2017/2018

KPN Health, Inc.
Quality Payment Program Solutions Guide

KPN Health, Inc.
A CMS Qualified Clinical Data Registry (QCDR)

KPN Health, Inc.
214-591-6990
info@kpnhealth.com
www.kpnhealth.com
2017/2018 Quality Payment Program Solutions Guide

KPN Health, Inc.
2017/2018 Quality Payment Program (QPP) Guide

Introduction

The Quality Payment Program (QPP) was established as part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Prior to MACRA, Medicare was based on a fee-for-service system, where clinicians were paid based on volume of service, not value. This new program improves Medicare by focusing on quality of care and making patients healthier. Medicare payments reward high-value, patient centered care.

This toolkit will help your organization implement real, quality improvement strategies to ensure success in an accountable care environment where quality and cost reductions drive reimbursement.

The ***KPN Health, Inc. 2017 QPP Solutions Guide*** provides the following information based on CMS regulations and documents:

KPN Health, Inc. – Subject Matter Experts

KPN Health, Inc.'s subject matter experts are available to provide advisory services. Additionally, they will be hosting **free** webinars over the coming months. Frequently Asked Questions (FAQs), articles and other resources are available on our website at www.kpnhealth.com.

KPN Health, Inc. would like to be your Qualified Clinical Data Registry (QCDR) to ensure you successfully report your 2017 performance measures. For more information about our services or to schedule a consultation, please contact:

KPN Health, Inc.
12750 Merit Dr., Suite 815
Dallas, TX 75251
O: 214-593-6990
info@kpnhealth.com
www.kpnhealth.com

Quality Payment Program

The Quality Payment Program provides new opportunities to improve care by rewarding clinicians for engaging patients, families and caregivers and improving care coordination and population health management. The program is based on three fundamental principles:

- High-quality patient-centered care
- Useful feedback
- Continuous improvement

How Does the Quality Payment Program Benefit Clinicians and Patients?

Clinicians

- Streamline reporting
- Standardize measures (evidence-based)
- Eliminate duplicative reporting so clinicians may spend more time with patients
- Incentivize care that focuses on improved quality outcomes

Patients

- Increase access to better care
- Enhance coordination through a patient-centered approach
- Improve results

What Is the Reporting Period?

The first performance year is January 1, 2017 – December 31, 2017 with data collected between January 1, 2017 - October 2, 2017. Performance data must be submitted by May 31, 2018. Clinicians choose the best way to participate in the program based on practice size, specialty, location or patient population.

How Are Payment Adjustments Determined?

Clinicians may choose from two payment methods: Merit-based Incentive Program System (MIPS) or the Advanced Alternative Payment Models (APM). If the MIPS track is chosen, payment adjustments are based on the performance information submitted— not on the amount of information or length of time submitted. In addition, MACRA allows for additional positive adjustments for exceptional performance. 2019 Medicare payments will be adjusted up, down or not at all if 2017 data is submitted by the deadline date:

1. Negative 4% adjustment if no data is submitted
2. Neutral or small adjustment when a minimum amount of data is submitted
3. Small positive payment adjustment when 90 consecutive days of is submitted
4. Moderate positive payment adjustment when a full year is submitted

Participation in an Advanced APM earns a 5% Medicare incentive payment in 2019.

Merit-based Incentive Payment System (MIPS)

MACRA replaced three Medicare reporting programs: (i) Medicare EHR Incentive Program (Meaningful Use); (ii) the Physician Quality Reporting System (PQRS); and (iii) the Value-Based Payment Modifier into one performance-based payment program, MIPS, that measures eligible clinicians on four different performance categories: Quality, Improvement Activities, Advancing Care Information and Cost (Resource Use).

What Are the Performance Category Weights for 2017?
Weights are assigned for each category based on a scale of zero to 100 points and will significantly influence Medicare reimbursement payments each year.

