OncologyMetrics

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Accelerating Advancements in Cancer Care

The Medicare Incentive Programs and Meaningful Use: It's not too late!

Premier Oncology Hematology Management Society

May 11, 2012

Medicare Incentive Programs

- Physician Quality Reporting System (PQRS)
- ePrescribing (eRx) Incentive Program
- EHR Incentive Program

Why?

- Embrace technology
- Prepare for new payment models
- Focus on quality of care

CMS.gov
Centers for Medicare & Medicaid Services

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

PQRS

- 170+ measures, including many oncology specific
  - All 44 EHR clinical quality measures for the Medicare EHR Incentive Program are now available for PQRS reporting
- 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

eRx Requirements

- EPs must report G8553 in conjunction with services identified in the measure (mostly E/M services)
  - Must have and use a qualified eRx system or qualified EHR (new in 2012)
  - Must meet the criteria for a successful ePrescriber for the reporting period
  - At least 10% of Medicare Part B services must be made up of codes in the measure
- In 2012, successful participants will report the eRx measure 25 times to earn a 1% incentive payment
  - Incentive payment is 0.5% in 2013

eRx: Payment Adjustments

- Penalties have begun in 2012 for EPs who are not successful e-prescribers
  - 1% payment adjustment in 2012
    - For EPs who did not report G8553 for at least 10 eligible eRx events for services provided January 1, 2011 through June 30, 2011
  - 1.5% in 2013
    - To avoid the 2013 eRx payment adjustment, EPs would have had to have been a successful electronic prescriber in 2011 or will need to report the G8553 code via claims for at least 10 billable Medicare Part B PFS services provided January 1, 2012 through June 30, 2012
  - 2% in 2014

Hardship Exemptions for 2013 eRx Payment Adjustment

- CMS may exempt EPs and group practices from the 2013 payment adjustment if they fall into one of 4 categories
  - Unable to prescribe electronically due to local, state or Federal law or regulation
  - Has or will prescribe fewer than 100 prescriptions in the January 1 to June 30, 2012 reporting period
  - Practices in a rural area without sufficient high speed internet access (G8642)
  - Practices in an area without sufficient available pharmacies for electronic prescribing (G8643)
- Must submit hardship exemption requests between March 1 and June 30, 2012

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 assistnat

  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*

Timelines

Incentive	2012	2013	2014	2015
PQRS	0.5%	0.5%	0.5%	
eRx	1.0%	0.5%		
EHR	Y	Y	Y	Y

Penalty	2012	2013	2014	2015
PQRS				-1.5%
eRx	-1%	-1.5%	-2%	
EHR				-1%

Medicare EPs subject to payment adjustments if they do not adopt EHRs before CY 2015

Timelines

Incentive	2016	2017	2018	2019
PQRS				
eRx				
EHR	Y			

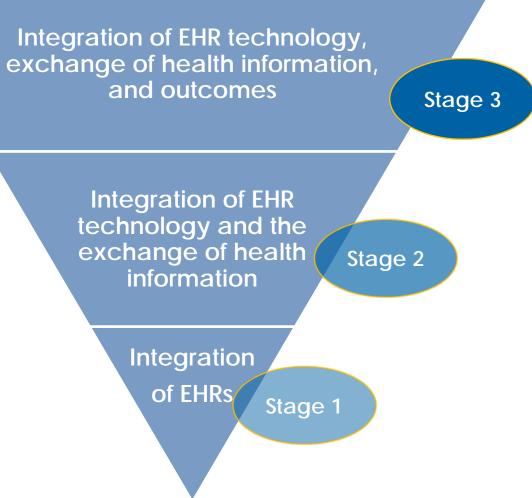| Penalty	2016	2017	2018	2019
PQRS	-2%	-2%		
eRx				
EHR	-2%	-3%	-4%	-5%

EHR Incentive Program and Meaningful Use

Let's start with some definitions…

- 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 are available to eligible professionals (EPs) and eligible hospitals for "meaningful use of certified EHR technology"

