What Practices Need to Know in 2018
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Innovative treatments require an equally innovative approach to gathering insights.
We respect and value your time as a busy clinician. Which is why we have created a streamlined recruitment site that determines in real time if you are a possible candidate for:

  Online surveys    |    Telephone-based interviews    |    In-person events

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Selected participants are paid honoraria for their participation.
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Positioning Your Practice for Positive Reimbursement Adjustments

How a focus on continual improvement can increase revenue

By Ronda Bowman, MHA, RN, OCN, and Natasha Clinton, MSN, APRN, AOCNP
As reimbursement shifts from a fee-for-service model (quantity) to a fee-for-value model (quality and cost), practices may face challenges in transforming their patient care delivery model to meet the new measures and reporting demands. Practices may need support as they continue their focus on day-to-day operations while looking forward to the future of value-based care.

The Centers for Medicare & Medicaid Services (CMS) has noted that their transfer to the Quality Payment Program (QPP) is aimed at better care for individuals, better health for populations and lower cost. The shift was catalyzed by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which ended the Sustainable Growth Rate formula and implemented the QPP.

Most practices will participate in the QPP through the Merit-Based Incentive Program (MIPS) or an advanced Alternative Payment Model (APM). The potential reimbursement under MIPS will range from +/- 4.0 percent in 2019, increasing to +/- 9.0 percent in 2022, based on a series of reporting measures. Practices also have an opportunity to reach exceptional performance, thereby increasing their positive adjustment potential.

The MIPS reimbursement program was designed to be “budget-neutral,” with the higher performing practices benefiting at the expense of the lower-performing practices. And for the first time, CMS has decided to include Medicare Part B drugs in their reimbursement plan, placing a significant financial risk on the practice as reimbursements are calculated.

What does that mean to an oncology practice?

In 2017, the MIPS payment adjustments will be applied to payments for both items and services under Medicare Part B, including any Part B drugs administered in the practice – if the drugs can be attributed to your practice’s TIN (tax identification number) or NPI (national provider identifier).

For example: In an oncology practice, if the Eligible Clinician (EC)/practice does not submit any data for 2017 each EC will incur a negative 4 percent Medicare adjustment on the Medicare allowable in 2019. If the 2019 Medicare allowable for all Medicare services is $1.5M (including drugs), in turn the EC would see a loss of $60K – a negative 4 percent downward adjustment.

At the same time, if the EC/practice submits data at the highest level of performance and receives a positive 4 percent upward adjustment, the EC would see an additional $60K in reimbursements.

The incentives to report fully in all categories and strive for continual improvements in quality can make a significant financial impact on the practice, especially as the reimbursement range increases to 9 percent in a few years.

The new system aligns quality and cost in your practice’s patient care delivery model, as this reimbursement model is eventually expected to be adopted by the private payers.

Moving to a system where quality + cost = value

Quality in healthcare can be defined in a number of ways depending on your perspective. As a patient, you may look for personalized care, better care coordination, improved communication, timeliness of your care or psychosocial support. As a provider, you may understand quality to be present in evidence-based medicine, patient satisfaction and reimbursement to support your patient-centered care, to name a few. While payers may be looking for treatment pathways, outcomes related to cost and improved patient outcomes. Comparing the perspectives, some will align, while others will be valued independently – adding a layer of complexity to the equation.

“With community oncology practices focused on day-to-day operations, often they do not have the extra resources, time or ability to stay abreast of this rapidly changing healthcare market. Yet they look for continual improvement opportunities to help transform their practice and make improvements for patients.”

Natasha Clinton, MSN, APRN, AOCNP
Director of Clinical Quality Programs,
ION Solutions

1. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html
2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4031722/
The considerations in each factor of the equation will include:

- **Quality Care:** Patient navigation, access to care, financial navigation, patient engagement, patient education, to name a few
- **Cost-effective Care:** A decreasing number of ED visits, a decreasing number of hospitalizations, cost of care in the last 30 days of life, hospice admission greater than three days of death, to name a few
- **Value-based Care:** Shared decision making, end of life care, exceptional patient experience, to name a few

With the new world of patient care delivery, practices need to evaluate their own performance in both quality and cost as it relates to value in the new reimbursement model. Having a “culture of quality” for continual improvement will move the patient-centered care model into this new world.

