Merit-Based Incentive Payment System (MIPS)

Resource Guide

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CONTENTS

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

STATE ASSOCIATIONS OF ADDICTION SERVICES

Stronger Together.

SECTION 1

MIPS and Who It Applies To

The Medicare and CHIP Reauthorization Act (MACRA) of 2015 created sweeping reforms to reimbursement to providers under Medicare Part B and establishes the Medicare Quality Payment Program. The Quality Payment Program outlines two pathways for providers participating in Medicare Part B: Advanced Alternative Payment Models and the Merit-Based Incentive Payment Program (MIPS). The vast majority of providers will be reimbursed under MIPS. This MIPS Resource Guide includes a readiness checklist, details related to the performance reporting categories, and information on specific reporting options available to providers.

All of the information provided in this MIPS Resource Guide is based on detail in proposed rulemaking issued by the Centers for Medicare and Medicaid Services in April 2016. A final rule is expected by November 2016, for an effective date of January 1, 2017. The National Council will update this document once the final rule is released.

About MIPS

MIPS collapses three existing quality reporting programs into one, while adding a fourth category:

- The **Physician Quality Reporting System** (PQRS) becomes **Quality** under MIPS, and requires eligible clinicians to report certain quality measures on an annual basis.
- The **Value-based Payment Modifier Program** (VM) becomes **Resource Use** under MIPS, and compares costs to treat similar care episodes and clinical condition groups across practices.
- The **Medicare Electronic Health Record** (EHR) incentive program becomes **Advancing Care Information** under MIPS, and retains an emphasis on interoperability and information exchange.
- A brand-new reporting area is **Clinical Practice Improvement Activities** (CPIA), which rewards practices that engage in quality improvement activities, including for their Medicaid and other non-Medicare patient populations.

Each of the four categories listed above are weighted and collectively form a Composite Performance Score (CPS) on a scale from 0-100. The CPS will be used to compare practices and inform payment adjustments.

MIPS-Eligible Clinicians

Clinicians that will be counted for the 2017 reporting year include physicians (including psychiatrists), nurse practitioners, physician assistants, clinical nurse specialists and nurse anesthetists.

In 2017, MIPS does **NOT** apply to:

- Clinical psychologists & licensed clinical social workers (LCSWs)
- First-year Medicare providers
- Qualifying Advanced APM clinicians
- Hospitals and facilities (e.g., skilled nursing facilities)
- Clinicians who fall beneath CMS's low-volume threshold, who serve fewer than 100 Medicare recipients and bill Medicare less than $10,000 per year.
- Clinicians and groups who are not paid under the Physician Fee Schedule (e.g., FQHCs and partial hospitalization programs); MIPS does not apply to Managed Care payments.

Although they are not considered eligible in 2017, the proposed rule states that clinical psychologists and LCSWs may be added to the MIPS eligible clinician list in 2019.

SECTION 2

Preparation Checklist

Start NOW and Keep Going

1

Determine if you're eligible for MIPS.

- Is your organization below the low-volume threshold of seeing fewer than 100 Medicare patients and billing Medicare less than $10,000 per year, per eligible clinician?
- Is 2017 your first year billing Medicare Part B using the physician fee schedule?
- If your organization an FQHC, hospital or facility (i.e. a skilled nursing facility)?

If the answer is yes to any of these questions, MIPS does NOT apply to you in 2017.

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If MIPS does NOT apply to you, learn as much as you can anyway.

Value-based payments are an important goal for all the major payers, not just Medicare. To meet these demands, all behavioral health organizations will need to cultivate an organizational culture that embraces change, and develop the infrastructure needed to measure progress, demonstrate value and improve health outcomes.

3

Educate your team.

Share information with practice administrators, clinicians and support staff. Make sure they understand how CMS will measure MIPS eligible clinicians' performance, and how MIPS may affect Medicare reimbursements starting in 2019.

(See http://www.thenationalcouncil.org/macra/ for helpful resources)

4

Connect with the CMS-funded Transforming Clinical Practice Initiative (TCPI).

TCPI supports 29 Practice Transformation Networks and Support and Alignment Networks across the country, which provide resources and technical support to help practices improve quality of care, reduce costs, and prepare for value-based payment arrangements. Visit http://www.healthcarecommunities.org/ or contact the National Council to learn more.