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Three stages

- 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

Integration of EHR technology, exchange of health information, and outcomes

Stage 3

Integration of EHR technology and the exchange of health information

Stage 2

Integration of EHRs

Stage 1

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

- 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, 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

PQRS, eRx & EHR

- If an eligible provider opts to receive EHR incentives under Medicare
  - May collect PQRS and EHR incentives
  - May NOT collect eRx incentives

- If an eligible provider opts to receive EHR incentives under Medicaid
  - May collect PQRS, EHR, and eRx incentives

Getting to meaningful use is a process

1. Ensure that your EMR is certified for meaningful use
2. Identify a Meaningful Use champion in your practice
   - Use CMS resources to learn about MU and teach others in the practice
   - Use your EMR vendor as a resources
3. Register to participate in MU
   - http://www.cms.gov/EHRIncentivePrograms/Downloads/EHRMedicareEP_RegistrationUserGuide.pdf
4. You only need three months of data to submit for payment in your first year, so pay attention
5. Mind your N and Ds (Numerators and Denominators)
6. Complete your attestation
7. Cash your check

Getting started

- Obtain a National Provider Identifier (NPI)
- Enroll in the CMS Provider Enrollment, Chain, and Ownership System (PECOS)
- Register for the EHR incentive program online
- Adopt and use a certified EHR
- Meaningfully use the certified EHR to report certain measurements in order to achieve certain health objectives for a designated reporting period

Timeline for 2012

- First year of attestation, regardless of the year, is for 90 consecutive days in one calendar year
  - If you attested for 90 days in 2011, you must attest for the full calendar year in 2012
  - If you plan to attest for the first time in 2012, you will attest for 90 consecutive days in 2012 and start attesting for the full year in 2013
  - The last 90-day period in 2012 will be from October 3 to December 31, 2012

Attestation

- To receive the incentive payment for a given year, you must "attest" that you meet the criteria
- Last day to register and attest for 2012 incentive payment for EPs is February 28, 2013

Stage 1 Requirements

Measures	# needed to attest in 2011 and 2012	Requirements
15 core measures (C-1 to C-15)	All 15	Must pass each core measure based on required percentage per measure
10 menu set measures (M-1 to M-10)	5 selected	Must pass M-9 or M-10 plus four other menu set measures based on required percentage
Clinical quality measures (C-10)	6 selected	Must report on 3 clinical quality measures from CQ-1 to CQ-6 with a denominator >1, and 3 other clinical quality measures

15 Core Measures & Stage 1 Requirements

C-1. Use computerized physician order entry (CPOE) for medication orders directly entered by a licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines

- More than 30% of unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE

C-2. Implement drug-drug and drug-allergy interaction checks

- The EP has enabled this functionality for the entire EHR reporting period

C-3. Maintain an up-to-date problem list of current and active diagnoses

- More than 80% of unique patients seen by the EP have at least one entry, or indication that no problems are known for the patient, recorded as structured data

C-4. Generate and transmit permissible prescriptions electronically (eRx) during EHR reporting period

- More than 40% of all permissible prescriptions written by EPs are transmitted using a certified EHR.

15 Core Measures & Stage 1 Requirements

C-5. Maintain active medication list

- More than 80% of unique patients seen by the EP have at least one entry, or indication that patient is not currently prescribed any medication, recorded as structured data

C-6. Maintain active medication allergy list

- More than 80% of unique patients seen by EP have at least one entry, or indication that patient has no known Rx allergies, recorded as structured data

C-7. Record demographics: preferred language, gender, race, ethnicity, and date of birth

- More than 50% of unique patients seen by EP have demographics recorded as structured data

C-8. Record and chart changes in vital signs: height, weight, BP, body mass index, growth charts for children

- For more than 50% of all unique patients age 2 and older seen by EP, height, weight and BP are recorded as structured data

