Succeed Under MACRA Medicare: How to Meet CPIAs for Full Credit in MIPS

written by Theresa Hush | July 6, 2016

Although many parts of MACRA's MIPS continue Medicare's existing quality programs, Clinical Performance Improvement Activities (CPIAs) forge a new direction. CPIAs are one of four MIPS components that practices must meet in order to obtain full reimbursement from Medicare.

Forward planning is essential. It takes time to strategize and implement performance improvements, including partnerships and technology. To make this happen in 2017—the base year for performance measurement—providers must prepare before the MACRA rules are finalized.

CPIAs are a unique sign of Medicare's intent to hold practices accountable for improving health care outcomes. That's a significant step in Medicare's evolving role as an agent in health care delivery transformation and away from fiduciary or insurance functions. Even in the MIPS program, which remains fee for service, Medicare will insist that practices take active steps to change how they manage patient care.

Currently most providers perceive Medicare's Value-Based Health Care efforts such as PQRS and Meaningful Use as time-consuming, costly administrative efforts to report quality. The Value Modifier program, calculated by Medicare and focused on performance in cost and quality, was not even on the radar for many providers, who never understood the important role it played in their reimbursement—or, why they had to deal with it at all.

Proposed MACRA Rules attempt to change all that. The new Quality Payment Programs under

MACRA, both MIPS and APMs, foster models of care that are intended to point every practice in the direction of improvement. Since most providers, even those in ACOs, will participate in the MIPS program initially, the MIPS scoring structure is designed to get providers in motion for the next phase, which is Risk. CPIAs are the mechanism for that transition.

What Counts as a Clinical Performance Improvement Activity?

CMS will be creating an inventory of CPIAs that can be met by various practice types and specialties. That list of activities and assignment of value to specific CPIAs is still in process, but CMS has provided categories and examples of what will be included, as well as some guidelines about the criteria for high and medium value CPIAs.

In addition to Medical Home or APM participation, general types of CPIAs include:

- Expanding practice access through same-day appointments or off-hours access to providers;
- Population health management, including participation in a QCDR or the monitoring of populations of patients;
- Coordination of care, such as timely communication of results and exchange of information to patients, use of remote monitoring or telehealth;
- Patient engagement, including development of individual care plans, patient self-management assessment and shared decision-making;
- Patient safety, such as use of surgical or clinical checklists and protocols;
- Integrated behavioral health and medicine, including shared primary care and behavioral health records, integration and coordination of care to manage alcohol and substance abuse or mental health issues, and co-location of services.
- Achieving health equity by serving dual Medicare-Medicaid eligible, participating in insurance exchanges, and maintaining facilities and equipment to serve patients with disabilities;
- Emergency Preparedness and Response to support disasters and emergencies.

How Does CPIA Scoring Work?

MIPS contains four categories for scoring: Quality Reporting, Advancing Care Information, CPIAs and Resource Use. The aggregate contribution of Clinical Performance Improvement Activities is 15 percent of the total MIPS Score in Year 1 of MIPS. But it's not that simple. CPIA is a point-based score, and 60 points are needed to get credit for the full 15 percent. Here's how it works:

- Each CPIA is assigned 10 or double (20) points, depending on value;
- A baseline of at least one CPIA is required to get any partial score for CPIA;
- Groups or individuals can mix and match between medium- and high-value activities to

reach the 60 points;
Practices in an accredited patient-centered Medical Home get full credit for CPIAs;
Participation in an APM provides at least half the full credit to practices, which can then add additional activities to reach the full score;
Some groups may have the opportunity to participate in a research and measurement initiative by CMS to achieve credit;
QCDRs are called out under the Proposed Rules as a possibility for meeting multiple CPIAs;
Achievement of the CPIA score will be by attesting the activities through one of four reporting entities: a QCDR, authorized Registry, EHR, CMS web interface (large practices) or administrative claims (if the activity can be measured by claims).

If the scoring appears more specific than the actual qualifying activities to meet CPIA credit, that is not accidental. The list of CPIAs is evolving and will change over time.

How to Get Started Now for CPIA Credit

It will take as many as six programs of medium-level CPIA value to achieve full credit. For a practice just getting started with improvement initiatives, this would be overwhelming. Therefore, we recommend that practices stack the deck to achieve a number of high-value initiatives with the least pain and cost involved. Here are our recommendations for initiatives or activities that will give you the strongest foundation for 2017 and beyond:

Choose a QCDR to fast-track your MIPS initiative. The best QCDR should be able to help you meet maximum scoring under MIPS, including CPIA requirements, Quality, Advancing Care Information and CPIA components. The ICLOPS QCDR even has services to predict scoring under Resource Use, giving you coverage for all of MIPS. A QCDR should have:

Benchmarking of performance, practice assessments;
Population management that can include separately tracked improvement projects;
Projects to establish communication or engagement of patients;
Interventions to support outcomes improvement;
Specialized registries to support behavioral health integration into care;
Tracking of care plans and mechanisms for patient-reported outcomes;
Consulting to support development of other CPIA initiatives.

For primary care practices, evaluate your potential as a Medical Home, and, if feasible, target that as an initiative. Medical homes have special status under MACRA even if they are not an APM, so it makes sense to evaluate your options.
Start at least one population health initiative. Not only will population health initiatives tend to fall into the “high value” CPIAs, but also they will have the most far-reaching

impact on your patient outcomes. You will need to consider how you are tracking outcomes for populations over time—you may need a QCDR to do this, if your EHR reports latest results only, rather than long-term outcomes. Care plans are a natural next step for assisting patients who are at high risk or have poor outcomes in the population, so that you are likely to be able to meet more than one CPIA for every population health initiative that you establish.

Evaluate your referral networks to examine whether you can achieve coordination of care goals within a short timeframe. This will likely require the engagement of a consultant to analyze follow-up results or your QCDR consulting services. If your referring physicians are not meeting the requirements you need for attestation, it's time to communicate your expectations or reevaluate the relationships.

Plan mechanisms to increase your patient outreach, training and communication. Patient-reported outcomes and shared decision-making are two areas that will play key roles in the future, but require a step-wise strategy to avoid overwhelming providers and patients. Work with your QCDR to establish a test case that you can evaluate during 2017, which meets CPIA.

CPIA is the Ticket to the Future

For the uninitiated, clinical performance improvement is daunting new territory. It requires proactive steps to improve communication with patients and manage their path to better health. As such, practices must establish a support system to steer patients with up-to-date information, comparative data and technologies beyond what staff and existing systems can provide.

CPIAs are also the precursor to Life under Risk. CMS makes it clear in the Proposed MACRA Rules that its Quality Payment Program is designed to encourage providers to be under risk in advanced ACOs, patient-centered Medical Homes and other models. CPIAs are the primary mechanism that will make those models meet lower costs and better outcomes. Failure to undertake CPIAs will be costly. Mastering CPIAs under MIPS will prepare you for the big game, when even more in incentives and penalties will be at stake.

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