How is MIPS working?

At what cost?

Is this the best we can do?

Aaron Lyss
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Adaptation to new payment models

“Challenges, Perceptions, and Readiness of Oncology Clinicians for the MACRA Quality Payment Program”

- 4% “in-depth knowledge
- 9% never heard of it
- 44% recognized the name but not familiar w/ requirements
- 43% somewhat familiar


Disclaimer: this presentation includes opinions and perspectives that should not be assumed to reflect official policies or positions of Tennessee Oncology PLLC.
Impact so far?

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Is this the best we can do?

Intentions:
1. create performance-based variation in reimbursement
2. reimbursement commensurate with provider influence over the outcome
3. increase provider consideration of cost

Intentions:
• correlate w/ program requirements & measures
• include patient experience measures & required patient-centric activities

Reality:
• relative impact on program performance overwhelmed by extent of other requirements & measures
• Computer-centric > patient-centric

Individual frustration:
• Care teams prefer patients to computers, time is zero sum

Organizational economics:
• Performance driven by increase in technology and FTE resources

Reality:
• Insufficiently nuanced for specialists
• Questionable counterfactual outcomes & cost

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Could there be a better alternative?

“If everything is important, then nothing is” -- Patrick Lencioni

1. Multi-dimensional performance evaluation
2. Extent of program requirements & measures
3. Resources required to achieve high performance

Overall workforce health driven by:
1. Mitigating provider burden
2. Clarity of program structure leading to point-of-care understanding & influence over outcomes
Why not A-APM?

15x

Uncertainty that payers can evaluate performance while accounting for:
1. Cost of all care
   - Incl. on-pathway drugs
2. Case mix severity

X

+5% “bonus”
(based on Part B prof. service fees)

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