15 Core Measures & Stage 1 Requirements

C-9. Record smoking status for patients 13 years old or older

- More than 50% of unique patients age 13 and older seen by EP have smoking status recorded

C-10. Report ambulatory clinical quality measures to CMS or the states

- For 2011, aggregate numerator, denominator and exclusions provided through attestation. For 2012, clinical quality measures submitted electronically

C-11. Implement one clinical decision support rule relevant to specialty or high clinical priority along with ability to track compliance with rule

- One clinical decision support rule implemented
  - *Suggestion: Staging for all appropriate patients*

C-12. Provide patients with electronic copies of their health information (diagnostic test results, problem list, medication lists, medication allergies) upon request

- More than 50% of an EP's patients who request an electronic copy of their health information are provided it within 3 business days

15 Core Measures & Stage 1 Requirements

C-13. Provide clinical summaries for patients for each office visit

- Clinical summaries provided to patients for more than 50% of all office visits within 3 business days

C-14. Provide proof of capability to exchange key clinical information (problem list, medication list, medication allergies, diagnostic test results) among providers of care and patient authorized entities electronically

- Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information

C-15. Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities

- Conducted or reviewed a security risk analysis and corrected identified security deficiencies as part of risk management process

Menu Set requirements

The EP must demonstrate at least 5 of the following 10 items in Stage 1 (must include M-9 or M-10):

M-1. Implement drug-formulary checking

- EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period

M-2. Incorporate lab test results into the EHR as structured data

- More than 40% of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a +/- or numerical format are incorporated in certified EHR technology as structured data

M-3. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach

- At least one report generated listing patients of the EP with a specific condition

Menu Set requirements

M-4. Send reminders to patients (per patient preference of format) for preventive and follow-up care

- More than 20% of all unique patients age 65 or older or age 5 or younger were sent an appropriate reminder during the EHR reporting period

M-5. Provide patients with timely electronic access to their health information

- More than 10% of all unique patients seen by EP are provided timely electronic access to their health information subject to the EPs discretion to withhold certain information

M-6. Use certified EHR technology to identify patient-specific education resources, and provide those to the patient as appropriate

- More than 10% of all unique patients seen by EP are provided patient-specific education resources

Menu Set requirements

M-7. The EP who receives a patient from another setting or provider of care or believes an encounter is relevant should perform medication reconciliation

- Perform medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the EPs care

M-8. Provide summary of care record for patients transferred to another provider or setting

- Provide a summary of care record for more than 50% of transitions of care and referrals

M-9. Immunization registries.

Menu Set requirements

- M-10. Provide proof of capability to submit electronic syndromic surveillance to public health agencies and actual submission in accordance with applicable law and practice
  - Performed at least 1 test of certified EHR's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information has the capacity to receive the information electronically)

Clinical quality measures

- EPs must report on 6 clinical quality measures (CQM)
  - 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 (other than the core/alternate core measures)

CQM for Oncology – Core, Alternate

- Core and Alternate Core (Must report 3)

  C-10 – CQ1. Adult Weight Screening and Follow-Up

  C-10 – CQ2. Hypertension: Blood Pressure Measurement

  C-10 – CQ3. Preventive Care and Screening Measure Pair: Tobacco use assessment; tobacco cessation intervention

  C-10 – CQ4. Preventive Care and Screening: Influenza immunization for Patients 50 and older

  C-10 – CQ5. Weight Assessment and Counseling for Children and Adolescents

  C-10 – CQ6. Childhood Immunization Status

CQM

- CQ-1. 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.

- CQ-2. 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.

