

What Does the Future Hold? The Impact of Value Based Payments in Healthcare – 2017 and Beyond

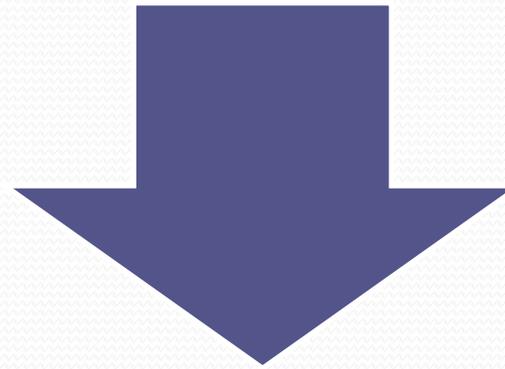
Dawn Holcombe, MBA, FACMPE, ACHE

DGH Consulting

Agenda

- In 2016, implementation of Center for Medicare and Medicaid Innovation's (CMMI) Oncology Care Model (OCM) began. Nearly 200 physician group practices and 17 health insurance companies selected to participate in the OCM pilot utilizing data for a performance period starting in 2017. Successes from the OCM are meant to encourage financial and performance accountability and will have lasting implications for future oncology models. It is imperative non OCM participating practices also understand the components of this model and how it may impact treatment choices and reimbursement.
 - What lessons can we learn from those who have broken ground with the OCM expectations over the last several months?
 - What changed in the MIPS Final Rule that affect oncology physicians?
 - You know the basics about MIPS, but what are the specifics: what decisions do you need to make tomorrow, and what actions will you want to take to start preparing for beyond 2017?
 - As a bonus, you will receive a short update on the impact of the **USP Pharmacy Regulations on Oncology**.

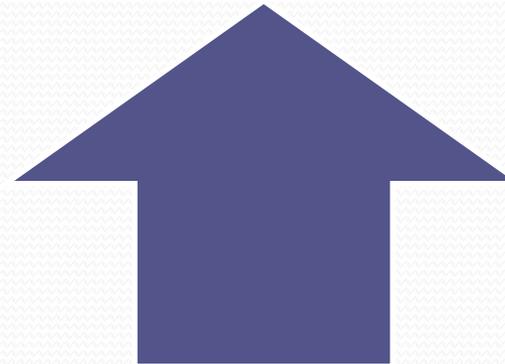
Pressures Around Oncology



Population Health and
Cost Management
Payer/Employer Cost
Burden
Patient Cost Burden
Provider Cost Burden



Innovation
Cure
Palliation
Managing the Disease



CMMI Oncology Care Model

Overview of CMS Goals with OCM

- The Center for Medicare and Medicaid Innovation (CMS Innovation Center)
 - developing new payment and delivery models designed to improve the effectiveness and efficiency of specialty care.
 - the Oncology Care Model (OCM), an innovative new payment model for physician practices administering chemotherapy.
 - practices will enter into payment arrangements that include financial and performance accountability for episodes of care surrounding chemotherapy administration to cancer patients.
 - the participation of other payers in the model.
 - This model aims to provide **higher quality, more highly coordinated oncology care at a lower cost** to Medicare.

CMS Background on Oncology Care Needs

- One specialty practice area where the Innovation Center aims to improve effectiveness and efficiency is **oncology care**.
- More than 1.6 million people are diagnosed with cancer in the United States each year. Approximately half of those diagnosed are over 65 years old and Medicare beneficiaries. Cancer patients comprise a medically complex and high-cost population served by the Medicare program.
- About 50% of patients in oncology practices are Medicare beneficiaries
- The Innovation Center has the opportunity to further its goals of better care, smarter spending, healthier people through an oncology payment model.

CMS OCM Goals

- The Innovation Center's Oncology Care Model (OCM) focuses on an episode of cancer care, specifically a chemotherapy episode of care
- The goals of OCM are to utilize appropriately aligned financial incentives to improve:
 - Care coordination
 - Appropriateness of care
 - Access for beneficiaries undergoing chemotherapy
- Financial incentives encourage participating practices to **work collaboratively** to **comprehensively** address the complex care needs of beneficiaries receiving chemotherapy treatment, and **encourage the use of services that improve health outcomes.**

CMS OCM Overview

- **Episode-based**
 - Payment model targets chemotherapy and related care during a 6-month period following the initiation of chemotherapy treatment
- **Emphasizes practice transformation**
 - Physician practices are required to engage in practice transformation to improve the quality of care they deliver
- **Performance Periods**
 - There are 9 six month performance periods in the OCM.
 - OCM baseline, benchmark, and target prices are based on total cost of care, which corresponds to all Part A/B expenditures and certain Part D expenditures (low-income subsidy and 80% of gross drug cost above the catastrophic threshold)
- **Multi-payer model**
 - Includes Medicare fee-for-service and other payers working in tandem to leverage the opportunity to transform care for oncology patients across the population

CMMI OCM Episode Definitions

- **Types of cancer**
 - OCM-FFS includes nearly all cancer types
- **Episode initiation**
 - Episodes initiate when a beneficiary starts chemotherapy
 - The Innovation Center has devised a list of chemotherapy drugs that trigger OCM-FFS episodes, including endocrine therapies but excluding topical formulations of drugs
- **Included services**
 - **All** Medicare A and B services that Medicare FFS beneficiaries receive during episode (**not just oncology**)
 - Certain Part D expenditures will also be included
- **Episode duration**
 - OCM-FFS episodes extend six months after a beneficiary's chemotherapy initiation.
 - Beneficiaries may initiate multiple episodes during the five-year model performance period

Implications of the CMS OCM Approach

- First time a major payer has made MDs accountable for total costs of care
- First time MDs have been given total claims for patients on a large scale
- Drugs are part of the cost structure
- The bottom line becomes a top line target
- Extensive quality measure reporting in effort to avoid shortcuts in care
- A True Game Changer

CMMI OCM Requirements of Practices

OCM Practice Transformation – from Day 1

- Provide the core functions of patient navigation;
- Document a care plan that contains the 13 components in the Institute of Medicine Care Management Plan outlined in the Institute of Medicine report, “Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis”;^[2]
- Provide 24 hours a day, 7 days a week patient access to an appropriate clinician who has real-time access to practice’s medical records;
- Treat patients with therapies consistent with nationally recognized clinical guidelines;
- Use data to drive continuous quality improvement; and
- Use an ONC-certified electronic health record and attest to Stage 2 of meaningful use by the end of the third model performance year.