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Stay Up-to-Date

CMS will release the final rule in November, but will likely update requirements on an annual basis. The National Council will help you stay informed so you can meet your requirements every year. Subscribe to the National Council's Capitol Connector blog, register for our MACRA webinar series, and check out our website's MACRA resources.

Quality

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If your practice currently participates in PQRS…

- What type of feedback have you received on your prior performance? (If you have not already received feedback via your Quality and Resource Use Report (QRUR), refer to CMS guidance here).
- What can you do to improve your performance? Remember: Unlike PQRS, MIPS is not a pay-for-reporting mechanism. The data you submit for each quality measure will be compared to benchmarks in order to determine your Quality score. The baseline period for deriving benchmarks will be two years prior to the performance year, which will enable CMS to publish measure benchmarks prior to the start of the relevant performance year.
- Review the MIPS quality measures, including the Behavioral/Mental Health measure set. Which quality measures would make the most sense for your practice to report on in 2017? (Don't forget to identify at least one cross-cutting and one outcome/high-priority measure).

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If your practice does NOT currently participate in PQRS…

- Review the MIPS quality measures, including the Behavioral/Mental Health measure set.
- Which quality measures would make the most sense for your practice to report on in 2017?
- Work with your staff to determine how you will incorporate data collection into current workflows.
- Start collecting data and measuring performance on 1-2 of your chosen measures to start. Determine your baseline so you know how much you will need to improve your performance once CMS determines performance thresholds for each measure.
- Note: If your practice does NOT participate in PQRS in 2017, you may receive a negative payment adjustment in 2018.

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Keep an eye out for the MACRA final rule.

MIPS will likely include a process similar to the Metric Applicability Validation (MAV) process under PQRS. CMS will use this process to determine the Quality performance score for MIPS eligible clinicians who are not able to report on the minimum six quality measures. This may include many behavioral health care providers, since there are so few behavioral health-related quality indicators. You can stay on top of the final rule by subscribing to the National Council's Capitol Connector blog and checking out our website at http://www.thenationalcouncil.org/macra/.

Resource Use

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Understand your cost of care.

If your practice participated in PQRS last year, review your Quality and Resource Use Report (QRUR). This report explains your performance in terms of cost and quality so you can prioritize areas for improvement. (If you have not received your QRUR, please refer to CMS's guidance on how to obtain it).

Note: CMS will assess performance in the Resource Use performance category using measures based on administrative Medicare claims data. Therefore, MIPS eligible clinicians are not required to independently report for this category.

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If you cannot report in this category, pay extra attention to your performance in the Quality category.

If an individual clinician or group cannot report on Resource Use (i.e. s/he does not have enough attributed cases to meet the proposed case minimum of 20 for the total per capita cost measure) BUT s/he reports on at least three quality measures, CMS proposes to take the Resource Use weight (10%) and add it to the Quality category, which would then be worth 60% of your total score.

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Keep an eye on the final rule.

While CMS intends to include several clinical condition and treatment episode-based measures in the Resource Use category, the proposed rule did not include clinical condition groupings or treatment episode-based measures that apply to behavioral health. This may change in the final rule. Stay up-to-date at http://www.thenationalcouncil.org/macra/.

Advancing Care Information

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If you have an EHR, make sure it is certified EHR technology (CEHRT)

A well-designed CEHRT can help you fulfill current quality reporting requirements and provide real-time summaries of your progress on quality measures. If you have an EHR, determine whether it is 2014- or 2015- edition certified—the version will determine your reporting measures in 2017.

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If you do NOT have an EHR, use a qualified clinical data registry.

CMS defines a qualified clinical data registries (QCDR) as an approved entity that collects medical and/or clinical data for the purpose of patient and disease tracking to improve the quality of patient care. They can streamline reporting, help you identify high-risk populations, and make targeted improvements in clinical practice. CMS approved this list of QCDRs for reporting in 2016.

(Note: Using a QCDR will earn you 20 points under the Clinical Practice Improvement Activity performance category)

Clinical Practice Improvement Activities (CPIAs)

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Review the list of Clinical Practice Improvement Activities (see page 15).

- Which quality improvement activities do you currently have in place? How many points would they earn for your practice?
- Would any of your current quality improvement activities need to be modified to comply with CMS's definition?
- If your organization is currently not engaging in any quality improvement activities, or is not engaging in enough activities to earn a full 60 points, which activities would be the easiest to implement, and make the most sense for your practice?

