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Quality Payment Program Changes for 2018

Changes to the Quality Payment Program's Merit-based Incentive Payment System affects all participating clinicians.

The Quality Payment Program (QPP), established by the Medicare Access and CHIP Reauthorization Act (MACRA), is a payment incentive program that rewards eligible clinicians based on standards of quality and value. Changes have been made to the QPP's Merit-based Incentive Payment System (MIPS) for the 2018 reporting year. The changes affect all those who participate in the MIPS program.

The MIPS performance assessment is divided into four categories in which clinicians submit data. The assessment categories are Quality, Improvement Activities, Accountable Care Information, and Cost (new in 2018). Each category weighs differently into the overall performance score.

Category Changes for 2018

In its second year, the program will continue to minimize the burden on clinicians, coordinate care more efficiently, and ensure that the program's processes and outcomes are meaningful. The transition to full implementation of the QPP is still in progress, so the requirements are still in a flexible stage working toward full implementation next year.

For the 2018 reporting year, there will be four categories for reporting as opposed to three categories last year. The four categories for this year are:

1. **Quality** is worth 50% of the total assessment score. Full-year reporting is required and clinicians must report six quality measures including one high-priority outcome measure. Alternatively, a specialty measure set may be selected. Each measure must be reported on 60% of the time, and each is worth three points. Those that don't meet the completeness criteria will earn one point (except for small practices, which will earn three). Clinicians may choose from more than 200 individual measures or 30 specialty measures. An all-cause readmissions measure is calculated from administrative claims for groups of 16 or more clinicians with at least 200 attributed cases in addition to the measures above. Bonus points are available for reporting additional outcomes or high priority measures as well as for using Certified Electronic Health Record Technology (CEHRT).

2. **Improvement Activity** is worth 15%. Clinicians must earn 40 points in this category to earn the full 15% of the score. Certified Patient Centered Medical Homes will receive 15 points. The requirements remain the same as in the 2017 reporting year. A 90-day reporting period is in place. Clinicians may choose from 112 improvement activities and must report up to four activities.

3. **Advancing Care Information** is worth 25% of the score. The reporting requirements remain the same as in the 2017 reporting year. This portion of the assessment is comprised of four required objectives: performing a Security Risk Assessment (SRA), E-Prescribing, providing patients access to their data, and Health Information Exchange. There is a 90-day reporting period. Clinicians may use the CEHRT from 2014 or 2015. They will receive a 10% bonus if they use only 2015. Exemptions from this category include:

    - A significant hardship exception in which no five-year limit is applied. MIPS-eligible clinicians in small practices are exempt if there are 15 or fewer clinicians.
    - An exemption is in place for hospital-based MIPS Eligible Clinicians and Ambulatory-Surgical-Center-based clinicians.
    - An exemption also exists if the EHR has been decertified.

We highly encourage physicians to consider the cost-savings and increased value of outsourcing your Security Risk Assessment. Yeo & Yeo Medical Billing has partnered with its affiliate, Yeo & Yeo Computer Consulting, to provide targeted, above average reporting from your required assessment at a decreased cost. Our goal is to help you meet the ACI requirements while making your dollars worthwhile giving you action items to improve and most importantly, avoid fines.

4. **Cost** is a new reporting category for the second year of the QPP. A full year of reporting is required and is worth 10% of the assessment score. The Centers for Medicare & Medicaid Services (CMS) will provide feedback based on 2017 claims data. All measures are calculated by CMS based on administrative claims collected for a full calendar year. No separate reporting is required. The measures for this category include total per capita costs for all attributed beneficiaries, Medicare spending per beneficiary, and episode-based measures. The clinician's performance will be compared with that of other Eligible Clinicians during that performance period. The performance category score is then found by averaging the two measures.

Points earned in the categories are combined to determine the assessment score. Participating clinicians will receive either a 5% increase or decrease in their payment outcome in 2020 based on the 2018 assessment. Below is a table outlining the point value earned in the assessment and its corresponding adjustment to the payment received in 2020.

Points	Adjustment
≥ 70 points	Positive adjustment and an additional minimum adjustment of 0.5%
15.01 - 69.99	Positive adjustment
15.00	Neutral
3.76 - 14.99	Negative adjustment less than 5%, greater than 0%
0 - 3.75	Negative payment adjustment of 5%

Also New This Year

- The performance threshold is being raised to 15 points in the 2018 reporting year.
- Bonus points can be earned toward your final score for treating complex patients (five points), being a small practice (five points), and using 2015 technology when using the 2014 and/or 2015 CEHRT.
- Virtual groups are included as an option for the 2018 reporting year. A virtual group is made up of two or more Taxpayer Identification Numbers (TINs) made up of solo practitioners and groups of 10 or fewer eligible clinicians who have virtually come together to participate in MIPS for a performance period of a year.
- A new policy is in place to address circumstances such natural disasters. Clinicians impacted by a natural disaster will automatically have the weighting of Quality, ACI, and Improvement Activities set to 0% of the final score.

An alternative to the MIPS assessment is the Advanced Alternative Payment Model (AAPM). Medicare administrators hope more clinicians will participate in APMs and are making revisions to make it easier to participate and more beneficial to the eligible clinicians. Please visit the Medicare website for more information about eligibility and the requirements of this alternative program.

Call on Yeo & Yeo Medical Billing & Consulting for Assistance

As QPP advances the reporting requirements will continue to change. Yeo & Yeo stays up to date on the changing requirements of the Quality Payment Program. Contact Kati Kruger, President of Yeo & Yeo Medical Billing, at 989.797.1400 or katkru@yeoandyeo.com with questions you may have about QPP reporting and assessments.