Care Management – not just treating

1. Patient information (e.g., name, date of birth, medication list, and allergies)
2. Diagnosis, including specific tissue information, relevant biomarkers, and stage
3. Prognosis
4. Treatment goals (curative, life-prolonging, symptom control, palliative care)
5. Initial plan for treatment and proposed duration, including specific chemotherapy drug names, doses, and schedule as well as surgery and radiation therapy (if applicable)
6. Expected response to treatment
7. Treatment benefits and harms, including common and rare toxicities and how to manage these toxicities, as well as short-term and late effects of treatment
8. Information on quality of life and a patient's likely experience with treatment
9. Who will take responsibility for specific aspects of a patient's care (e.g., the cancer care team, the primary care/geriatrics care team, or other care teams)
10. Advance care plans, including advanced directives and other legal documents
11. Estimated total and out-of-pocket costs of cancer treatment
12. A plan for addressing a patient's psychosocial health needs, including psychological, vocational, disability, legal, or financial concerns and their management
13. Survivorship plan, including a summary of treatment and information on recommended followup activities and surveillance, as well as risk reduction and health promotion activities

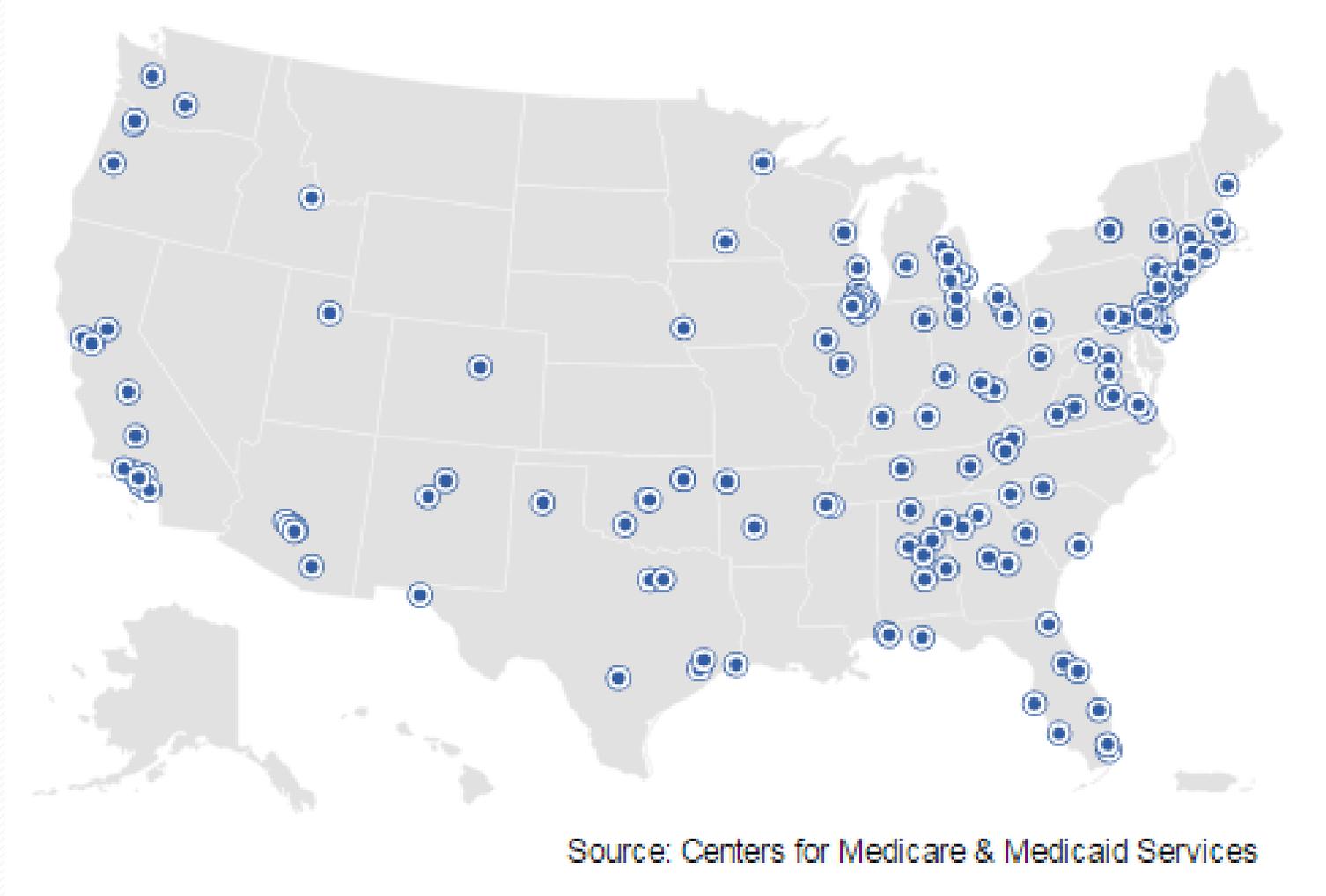
Patient Navigation - Proactive

1. Coordinating appointments with providers to ensure timely delivery of diagnostic and treatment services
2. Maintaining communication with patients, survivors, families, and the health care providers to monitor patient satisfaction with the cancer care experience
3. Ensuring that appropriate medical records are available at scheduled appointments
4. Arranging language translation or interpretation services
5. Facilitating financial support and helping with paperwork
6. Arranging transportation and/or child/elder care
7. Facilitating linkages to follow-up services
8. Community outreach
9. Providing access to clinical trials, and
10. Building partnerships with local agencies and groups (e.g., referrals to other services and/or cancer survivor support groups).