15 Subscribe to the BHive to stay abreast of upcoming practice improvement projects offered by the National Council. Contact Communications@thenationalcouncil.org to sign up!

SECTION 3

Quality Performance Category (50%)

For the 2017 reporting year, the Quality Performance Category is worth 50% of the Composite Performance Score. An adaptation of the Physician Quality Reporting System (PQRS) program, the MIPS Quality category requires clinicians to choose six measures to report that best reflect their practice. One measure must be a "cross cutting" measure, and at least one must be an outcome or other high-priority measure.

Clinicians may report measures from the Mental/Behavioral Health Specialty Set to fulfill this requirement (see Table 1), but MIPS provides a very limited number of behavioral health-related quality measures. If a clinician/group can only report on fewer than six measures, CMS may reduce the weight of the Quality category and reassign the missing weight proportionally to other performance categories.

Table 1. **MIPS Mental/Behavioral Health Quality Indicators**

Anti-Depressant Medication Management	Percentage of patients 18 years of age and older who were diagnosed with major depression and treated with antidepressant medication, and who remained on antidepressant medication treatment. **Two rates are reported:** a. Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks) b. Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months)
Screening for Clinical Depression & Follow-Up Plan	Percentage of patients aged 12 years and older screened for clinical 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 screen.
Elder Maltreatment Screen & Follow-Up Plan	Percentage of patients aged 65 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening Tool on the date of encounter AND a documented follow-up plan on the date of the positive screen

Dementia: Cognitive Assessment	Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period
Dementia: Functional Status Assessment	Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of functional status is performed and the results reviewed at least once within a 12 month period
Dementia: Neuropsychiatric Symptom Assessment	Percentage of patients, regardless of age, with a diagnosis of dementia and for whom an assessment of neuropsychiatric symptoms is performed and results reviewed at least once in a 12 month period
Dementia: Management of Neuropsychiatric Symptoms	Percentage of patients, regardless of age, with a diagnosis of dementia who have one or more neuropsychiatric symptoms who received or were recommended to receive an intervention for neuropsychiatric symptoms within a 12 month period
Dementia: Counseling Regarding Safety Concerns	Percentage of patients, regardless of age, with a diagnosis of dementia or their caregiver(s) who were counseled or referred for counseling regarding safety concerns within a 12 month period
Dementia: Caregiver Education & Support	Percentage of patients, regardless of age, with a diagnosis of dementia whose caregiver(s) were provided with education on dementia disease management and health behavior changes AND referred to additional sources for support within a 12 month period
Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions	Percentage of medical records of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) and a specific diagnosed comorbid condition (diabetes, coronary artery disease, ischemic stroke, intracranial hemorrhage, chronic kidney disease [stages 4 or 5], End Stage Renal Disease [ESRD] or congestive heart failure) being treated by another clinician with communication to the clinician treating the comorbid condition
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescriptions filled for any antipsychotic medication and who had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months)
Follow-up After Hospitalization for Mental Illness	The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. **Two rates are reported:** a. The percentage of discharges for which the patient received follow-up within 30 days of discharge b. The percentage of discharges for which the patient received follow-up within 7 days of discharge

SECTION 4

Resource Use Performance Category (10%)

For the 2017 reporting year, the Resource Use Performance Category is worth 10% of the Composite Performance Score. An adaptation of the Value-based Modifier payment program, this category compares one MIPS eligible clinician's Medicare Part B charges for care episodes or clinical condition groups against other providers' charges. The MACRA proposed rule states that clinicians will be assessed under all available resource use measures as applicable to the clinician, but the proposed rule does not include any behavioral health-related measures.

A clinician or group practice's Resource Use score is based on a CMS claims analysis and does not require independent reporting. If an individual clinician or group cannot report in this category and reports on at least three quality measures, the Resource Use weight will be added to the Quality category (60%).

Value Modifier	Resource Use
6 measures: Total per capita costs for all attributed beneficiaries, Medicare Spending per Beneficiary (MSPB)	2 of the 6 VM measures: Total per capita costs for all attributed beneficiaries, Medicare Spending per Beneficiary (MSPB)
Total per capita cost measures for the four condition-specific groups (chronic obstructive pulmonary disease, congestive heart failure, coronary artery disease, and diabetes mellitus). No episodes used for payment.	Removes total per capita cost measures for the four condition-specific groups.No episodes used for payment. 41 episodes proposed representing a large portion of Medicare charges.
Attribution to the group practice (TIN)	Attribution to group (TIN) or individual (TIN/NPI)

SECTION 5
Advancing Care Information Performance Category (25%)

For the 2017 reporting year, the Advancing Care Information Performance Category is worth 25% of the Composite Performance Score. Under the Merit-Based Incentive Payment System (MIPS), the Advancing Care Information (ACI) performance category replaces the Medicare EHR Incentive Program, often called "Meaningful Use." The ACI performance score comprises 25% of each MIPS eligible clinician or group's Composite Performance Score. The ACI score includes a base score and performance score, and the potential to earn bonus points. Although a MIPS eligible clinician or group may earn up to 131 points, the maximum score in this category is 100.

