Objective

This webcast will address CMS’s Incentive Program reporting requirements with regard to PQRS, eRx, EHR, and meaningful use.
Why is 2013 so important?

- 2013 is a critical year for Medicare eligible professionals (EPs) for these programs
  - CMS has adopted the concept of a “two-year look back period” for payment adjustments
- Your participation this year is critical to avoid reduced reimbursement from CMS
Medicare Incentive Programs

• Physician Quality Reporting System (PQRS)
• ePrescribing (eRx) Incentive Program
• EHR Incentive Program ("meaningful use")

• Other programs
  ▪ Value Based Modifier Program (VBM)
  ▪ Hospital Outpatient Quality Reporting Program (Hospital OQR Program or HOQR Program)
  ▪ Reporting Measures for PPS-Exempt Cancer Hospitals
PQRS

• Voluntary reporting program implemented in 2007 that provides incentive payment to eligible professionals (EPs) who satisfactorily report data on quality measures
  ▪ For covered MPFS services
  ▪ Furnished to Medicare Part B beneficiaries
  ▪ During a specified reporting period
• Eligible professionals (EPs) include physicians, practitioners, therapists
• Incentive payments available until 2014
• Payment adjustments begin in 2015
eRx Incentive Program

• Incentive program for EPs who are successful electronic prescribers
  ▪ Separate from and in addition to PQRS
  ▪ EPs may not earn incentives under eRx and EHR programs at the same time
• EPs include physicians, practitioners, therapists (with prescribing authority)
• Incentive payments available until 2013
• Payment adjustments began in 2012 for EPs who are not successful e-prescribers
EHR Incentive Program

• Medicare and Medicaid programs to provide incentive payments to EPs and hospitals for the meaningful use of certified EHR technology

• EPs
  ▪ Medicare: doctor of medicine or osteopathy; dental surgery or dental medicine; podiatric medicine; optometry; chiropractor
  ▪ Medicaid: physicians, nurse practitioners, certified nurse-midwives, dentists, and physician assistants who practice in FQHC or rural health clinics led by a physician assistant

Note: hospital-based EPs are not eligible for payments in EHR program
EHR Incentive Program

- Program began in calendar year 2011
- Incentive payments for up to 5 years in the Medicare program; maximum of $44,000
- Payment adjustments begin in 2015 for Medicare EPs who cannot successfully demonstrate meaningful use of EHR technology

- No Medicare EHR incentive payments will be made to EPs whose first year of participation in the Medicare EHR program is 2015 or later
Alignment

The National Quality Strategy (created by the Affordable Care Act) established the “triple aim”, improving health, improving healthcare, reducing cost:

- Outlines a vision for quality improvement and creates an opportunity for programs to align quality measures and incentives across the continuum of care.

CMS believes that alignment of CMS quality improvement programs will decrease the burden of participation on physicians and allow them to spend more time and resources caring for beneficiaries:

- Goal to align program requirements between PQRS, eRx, EHR (and VBM) wherever possible.
Now for the details....
PQRS

• PQRS includes 203 quality measures for claims and/or registry-based reporting in 2013
  ▪ These measures include all specialties; there are few that are specific to cancer care
  ▪ ASCO has prepared a list of measures related to oncology/hematology (provided as appendix)
• Can report as individual EP or as a group practice (defined as a single Tax ID number with 2 or more EPs)
• Can choose to report on several self-selected individual measures or on a CMS-defined measures group
  ▪ Be sure you are using the most current version of the 2013 PQRS measure specifications as you choose your measures
Reporting Options

• Claims-based Reporting
• Registry-based Reporting
• Electronic Health Record (EHR)-based Reporting
• Group Practice Reporting Option
• NEW: Administrative Claims Reporting Option
New! Oncology Measures Group

