On October 14, 2016, CMS released the final rule on the Quality Payment Program, which includes both the Merit-Based Incentive Payment Program (MIPS) and Advanced Alternative Payment Models (APMs). The final rule establishes regulations on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), signed into law in April 2015. The new law changes the way Medicare incorporates quality measurement into payments and develops incentives for participation in alternative payment models.

For the first performance year of MIPS, 2017, CMS is providing several different options for providers to choose their participation level and performance period.

To avoid a penalty for 2019, in 2017, providers can choose to report either:
  • One quality measure for one patient, and not have to meet the measure benchmark, or
  • One improvement activity, or
  • The required base measures for Advancing Care Information.

To be eligible for a small bonus, providers can choose to report for at least 90 days:
  • Two or more quality measures on at least one patient, and not have to meet the measure benchmarks, or
  • More than one improvement activity, or
  • The required base measures and additional performance measures for Advancing Care Information.

Providers who report all the required measures and meet the thresholds and benchmarks in each of the categories for at least 90 days—or up to the full year—have the greatest potential for a larger bonus.

This guide is developed for ASCRS•ASOA members to familiarize themselves with the full requirements of the Improvement Activities category, and to assist them in choosing the best participation option for their practice. ASCRS also has developed guides on the other three categories of MIPS. In addition, ASCRS•ASOA has developed a guide on Advanced APMs and MIPS APMs. Physicians participating in MIPS APMs, such as Medicare Shared Savings Track 1 ACOs, should consult that guide for details regarding their scoring under the MIPS program.

**Improvement Activities Category Weight – 15%**

For 2017, the first performance year of MIPS, CMS will weight a provider’s Improvement Activities score at 15% of the overall MIPS composite score.

**Improvement Activities Reporting Requirements**

Physicians must achieve a total of 40 points from improvement activities during a 90-day reporting period. CMS will score individual improvement activities as either high- or medium-weighted. High-weighted activities are worth 20 points, while medium-weighted activities are worth 10 points. Providers are required to perform four medium-weighted or two high-weighted activities, or any combination of high- or medium-weighted activities for 2017.
Physicians in groups of 15 or fewer are only required to complete one high-weighted or two medium-weighted activities for full credit—40 points—for the category. For small practices, CMS will weigh the improvement activities at double the value for larger practices. Therefore, high-weighted activities are worth 40 points, while medium-weighted activities are worth 20 points. Providers in groups of 15 or fewer can achieve half of the total category score by completing one medium-weighted improvement activity.

Providers participating in a patient-centered certified medical home will automatically receive full credit for the Improvement Activities category of MIPS. Providers participating in an Advanced Alternative Payment Model (APM) will receive 50% of the full score for the improvement activities category of MIPS.

**Improvement Activities Score**

To determine a provider’s Improvement Activities category score, CMS will divide the sum of the points earned by the provider by 40, the total available points for the category. The improvement activities category score would then be counted as 15% of the MIPS composite score.

Despite opposition from ASCRS and the medical community in comments on the proposed rule, CMS will assign scores based on providers’ performance or improvement on improvement activities in future years. Since there is no current analogous program to improvement activities to develop baseline performance or benchmarks, CMS will not score performance for the first year.

**Improvement Activities**

The final rule includes a list of individual improvement activities. The activities are grouped in eight sub-categories corresponding to CMS’ stated goals. Providers may choose any combination of improvement activities, regardless of category.

The categories and examples of activities included are listed below:

- **Expanded Practice Access**: Improvement Activities include expanded practice hours, telehealth services, and participation in models designed to improve access to services.
- **Population Management**: Improvement Activities include participation in chronic care management programs, participation in rural and Indian Health Services programs, participation in community programs with other stakeholders to address population health, and use of a Qualified Clinical Data Registry (QCDR) to track population outcomes.
- **Care Coordination**: Improvement Activities include use of a QCDR to share information, timely communication and follow up, participation in various CMS models designed to improve care coordination, implementation of care coordination training, implementation of plans to handle transitions of care, and active referral management.
- **Beneficiary Engagement**: Improvement Activities include use of EHR to document patient-reported outcomes, providing enhanced patient portals, participation in a QCDR that promotes the use of patient engagement tools, and use of QCDR patient experience data to inform efforts to improve beneficiary engagement.
- **Patient Safety and Practice Assessment**: Improvement Activities include use of QCDR data for ongoing practice assessments and patient safety improvements, and use of tools such as the Surgical Risk Calculator.
- **Achieving Health Equity**: Improvement Activities include seeing new and follow-up Medicaid patients in a timely manner, and use of QCDR for demonstrating performance of processes for screening for social determinants.
- **Emergency Response and Preparedness**: Improvement Activities include participation in disaster medical teams or participation in domestic or international humanitarian volunteer work.
- **Integrated Behavioral and Mental Health**: Improvement Activities include tobacco intervention and smoking cessation efforts, and integration with mental health services.

For the full list of proposed improvement activities, please refer to Table H of the final rule: [https://qpp.cms.gov/docs/CMS-5517-FC.pdf](https://qpp.cms.gov/docs/CMS-5517-FC.pdf)

**Data Submission**
Providers can submit improvement activities data using the following mechanisms: qualified registry, EHR, QCDR, CMS Web Interface, and attestation data submission mechanisms. CMS will be releasing additional guidance for how to submit data through its attestation system. If technically feasible, CMS will use administrative claims data to supplement improvement activities submissions in future years.

For the first performance year, all submission mechanisms must designate a “yes/no” response for submitting improvement activities.

Additional Resources

For additional information, you may contact Allison Madson, manager of regulatory affairs, at amadson@ascrs.org or 703-591-2220.