Meaningful Use	Advancing Care Information
Must report on all objective and measure requirements	Streamlines measures and emphasizes interoperability, information exchange and security measures. Clinical Decision Support and Computerized Provider Order Entry are no longer required.
One size fits all; all measures reported and weighed equally	Customizable—MIPS eligible clinicians can choose which measures fit their practice
All-or-nothing EHR measurement and quality reporting	Flexible—multiple paths to success
Misaligned with other Medicare reporting programs	Aligned with other Medicare reporting programs. No need to report quality measures as part of this category

BASE SCORE (50%)

CMS proposes six objectives, which were adopted in the 2015 EHR Incentive Programs Final Rule for Stage 3:

- Protect Patient Health Information
- Electronic Prescribing
- Patient Electronic Access to Health Information
- Care of Coordination Through Patient Engagement
- Health Information Exchange
- Public Health and Clinical Data Registry Reporting

To receive the full base score of 50 points, MIPS eligible clinicians must simply provide the numerator/denominator or yes/no for each objective and measure (See Table 4).

Note: Because of the importance of protecting patient privacy and security, MIPS eligible clinicians must be able to report "yes" to the Protect Patient Health Information objective to receive any score in the ACI performance category. Also, failure to meet the submission criteria and measure specifications for any measure in any of the objectives would result in an ACI performance category score of zero.

Table 4. **Advancing Care Information Score Objectives and Measures**	
Protect Patient Health Information	Protect electronic protected health information (ePHI) created or maintained by the certified EHR technology through the implementation of appropriate technical, administrative, and physical safeguards.
Security Risk Analysis Measure	Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI data created or maintained by certified EHR technology in accordance with requirements in 45 CFR164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the MIPS eligible clinician's risk management process.
Electronic Prescribing	MIPS eligible clinicians must generate and transmit permissible prescriptions electronically.
ePrescribing Measure	At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using certified EHR technology. • **Denominator:** Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the performance period; or number of prescriptions written for drugs requiring a prescription in order to be dispensed during the performance period. • **Numerator:** The number of prescriptions in the denominator generated, queried for a drug formulary, and transmitted electronically using certified EHR technology
Patient Electronic Access	The MIPS eligible clinician provides patients (or patient authorized representative) with timely electronic access to their health information and patient-specific education.
Patient Access Measure	For at least one unique patient seen by the MIPS eligible clinician: (1) The patient (or the patient authorized representative) is provided timely access to view online, download, and transmit his or her health information; and (2) The MIPS eligible clinician ensures the patient's health information is available for the patient (or patient— authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programing Interface (API) in the MIPS eligible clinician's certified EHR technology. • **Denominator:** The number of unique patients seen by the MIPS eligible clinician during the performance period. • **Numerator:** The number of patients in the denominator (or patient authorized representative) who are provided timely access to health information to view online, download, and transmit to a third party and to access using an application of their choice that is configured meet the technical specifications of the API in the MIPS eligible clinician's certified HER technology.
Patient-Specific Education Measure	The MIPS eligible clinician must use clinically relevant information from certified EHR technology to identify patient-specific educational resources and provide electronic access to those materials to at least one unique patient seen by the MIPS eligible clinician.

