

## Improvement Activities Performance Category

### Call for Activities Submission Form

Activities recommended for inclusion or modification should be sent using the Improvement Activities Submission Template (below) to the email: [CMSCallforActivities@abtassoc.com](mailto:CMSCallforActivities@abtassoc.com). Stakeholders will receive an email confirmation for their submission. If our proposals to adopt a revised Call for Improvement Activities period is adopted in the Quality Payment Program Year 3 (2019) final rule as proposed improvement activities submitted by June 28, 2019 will be considered for inclusion for the Quality Payment Program Year 5 (2021). Improvement activities submitted after June 30, 2019 will be considered for inclusion in future years of the Quality Payment Program. All fields of this form must be completed in order for your submission to be considered.

We also refer submitters to the [2018 MIPS Improvement Activities list](#) on the [CMS Quality Payment Program resource library](#), which lists the complete inventory of current improvement activities for the Quality Payment Program Year 2 (2018). Submitters should ensure that proposed new activities do not duplicate existing ones.

MIPS improvement activities considered for selection should meet one or more of the criteria. If our proposals to add one criteria and remove one criteria are adopted in the Quality Payment Program Year 3 (2019) final rule as proposed, the new list of criteria for CY 2019 and future years would be as follows:

- Relevance to an existing improvement activities subcategory (or a proposed new subcategory);
- Importance of an activity toward achieving improved beneficiary health outcomes;
- Importance of an activity that could lead to improvement in practice to reduce health care disparities;
- Aligned with patient-centered medical homes;
- Focus on meaningful actions from the person and family's point of view;
- Supports the patient's family or personal caregiver;
- 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;
- Include a public health emergency as determined by the Secretary; or\*
- CMS is able to validate the activity\*

*\*New submission criteria for submissions made in CY 2019*



## Proposed New Improvement Activities Recommended for Inclusion in the Quality Payment Program: Submission Template

<p><b>Activity Sponsor:</b> Provide entity name, URL, and individual contact information: name, address, phone, email—in case we need to contact submitter.</p>	
<p><b>CMS NPI # or Sponsor Type:</b> Include NPI number, or indicate other entity type, e.g. EHR vendor, specialty group, or other—25 words or less.</p>	
<p><b>Activity Title:</b> Provide the activity title only—10 words or less.</p>	
<p><b>Activity Description:</b> Provide a brief description of the proposed activity—300 words or less. Please be as specific as possible about what the activity entails. E.g., “Eligible clinician must perform/do XXXX.”</p>	
<p><b>Proposed Subcategory:</b> Select the ONE (1) subcategory under which your proposed improvement activity best fits from among the following nine options:</p> <ul style="list-style-type: none"> <li>• Achieving Health Equity</li> <li>• Behavioral and Mental Health</li> <li>• Beneficiary Engagement</li> <li>• Care Coordination</li> <li>• Emergency Response and Preparedness</li> <li>• Expanded Practice Access</li> <li>• Patient Safety and Practice Assessment</li> <li>• Population Management</li> </ul>	

**Validation of Activity: Supporting Documentation (e.g., peer-reviewed articles, other publications, websites)**

*Provide supporting validation documentation that indicates that this activity has been used successfully in the field, and that it can lead to practice quality improvement and improvement in patient health, experience, etc. Please provide citations of or links to established processes, validated tools, etc., that are referenced in the activity.*

**Documentation to Use as Proof of Activity Completion:**

*Include data or primary sources that could be used to substantiate performance of the improvement activity (e.g. medical charts, office schedules, data reports, quality improvement reports or submissions to funders/payers, meeting minutes).*

**Level of Effort:**

*Include data, primary sources or personal experience to substantiate the level of effort the submitter anticipates are required to complete the proposed improvement activity on an annual basis. (This estimate could be in hours/days, dollars, staffing needs/FTE, external resources/supports or any combination thereof).*

## Proposed Modifications to Improvement Activities Recommended for Inclusion in the Quality Payment Program: Submission Template

<b>Existing IA Proposed to Modify (please list IA subcategory/number, e.g., IA_AHE_1):</b>	
<b>Modification proposed: Please check off the type of modification you are proposing</b>	<ul style="list-style-type: none"> <li><input type="radio"/> Weight</li> <li><input type="radio"/> Subcategory</li> <li><input type="radio"/> Description</li> </ul>
<b>Please list the modification you propose INCLUDING a rationale for why you believe this modification is warranted.</b>	

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is XXXX-XXXX (Expiration date: XX/XX/XXXX). The time required to complete this information collection is estimated to average 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. \*\*\*\*CMS Disclosure\*\*\*\* Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact QPP@cms.hhs.gov.