OCM Payment to Practices

- 5 years – Monthly Enhanced Oncology Services (MEOS) \$160/month for 6 month episodes for patients in active chemotherapy (Part B and most Part D) Plus standard Fee For Service payments
- Episodes will begin on the date of an initial chemotherapy administration claim or an initial Part D chemotherapy claim and will not include services provided prior to that date
- Performance payments starting 8 months after first reconciliation and review period
 - CMMI sets target for practice based upon actual total costs of care history as measured by CMS
 - CMMI reduces target by 4%, the minimum savings expected by CMMI
 - Any remaining savings between the reduced target and actual total expenditures becomes available for potential performance payments, subject to performance on quality and performance measures defined by CMMI
- If two sided risk is elected, CMMI sets a 2.75% target reduction, and the practice may participate in a corridor of 20% of the savings – shared savings or cost repayment to CMMI
- CMMI adjusts any potential performance payments to practices by both the 2% sequestration rate and the total amounts already paid to practices as MEOS.
- **Both Carrots and Sticks – for medical decision making**

OCM Practice Participation (196) – BUT MIPS affects all practices in the country



CMMI OCM Payer Participation (16)

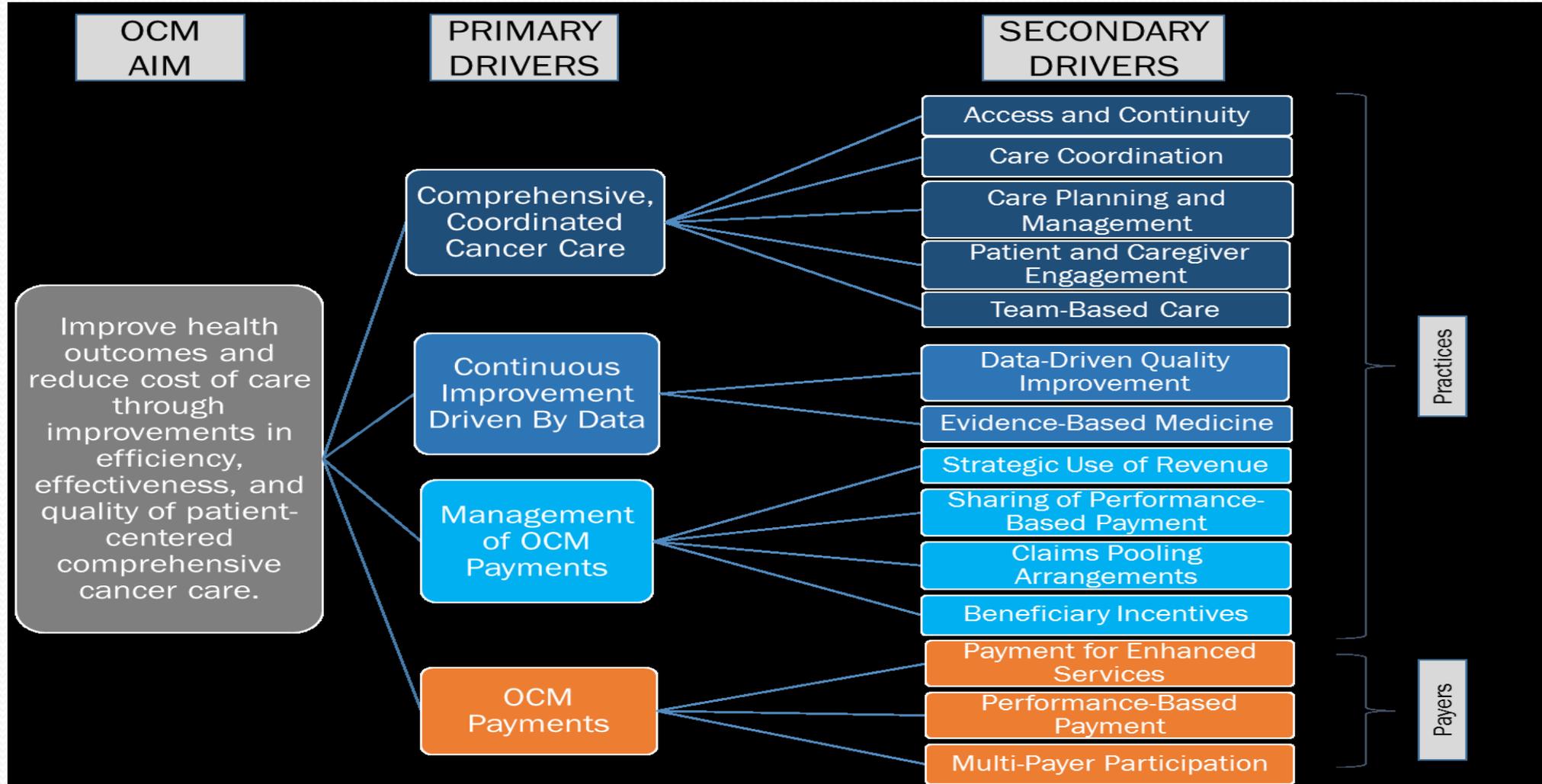
- Aetna
- Blue Cross Blue Shield of Michigan/Blue Care Network
- Blue Cross Blue Shield of New Mexico
- Blue Cross Blue Shield of Oklahoma
- Blue Cross Blue Shield of Texas
- BlueCross BlueShield of South Carolina
- Capital BlueCross, Inc.
- Cigna Life & Health Insurance Company
- EmblemHealth
- Health Alliance Plan
- Highmark, Inc.
- Priority Health
- SummaCare
- The University of Arizona Health Plans
- UPMC Health Plan
- VIVA Health, Inc

CMMI OCM Support and Resources – Serious Business

- Participant hourly calls
 - 2 to 3 times a month, transcripts, slides
- Thousands of pages of guidance and FAQs
- Support Communities
 - CMMI OCM
 - Association of Community Cancer Centers
 - Community Oncology Alliance
 - Regional and state groups
- BUT, they also are listening and have made some significant modifications

