



ONCOLOGYMETRICS

Accelerating Advancements in Cancer Care



Meaningful Use: No Cash for Clunkers

EHR Certification & Meaningful Use

ANCO/MOASC Business of Oncology:
2010 and Beyond
October 28, 2010

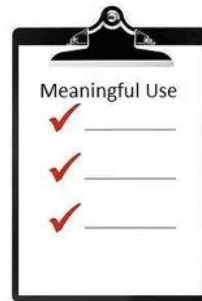
Cash for Clunkers



ONCOLOGYMETRICS

NO Cash for Clunkers

*Connecting America
for Better Health*



What is a clunker?

- No EMR
- EMR not certified
- Physician NPI is incorrect
- Not registered for EHR incentive program
- EMR cannot meet meaningful use criteria



Final rules simpler and clearer

- In June/July, final rules were released for:
 - **Certification**, explaining the standards that EMR/EHR vendors must meet to be deemed ONC certified
 - **Meaningful Use**, explaining what a physician or hospital must do in order to demonstrate their meaningful use of EMRs/EHRs



Certification is in process

Practices: Be aware of the certification process/timeline

1. In mid-June, the final rule establishing a temporary certification program for EHR technology was released by HHS
2. Organizations applied to ONC to become qualified to certify EHRs/EMRs
3. In late August, the Certification Commission for Health Information Technology (CCHIT®), Chicago, Ill. and the Drummond Group Inc. (DGI), Austin, Texas, were named as the first technology review bodies that have been authorized to test and certify electronic health record (EHR) systems; others are continuing to be named
4. EHR/EMR software must prove it's capable of supporting all of the meaningful use requirements for providers

Action items for oncology practices

Make sure your EMR vendor is certified as quickly as possible:

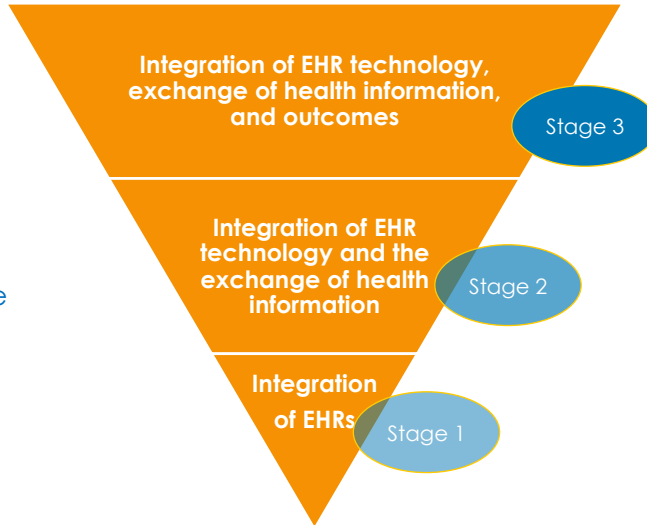
- ✓ Contact your vendor for an update
- ✓ Familiarize your staff with the meaningful use requirements
- ✓ Have a plan in place for qualifying for stimulus funds

Let's define some terms...

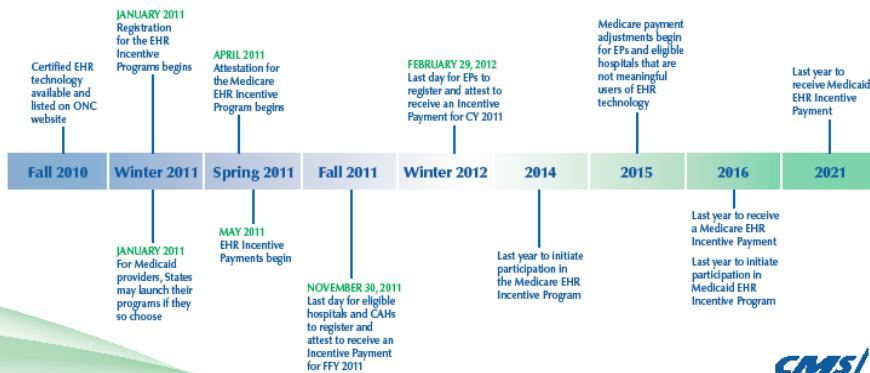
- ARRA - the American Recovery and Reinvestment Act (ARRA), federal stimulus program passed in 2009 which included incentive payments from the government for implementing electronic health record (EHR) technology (among other programs)
- HITECH Act - a provision of ARRA, the Health Information Technology for Economic and Clinical Health Act of 2009
 - Under the HITECH Act, Medicare and Medicaid incentive payments of up to \$27 billion from 2011-2011 will be available to eligible professionals (EPs) and eligible hospitals for "meaningful use of certified EHR technology".
 - The HITECH Act provisions are designed to serve the dual goals of improving health care through increased efficiencies and improved care decisions, while also stimulating economic recovery.