- CQ-3. 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 past 24 months and have been seen for at least 2 office visits, who received cessation intervention.
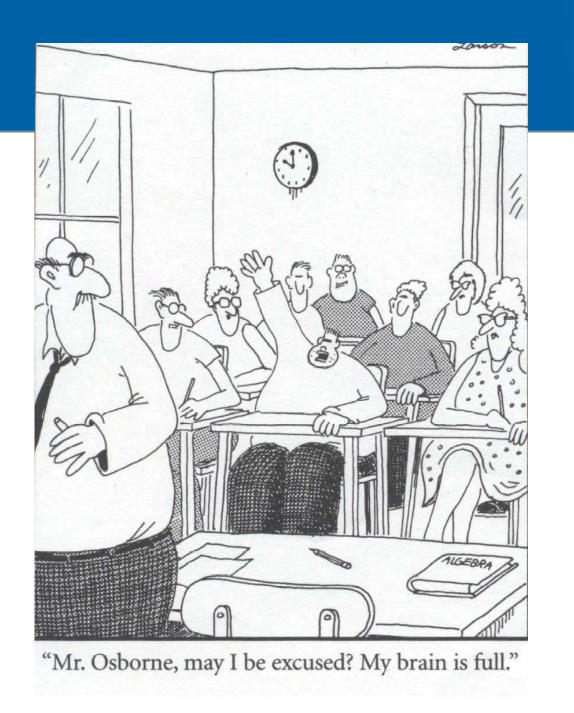
Examples of oncology-specific CQMs

- 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-IIIC 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.

Examples of oncology-specific CQMs

- 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.

Look familiar?

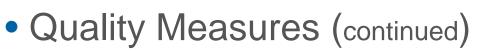"Mr. Osborne, may I be excused? My brain is full."

Meaningful Use stages

- HHS/CMS has announced a delay to Stage 2 meaningful use to 2014
  - Give vendors time to develop certified EHR technologies for Stage 2 and providers more time to implement new software and meet Stage 2 requirements
  - All providers attesting to MU in 2011 or 2012 will begin Stage 2 in 2014
- Notice of Proposed Rulemaking published March 7, 2012; 60-day comment period ended May 7, 2012
  - If you didn't comment – no worries – all of oncology is just a spec in the scope of this total rule
- Stage 3 is expected to be implemented in 2016

Stage 2
Proposed requirements of note

- Relaxation of time lines
  - Those that attest to meaningful use first in 2011 must meet Stage 2 criteria in 2014 and Stage 3 in 2016. All others will be required to demonstrate two years at each stage.

- Clinical Quality Measures
  - Now a distinct category of meaningful use
  - Not tied to MU stage; in 2014 all those attesting to any stage of meaningful use will submit 12 measures. (Some may be required, others selected from a long list of potential measures.)

Stage 2
Proposed requirements of note

- Quality Measures (continued)
  - At least one measure will need to be reported from each quality domain: Patient Engagement, Patient Safety, Care Coordination, Population and Public Health, Efficient Use of Resources, and Clinical Effectiveness.
  - The final list of quality measures will be published with the final rule.
- Many of the thresholds from Stage 1 have been raised
- Patient portal requirements

Stage 2
Proposed requirements of note

- Maintain medication, problem/diagnosis, allergy lists
    - Stage 1: 80% of patients have an entry or indication of none
    - Stage 2: No longer separate requirement, now must be included in the electronic record for patient access and transmitted at transitions in care

Stage 2 proposed changes

- Demographics recorded
  - Stage 1: 50% of patients
  - Stage 2: 80% of patients

- Vital signs recorded
  - Stage 1: 50% of patients over age 2
  - Stage 2: 80% of patients over age 3

- Smoking status recorded
  - Stage 1: 50% of patients over 13
  - Stage 2: 80% of patients over 13

Stage 2 proposed changes

- Family history
  - Stage 1: Not required
  - Stage 2: Menu item: 20% of patients have family history recorded **as structured data**

- Computerized Physician Order Entry (CPOE)
  - Stage 1: 30% of patients have a CPOE medication order if they have any med orders
  - Stage 2: 60% of medication, laboratory and radiology orders entered using CPOE

Stage 2 proposed changes

- Drug-drug and drug-allergy checking
  - Stage 1: Enabled
  - Stage 2: Enabled and one requirement for decision support