The Reality of OCM Practice Changes – Implications for Non OCM Practices

CMMI OCM Key Drivers



OCM Practice Challenges for Transformation

- Technology Infrastructure (access to own data)
 - Patient Identification and Billing
 - Patient Reconciliation
 - Coding – Billing and Comorbidities
 - Building Quality Measure Tracking and Reporting
 - Patient Care Plan, Navigation and Care Management Fulfillment, Work Flow and Reporting for Continuous Quality Improvement
 - Quality Measures tracking, and reporting to CMS and payers
 - CMS Data Analytics, Prediction, and Risk Assessment
- Resources and Work Flow
 - Patient Communication
 - HUDDLES
 - Care Management
 - Team Integration Across Practice
 - Staffing, Training, Rapid Implementation
- Quality
 - Identification of Gaps
 - Reporting, Analytics, Integration into Teams and Daily Practice Life
 - Reviewing for Continuous Quality Improvement
- Costs
 - Recognizing and Tracking Costs external to practice: drivers, existence, barriers, opportunities
 - Patient severity and risk stratification
 - Eye on the goal: CMS savings of 2.75% or 4% for each performance period

Dashboard Measures – Practice, Physician

- Emergency Department Visits (Frequency, Cause)
- Outpatient Visits (Frequency, Cause)
- Inpatient Utilization (Frequency, Cause)
- Days of Treatment before Death
- Days in Hospice Care at End of Life
- Advanced Care Planning Discussions
- Lines of Therapy
- Medical CoMorbidity
- Orals Compliance
- Actionable Opportunities to intervene in care process to change costs and variation – Actual Care Planning and Navigation
- Avg PMPY
- Active Chemo Mbr Months
- Active chemo PMPM
- IP Avg LOS (with Cause)
- Annual pnt costs (by category – labs, drugs, etc)
- Clinical Care Plan Measures – Patient screening results and responses
- High Risk Patients – Daily, Weekly, Monthly Status

Implications for Non OCM Practices

- Data is King
 - NOT just cost of drug
 - Ripple effects of treatment choices – timing, side effects, additional tests, unique tests vs panels, site of care (home more important)
 - More Knowledge may lead to more or reduced access and treatment
- Patient Management is King
 - 2 way communication 24/7
 - Repeated training on side effects, disease, self=management
 - Questions and Expectations plus Impact affect Access and Treatment
- Financials and Accountability – Eventually Risk - are King
 - Both MDs and patients will be asking more detailed questions about costs and benefits (value)
- It is time to look at patients as populations, not individuals

CMMI OCM and Payers

Provider Payer Interactions – Slow (May see more action outside of OCM)

- CMMI has just recently opened their payer portal and has been engaging payers in OCM implementation options and challenges
- To date, OCM practices have focused on getting up to speed with OCM obligations, and not aggressively moved into other payer interactions
- Currently 16 actual participating payers. Anthem is a notable recent absence.
- Payers may create their own payment approach as long as it aligns with OCM's two-part payment approach. Payers must provide payments for enhanced services; the specifics of the payment amounts, schedules, and methodologies may differ from those of CMS.
- For purposes of OCM participation, practices may not partner with payers that were not selected for the model. They are welcome to engage in oncology alternative payment models with non-OCM payers, but participation in those models is separate from the OCM participation. For this reason, practices cannot refer to payment arrangements with payers that are not in OCM as part of OCM.
- The OCM application period is closed for practices and payers at this time. It may open to more practices in 2018.

Implications for Non OCM Practice

- OCM is a blunt instrument - no results yet, no proof of concept, complicated to deliver as a payer
- No incentives for private payers to stay with OCM
- Non-OCM models may provide more flexibility
- Current focus heavily on drugs – easily managed
 - Will payers shift responsibility for costs to providers?
 - Will accountability shift management strategy? = Not likely in the short term
- **Payers are responsible to customers for cost management**
 - Payer customer contracts are annual
 - Accountability models long term strategy
 - Drug management is short term strategy with immediate visibility
- Drug Management is likely to **expand** by both payers and providers under OCM and MIPS, not contract

The Looming Impact of OCM - Risk

Risk – the scary end game

- An amendment to the OCM Participation Agreement will allow OCM practices to request two-sided risk for episodes beginning on or after January 1, 2017. Under the current OCM Participation Agreement, practices may not elect two-sided risk until the beginning of Performance Period 4 (i.e., for episodes beginning on or after July 1, 2018).
- The OCM Discount varies depending on whether practices select one- or two-sided risk. Practices that select the two-sided Risk Arrangement will have an OCM Discount of 2.75% applied to their Benchmark Price to generate their Target Price for each episode. Practices in the one-sided Risk Arrangement will have an OCM Discount of 4% applied to their Benchmark Price to generate their Target Price for each episode.
- **Would a new insurance company open if they only had 400 covered lives?**
- **The CA Landscape – Risk is accepted in some groups – lessons to be shared**

Impact of OCM on Practices and Oncology

- Gamechanger
- Forcing changed perspective along a continuum toward patient and then population management (every practice at a different point)
- All encompassing
 - Staffing, operations, work flow, technology infrastructure, reporting and analytics, team huddles, patient communications and interactions inside and outside the office, other healthcare communications and interactions inside and outside the office and more
 - Over 100 individual documents, tables, FAQs, and program definitions/descriptions issued since summer of 2016 – thousands of pages
 - “some of the data required for OCM may not be captured in some EHR systems and will need to be manually reported. “ ...i.e. Clinical data such as “number of lymph nodes examined” may not be a reportable field in the EHR.
 - Not all oncology tools and resources for patient management qualify...” The measure steward reviewed both the ESAS tool and the NCCN Distress Thermometer and determined that neither of these tools meet the requirements to be used for depression screening for OCM-5
 - OCM participants are responsible for **coordination of care for all patients**, and are therefore responsible for ensuring all information needed for clinical and quality data reporting is captured. ..even if clinical pathologists may not have recorded all information needed in reports. Now the **OCM responsibility**
- No road map
- Hope that this positions them for the future
- Not as far ahead as perceived, this is a challenge!
- Happening Anyway – with or without their permission or participation

Performance Requirements

- To receive a PBP, a practice or pool must meet the following criteria:
 - The practice's/pool's actual episode expenditures must be less than the target amount for the performance period.
 - The practice/pool must have submitted the required data to the OCM data registry.
 - The practice or, in the case of a pool, each practice in the pool implemented all of the Practice Redesign Activities.
 - The practice/pool must have achieved a minimum Aggregate Quality Score (AQS) of 30%.
- The CMS discount is 4% in one-sided risk and 2.75% in two-sided risk. It represents direct savings to CMS in OCM.