Three stages to HITECH

- HITECH goal is to drive meaningful use of EHR/EMRs
- It's a multi-year process with 3 distinct stages
- Each stage will require greater use of EHRs/EMRs
- **Starting now is the smart move**



CMS Medicare and Medicaid EHR Incentive Programs Milestone Timeline



Rationale driving Meaningful Use

The focus is on:

- Electronically capturing health information in a coded format
- Using that information to track key clinical conditions
- Communicating that information for care coordination purposes
- Initiating the reporting of clinical quality measures and public health information

Significant dollars are available

- As much as \$27 billion may be expended in incentive payments over 10 years
- Eligible providers can receive as much as:
 - \$44,000 under Medicare
 - Physicians operating in a “health provider shortage area” (HPSA) will be eligible for an extra 10%, up to a maximum of \$48,400
 - \$63,750 under Medicaid (must meet volume requirements)
 - Hospitals may receive millions of dollars for implementation and meaningful use of certified EHRs under both Medicare and Medicaid

Qualifying for incentive payments

For Medicare **incentive payments**, Medicare Eligible Providers must successfully demonstrate Meaningful Use for each year of program participation

- Providers must meet Meaningful Use criteria for a minimum of **90 consecutive days** to be eligible for stimulus funds in year one, which begins 1/1/11
- In subsequent years, providers will need to meet Meaningful Use criteria for the **full year**

Understanding the incentives

- For 2011-2016, eligible providers can receive up to \$44,000 over 5 years under the Medicare incentive program.
 - Incentive payments are made based on the calendar year
 - For maximum incentive payment, Medicare EPs need to participate by 2012

First Calendar year in which the EP receives an Incentive Payment					
CY	CY 2011	CY 2012	CY 2013	CY 2014	CY2015 & later
2011	\$18,000	--	--	--	--
2012	\$12,000	\$18,000	--	--	--
2013	\$8,000	\$12,000	\$15,000	--	--
2014	\$4,000	\$8,000	\$12,000	\$12,000	--
2015	\$2,000	\$4,000	\$8,000	\$8,000	\$0
2016	--	\$2,000	\$4,000	\$4,000	\$0
Total	\$44,000	\$44,000	\$39,000	\$24,000	\$0

Registering for incentives

Online registration for both Medicare and Medicaid incentive programs begins Jan. 1, 2011 with:

- Name, NPI, business address, and business phone
- TIN to which payments are to be made
- Choose participation in Medicare or Medicaid programs (can change once before 2014)

 Centers for **Medicare & Medicaid** Services

Payment of incentives

For the Medicare program:

- First chance to file for incentives is April 1, 2011
- Medicare EHR incentive payments will begin in mid-May 2011
- Future payments within 15-45 days of CMS receiving attestation of Meaningful Use

 Centers for **Medicare & Medicaid** Services

HITECH, PQRI, & eRx

- If an eligible provider opts to receive incentives under Medicare
 - May collect PQRI and HITECH incentives
 - May NOT collect eRx incentives
- If an eligible provider opts to receive incentives under Medicaid
 - May collect PQRI, HITECH, and eRx incentives

Defining Eligible Providers

- Eligible Professionals include:
 - Doctors of Medicine or Osteopathy
 - Doctors of Dental Surgery or Dental Medicine
 - Doctors of Podiatric Medicine
 - Doctors of Optometry
 - Chiropractors

PAs as Eligible Providers

Three instances in which a physician assistant (PA) qualifies as an eligible provider:

1. If the PA is the primary provider at the clinic:
 - If a physician is part time and the PA is full time, the PA is the eligible provider
2. When the PA is a clinical or medical director at the clinical site of practice
3. When the PA is the owner of the registered health center (RHC), regardless of the status of the other providers at the RHC

Core Set & Menu Set requirements

The final rules provide increased flexibility in the choice of items on which providers must report and more accessible thresholds

- Requirements are now divided into:
 - **Core Set**
15 mandatory requirements must be met by providers
 - **Menu Set**
Practices select 5 out of 10 requirements to demonstrate in Stage 1 (The remaining 5 will need to be demonstrated in Stage 2 in 2013)

Meaningful Use requirements

Core criteria for ambulatory settings

To prove Meaningful Use, physicians must:

1. Record patient demographics, including gender, race/ethnicity, date of birth, and preferred language at least 50% of the time
2. Record vital signs, including height, weight, blood pressure, and body mass index at least 50% of the time
3. Maintain up-to-date problem lists at least 80% of the time
4. Maintain active medication lists at least 80% of the time
5. Maintain active medication allergy lists at least 80% of the time
6. Record smoking status for patients >13 years of age at least 50% of the time
7. Provide patients with a clinical summary for each office visit within 3 business days, at least 50% of the time



Meaningful Use requirements

Core criteria for ambulatory settings (cont'd)