### How practices adapt to be successful in the new value-based models

As the value-based reimbursement models change, practices will need to focus on continual improvement. Measures under the reimbursement program will change as they are “topped out,” where CMS suggests there is little room for future improvement. Topping out will require practices to make frequent improvements to meet the standards for the measures under MIPS.

In the past year, ION Solutions’ Clinical Quality Consulting team developed a comprehensive Clinical 360 assessment to identify a practice’s strengths, risks and opportunities for improvement. The external observation allows for a different lens and frame of reference from an outside perspective by a team with more than 30 years of community oncology practice experience and expertise on the transition to value-based care.

The practice assessment uses a clinical excellence framework referenced by best practices in oncology care and key data elements for a standardized approach to practice evaluation. The assessment is performed by evaluating clinical oncology workflows, compliance with oncology nursing standards and current approaches to continual quality improvement. At the conclusion of the Clinical 360, a report of findings, recommendations and an optimization plan with a Clinical Roadmap for Clinical Quality Improvement is created. The Clinical Quality Consulting team can support and guide the practice through the Clinical Roadmap for Quality Improvement and practice transformation.

Value-based patient care initiatives that are evaluated within the practice include:

- Patient-centered care
- Standardized patient care delivery
- Patient navigation
- Care coordination
- Team-based care
- Access to care
- Policy and procedures, and best practices

### The New World of Patient Care Delivery

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<th>Quality Care</th>
<th>Cost-effective Care</th>
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<td>Patient-centered care</td>
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Practices that work with the Clinical Quality Consulting team will receive support and guidance to assist them in the shift from fee-for-service to value-based payment models. We offer practices a comprehensive clinical practice evaluation and a report on the findings with recommendations to highlight practices’ strengths as well as opportunities for continual improvement.

Ronda Bowman, MHA, RN, OCN
Senior Director of Clinical Quality Programs,
ION Solutions

Advanced Practice Provider program
Continual quality improvement
Clinical risk management and patient safety
Opportunity for quality recognition

The Clinical Optimization Plan prioritizes risks and opportunities for overall patient care delivery optimization that supports the practice transformation to a value-based care delivery model.

An example of a specific recommendations could include:

1. A formal training plan, including the use of a clinical competency assessment which would provide consistency in the delivery of care to patients by the clinical staff. A standardized assessment of current competency conducted annually for all roles and members of the clinical staff would validate and improve consistency in the delivery of care to patients. An annual clinical competency assessment is recommended for all clinical staff roles.

2. Infusion suite policy and procedures that provide best practice guidelines, alignment among all clinical staff members on care delivery and standardized high quality and safe patient care are an essential for any oncology practice.

What does the future hold for practices?

Enduring pressure from both government and private payers to improve outcomes and lower costs will warrant practices to make the transition to a value-based care delivery model. A practice can prepare for the transition to value-based care through the support and guidance of the clinical expert team of ION Solutions’ clinical consultants.

To learn more about the Clinical 360 assessment or how the Clinical Quality Consulting team can help your practice, please send an email to clinicalqualityconsulting@iononline.com.

Ronda Bowman, MHA, RN, OCN, is ION Solutions senior director of Quality. She is an Oncology Certified Nurse and is a presenter on the topics of comprehensive oncology practice services, value-based healthcare and continuous quality improvement.

Natasha Clinton, MSN, APRN, AOCNP, is ION Solutions director of Quality Programs. Her responsibilities include serving as an expert in healthcare operations, clinical nursing, healthcare education, clinical research, quality and process improvement initiatives and innovative patient care initiatives. Natasha is a Board Certified Family Nurse Practitioner and an Advanced Oncology Certified Nurse Practitioner.
Barry Fortner Returns to Capitol Hill to Advocate for Community-based Care

On November 3, 2017, Barry Fortner, President of Oncology Supply, and Brad Tallamy, Director of Government Affairs at AmerisourceBergen, urged Congressional leaders to pass H.R. 1920, cosponsored by Reps. Fred Upton (R-MI), Gene Green (D-TX), John Shimkus (R-IL), Diana DeGette (D-CO), Pat Tiberi (R-OH), Peter King (R-TX), Ron Kind (D-WI), Pete Sessions (R-TX), Buddy Carter (R-GA), and Pat Meehan (R-PA) which excludes distributor prompt pay discounts from Medicare Part B Reimbursement. This long-sought exclusion would correct an error that reduces reimbursement for Part B providers, hitting community-based practices particularly hard – AmerisourceBergen alone has lost nearly 1,200 physician practice customers since 2005.