	• **Denominator:** The number of unique patients seen by the MIPS eligible clinician during the performance period. • **Numerator:** The number of patients in the denominator who were provided electronic access to patient-specific educational resources using clinically relevant information identified from certified EHR technology during the performance period
Coordination of Care Through Patient Engagement	Use certified EHR technology to engage with patients or their authorized representatives about the patient's care.
View, Download or Transmit (VDT) Measure	During the performance period, at least one unique patient (or patient-authorized representatives) seen by the MIPS eligible clinician actively engages with the EHR made accessible by the MIPS eligible clinician. An MIPS eligible clinician may meet the measure by either—(1) view, download or transmit to a third party their health information; or (2) access their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the MIPS eligible clinician's certified EHR technology; or (3) a combination of (1) and (2). • **Denominator:** The number of unique patients seen by the MIPS eligible clinician during the performance period. • **Numerator:** The number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient's health information during the performance period and the number of unique patients (or their authorized representatives) in the denominator who have accessed their health information through the use of an API during the performance period.
Secure Messaging Measure	For at least one unique patient seen by the MIPS eligible clinician during the performance period, a secure message was sent using the electronic messaging function of certified EHR technology to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative). • **Denominator:** The number of unique patients seen by the MIPS eligible clinician during the performance period. • **Numerator:** The number of patients in the denominator for whom a secure electronic message is sent to the patient (or patient-authorized representative) or in response to a secure message sent by the patient (or patient-authorized representative), during the performance period.
Patient-Generated Health Data Measure	Patient-generated health data or data from a non-clinical setting is incorporated into the certified EHR technology for at least one unique patient seen by the MIPS eligible clinician during the performance period. • **Denominator:** The number of unique patients seen by the MIPS eligible clinician during the performance period. • **Numerator:** The number of patients in the denominator for whom data from nonclinical settings, which may include patient-generated health data, is captured through the certified EHR technology into the patient record during the performance period.

Health Information Exchange	The MIPS eligible clinician provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other health care providers into their EHR using the functions of certified EHR technology.
Patient Care Record Exchange Measure	For at least one transition of care or referral, the MIPS eligible clinician that transitions or refers their patient to another setting of care or health care provider—(1) creates a summary of care record using certified EHR technology; and (2) electronically exchanges the summary of care record. • **Denominator:** Number of transitions of care and referrals during the performance period for which the MIPS eligible clinician was the transferring or referring clinician. • **Numerator:** The number of transitions of care and referrals in the denominator where a summary of care record was created using certified EHR technology and exchanged electronically
Request/Accept Patient Care Record Measure	For at least one transition of care or referral received or patient encounter in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician receives or retrieves and incorporates into the patient's record an electronic summary of care document. • **Denominator:** Number of patient encounters during the performance period for which a MIPS eligible clinician was the receiving party of a transition or referral or has never before encountered the patient and for which an electronic summary of care record is available. • **Numerator:** Number of patient encounters in the denominator where an electronic summary of care record received is incorporated by the clinician into the certified EHR technology.
Clinical Information Reconciliation Measure	For at least one transition of care or referral received or patient encounter in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician performs clinical information reconciliation. The clinician must implement clinical information reconciliation for the following three clinical information sets: (1) Medication. Review of the patient's medication, including the name, dosage, frequency, and route of each medication. (2) Medication allergy. Review of the patient's known medication allergies. (3) Current Problem list. Review of the patient's current and active diagnoses. • **Denominator:** Number of transitions of care or referrals during the performance period for which the MIPS eligible clinician was the recipient of the transition or referral or has never before encountered the patient. • **Numerator:** The number of transitions of care or referrals in the denominator where the following three clinical information reconciliations were performed: Medication list, medication allergy list, and current problem list.
Public Health and Clinical Data	The MIPS eligible clinician is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice. (Note: MIPS eligible clinicians can only earn up to one bonus point)

(Required) Immunization Registry Reporting Measure	The MIPS eligible clinician is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).
OPTIONAL (Worth one bonus point)	**Syndromic Surveillance Reporting Measure:** The MIPS eligible clinician is in active engagement with a public health agency to submit syndromic surveillance data from a non-urgent care ambulatory setting where the jurisdiction accepts syndromic data from such settings and the standards are clearly defined. **Electronic Case Reporting Measure:** The MIPS eligible clinician is in active engagement with a public health agency to electronically submit case reporting of reportable conditions. **Public Health Registry Reporting Measure:** The MIPS eligible clinician is in active engagement with a public health agency to submit data to public health registries. **Clinical Data Registry Reporting Measure:** The MIPS eligible clinician is in active engagement to submit data to a clinical data registry.

Performance Score

MIPS eligible clinicians can select the performance score measures that best fit their practice from three objectives —Patient Electronic Access, Coordination of Care through Patient Engagement, and Health Information Exchange. Each measure would be assigned a total of 10 possible points. For each measure, a MIPS eligible clinician may earn up to 10 percent of their performance score based on their performance rate for the given measure.