- CMS has approved a new oncology measures group for 2013; must be reported via registry
- Approved registries are named by CMS in early summer of the reporting year
- Each registry vendor will have its own administrative requirements and fee structure
- Generally reporting via registry occurs late in the calendar year or early the following year
<table>
<thead>
<tr>
<th>NQF #</th>
<th>PQRS #</th>
<th>National Quality Strategy Domain</th>
<th>Measure Description</th>
<th>Measure Developer</th>
</tr>
</thead>
<tbody>
<tr>
<td>0387</td>
<td>71</td>
<td>Clinical Process/ Effectiveness</td>
<td><strong>Breast Cancer: Hormonal Therapy for Stage IC - IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer:</strong> 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.</td>
<td>AMA-PCPI/ASCO/NCCN</td>
</tr>
<tr>
<td>0385</td>
<td>72</td>
<td>Clinical Process/ Effectiveness</td>
<td><strong>Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients:</strong> Percentage of patients aged 18 through 80 years with AJCC Stage III colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period.</td>
<td>AMA-PCPI/ASCO/NCCN</td>
</tr>
<tr>
<td>0041</td>
<td>110</td>
<td>Population/ Public Health</td>
<td><strong>Preventive Care and Screening: Influenza Immunization:</strong> Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.</td>
<td>AMA-PCPI</td>
</tr>
<tr>
<td>0419</td>
<td>130</td>
<td>Patient Safety</td>
<td><strong>Documentation of Current Medications in the Medical Record:</strong> Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counter, herbas, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.</td>
<td>CMS/QIP</td>
</tr>
<tr>
<td>0384</td>
<td>143</td>
<td>Patient and Family Engagement</td>
<td><strong>Oncology: Medical and Radiation – Pain Intensity Quantified:</strong> Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified.</td>
<td>AMA-PCPI</td>
</tr>
<tr>
<td>0383</td>
<td>144</td>
<td>Patient and Family Engagement</td>
<td><strong>Oncology: Medical and Radiation – Plan of Care for Pain:</strong> Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain.</td>
<td>AMA-PCPI</td>
</tr>
<tr>
<td>0386</td>
<td>194</td>
<td>Clinical Process/ Effectiveness</td>
<td><strong>Oncology: Cancer Stage Documented:</strong> Percentage of patients, regardless of age, with a diagnosis of cancer who are seen in the ambulatory setting who have a baseline AJCC cancer stage or documentation that the cancer is metastatic in the medical record at least once within 12 months.</td>
<td>AMA-PCPI/ASCO</td>
</tr>
<tr>
<td>0028</td>
<td>226</td>
<td>Population/ Public Health</td>
<td><strong>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:</strong> Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.</td>
<td>AMA-PCPI</td>
</tr>
</tbody>
</table>
## 2013 PQRS Oncology Measure Group
### Denominator Criteria

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>For patients older than 18 years of age</th>
<th>For patients older than 50 years of age</th>
</tr>
</thead>
</table>
| Measures for all patients with cancer | • 130: Document Current Medications  
• 143: Oncology - Pain intensity quantified  
• 144: Oncology - Documented plan of care to address pain  
• 194: Oncology - Cancer Stage Documented  
• 226: Tobacco Use - Screening and Cessation |                                                                 |
| Measures for female patients with breast cancer only | • 71: Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/ |                                                                 |
| Measures for patients with colon cancer only | • 72: Colon Cancer Chemotherapy for Stage III Colon Cancer Patients | • 110: Preventive Care and Screening - Influenza Immunization for Patients ≥ 50 Years Old |
# Reporting Individual Quality Measures

## 2013 Requirements for Satisfactory Reporting Individual Quality Measures

<table>
<thead>
<tr>
<th>Reporting Mechanism</th>
<th>Reporting Requirements</th>
<th>Reporting Period</th>
</tr>
</thead>
</table>
| Claims-based reporting               | Report at least 3 PQRS measures, **OR**, if less than 3 measures apply to the eligible professional (EP), report 1-2 measures. *With either option, report each measure for at least 50% of EP’s Medicare Part B FFS patients seen during the reporting period to whom the measure applies.*  
  *Subject to the Measure-Applicability Validation (MAV) process. Measures with a 0% performance rate will not be counted.*                                                                                                           | January 1, 2013 – December 31, 2013    |
| Registry-based reporting             | Report at least 3 PQRS measures **AND** report each measure for at least 80% of the EP’s Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate will not be counted.                                                                                           | January 1, 2013 – December 31, 2013    |
| Qualified Direct EHR Product         | **Option 1:** Report on all three Medicare EHR Incentive Program core measures. If the denominator of one or more of the Medicare EHR Incentive Program core measures is 0, report on up to three Medicare EHR Incentive Program alternate core measures.  
  **Option 2:** Report on three (of the 38) additional measures available for the Medicare EHR Incentive Program.                                                                                                                                                                               | January 1, 2013 – December 31, 2013    |
| Qualified EHR Data Submission Vendor | **Option 1:** Report on ALL three PQRS EHR measures that are also Medicare EHR Incentive Program core measures (Stage 1). If the denominator for one or more of the Medicare EHR Incentive Program core measures is 0, report on up to three PQRS EHR measures that are also Medicare EHR Incentive Program alternate core measures **AND** report on three additional PQRS EHR measures that are also measures available for the Medicare EHR Incentive Program.  
  **Option 2:** Report at least 3 measures **AND** report each measure for at least 80 percent of the eligible professional’s Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate will not be counted in option 2. | January 1, 2013 – December 31, 2013    |
# Reporting Measure Groups