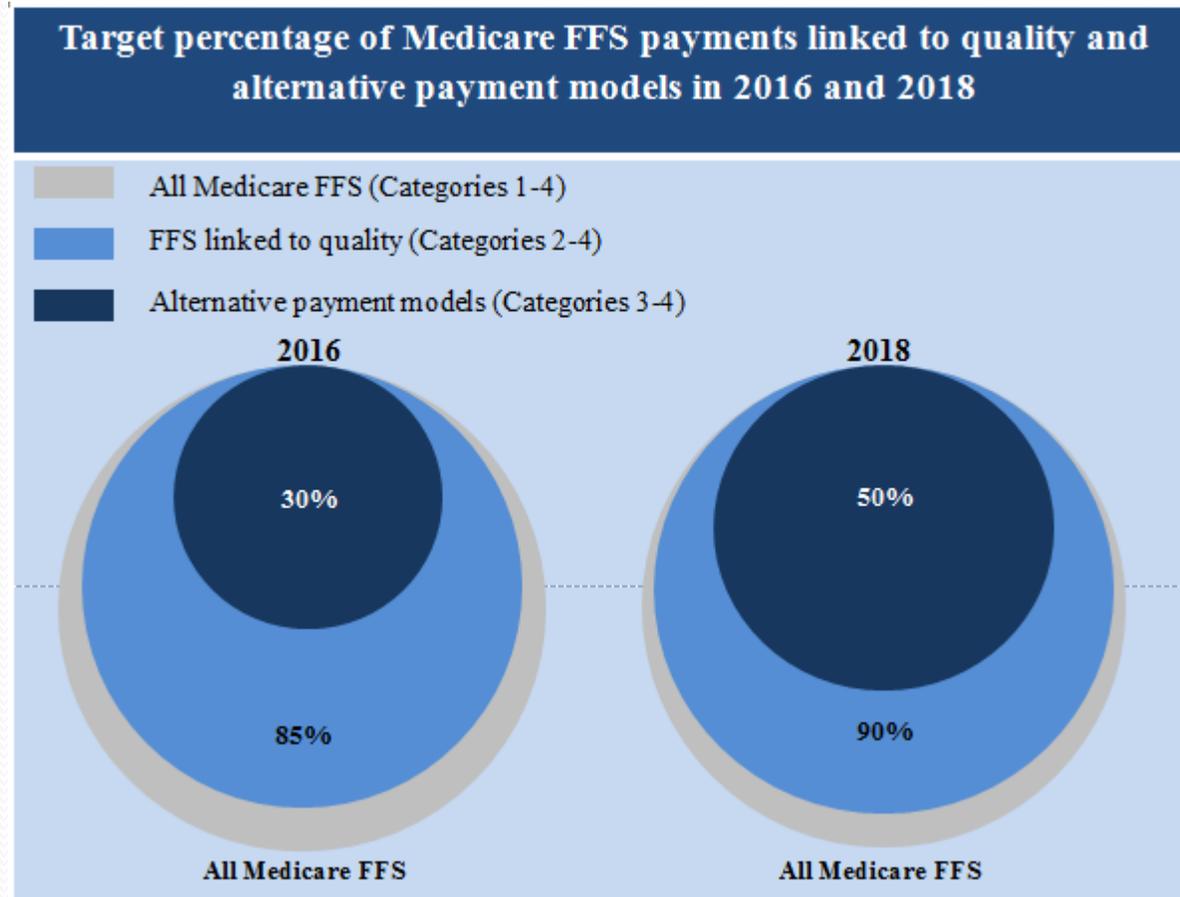
CMS Adjusting Quality Reporting Expectations

Measure/Data Type	Applicable Data	Reporting Timeframe
Aggregate Practice-Level Measures	OCM-7, OCM-8, OCM-9, OCM-10, and OCM-11	Practices are required to report aggregate-level data for the first 6-month measurement period (July 1, 2016 - December 31, 2016).
Beneficiary-Level Encounter-Based Measures	OCM-4a, OCM-4b, and OCM-12	Practices will report data for episodes initiating after January 1, 2017. Practices are no longer required to report data for the first 6-month measurement period (July 1, 2016- December 31, 2016).
Beneficiary-Level and Patient-Based Measures	OCM-5, OCM-24, and OCM-30	Practices will report data for episodes initiating after January 1, 2017. Practices will no longer be required to report data for the quarter that the data registry goes live (October 1, 2016- December 31, 2016).
Clinical Data	All Beneficiaries	Practices will be required to document clinical data for all beneficiaries that are in active episodes as of January 1, 2016.

