Successful physicians, practices, and hospitals are stepping into Year Two of CMS' Quality Payment Programs (QPP). While Year One was characterized by changing requirements and changing expectations, Year Two offers alternatives meant to reduce reporting burden and additional opportunities for successful participation.

Now more than ever, harnessing the power of clinical data delivers significant advantages in meeting quality reporting requirements. Understanding the new payment models and how Medicare reimbursement has moved to a system focused on rewarding high-value, patient-centered care is essential. In the pursuit of favorable performance, one critical success factor will prove to be the effective utilization of business intelligence and analytics tools.

For the QPP, physicians may choose the Merit-Based Incentive Payment System (MIPS) or one of the other Alternative Payment Models (APMs). As we enter Year Two of reporting, the MIPS composite score consists of four performance categories: Quality, Improvement Activities, Promoting Interoperability, and Cost. (For QPP resources and guidelines, visit www.qpp.cms.gov.)

KAMMCO offers analytics tools designed to aid in reporting in all four MIPS categories. The unique underlying value to these analytics resides in the fact that analysis is performed across patients' longitudinal medical records inclusive of the data submitted by all health information exchange participating providers.

It is important for physicians to be mindful of CMS's deadlines. The most current participation deadlines for the Quality Payment Program can be found at the website: https://qpp.coms.gov.

For more information contact Susan Penka, KAMMCO Business Development Representative (spenka@KAMMCO.com) or visit www.KAMMCO.com.

To set up your analytics dashboard demonstration call Susan Penka at 800.232.2259 or email to spenka@KAMMCO.com
Can You Meet the New MIPS Requirements?

The new KAMMCO analytics dashboards can ease the transition to MIPS reporting by providing physicians quick and easy access to their patients’ aggregated data from the health information exchange presented through meaningful analysis. Users can manipulate the view, download reports, and import data into other software tools.

Dashboard Reports include:

High Risk Patient dashboard identifies patients considered most at risk for poor health outcomes, high resource utilization and in need of care coordination. Identifying high risk patients can help meet the Clinical Practice Improvement (CPI) requirements under MIPS. For this analysis, high risk patients are defined as patients with three or more chronic conditions and five or more emergency department visits in a 12-month period.

Quality Metrics dashboard displays analysis of preventive care procedures commonly required and approved for quality reporting programs for clinic practices. Individual measures are structured to meet NCQA, CMS, and HEDIS requirements. Current reported measures include screening for colorectal, cervical and breast cancers, osteoporosis, and pneumonia and influenza vaccines.

CMS has identified seven clinical conditions for which hospitals could receive a readmit penalty if a patient is readmitted at the same or any other eligible facility within 30 days of discharge for any reason. Readmission measures include acute myocardial infarction, chronic obstructive pulmonary disease, heart failure, elective hip or knee replacement, stroke, pneumonia, and coronary artery bypass graft.

Disease Registries display specific patient populations with certain high or at risk conditions, and sets the stage for physicians to take steps that mirror many of the MIPS CPI activities. The disease registry data provides information about the health status of communities and identifies opportunities for care coordination, referral to community resources, and evidence-based practices.

Population Health presents opportunities for community resource coordination and planning for at risk members of a defined geographic region. Analysis is currently provided on 12 predetermined criteria selections such as hypertension, ischemic heart disease, pre-diabetes, diabetes, heart failure, and A1C poor control, to name a few.

Behavioral Health presents an overview of specific metrics that address early detection, treatment and management of patients with behavioral health and medical conditions, including depression, suicide risk, diabetes, high blood pressure and other related health conditions. Compliance for each measure is also available.

Utilization dashboard presents recent patient activity for inpatient admissions, emergency department and office visits. View selection includes filters for date ranges from 24 hours to 120 days and selection of a single or group of facilities. This dashboard displays all patients in the population with eligible service activity, un-restricted by age, disease condition or level of utilization. Additional charts display office visit activity.

Physician Attribution provides a simple interface for management and assignment of patients based on provider and payer. The summary view displays patient name, visit activity and most recent primary provider and payer. Patient level encounter detail is available. Views include a provider specific list and an administrative overview of all patients.

Controlled Substances dashboard presents patient activity where at least one prescription in the controlled substances category is prescribed and dispensed, as well as those that received an overlapping opioid prescription. Chart overviews include breakouts by facility and date range of prescription, overlapping prescriptions over 12 months, and top 5 opioid medications prescribed.