## 2013 Requirements for Satisfactory Reporting Measure Groups

**American Society of Clinical Oncology**

<table>
<thead>
<tr>
<th>Reporting Mechanism</th>
<th>Reporting Requirements</th>
<th>Reporting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims-based reporting</td>
<td>Report at least 1 PQRS measures group <strong>AND</strong> report each measures group for at least 20 Medicare Part B FFS patients. Measures with a 0% performance rate will not be counted.</td>
<td>January 1, 2013 – December 31, 2013</td>
</tr>
<tr>
<td>Qualified Registry (12-month reporting)</td>
<td>Report at least 1 measures group <strong>AND</strong> report each measures group for at least 20 patients, a majority of which must be Medicare Part B FFS patients. Measures with a 0% performance rate will not be counted.</td>
<td>January 1, 2013 – December 31, 2013</td>
</tr>
<tr>
<td>Qualified Registry (6-month reporting)</td>
<td>Report at least 1 measures group <strong>AND</strong> report each measures group for at least 20 patients, a majority of which must be Medicare Part B FFS patients. Measures with a 0% performance rate will not be counted.</td>
<td>July 1, 2013 – December 31, 2013</td>
</tr>
</tbody>
</table>
How to Avoid the 2015 PQRS Payment Adjustment

1. Meet the criteria for satisfactory reporting for the 2013 PQRS incentive

2. Report 1 valid measure or measures group using the claims, registry or EHR-based reporting mechanisms

3. Elect to be analyzed under the (new) administrative claims-based reporting mechanism
   - The election period will be available via web beginning in the summer of 2013 and will end October 15, 2013 – CMS will distribute the URL when it becomes available
Administrative Claims

• A new reporting mechanism to avoid the 2015 PQRS payment adjustment.
  ▪ CMS will analyze claims data to determine which measures were satisfactorily reported for the 2013 program year.
  ▪ More information regarding administrative claims and how EPs can elect this option will be posted on the CMS website as it becomes available.
For more information…

- PQRS
- PQRS payment adjustment

e-Rx Incentive Program

- EPs must report that they have electronically prescribed a specific number of times during the reporting period to qualify for the incentive.
- EPs must e-prescribe during an office visit; prescriptions ordered without an accompanying patient visit do not count.
e-Rx Incentive Program


2. Determine if you will report individually or as part of a group.
   - Group practice definition is 2 or more EPs sharing a Tax ID number.

4. For individual EPs, report G8553 as follows:
   - To avoid the 2014 penalty: report G8553 10 times between January 1 and June 30, 2013; submit claims by July 31, 2013.
   - To qualify for 2013 incentive: report G8553 a total of 25 times between January 1 and December 31, 2013. Submit claims by February 28, 2014. (The 25 instances here include the 10 instances potentially submitted during January – June.)

   - For group practice reporting options, see the CMS website. Reporting requirements vary by group size.
Incentives and Penalties

- Providers who successfully report for the eRx program in 2013 can earn a bonus payment of 0.5% on their Medicare Part B Physician Fee Schedule allowed charges.
- Physicians who do not adopt an e-Rx system and participate in the program (by June 30, 2013) will have 2.0% automatically deducted from their Medicare PFS-covered charges in 2014.
- There are no incentive payments in 2014, making 2013 the last possible year to earn an e-Rx incentive payment.
Incentives and Penalties

• It is possible to earn the incentive in 2013 and still be penalized in 2014.
  ▪ CMS is legislatively required to impose penalties on EPs if they do not adopt eRx in 2013. CMS must begin imposing penalties on 1/1/14. If an EP begins participation in late 2013, CMS does not have time to process the claims.
  ▪ To avoid the 2014 penalty, EPs must successfully report for the eRx program in January – June 2013.
## eRx Hardship Exemptions