Cost (Resource Use) – Begins in 2018

Who Is Eligible?
To be eligible for MIPS, clinicians must have: More than $30,000 a year in billing for Medicare Part B **and** provide care for more than 100 Medicare patients a year. The billing requirement and number of patients must be met to participate in MIPS. To participate in MIPS, a clinician must be a:

- Certified Registered Nurse Anesthetist
- Clinical Nurse Specialist
- Nurse Practitioner
- Physician
- Physician Assistant

Who Is Excluded?
Clinicians are excluded from MIPS if they meet the following criteria:

- Enrolled in Medicare for the first time during the performance period
- Below the low-volume threshold
    - Medicare Part B allowed charges ≤ to $30,000 a year or see 100 or fewer Medicare Part B patients a year
- Significantly participating in Advanced APMs

Individual vs. Group Reporting?
Clinicians may submit data individually or as a group. A group is defined as two or more clinicians (NPIs) who have reassigned their billing rights to a single TIN (Tax ID). If clinicians participate as a group, they are assessed as a group across all four MIPS performance categories. Each practice should let its clinicians know their MIPS status.

MIPS: Quality Performance

This performance category replaces PQRS (Physician Quality Reporting System) and the Quality portion of the Value-based Payment Modifier (VM). There are also specialty-specific measures available.

What Are Requirements for Submission?

- Six measures from approximately 300 available quality measures must be reported.
  - One of these measures must be an Outcome measure; if no Outcome measure is available, then a High Priority measure may be selected.
- If a measure is reliably scored against a benchmark, then the clinician receives 3 to 10 points.
- Each quality measure is based on performance (numerator/denominator) and its relation to historical benchmarks.
- Failure to submit performance data for a measure = zero points.

What Does Reliably Scored Mean?

Reliably scored means that there is:

- Sufficient case volume (≥ 20 cases for most measures; ≥ 200 cases for readmissions)
- Data completeness met (at least 50% of data submitted)
- Performance is greater than zero percent.

What Are Quality Measure Benchmarks?

When a clinician submits measures, each measure is assessed against a benchmark to determine how many points are earned. There are separate benchmarks for each of the different reporting mechanisms (EHR, QCDR/registries, claims and CMS web Interface). The benchmarks are based on performance data submitted to PQRS in 2015. Benchmarks for measures submitted via CMS Web Interface are based on the Shared Savings Program. All reporters (individuals or groups) regardless of specialty or practice size are combined into one benchmark. If a measure **cannot** be reliably scored against a benchmark, then the clinician receives 3 points.

How Do Benchmarks Estimate Points?

Each benchmark is presented in terms of deciles. Achievement points are awarded within each decile. Performance measures in the first or second decile receive 3 points. For example, if a clinician submits data showing 88% on a measure, and the 8th decile starts at 80% and the 9th decile starts at 90% then the clinician will receive 8-8.9 points.

Decile	Number of Points Assigned for the 2017 MIPS Performance Period
Below Decile 3	3 points
Decile 3	3-3.9 points
Decile 4	4-4.9 points
Decile 5	5-5.9 points
Decile 6	6-6.9 points
Decile 7	7-7.9 points
Decile 8	8-8.9 points
Decile 9	9-9.9 points
Decile 10	10 points

**For inverse measures, the order would be reversed. Where Decile 1 starts with the highest value and decile 10 has the lowest value.*

How to Collect Bonus Points?

Clinicians receive bonus points for either of the following options:

- Option 1: Submitting additional high-priority measures (capped at 10% of the total possible points for the Quality performance category)
  - 2 bonus points for each additional outcome
  - 1 bonus point for each additional high priority measure
- Option 2: Using CEHRT to submit measures to registries or to CMS (capped at 10% of the total possible points for the Quality performance category)
  - 1 bonus point per measure for submitting electronically end to end (electronic collection and reporting of quality measures)

Bonus Measures do NOT have to be in the "top 6" to receive bonus points.

How Is the Quality Performance Score Calculated?