For example, a performance rate of 95 percent on a given measure would earn 9.5 percentage points of the performance score for the ACI performance category. Table 5 provides an example of the proposed performance score methodology.

Table 5. Sample Advancing Care Information Performance Score

Objectives	Patient Electronic Access		Coordination of Care Through Patient Engagement			Health Information Exchange (HIE)		
Measures	Patient Access	Patient-specific Education	View, Download or Transmit (VDT)	Secure Messaging	Patient-generated health data	Patient Care Record Exchange	Request/ Accept Patient Care Record	Clinical Information Reconciliation
Performance Rate Score	95%	65%	33%	31%	25%	22%	38%	57%
Percentage Points Earned	9.5%	6.5%	3.3%	3.1%	2.5%	2.2%	3.8%	5.7%
Performance Score	**36.5%**							

Total Score (100%)

To determine the MIPS eligible clinician's overall ACI performance category score, CMS will use the sum of the base score, performance score, and the potential Public Health and Clinical Data Registry Reporting bonus point (see below). If the sum of the MIPS eligible profession's base score (50 percent) and performance score (out of a possible 80 percent) with the Public Health and Clinical Data Registry Reporting bonus point are greater than 100 percent, CMS will apply an ACI performance category score of 100 percent.

SECTION 6

Clinical Practice Improvement Activity Performance Category (15%)

For the 2017 reporting year, the Clinical Practice Improvement Activity (CPIA) Performance Category is worth 25% of the Composite Performance Score. CPIA is a new performance category enables clinicians to choose from a list of more than 90 quality improvement activities and determine which ones best suit their practice. CPIAs fall into nine categories (see below). MIPS eligible clinicians may choose activities within the Integrated Behavioral and Mental Health category (Table 2) or other CPIAs that apply to behavioral health care (Table 3), including participation in CMS's four-year Transforming Clinical Practice Initiative. "Medium" weighted CPIAs are worth 10 points, and "high" weighted CPIAs are worth 20 points. MIPS eligible clinicians/groups can earn up to 60 points in this performance category.

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 a medical home model	Integrated Behavioral and Mental Health

Table 2. **Integrated Behavioral and Mental Health CPIAs**	
Activity	**Weight***
Diabetes screening for people with schizophrenia or bipolar disease who are using anti-psychotic medication	Medium
Tobacco use: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and 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	Medium
Unhealthy alcohol use: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including screening and brief counseling (refer to NQF #2152) for patients with co-occurring conditions of behavioral or mental health conditions.	Medium
Major depressive disorder: Regular engagement of MIPS eligible clinicians or groups in integrated prevention and treatment interventions, including suicide risk assessment (refer to NQF #0104) for mental health patients with co-occurring conditions of behavioral or mental health conditions	Medium
Integration facilitation, and promotion of the colocation of mental health services in primary and/or non-primary clinical care settings	High
Enhancements to an electronic health record to capture additional data on behavioral health (BH) populations and use that data for additional decision-making purposes (e.g., capture of additional BH data results in additional depression screening for at-risk patient not previously identified).	Medium
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	Medium
Offer integrated behavioral health services to support patients with behavioral health needs, dementia, and poorly controlled chronic conditions that could include one or more of the following: • Use evidence-based treatment protocols and treatment to goal where appropriate; • Use evidence-based screening and case finding strategies to identify individuals at risk and in need of services; • Ensure regular communication and coordinated workflows between eligible clinicians in primary care and behavioral health; • Conduct regular case reviews for at-risk or unstable patients and those who are not responding to treatment; • Use of a registry or certified health information technology functionality to support active care management and outreach to patients in treatment; and/or • Integrate behavioral health and medical care plans and facilitate integration through co-location of services when feasible.	High

