would then take the total points and divide them by 60, which results in the total possible CPIA points.

CMS notes that there may be some eligible clinicians who are in an APM like Million Hearts, but may not claim CPIA credit for being in an APM, unless they are also on the participant list for that APM, and have an APM participant identifier. Also, there are some alterations to the CPIA weighting in some circumstances. For the Shared Savings Program, the Next Generation ACO Model, and other MIPS APMs under the APM scoring standards that submit quality data through the CMS web interface, the CPIA is weighted at 20% towards the total performance score. MIPS APMs that do not submit quality data through the CMS web interface would receive 25% towards the total score.

Special Scoring Considerations

CMS outlined some additional scoring considerations:

- Non-patient facing eligible clinicians and groups, small practices (15 or fewer professionals), practices located in rural areas, and geographic HPSAs will receive:
    - 50% of the 60 points for the first activity
    - 100% of the 60 points for the second activity
- APMs reporting in the CPIA performance category

- As proposed in the rule, APM eligible clinicians that are on the APM participant list maintained by CMS will receive half of the highest score if they report that they are in the APM, with opportunities to select additional activities for full credit.

- Certified patient-centered medical homes, comparable specialty practices, or Medical Homes would receive the highest possible score.

Feedback and Review Process

Feedback on performance will be available at least annually, beginning July 1, 2017. Quality and cost performance categories will be addressed. Also, MIPS eligible clinicians or groups will have an opportunity to request a targeted review of the calculation of their payment adjustment.

CMS Study on Practice Improvement and Measurement

MIPS eligible clinicians or groups may elect to join a study examining clinical quality workflows and data capture using a simpler approach to quality measures. Selected participants who complete the study will receive full credit for CPIA. Those interested in volunteering are urged to send a request to the MIPS inquiry mailbox at MacraMipsInquiry@cms.hhs.gov.

Questions and Answers

1. ***Question: Is there any way that CMS will be able to alert physicians who are at or below exceptional levels of care prior to end of the reporting period, so that they will know how well they are doing?***

   Answer: CMS plans to put the performance threshold out later at the end of this year, before the performance period begins, and when that period comes up, then you will know what the points are to get a positive adjustment, and that will drive what it takes to get the exceptional performance threshold.

2. ***Question: Some of the proposed clinical practice improvement activities listed are kind of vague? How will clinicians know whether they meet or exceed these activities or not?***

   Answer: CMS has purposely left these activities broad because it wants to be sure that eligible clinicians over a variety of specialties can participate. CMS sought comment on these activities, and encouraged everyone to submit comments where things are not clear.

3. ***Question: Are clinicians going to need to give a "Yes" or "No" answer to all activities when they do their reporting?***

   Answer: The proposed list is a little over 90 activities. You will not have to do a set number. CMS is proposing a minimum of one, but if you want to do more activities to earn a higher score to get to the 60 points, it is allowing that. Right now, it is a simple attestation, so it would be a "Yes" or "No" response.

4. ***Question: We are a group of 25 providers. A number of our providers are in the HPSA area. We have not made the decision to go GPRO or individual. Would it make a difference if we went GPRO vs. individual when it comes to HPSA scoring?***

   Answer: As you are evaluating your options for group vs. non-group, you might want to look carefully at the whole inventory of activities for your practice, and let CMS know if it makes a difference, if you are categorized one way or the other, on why it makes a difference. Also, there is a ***Flexibility and Support for Small Practices*** fact sheet on the Quality Payment Program page where you will see the flexibilities outlined specifically for rural and small practices. This might be helpful as you start to evaluate your reporting options.

5. ***Question: If I report CPIA as an individual vs group, does it have to be consistently across all categories?***

   Answer: CMS has proposed that you report the same way for all four categories. So, if you report individually, you do it individually for all four categories, if you report as a TIN (tax identification number), you would do it for all four categories; and APMS have their own special scoring logic.

6. ***Question:*** Are chiropractors eligible to participate under MIPS?

   Answer: Depending on your state, you are included in MIPS, so if you are in PQRS, for example, you are most likely included in MIPS.

7. ***Question: What adjustments take place if all the eligible clinicians in America exceed the performance threshold for a given performance year?***

   Answer: It is a budget neutral program, so CMS redistributes the dollars from one side to the other, but it has to consider previous performance when it looks at setting the performance thresholds, so it will look at the data. In a few years, the data is going to be set at the median. CMS has proposed that for the performance threshold this year, it will model the best it can, and set it approximately at the median score. There is $500 million for the exceptional performance money that is not budget neutral, so this money will be redistributed to folks who are beyond the exceptional performance threshold.

8. ***Question: We are a free-standing rural health clinic, but we are also in PCMH through the state of Arkansas. Where does that put us? Can we participate?***

   Answer: In the proposed rule, CMS outlines which patient-centered medical homes would qualify and also sought comment on this. This information can be found in the proposal, on page 28209 of the hard copy, and page 49 of the pdf.

9. ***Question: I am with a billing service in Michigan, and we're a kind of a good sized group. Only three of our clients have even attempted to do PQRS, and all of them have failed at it. Is there somewhere, other than the Federal Register, that clearly states how a provider can go about starting at step one?***

   Answer: This is definitely in the works. CMS know that its communication did not hit the mark in the past, so it has done a ton of user research to outline, in a comprehensive way that makes sense, here is where you start to get to where you need to be. Pretty soon, you will see this information roll out a little closer to the final rule.

More Information

For more ways to learn about the Quality Payment Programs, including MIPS information, visit https://go.cms.gov/qualitypaymentprogram. This site includes details on scheduled open door forums, webinars, and more. CMS is also organizing groups across the country to help clinicians as they get ready for this program.