The Future includes both OCM and
MACRA/MIPS – An inevitable Transition
Toward Value

CMS is the tail wagging the dog, but Private Payers Not Far Behind (Aetna, United, Anthem)

- CMS Goal – transfer Fee For Service Care to Value Based Payments for



CMS Definition of Value Payment Evolution

Payment Taxonomy Framework				
	Category 1: <i>Fee for Service—No Link to Quality</i>	Category 2: <i>Fee for Service—Link to Quality</i>	Category 3: <i>Alternative Payment Models Built on Fee-for-Service Architecture</i>	Category 4: <i>Population-Based Payment</i>
Description	<i>Payments are based on volume of services and not linked to quality or efficiency</i>	<i>At least a portion of payments vary based on the quality or efficiency of health care delivery</i>	<i>Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk</i>	<i>Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥ 1 yr)</i>
Medicare PFS	<ul style="list-style-type: none"> Limited in Medicare fee-for-service Majority of Medicare payments now are linked to quality 	<ul style="list-style-type: none"> Hospital value-based purchasing Physician Value-Based Modifier Readmissions/Hospital Acquired Condition Reduction Program 	<ul style="list-style-type: none"> Accountable care organizations Medical homes Bundled payments Comprehensive primary care initiative Comprehensive ESRD Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model 	<ul style="list-style-type: none"> Eligible Pioneer accountable care organizations in years 3-5

Value Models in Transition – outside of OCM

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	
CURRENT LAW	PQRS (PhysicianQualityReportingSystem) Penalties												
	-1.5%	-2.0%	2016 FORWARD										
	Meaningful Use Penalties (Up to.....)												
	-1.0%	-2.0%	-3.0%	-4.0%	-5.0%?	FORWARD							
	Value-Based Payment Modifier Penalties Up to.....)												
	-1.0%	-2.0%	-4.0%	????	2018 FORWARD								
MACRA FIRST TRACK	Existing penalties under PQRS, VBM, HER sunset on 12/21/2108												
	Permanent Repeal of SGR												
	Updates in Physician Payments												
	0.5%	(7/2015 - 2019)				0% 2020 - 2025					0.25% 2026 FORWARD		
	MIPS (Merit-Based Incentive Payment System) adjustments												
	+ to - 4%	+ to 15%	+ to - 7%	+ to - 9%	2022 FORWARD								
	MIPS Exceptional Performance adjustment; Up to 10% annually 2019 - 2024												
MACRA 2ND TRACK	APM (Alternative Payment Model) participating providers exempt from MIPS;												
	receive annual 5% bonus (2019 - 2014)										0.75% Update 2026 FORWARD		

Credited to Bobbi Buell, 2/25/2016

MACRA

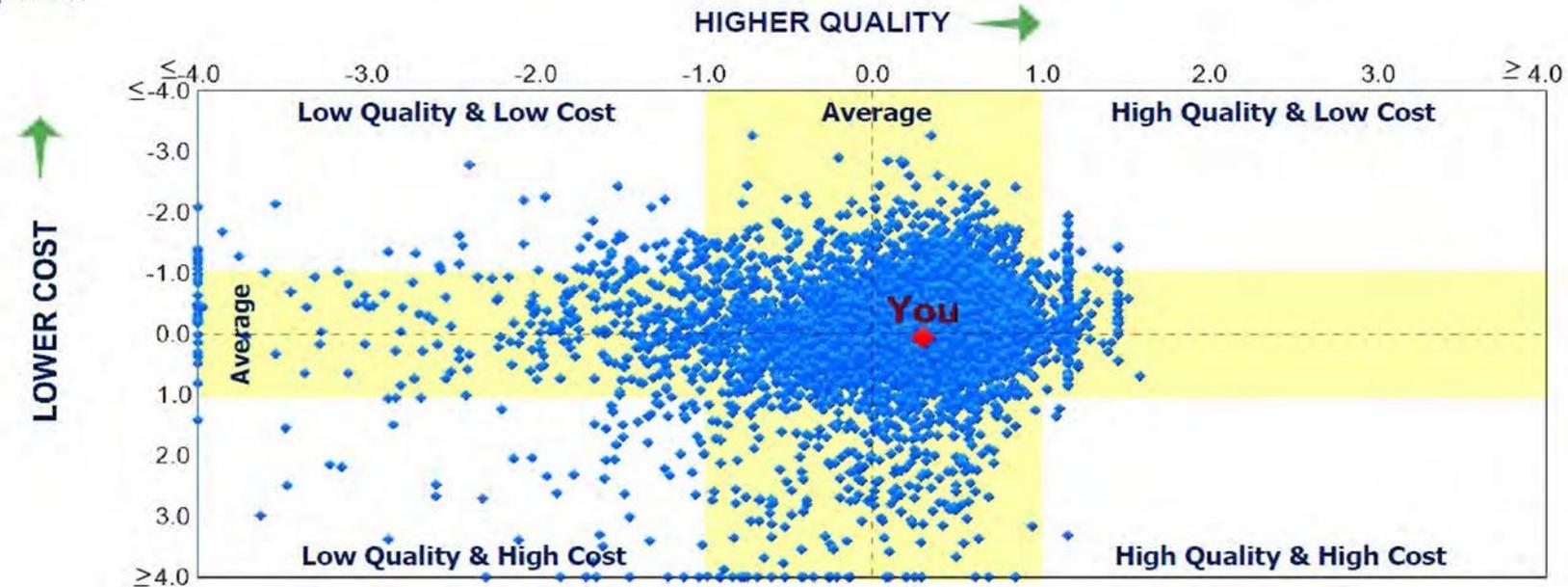
- Medicare Access and CHIP Reauthorization Act of 2015
 - Repeals the Sustainable Growth Rate (SGR) Formula
 - Authorizes CMS to establish the new Quality Payment Program to increase payments based upon value, not volume
 - Streamlines current reporting programs into 1 new system: **Merit Based Incentive Payment System (MIPS)**
 - Incentivizes involvement in Alternate Payment Models (APMs), especially Advanced APMs

Value = Quality and Cost

- Value Based Modifier Scoring and Comparisons – CMS Quality Resource Utilization Report (QRUR)

Your TIN's Performance: Average Quality, Average Cost

The scatter plot below displays your TIN's quality and cost performance ("You" diamond), relative to that of your peers.



MACRA 2017 Choices

Advanced Payment Model

Full Year- Report for at least a 90 day period and up to the full year the required measures for full reporting in each category.