*Medium weight = 10 points; High weight = 20 points

Table 3. **Select CPIAs that are Relevant to Behavioral Health Care**		
Category	**Activity**	**Weight**
Expanded Practice Access	Provide 24/7 access to MIPS eligible clinicians, eligible 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)	HIgh
Expanded Practice Access	Use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consults, or tele-audiology pilots that assess ability to still deliver quality care to patients	Medium
Expanded Practice Access	Collection of patient experience and satisfaction data on access to care and development of an improvement plan, such as outlining steps for improving communications with patients to help understanding of urgent access needs	Medium
Population Management	Use of a Qualified Clinical Data Registry to generate regular feedback reports that summarize local practice patterns and treatment outcomes, including for vulnerable populations.	High
Population Management	Participation in research that identifies interventions, tools or processes that can improve a targeted patient population	Medium
Population Management	Empanel (assign responsibility for) the total population, linking each patient to a MIPS eligible clinician or group or care team.	Medium
Population Management	Implementation of regular reviews of targeted patient population needs which includes access to reports that show unique characteristics of eligible professional's patient population, identification of vulnerable patients, and how clinical treatment needs are being tailored, if necessary, to address unique needs and what resources in the community have been identified as additional resources.	Medium
Population Management	Provide longitudinal care management to patients at high risk for adverse health outcome or harm	Medium
Population Management	Provide episodic care management, including management across transitions and referrals	Medium
Care Coordination	Participation in the CMS Transforming Clinical Practice Initiative	High
Care Coordination	Membership and participation in a CMS Partnership for Patients Hospital Engagement Network	Medium
Care Coordination	Implementation of regular care coordination training.	Medium
Beneficiary Engagement	Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan	High
Beneficiary Engagement	Participation in a QCDR, demonstrating performance of activities that promote implementation of shared clinical decision making capabilities	Medium

Category	Activity	Weight
Beneficiary Engagement	Use evidence-based decision aids to support shared decision-making	Medium
Beneficiary Engagement	Regularly assess the patient experience of care through surveys, advisory councils, and/or other mechanisms	Medium
Beneficiary Engagement	Engage patients and families to guide improvement in the system of care.	Medium
Beneficiary Engagement	Provide peer-led support for self-management.	Medium
Beneficiary Engagement	Provide condition-specific chronic disease self-management support programs or coaching or link patients to those programs in the community	Medium
Beneficiary Engagement	Provide coaching between visits with follow-up on care plan and goals.	Medium
Beneficiary Engagement	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	Medium
Achieving Health Equity	Collection and follow-up on patient experience and satisfaction data on beneficiary engagement, including development of improvement plan	High
Patient Safety and Practice Assessment	Use of QCDR data, for ongoing practice assessment and improvements in patient safety.	Medium
Patient Safety and Practice Assessment	Completion of training and obtaining an approved waiver for provision of medication –assisted treatment of opioid use disorders using buprenorphine.	Medium
Patient Safety and Practice Assessment	Ensure full engagement of clinical and administrative leadership in practice improvement	Medium
Patient Safety and Practice Assessment	Adopt a formal model for quality improvement and create a culture in which all staff actively participates in improvement activities	Medium

SECTION 7

Reporting Mechanisms for MIPS Categories

Depending on how you choose to report—as an individual or group--MIPS data can be reported through several different mechanisms, which vary slightly by performance category (Table 6).

Table 6. Group and Individual MIPS Reporting Mechanisms by Performance Category

	Individual Reporting	Group Reporting
Quality	• Claims • QCDR • Qualified registry • EHR • Administrative claims (no submission required)	• Qualified Clinical Data Registry (QCDR) • Qualified registry • EHR • CMS Web Interface (groups of 25 or more) • CMS-approved survey vendor for CAHPS for MIPS (must be reported in conjunction with another data submission mechanism) • Administrative claims (no submission required)
Advancing Care Information	• Attestation • QCDR • Qualified registry • EHR	• Attestation • QCDR • Qualified registry • EHR • CMS Web Interface (groups of 25 or more)
Clinical Practice Improvement Activities	• Attestation • QCDR • Qualified registry • EHR • Administrative claims (if feasible, no submission required)	• Attestation • QCDR • Qualified registry • EHR • CMS Web Interface (groups of 25 or more) • Administrative claims (if technically feasible, no submission required)
Resource Use	No independent reporting required for individuals or group practices	

SECTION 8

Additional Resources

National Council for Behavioral Health

MACRA webpage: www.TheNationalCouncil.org/MACRA

MACRA Webinar Series

MACRA Fact Sheet

Capitol Connector Blog

Centers for Medicare and Medicaid Services (CMS)

MACRA Proposed Rule

Overview of the MACRA Quality Payment Program

Quality Payment Program Presentation

Transforming Clinical Practice Initiative

Flexibilities and Support for Small Practices

CMS Quality Measure Development Plan

Advancing Care Information Performance Category presentation

Resource Use Performance Category presentation

Clinical Practice Improvement Performance Category presentation

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QUESTIONS?

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