<table>
<thead>
<tr>
<th>Significant Hardship Exemption Category</th>
<th>Method of Submission</th>
<th>Deadline for 2014 Exemption</th>
</tr>
</thead>
<tbody>
<tr>
<td>EP or group practice is unable to electronically prescribe due to local, state or Federal laws or regulations</td>
<td>Web-based Communication Support Page</td>
<td>June 30, 2013</td>
</tr>
<tr>
<td>EP or group practice has limited prescribing activity, as defined by an EP generating fewer than 100 prescriptions during a 6-month reporting period</td>
<td>Web-based Communication Support Page</td>
<td>June 30, 2013</td>
</tr>
</tbody>
</table>
## eRx Hardship Exemptions

<table>
<thead>
<tr>
<th>Significant Hardship Exemption Category</th>
<th>Method of Submission</th>
<th>Deadline for 2014 Exemption</th>
</tr>
</thead>
<tbody>
<tr>
<td>* 2014 Adjustment: EP or group practices who achieve meaningful use during the 2014 12- and 6-month eRx payment adjustment reporting periods (that is, January 1, 2012 – June 30, 2013)</td>
<td>EHR Incentive Program’s Registration/Attestation Page</td>
<td>June 30, 2013</td>
</tr>
<tr>
<td>** EP or group practices who demonstrate intent to participate in the EHR Incentive Program and adoption of Certified EHR Technology</td>
<td>EHR Incentive Program’s Registration/Attestation Page</td>
<td>June 30, 2013</td>
</tr>
</tbody>
</table>

* CMS will identify providers who achieve or register for EHR incentive program and will automatically exempt these professionals from the eRx program.

** “Intent to participate” includes registration with certification # for the certified EHR product. Limited to EPs new to the EHR incentive program.
For more information…

- ePrescribing Incentive Program: Updates for 2013

- Payment adjustment information
  - [http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/20_Payment_Adjustment_Information.html](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/20_Payment_Adjustment_Information.html)

- Payment adjustment fact sheet
EHR Incentive Program and Meaningful Use
Let’s start with some history…

- **ARRA** - the American Recovery and Reinvestment Act
  - Federal stimulus program passed in 2009
- **HITECH Act** - the Health Information Technology for Economic and Clinical Health Act of 2009, a provision of ARRA
  - Under the HITECH Act, Medicare and Medicaid incentive payments of up to $27 billion available to eligible professionals (EPs) and eligible hospitals for “meaningful use of certified EHR technology”
Why meaningful use?

• Meaningful use is using certified electronic health record (EHR) technology to:
  ▪ Improve quality, safety, efficiency, and reduce health disparities
  ▪ Engage patients and family
  ▪ Improve care coordination, and population and public health
  ▪ Maintain privacy and security of patient health information
Three stages of meaningful use

• Goal is to drive meaningful use of EMRs
• It’s a multi-year process with 3 distinct stages
• Each stage will require greater use of EMRs
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<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
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<td>TBD</td>
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<td>2012</td>
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<td>2013</td>
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<td>3</td>
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<td>2016</td>
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<td>2017</td>
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<td>3</td>
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## Incentive Payments over Time

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<td>$18,000</td>
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<tr>
<td>2013</td>
<td>$8,000</td>
<td>$12,000</td>
<td>$15,000</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>2014</td>
<td>$4,000</td>
<td>$8,000</td>
<td>$12,000</td>
<td>$12,000</td>
<td>--</td>
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<tr>
<td>2015</td>
<td>$2,000</td>
<td>$4,000</td>
<td>$8,000</td>
<td>$8,000</td>
<td>$0</td>
</tr>
<tr>
<td>2016</td>
<td>--</td>
<td>$2,000</td>
<td>$4,000</td>
<td>$4,000</td>
<td>$0</td>
</tr>
<tr>
<td>Total</td>
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<td>$44,000</td>
<td>$39,000</td>
<td>$24,000</td>
<td>$0</td>
</tr>
</tbody>
</table>
Penalties begin in 2015 for Medicare EPs that have not achieved meaningful use
  - Penalty based on demonstrating MU two years prior