8. On request, provide patients with an electronic copy of their health information including test results, problem lists, meds lists, and allergies within 3 business days, at least 50% of the time
9. Generate electronic prescriptions at least 40% of the time
10. Use Computerized Physician Order Entry (CPOE) for medication orders at least 30% of the time. Note: This CPOE is ONLY for medications, not for lab ordering, imaging ordering, and referrals, etc.
11. Implement drug-drug and drug-allergy interaction checks at least 40% of the time



Core criteria for ambulatory settings (cont'd)

12. Be able to exchange key clinical information among providers by performing at least one test of the EHR's ability to do this
13. Implement one "clinical decision support rule" and ability to track compliance with the rule
14. Implement systems that protect privacy and security of patient data in the EHR, by conducting or reviewing a security risk analysis, and taking corrective step if needed
15. Report clinical quality measures to CMS or states - for 2011 provide aggregate numerator and denominator through attestation; for 2012, electronically submit measures (this refers to PQRI measures)

Menu Set requirements

The physician must also demonstrate at least 5 of the following 10 items in Stage 1:

1. Implement drug-formulary checking
2. Incorporate lab test data into the EHR as structured data
3. Generate lists of patients by specific conditions to use for quality improvement, reduce disparities, research, or outreach
4. Use EHR technology to identify patient-specific education resources, and provide those to the patient as appropriate - and do this at least 10% of the time
5. Provide medication reconciliation between care settings, at least 50% of the time

Menu Set requirements (continued)

6. Provide summary of care record for patients transferred to another provider or setting, at least 50% of the time
7. Submit electronic immunization data to local registries, performing at least one test of data submission, where registries can accept them
8. Submit electronic syndromic surveillance to public health agencies, performing at least one test, where local agencies can accept them
9. Send reminders to patients (per patient preference of format) for preventive and follow-up care, at least 20% of the time
10. Provide patients with timely electronic access to their health information, at least 10% of the time.

CQM for MU

- 3 required core CQM, and if the denominator of 1 or more of the required core measures is 0, then EPs are required to report results for up to 3 alternate core measures
- EPs also must select 3 additional CQM from a set of 38 CQM (other than the core/alternate core measures)
- In sum, EPs must report on 6 total measures: 3 required core measures (substituting alternate core measures where necessary) and 3 additional measures

Clinical Meaningful Use for Oncology

- Implement one clinical decision support rule.
 - Staging for all patients
- Core and Alternate Core (Must Report)
 - ❌ Childhood Immunization Status
 - ❌ Preventive Care and Screening: Influenza immunization for Patients 50 and older
 - ❌ Weight Assessment and Counseling for Children and Adolescents
 - Adult Weight Screening and Follow-Up
 - Hypertension: Blood Pressure Measurement
 - Preventive Care and Screening Measure Tobacco

Clinical Meaningful Use for Oncology

- **Adult Weight Screening and Follow-Up** Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.
- **Hypertension: Blood Pressure Measurement:** Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.
- **Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment, b. Tobacco Cessation / Intervention** Percentage of patients aged 18 years and older who have been seen for at least 2 office visits who were queried about tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older identified as tobacco users within the

Oncology Clinical Measures (Need 3)

- **Breast Cancer Screening:** Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.
- **Cervical Cancer Screening :** Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer.
- **Colorectal Cancer Screening:** Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.
- **Oncology Breast Cancer: Hormonal Therapy for Stage IC-III C Estrogen Receptor/Progesterone Receptor(ER/PR) Positive Breast Cancer:** Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period.

Oncology Clinical Measures (Need 3)

- **Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients:** Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period.
- **Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients:** Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.

While there are frustrations...



...the incentive is real



And there will be penalties

- 2015: Medicare “payment adjustments” begin for EPs that are not meaningful users or EHR technology
 - 2015: 1 %
 - 2016: 2 %
 - 2017 and beyond: 3%
 - 2019 and beyond: ARRA permits HHS to decrease payments by as much as 5%



How oncology practices can prepare

1. You must have a certified EMR
 - Confirm that your vendor has submitted for certification
 - You will need your vendor's HHS ONC certification number when you apply for funding
2. Your practice must become a meaningful user
 - Designate a staff member to:
 - Become the HITECH and Meaningful Use expert
 - Communicate with your EMR vendor
 - Review the core set, menu set and CQM set with providers to begin planning to integrate them into your practice
 - Develop a timeline for meeting the Meaningful Use requirement

How oncology practices can prepare

3. Set a target date for submitting your attestation
 - In year one, you will run key reports from the EMR re: quality measures listed in the MU summary and submit these reports when you apply for funds
 - Medicare announced that PECOS records will be used to verify Medicare enrollment prior to making incentive payments
4. Congratulate yourself and team for a job well done!

Next Steps for non-EMR practices

- If your practice doesn't have an EMR:
 - Start researching vendors and set up demonstrations
 - Get your practice organized to select an application
 - Begin implementation

Thanks for taking care of patients with cancer!

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