There are 60 available points for the quality category. The calculation for scoring:

(Achievement Points 6 quality measures + bonus points/60) x 60% Quality Category Weight x 100

Are There Different Requirements for Small Practices?

Small practices are defined as having 15 or fewer clinicians and practices in rural areas and health professionals in shortage areas. For the Quality Performance Category, the are no differences in requirements. Clinicians in small practices who report can do just as well as mid-size or larger practices. CMS expects the number of small practices reporting to increase.

Are There Different Requirements for Groups with More Than 15 Clinicians?

One additional measure, All-Cause Hospital Readmissions (ACR), will be calculated by CMS exclusively from Claims data. This changes the Quality points from 60 to 70. The category weight remains at 60%.

Note:

There are different requirements for groups reporting via CMS Web Interface or those in MIPS APMS.

MIPS: Improvement Activities

This performance category assesses how much the clinician participates in activities to improve clinical practice. Activities include ongoing care coordination; clinician and patient shared decision making; implementation of patient safety practices and expanding patient access.

What Are the Requirements for Submission?

- Clinicians choose activities from more than 90+ activities.
- Clinicians attest by indicating "YES" to each activity that is performed for at least 90 consecutive days during the performance period.
- There are no subcategories or required activities; clinicians can choose to attest to the most meaningful activities for their practice.
- Activities may be reported via a Qualified Clinical Data Registry such as KPN Health, a qualified registry, or EHR Technology. These intermediaries will need to certify that the clinician performed the activities as indicated.
- Since no reports are submitted to CMS, clinicians are encouraged to retain documentation for six years 3 months in case of a CMS audit.

Are There Bonus Points Associated with This Category?

There are no bonus points for Improvement Activities.

How Is the Improvement Activities Performance Score Calculated?

There are 40 available points for the Improvement Activities performance category. Each activity is weighted as medium (10 points) or high (20 points).

For groups with **more than 15 clinicians**, to get the maximum score of 40 points, clinicians choose 1 of the following combinations:

- 2 high-weighted activities
- 1 high-weighted activity and 2 medium-weighted activities
- At least 4 medium-weighted activities

For solo practitioners (small practices/groups **with 15 or fewer clinicians**, rural and underserved practices or non-patient facing clinicians or groups) to get the maximum score of 40 points, clinicians choose either of these combinations:

- 1 high-weighted activity
- 2 medium-weighted activities

The calculation for scoring:

(Points earned/40) x 15% IA Category Weight x 100

MIPS: Advancing Care Information

This performance category promotes patient engagement and the electronic exchange of information using certified EHR technology. It replaces the Medicare EHR Incentive Program also known as Meaningful Use.

Data submission is based on your Certified EHR Technology edition.
In 2017, there are 2 measure sets for reporting this category based on the EHR edition:

- Advancing Care Information Objectives and Measures (2015)
- 2017 Advancing Care Information **Transition** Objectives and Measures (2014)

The Advancing Care Information score is the combined total of Base Measures, Performance Measures and Bonus score.

What Are the Base Measure Requirements for Submission?
There are 50 available points and MIPS eligible clinicians need to fulfill the requirements of all the base score measures to receive credit for the base score. If the requirements are not met, a zero will be given for the performance category score.

How Is the Base Score Calculated?
To receive the 50 available points, clinicians must submit a "YES" for the Security Risk Analysis measure and at least a 1 in the numerator/denominator for all remaining base measures.

Advancing Care Information Required Base Measures	2017 Advancing Care Information "Transition" Required Base Measures
Security Risk Analysis	Security Risk Analysis
e-Prescribing	e-Prescribing
Provide Patient Access*	Provide Patient Access*
Send a Summary of Care*	Health Information Exchange*
Request/Accept Summary of Care*	

*Measures are also included as performance measures

What Are the Performance Measures Requirements for submission?

There are 90 available points. These are optional measures however zero-10 points are given for each measure. The maximum score achievable is 155 however, the maximum score is capped at 100.