Up to a 4% payment reduction or bonus depending upon performance, as well as a potential exceptional performer bonus in 2019

Partial Year – Report for at least a 90 day period (can be longer) more than 1 quality measure, more than 1 clinical improvement activity, and more than the required advancing care information measures

No payment reduction, but a chance at a small payment bonus in 2019

Minimum – At least 1 quality measure, 1 clinical improvement activity or the 5 base advancing care information measures

No payment reduction, but no eligibility for bonus in 2019

Practices can transition into MIPS in 2017

- **Minimum** – At least 1 quality measure, 1 clinical improvement activity or the 5 base advancing care information measures
 - No payment reduction, but no eligibility for bonus in 2019
- **Partial** – Report for at least a 90 day period (can be longer) more than 1 quality measure, more than 1 clinical improvement activity, and more than the required advancing care information measures
 - No payment reduction, but a chance at a small payment bonus in 2019
- Report for at least a 90 day period and up to the full year the required measures for **full** reporting in each category.
 - Up to a 4% payment reduction or bonus depending upon performance, as well as a potential exceptional performer bonus in 2019

Quality Measures

- 60% weight in 2017, dropping to 30% by 2019
- Full reporting – 6 quality measures (down from 9), must include an outcomes based measures or high priority measure if there is not a quality measure applicable to a given specialty
- Groups in APMs qualifying for special scoring standards under MIPS, such as Shared Savings Program Track 1 or the OCM – will report quality measures through their APM and need do nothing additional for MIPS quality reporting.
- <https://qpp.cms.gov/measures/quality>

Cost Measures

- Weight – 0% in 2017, 10% in 2018, 30% thereafter
- Cost scores will not include Part D drug costs (**possibly significant**)
- Measured off claims data, so no direct reporting required from MDs
- Two measures apply to all physicians
 - Total per capita cost for all Medicare fee for service beneficiaries
 - Medicare spending per beneficiary
- Additional episode-based cost measures for specific procedures (still being finalized by CMS)

Clinical Practice Improvement Activities

- **Care Coordination, beneficiary engagement, and patient safety**
- Weight – 15% in the first year and thereafter
- CMS is finalizing more than 90 CPI activities from which to choose, each with a medium or high weight
- Minimum for 2017 is 2 high-weight activities, 4 medium-weight, or 1 high-weight and 2 medium-weight activities (continuous over 90 days)
- **Most – Attest to a minimum of 4 over a minimum of 90 days**
 - Small Groups – Attest to up to 2 over a minimum of 90 days
 - Certain APMs and OCM participants – automatic full credit
- Attest, but be prepared to prove and support upon audit
- More activities can raise your score

- **<https://qpp.cms.gov/measures/ia>**

Advancing Care Information Score

- Weight 25% in 2017 and thereafter, based upon two parts:
- Base Score (worth 50 out of 100 points)
 - Security risk analysis done
 - % of prescriptions by e-prescribing (at least 1)
 - % of patients given timely electronic access to health information (at least 1)
 - % of transitions of care and referrals where summary of care record created and sent electronically (at least 1)
 - % of patient encounters where clinician received transition of care or referral and accepted a summary of care record electronically (at least 1)
- Performance Score (worth up to 80 out of 100 available points)
 - MUST qualify for base score first
 - Based on performance on measures within 8 objectives, including:
 - Protection of patient health information
 - Patient electronic access
 - Secure messaging
 - Participation in health information exchanges and public health databases
- **<https://qpp.cms.gov/measures/aci>**

Weighing the Numbers to a **Composite Score**

- CY – 2017 (2019 Bonus/Penalty – could gain/lose up to 4% of Medicare Part B Payments)
 - **Quality 60%**, **Cost 0%**, CPIA 15%, Advancing Care Info 25%
- CY – 2018 (2020 Bonus/Penalty – could gain/lose up to 5% of Medicare Part B Payments)
 - **Quality 50%**, **Cost 10%**, CPIA 15%, Advancing Care Info 25%
- CY – 2019 (2021 Bonus/Penalty – could gain/lose up to 7% of Medicare Part B Payments)
 - **Quality 30%**, **Cost 30%**, CPIA 15%, Advancing Care Info 25%

2022 Bonus/Penalty – could gain/lose up to 9% of Medicare Part B Payments every year after

CMS estimates that 70,000 to 120,000 will participate successfully in APMs vs 592,000 to 642,000 will be subject to MIPS

Advanced Payment Models (APM)

- Must Qualify
 - Requires at least 50% of eligible clinicians use certified HER technology, up to 75% after 2017
- Paid based on quality measures similar to MIPS measures
- Either a recognized CMS “medical home” or bear a risk for losses
- Extra incentives possible, but must meet all qualifying rules
- Rewards – IF receive at least 25% of Part B payments or see at least 20% of Medicare patients through the APM, will:
 - Receive incentive of 5% of Part B payments, and exempt from MIPS adjustments
- Partial qualifications (20% of payments or 10% of patients)
 - No incentive payment, but still exempt from MIPS adjustments

Implications for Non OCM Practices for MIPS

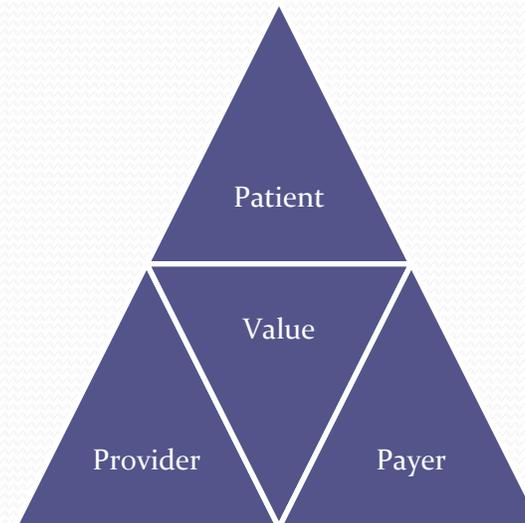
- Cost measures kick in gradually
- Quality measures are key from 2017 forward
- How ready are you to accept disease management and accountability?
- How will you obtain total cost data for analytics? What can you measure internally in the interim?
- How creative can you get in moving the QRUR needle and your positioning within MIPS?
- 196 OCM practices are the bellwether for all practices in the country under MIPS

What Does the Future Hold for Oncology?