You must continue to demonstrate MU to avoid future penalties

Penalties increase from 1% to 5% each year
Stage 1 Requirements

- Meaningful use includes both a core set and a menu set of objectives.
- For EPs, there are a total of 24 meaningful use objectives. To qualify for an incentive payment, 19 of these 24 objectives must be met:
  - 14 required core objectives
  - 5 objectives chosen from a list of 10 menu set objectives.
Stage 1 Requirements

- In addition to meeting the core and menu objectives, EPs are also required to report clinical quality measures.
  - EPs must report on 6 total clinical quality measures: 3 required core measures (or 3 alternate core measures) and 3 additional measures (selected from a set of 38 clinical quality measures).
Stage 1 Requirements Include:

- Basic data capture in structured format
  - Diagnoses, medications, allergies, demographics, smoking status, etc.
- Basic alerts and clinical decision support
  - Drug interaction checks, drug formulary
- Test exchanges of information
  - Immunization data submission
- Providing patients access to information
CMS provides Meaningful Use Specification Sheets that bring together critical information on each objective to help you understand what you need to do to meet the program requirements.

Each specification sheet covers a single eligible professional core or menu set objective in detail, including information on:

- Meeting the measure for each objective
- How to calculate the numerator and denominator for each objective
- How to qualify for an exclusion to an objective
- In-depth definitions of terms that clarify objective requirements
- Requirements for attesting to each measure
Stage 2

- Stage 2 begins in 2014
- All providers must achieve meaningful use under the Stage 1 criteria before moving to Stage 2
  - 90-day period of Stage 1 in first year of participation and a full year of Stage 1 in second year of participation, before moving to Stage 2 in year 3
  - EPs who were early demonstrators of meaningful use in 2011 will meet three consecutive years of meaningful use under the Stage 1 criteria before advancing to the Stage 2 criteria in 2014
For 2014 Only

• All providers regardless of their stage of meaningful use are only required to demonstrate meaningful use for a three-month EHR reporting period.

• For Medicare EPs, this 3-month reporting period is fixed to the quarter of the calendar year in order to align with the Physician Quality Reporting System (PQRS)

  ▪ CMS is permitting this one-time three-month reporting period in 2014 only so that all providers who must upgrade to 2014 Certified EHR Technology will have adequate time to implement their new Certified EHR systems.
Stage 2 Requirements

- To demonstrate meaningful use under Stage 2 criteria, EPs must meet 17 core objectives and 3 menu objectives (selected from a total list of 6), for a total of 20 core objectives.
- EPs must also report on 9 of the 64 approved Clinical Quality Measures.
Clinical Quality Measures (CQMs)

• In 2014, reporting of CQMs changes for all EPs
  ▪ EPs will be required to report using the new 2014 criteria regardless of whether they are participating in Stage 1 or Stage 2 of the Medicare Incentive Programs

• Also beginning in 2014, all EPs beyond their first year of demonstrating meaningful use must electronically report their CQM data to CMS
Stage 2 Requirements Include:

• Emphasis on exchange and care coordination
• Patient engagement required
  ▪ Accessing PHR and sending electronic messages
• Advanced clinical processes part of core set
  ▪ Transition of care summaries, lab results, drug formulary, medication reconciliation, patient education
• More registry reporting for public health
  ▪ Immunization and syndromic surveillance data
  ▪ Cancer registry and disease registries added to the menu set
Hardship Exceptions

• Infrastructure
  ▪ EPs must demonstrate that they are in an area without sufficient internet access or face insurmountable barriers to obtaining infrastructure (eg, lack of broadband)

• New EPs
  ▪ Newly practicing EPs can apply for a 2-year limited exception to payment adjustments

• Unforeseen Circumstances
  ▪ Examples may include a natural disaster or other unforeseeable barrier
Hardship Exceptions

• Patient Interaction
  ▪ Lack of face-to-face or telemedicine interaction with patients
  ▪ Lack of follow-up need with patients

• Practice at multiple locations
  ▪ Lack of control over availability of CEHRT for more than 50% of patient encounters

• Certain specialties are also automatically exempt and do not have to apply for a hardship
  ▪ Anesthesiology, radiology, pathology
The good news...

- Alignment is coming!
- In 2014, the PQRS and EHR programs have overlapping participation guidelines, including
  - The same quality measures
  - The same reporting criteria
  - The option to use the same reporting mechanism
For more information...