Advancing Care Information Performance Measures	% Points	2017 Advancing Care Information "Transition" Performance Measures	% Points
Provide Patient Access*	Up to 10%	Provide Patient Access*	Up to 20%
Send a Summary of Care*	Up to 10%	Health Information Exchange*	Up to 20%
Request/Accept Summary of Care*	Up to 10%	View, Download or Transmit (VDT)	Up to 10%
Patient Specific Education	Up to 10%	Patient Specific Education	Up to 10%
View, Download or Transmit (VDT)	Up to 10%	Secure Messaging	Up to 10%
Secure Messaging	Up to 10%	Medication Reconciliation	Up to 10%
Patient Generated Health Data	Up to 10%	Immunization Registry Reporting	0 or 10%
Clinical Information Reconciliation	Up to 10%		
Immunization Registry Reporting	0 or 10%		

How Is the Performance Score Calculated?

For each measure with a numerator/denominator, the percentage score (points) is determined by the performance rate. Points are awarded for each 10% performance level. The Immunization Registry Reporting measure is reported as a "Yes" (10 points) or "No" (0 points).

Performance Rates for Each Measure Worth Up to 10%	
Performance Rate 1-10 = 1% Performance Rate 11-20 = 2% Performance Rate 21-30 = 3% Performance Rate 31-40 = 4% Performance Rate 41-50 = 5%	Performance Rate 51-60 = 6% Performance Rate 61-70 = 7% Performance Rate 71-80 = 8% Performance Rate 81-90 = 9% Performance Rate 91-100 = 10%

Example for the Performance Score Calculation:

A MIPS clinician reports a numerator and denominator of 75/100 (75% Rate) for Secure Messaging. The clinician will earn 8 out of 10 points for this measure.

How Is the Bonus Score Calculated?

MIPS eligible clinicians may receive a total of 15 bonus points:

- Option 1
  - Reporting "Yes" to 1 or more additional public health and clinical data registries (non-public health agency entities) will result in 5 points.

Requirements for Bonus Score	% Points
*Report to 1 or more of the following public health and clinical data registries: • Syndromic Surveillance Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting	5%
Report certain improvement Activities using CEHRT	10%

Requirements for Bonus Score	% Points
*Report to 1 or more of the following public health and clinical data registries: • Syndromic Surveillance Reporting • Specialized Registry Reporting	5%
Report certain improvement Activities using CEHRT	10%

- Option 2
  - Reporting "Yes" to the completion of at least 1 activity from the specified Improvement Activities using CEHRT will result in 10 points.

How Is the Overall Advancing Care Information Score Calculated?

The calculation for scoring:

(Base Score + Performance Score + Bonus Score) x 25% ACI Category Weight

MIPS: Cost (Resource Use)

This category was designed by CMS to encourage more consideration for the costs of care associated with patients and replaces the Value-based Modifier Program. Measures require that clinicians who are most significantly responsible for the patient's care (as measured by Medicare allowed amounts) assume accountability for this care. Cost measures and quality of care assessment are aligned so that patient outcomes are improved and costs are lowered.

There is no reporting requirement in 2017 (0% of Composite Performance Score). CMS will provide feedback on this category to clinicians; however, it does not affect the clinician's 2019 payments. Since clinicians are assessed on their Medicare Administrative Claims Data there is no reporting requirements. All cost measures will be adjusted for:

1. Geographic Pay Rate
2. Beneficiary Risk Factors
3. Specialty Adjustments

What Is a Cost Measure?

A cost measure represents Medicare payments for the items and services furnished to a beneficiary (case) during an episode of care. The following cost measures have been identified for 2017:

1. Total Costs Per Capita for All Attributed Beneficiaries (Total Cost Per Capita)
2. Medicare Spending Per Beneficiary (MSPB)
3. Episode Based Measures (10 out of 41 Episode based measures will be used in 2017).

What Is Total Cost Per Capita and How Is It Scored?