- Possible Expansion in 2018 for OCM Practices in CMMI OCM
- Federal Government Changes may shift dollars and responsibility, but probably unlikely to slow the movement toward value and accountability for total costs of care
- As medical risk and accountability models increase for providers, treatment choices are likely to be closely scrutinized for delivery costs, likelihood of manageable or not manageable costly side effects and complications, and effectiveness that changes the quality and total costs of a patients care (positively and negatively)
- Probably direct employer involvement in oncology value models, possibly faster than payers in terms of provider relationships

Practice Dashboards for the Future – How Do Treatments Fit in?

- Patient – symptom, treatments, experiences, compliance, adherence
- Clinical – Disease, treatment, diagnostics, ER, hospitalization, symptoms, responses, compliance, adherence, concordance
- Population Management – Disease prevalence, medical acuity, total costs, screenings and disease management
- Collaborative, Informative, Catalysts

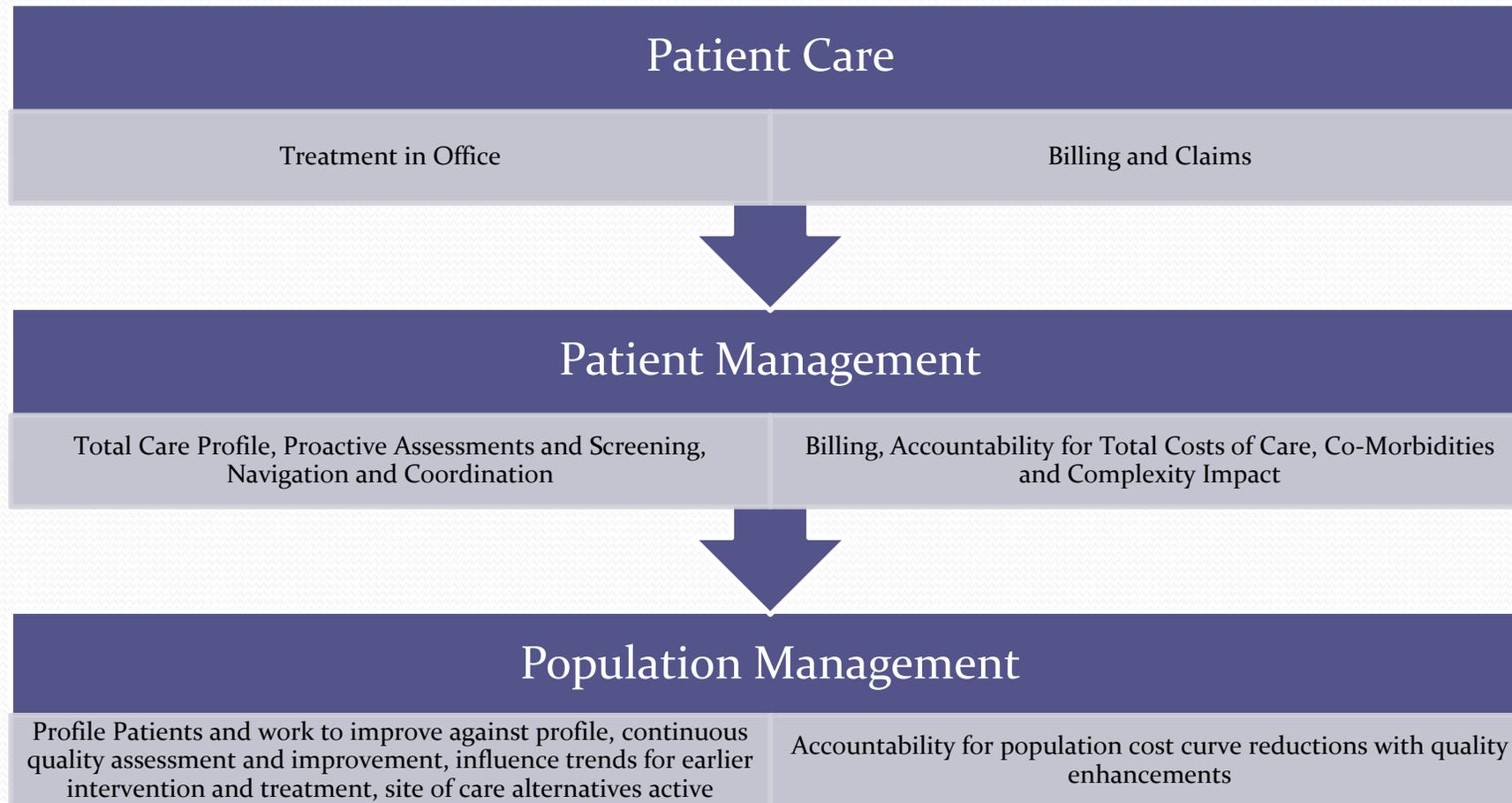


Key Points re OCM and Value

- Transition
- CMMI forcing action – will know full impact when/as program progresses
- Treatment to Patient Management to Population Management will completely change care delivery (medical choices, site of care, even provider resource allocation).....in ways still unknown
- Cost impact is transitional, but accountability for total costs is happening
- Technology is not there yet, and landscape will change...EHRs not likely to be sole source solutions, yet interoperability for practices and payers is a significant challenge
- Treatment decisions will change, not prevalent yet.
- Providers and Payers still fairly far apart – each operating in own silos, with marginal or pilot interaction. Stay tuned for rapid changes.

Transformation

Paradigm Shift



New Reality

- 4 Walls no longer
- New Mindsets
 - Patient management
 - External Costs Awareness and Management
 - Upstream and Downstream Accountability
 - Technology Expansion beyond HER
 - New Expectations Just to Stay in Game, let alone Maintain Role

New Skillsets

- Population management accounting and leadership
- Collaboration
 - Outside entities
 - Payers
 - Employers
- Analytics
 - Population (Practice and Global Claims, Screenings and Assessments)
 - Value
 - Risk
 - Bundling
- Regulatory Management/Advocacy



Thank You, and Good Luck

Dawn Holcombe, MBA, FACMPE

DGH Consulting

33 Woodmar Circle

South Windsor, CT 06074

860-305-4510

dawnho@aol.com

www.dghconsulting.net