- EHR Incentive Program
  - [https://www.cms.gov/EHRIncentivePrograms/](https://www.cms.gov/EHRIncentivePrograms/)

- “An Introduction to the Medicare EHR Incentive Program for Eligible Professionals”

- Stage 1 vs. Stage 2 Comparison Sheet

- 2014 Clinical Quality Measures
### Incentives and Payment Adjustments

<table>
<thead>
<tr>
<th>Year</th>
<th>PQRS</th>
<th>eRx</th>
<th>EHR Incentive</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>+ .5%</td>
<td>+ .5%</td>
<td>Variable incentive</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 1.5% (based on 2012 participation)</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>+ .5%</td>
<td>- 2.0% (based on 2013 participation)</td>
<td>Variable incentive</td>
</tr>
<tr>
<td>2015</td>
<td>- 1.5% (based on 2013 participation)</td>
<td></td>
<td>-1.0%</td>
</tr>
<tr>
<td>2016</td>
<td>- 2.0% (based on 2014 participation)</td>
<td></td>
<td>-2.0%</td>
</tr>
<tr>
<td>2017</td>
<td>-2.0% (based on 2015 participation)</td>
<td></td>
<td>-3.0%</td>
</tr>
<tr>
<td>2018</td>
<td></td>
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<td>-4.0%</td>
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<tr>
<td>2019</td>
<td></td>
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<td>-5.0%</td>
</tr>
</tbody>
</table>
Thank you for caring for patients with cancer!