Costs for all attributed beneficiaries (or cases) include payments to both Medicare Part A and Part B. Medicare payments under Part D for drug expenses are not included. Nursing visits that occur in a skilled nursing facility are excluded. Primary care services are aligned with the Medicare Shared Savings Program which include new care coordination codes for Chronic Care Management (CCM) and Transitional Care Management (TCM).

- An attribution process considers the level of primary care services received (measured by Medicare-allowed charges from final action claims during the performance period) and the provider specialties that performed these services. Only beneficiaries who received a primary care service during the performance period are considered in attribution.
- A minimum case volume of 20 is required to be scored on this measure.

What Is Medicare Spending Per Beneficiary (MSPB) and How Is It Scored?

This measure assesses the cost to Medicare of services performed during a MSPB episode. A MAPB episode includes all Medicare Part A and Part B claims with a start date falling between three days prior to an IPPS (Inpatient Prospective Payment System) hospital admission (index admission) through 30 days post-hospital discharge. Thirty days after a hospital discharge is included in an episode to emphasize the importance of care transitions and care coordination.

- Each MSPB episode is attributed to the one clinician (TIN) responsible for Part B services.
- A minimum case volume of 20 is proposed to be scored on this measure.

What Are Episode Based Measures and How Is It Scored?

Episode Based Measures are those conditions and procedures that have high cost, high variability in resource use or have high impact. These measures include Medicare Part A and Part B payments for services and are related to the triggering condition or procedure. Forty-one (41) episodes were proposed that represented a large portion of Medicare charges. Examples of proposed Clinical Episode Groups are:

- Knee Arthroplasty (Replacement), Spinal Fusion, TURP for Benign Prostatic Hyperplasia and AMI without PCI/CABG.
- Episode-based measures have different attribution methodologies since attributing episodes to the clinician with highest Part B charges is not always appropriate.
- Minimum of 20 cases required to be scored on this measure.

How Is the Overall Cost Performance Score Calculated?

Each measure is converted to points (1-10) and then divided by the total possible points.

Example for the Cost Performance Score Calculation:

[A] RU	[B] Type of Measure	Number of Cases	Performance	[D] Measure Perf. Threshold	[E] Points Based on Decile	[H] Total Possible Points (10 points x [F])
M1	MSPB	20	15,000	13,000	4.0	10
M2	Total Per Capita	21	12,000	10,000	4.2	10
M3	Episode 1	22	15,000	18,000	5.8	10
M4	Episode 2	10	11,000	9,000	Below Case Threshold	N/A
M5	Episode 3	0	N/A	N/A	No Attributed Cases	N/A
M36	Episode 4	45	7,000	10,000	8.3	10
TOTAL					22.3	40

Resource use performance category score = (22.3/40) or 55.8%

MIPS: Composite Performance Score (CPS)

The MIPS composite performance scoring accounts for:

- Conversion of measures/activities to points
- Weight of each performance category
- Exceptional performance factors
- Availability and applicability of measures for different categories and clinicians
- Group performance

The composite score will be aggregated from the MIPS performance categories (Quality, Improvement Activities and Advancing Care Information) in 2017.