Barry and Brad met with Energy and Commerce Health Subcommittee Chairman Michael Burgess (R-TX), Energy and Commerce Health Subcommittee Ranking Member Gene Green (D-TX), Rep. Terri Sewell (D-AL), as well as staff from the offices of Reps. Pete Olson (R-TX), Kenny Marchant (R-TX), Sam Johnson (R-TX), and Bill Flores (R-TX) to communicate this message and urge members to include H.R. 1920 in must-pass Medicare legislation.

Barry walked through data highlighting that community-based practices continue to provide cost-effective, high quality patient care and explained that correcting the prompt pay error will help preserve patient access to this site of care going forward. Following the meetings, Reps. Sewell and Marchant indicated that they would cosponsor the legislation. ABC has supported legislation correcting the prompt pay error for many years and will continue to push to ensure patient access to community-based care is preserved.

Conducting a Security Risk Analysis

With reimbursement reporting under the CMS, formerly under Meaningful Use (MU) and now under the Merit-based Incentive Payment System (MIPS), practices are required to report on their security risk analysis or protection of patient information. The government takes this protection very seriously. In 2016 alone, more than 329 breaches of more than 500 health records were reported, totaling more than 16 million patient records. While cyberattacks and hacking accounted for some of the breaches, sometimes records are lost because of loss or improper disposal.

While EHR vendors can provide training on the privacy aspects of their products, it is up to the practice to ensure that they take steps to ensure privacy and document the process. CMS suggests that supporting documentation for attestation be retained for a minimum of six years.

Internal security risk audits must be completed by the end of the current reporting year. Practices need to understand that it is not just putting a HIPPA policy in place – it is addressing questions that may come up about security.

Examples like:
- What if an administrator’s laptop is stolen out of a car? Is the laptop password protected? Or is the data encrypted? How do you notify patients?
- If your server goes down, what do you have in place for backup? And is that backup protected?
- When your reception area is checking in patients, can the patient read the screen? With computers in the exam rooms, does your staff log off before leaving the room or is there an automatic logoff?

Security risk compliance and HIPPA enforcement are some of the most audited subjects conducted by CMS. After receiving an audit letter, practices have little time to respond (often just 10 days to send documentation) and if not answered completely and successfully, providers can lose thousands of dollars in previous reimbursements.

If your practice needs to ensure you are answering all the possible questions, and documenting the process, ION Solutions experts have a checklist and template available for accuracy and completeness as part of their standard consulting services. If you are interested in learning more about conducting a security risk analysis, email us at sales@intrinsiq.com or call 877-570-8721 x2.

2018 Meeting Schedule

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*Meeting Dates Subject to Change*

Registration will be available approximately 60 days prior to each event. To register, visit www.iononline.com.
We Support the Health of your Practice
With the Same Dedication that You Support Your Patients

Your number one priority is the health of your patients. With the changing healthcare landscape, our number one priority is the business health of your practice.

Dedicated exclusively to the viability of community oncology, ION Solutions provides contracting, technology, education and advocacy support that ensures you have the tools to run your practice both efficiently and effectively. With the practice support of ION Solutions, you can navigate this changing environment and focus on providing quality care for your patients.

To learn how ION Solutions enables community oncology practices to improve operational efficiency, financial performance and quality of care, contact your Strategic Account Manager or visit IONonline.com.

To experience ION Solutions advocacy support, visit ourcommunitycounts.org.
Shrinking margins have pushed independent specialty practices to place even greater focus on operational efficiency. In response, successful practices have turned to their GPO and distribution partner for customized inventory management, as well as integrated technologies and business consulting, to increase time with patients. Improving cash flow takes a streamlined workflow. It takes AmerisourceBergen.