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Appendix

- PQRS Measures Related to Oncology/Hematology
<table>
<thead>
<tr>
<th>NQF #</th>
<th>PQRS #</th>
<th>National Quality Strategy Domain</th>
<th>Measure Description</th>
<th>Measure Developer</th>
<th>Reporting Options</th>
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<tbody>
<tr>
<td>0097</td>
<td>46</td>
<td>Patient Safety</td>
<td><strong>Medication Reconciliation:</strong> Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with.</td>
<td>AMA-PCPI/NCQA</td>
<td>Claims, Registry, GPRO/ACO</td>
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<tr>
<td>0326</td>
<td>47</td>
<td>Care Coordination</td>
<td><strong>Advance Care Plan:</strong> Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.</td>
<td>AMA-PCPI/NCQA</td>
<td>Claims, Registry, EHR</td>
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<tr>
<td>0377</td>
<td>67</td>
<td>Clinical Process/Effectiveness</td>
<td><strong>Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow:</strong> Percentage of patients aged 18 years and older with a diagnosis of MDS or an acute leukemia who had baseline cytogenetic testing performed on bone marrow.</td>
<td>AMA-PCPI/ASH</td>
<td>Claims, Registry</td>
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<tr>
<td>0378</td>
<td>68</td>
<td>Clinical Process/Effectiveness</td>
<td><strong>Hematology: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy:</strong> Percentage of patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy with documentation of iron stores within 60 days prior to initiating erythropoietin therapy.</td>
<td>AMA-PCPI/ASH</td>
<td>Claims, Registry</td>
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<tr>
<td>0380</td>
<td>69</td>
<td>Clinical Process/Effectiveness</td>
<td><strong>Hematology: Multiple Myeloma: Treatment with Bisphosphonates:</strong> Percentage of patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission, who were prescribed or received intravenous bisphosphonate therapy within the 12-month reporting period.</td>
<td>AMA-PCPI/ASH</td>
<td>Claims, Registry</td>
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<tr>
<td>0379</td>
<td>70</td>
<td>Clinical Process/Effectiveness</td>
<td><strong>Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry:</strong> Percentage of patients aged 18 years and older seen within a 12 month reporting period with a diagnosis of chronic lymphocytic leukemia (CLL) made at any time during or prior to the reporting period who had baseline flow cytometry studies performed and documented in the chart.</td>
<td>AMA-PCPI/ASH</td>
<td>Claims, Registry</td>
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<tr>
<td>0387</td>
<td>71</td>
<td>Clinical Process/Effectiveness</td>
<td><strong>Breast Cancer: Hormonal Therapy for Stage I - IIIC Estrogen Receptor/Progestogene Receptor (ER/PR) Positive Breast Cancer:</strong> Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR</td>
<td>AMA-PCPI/ASCO/NCCN</td>
<td>Claims, Registry, Oncology Measures Group</td>
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<td>Code</td>
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<td>0385</td>
<td>72</td>
<td>Clinical Process/Effectiveness</td>
<td>Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients: Percentage of patients aged 18 through 80 years with AJCC Stage III colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period.</td>
<td>AMA-PCPI/ASCO/NCCN  Claims, Registry, EHR, Oncology Measures Group (R)</td>
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<td>0391</td>
<td>99</td>
<td>Clinical Process/Effectiveness</td>
<td>Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade: Percentage of breast cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes), and the histologic grade.</td>
<td>AMA-PCPI/CAP Claims, Registry</td>
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<td>0392</td>
<td>100</td>
<td>Clinical Process/Effectiveness</td>
<td>Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade: Percentage of colon and rectum cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes) and the histologic grade.</td>
<td>AMA-PCPI/CAP Claims, Registry</td>
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<tr>
<td>0389</td>
<td>102</td>
<td>Efficient Use of Healthcare Resources</td>
<td>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.</td>
<td>AMA-PCPI Claims, Registry, EHR</td>
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<tr>
<td>0390</td>
<td>104</td>
<td>Clinical Process/Effectiveness</td>
<td>Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Prostate Cancer Patients: Percentage of patients, regardless of age, with a diagnosis of prostate cancer at high risk of recurrence receiving external beam radiotherapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH agonist or antagonist).</td>
<td>AMA-PCPI Claims, Registry, EHR</td>
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<td>0041</td>
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<td>Population/Public Health</td>
<td>Preventive Care and Screening: Influenza Immunization: Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.</td>
<td>AMA-PCPI Claims, Registry, EHR, GPRO/ACO, COPD Measures Group (C/R), Prev Care Measures Group (C/R), CKD Measures Group (C/R), Oncology Measures Group (R)</td>
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<td>0031</td>
<td>112</td>
<td>Clinical Process/Effectiveness</td>
<td>Preventive Care and Screening: Breast Cancer Screening: Percentage of women aged 40 through 69 years who had a mammogram to screen for breast cancer within 24 months.</td>
<td>NCQA EHR, GPRO/ACO, Prev Care Measures Group (R)</td>
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<tr>
<td>0034</td>
<td>113</td>
<td>Clinical Process/Effectiveness</td>
<td>Preventive Care and Screening: Colorectal Cancer Screening: Percentage of patients aged 50 through 75 years who received the appropriate colorectal cancer screening.</td>
<td>NCQA EHR, GPRO/ACO, Prev Care Measures Group (R)</td>
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<tr>
<td>0419</td>
<td>130</td>
<td>Patient Safety</td>
<td>Documentation of Current Medications in the Medical Record: Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counter, herbal, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications’ name, dosage, frequency and route of administration.</td>