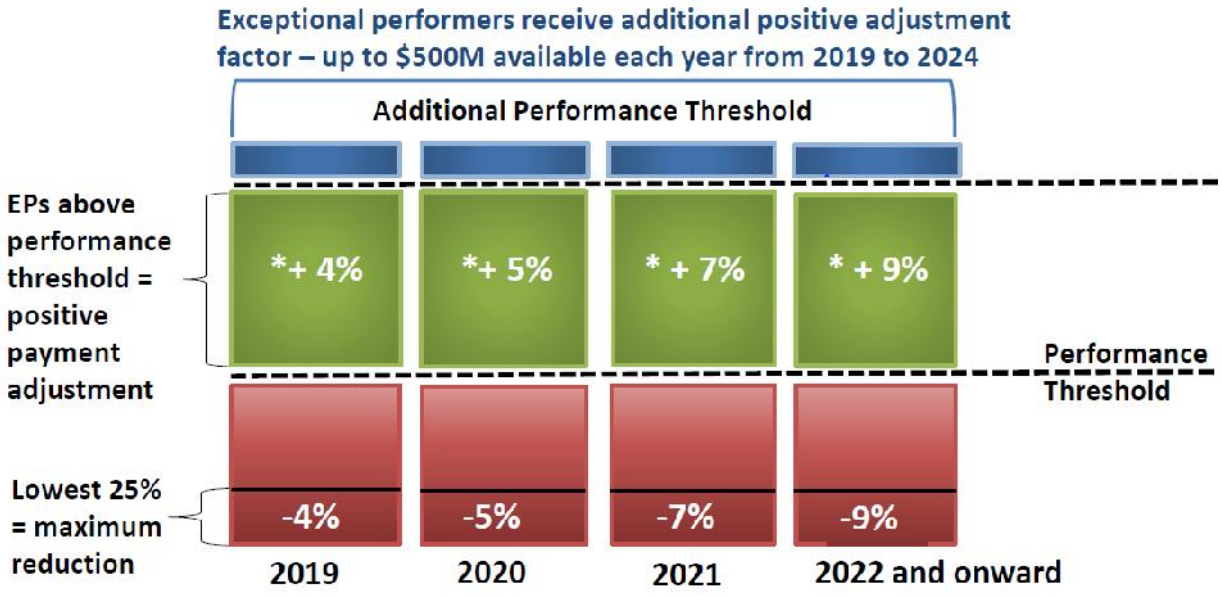
How Is the MIPS Payment Adjustment Determined?

1. Data is submitted to CMS
2. Each category (Quality, Improvement Activities and Advancing Care Information) is scored
3. A final Composite Performance Score (CPS) is calculated:

   Quality Score + Improvement Activities Score + Advancing Care Information Score
4. CPS is compared to the CPS "performance threshold"
5. Payment Adjustment and scaling is determined
6. CMS makes payment adjustment to clinicians (individual or group) in 2019

What Is the MIPS Incentive Payment Formula?

In 2017, exceptional performers who achieve MIPS Composite Performance Score of at least 70 are eligible for a bonus pool for the additional positive adjustment.



Getting Your Data To CMS

The saying, “You get what you pay for” has never been more accurate when it comes to the Quality Payment Program. CMS allows six reporting options with varying degrees of responsibility. The highest data management level is to be a Qualified Clinical Data Registry (QCDR).

KPN Health, Inc is a CMS approved QCDR.

The KPN Health approach is to extract **all** your Medicare and Non-Medicare patient data. KPN Health then analyzes the data and identifies measures with the best outcomes. Measure selection is then based on actual analysis – ensuring only your best outcomes are reported.

In addition, KPN Health has the following products that will help you identify “gaps” in care so you can provide the best possible care to your patients.

- **KPN Optimize™ Quality Performance Module**: A web-based quality performance module that is measure/metric based and allows for organizational specific quality performance assessments at an enterprise, Tax ID, clinic site or provider level.

- **KPN Optimize™ Point of Care Module**: A web-based clinical decision support module, that empowers providers to transform a routine acute care appointment into an effective and efficient disease management and prevention visit. It creates a process for achieving quality and performance goals by identifying gaps in care and providing a simple to use module that enhances efficiency and improves per patient visit revenue.

- **KPN Optimize™ Transitional Care Management Module:** KPN Optimize™ Transitional Care Management Module helps care managers track and monitor all important post-discharge timelines (e.g., 48-hour phone call, 7-day and 14-day face-to-face visit) required for billing the CMS Transitional Care Management codes. Missing these specific timelines increases chances for a 30-day readmission and reduces enhanced revenue opportunities.

This strategy makes a difference and will help you achieve MIPS reporting success.

For more information about our products and a list of resources, please visit www.kpnhealth.com.