<td>CMS/QIP Claims, Registry Oncology Measure Group (R)</td>
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<tr>
<td>0650</td>
<td>137</td>
<td>Clinical Process/Effectiveness</td>
<td>Melanoma: Continuity of Care – Recall System: Percentage of patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma whose information was entered, at least once within a 12 month period, into a recall system that includes: • A target date for the next complete physical skin exam, AND • A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment.</td>
<td>AMA-PCPI/NCQA Registry</td>
<td></td>
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<tr>
<td>0561</td>
<td>138</td>
<td>Care Coordination</td>
<td>Melanoma: Coordination of Care: Percentage of patient visits, regardless of age, with a new occurrence of melanoma who have a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis.</td>
<td>AMA-PCPI/NCQA Registry</td>
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<tr>
<td>0384</td>
<td>143</td>
<td>Patient and Family Engagement</td>
<td>Oncology: Medical and Radiation – Pain Intensity Quantified: Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified</td>
<td>AMA-PCPI Registry Oncology Measures Group (R)</td>
<td></td>
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<tr>
<td>0383</td>
<td>144</td>
<td>Patient and Family Engagement</td>
<td>Oncology: Medical and Radiation – Plan of Care for Pain: Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain.</td>
<td>AMA-PCPI Registry Oncology Measures Group (R)</td>
<td></td>
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<tr>
<td>0382</td>
<td>156</td>
<td>Patient Safety</td>
<td>Oncology: Radiation Dose Limits to Normal Tissues: Percentage of patients, regardless of age, with a diagnosis of pancreatic or lung cancer receiving 3D</td>
<td>AMA-PCPI Claims, Registry</td>
<td></td>
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<td>Code</td>
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<tr>
<td>0455</td>
<td>157</td>
<td>Patient Safety</td>
<td>Thoracic Surgery: Recording of Clinical Stage Prior to Lung Cancer or Esophageal Cancer Resection: Percentage of surgical patients aged 18 years and older undergoing resection for lung or esophageal cancer who had clinical staging provided prior to surgery.</td>
<td>STS</td>
<td>Claims, Registry</td>
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<tr>
<td>0386</td>
<td>194</td>
<td>Clinical Process/Effectiveness</td>
<td>Oncology: Cancer Stage Documented: Percentage of patients, regardless of age, with a diagnosis of cancer who are seen in the ambulatory setting who have a baseline AJCC cancer stage or documentation that the cancer is metastatic in the medical record at least once within 12 months.</td>
<td>AMA-PCPI/ASCO</td>
<td>Claims, Registry, Oncology Measure Group (R)</td>
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<tr>
<td>0562</td>
<td>224</td>
<td>Efficient Use of Healthcare Resources</td>
<td>Melanoma: Overutilization of Imaging Studies in Melanoma: Percentage of patients, regardless of age, with a current diagnosis of stage 0 through IIIC melanoma or a history of melanoma of any stage, without signs or symptoms suggesting systemic spread, seen for an office visit during the one-year measurement period, for whom no diagnostic imaging studies were ordered.</td>
<td>AMA-PCPI/NCQA</td>
<td>Registry</td>
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<tr>
<td>0028</td>
<td>226</td>
<td>Population/Public Health</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.</td>
<td>AMA-PCPI</td>
<td>Claims, Registry, EHR, GPRO/ACO, CAD Measures Group (R), COPD Measures Group (C/R), HF Measures Group (R), IBD Measures Group (R), IVD Measures Group (C/R), Prev Care Measures Group (C/R), Cardiovascular Prevention Measures Group (C/R), Oncology Measure Group (R)</td>
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<td>250</td>
<td>Clinical Process/Effectiveness</td>
<td>Radical Prostatectomy Pathology Reporting: Percentage of radical prostatectomy pathology reports that include the pT category, the pN category, the</td>
<td>CAP</td>
<td>Claims, Registry</td>
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<td>N/A</td>
<td>251</td>
<td>Clinical Process/ Effectiveness</td>
<td>Immunohistochemical (IHC) Evaluation of Human Epidermal Growth Factor Receptor 2 Testing (HER2) for Breast Cancer Patients: This is a measure based on whether quantitative evaluation of Human Epidermal Growth Factor Receptor 2 Testing (HER2) by immunohistochemistry (IHC) uses the system recommended in the ASCO/CAP Guidelines for Human Epidermal Growth Factor Receptor 2 Testing in breast cancer.</td>
<td>CAP</td>
<td>Claims, Registry</td>
</tr>
<tr>
<td>N/A</td>
<td>262</td>
<td>Patient Safety</td>
<td>Image Confirmation of Successful Excision of Image—Localized Breast Lesion: Image confirmation of lesion(s) targeted for image guided excisional biopsy or image guided partial mastectomy in patients with nonpalpable, image-detected breast lesion(s). Lesions may include: microcalcifications, mammographic or sonographic mass or architectural distortion, focal suspicious abnormalities on magnetic resonance imaging (MRI) or other breast imaging amenable to localization such as positron emission tomography (PET) mammography, or a biopsy marker demarcating site of confirmed pathology as established by previous core biopsy.</td>
<td>ASBS</td>
<td>Claims, Registry</td>
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<td>N/A</td>
<td>263</td>
<td>Clinical Process/ Effectiveness</td>
<td>Preoperative Diagnosis of Breast Cancer: The percent of patients undergoing breast cancer operations who obtained the diagnosis of breast cancer preoperatively by a minimally invasive biopsy method.</td>
<td>ASBS</td>
<td>Claims, Registry</td>
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<tr>
<td>N/A</td>
<td>264</td>
<td>Clinical Process/ Effectiveness</td>
<td>Sentinel Lymph Node Biopsy for Invasive Breast Cancer: The percentage of clinically node negative (clinical stage T1N0M0 or T2N0M0) breast cancer patients who undergo a sentinel lymph node (SLN) procedure.</td>
<td>ASBS</td>
<td>Registry</td>
</tr>
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