- Drug-formulary checking
  - Stage 1: Menu option
  - Stage 2: Incorporated as a requirement for e-Rx

- Medication reconciliation
  - Stage 1: Menu option, performed for 50%
  - Stage 2: Required

Stage 2 proposed changes

- e-Prescribing
  - Stage 1: 40% of prescriptions
  - Stage 2: 65% of prescriptions
- Summary-of-care record transmitted between providers at transitions in care
  - Stage 1: Menu option: performed for 50% of transitions (can be on paper)
  - Stage 2: Required for 65% of care transitions; must be electronic for 10%

Stage 2 proposed changes

- Ability to view images
  - Stage1: No requirement at all
  - Stage 2: Menu option: 40% of all scans and images available for viewing on the EHR

- Secure messaging
  - Stage 1: No requirement
  - Stage 2: EPs only. 10% of patients have sent at least one messages to eligible providers

Stage 2 proposed changes

- Electronic medication administration (eMAR)
  - Stage 1: No requirement
  - Stage 2: Required for 10% of all medication orders for hospital patients

- Encounter summaries
  - Stage 1: 50% of office visits within 3 days
  - Stage 2: Still 50% but now within 24 hours and with specified data elements, may be available on paper or electronic

Stage 2 proposed changes

- Electronic copies of health information
  - Stage 1: 50% of patients who request it
  - Stage 2: Replaced by requirement that 50% of patients have access and 10% of patients **_have used the capability to access and download their information_**

- Incorporate lab information as structured data
  - Stage 1: Menu option: 40% of patients
  - Stage 2: Required for 55% of all lab results

Stage 2 proposed changes

- Provide patient educational materials
  - Stage 1: Menu option: 10% of appropriate patients
  - Stage2: Required for 10% of all office visits and discharged patients and the EHR needs to be used to ID the provided materials, but they can be stored outside the EMR

- Send reminders for preventive, follow-up care
  - Stage 1: Menu option for office visits; 20% of patients under age 5 or over age 65
  - Stage 2: Required, 10% of all patients seen in the last 24 months

Stage 2 proposed changes

- Patients have access to their information
  - Stage 1: 10% of patients have access to view information from office visits
  - Stage 2: 50% have access and **10% of patients have used the capability to access and download their information**
- Electronically exchange patient information
  - Stage 1: Perform one test
  - Stage 2: Replaced by specific requirement for transitions in care

Stage 2 proposed changes

- Decision support rule
  - Stage 1: One rule
  - Stage 2: Implement drug-drug and drug-allergy checking *and* implement 5 interventions related to clinical quality measures
- Lists of patients for quality improvement
  - Stage 1: Menu option: one list
  - Stage 2: Required

Stage 2 proposed changes

- Submit immunization data
  - Stage 1: Menu option: perform one test
  - Stage 2: Required: submit data
- Submit syndromic surveillance data
  - Stage 1: Menu option - perform one test
  - Stage 2: Menu option - submit data
- Submit information to **cancer registries**
  - Stage 1: Not required
  - Stage 2: Menu option for EPs only

Stage 2 proposed changes

- Submit information to other specialty registries
  - Stage 1: Not required
  - Stage 2: Menu option for EPs only (QOPI perhaps?)
- Conduct security analysis
  - Stage 1: Conduct analysis
  - Stage 2: Expanded to include encryption of data at rest

Avoid the 2015 EHR Penalty

- EPs may avoid the 2015 EHR penalty
  - By being a successful meaningful user in 2013 **OR**
  - By first meeting meaningful use in 2014
    - Must demonstrate meaningful use at least 3 months prior to the end of the calendar year, **AND**
    - Must register and attest by October 1, 2014

  OR

  - Register and qualify for payment adjustment exception

Proposed Exceptions for….

- EPs who practice in areas without sufficient Internet access;

- New EPs could receive an exception for 2 years after they begin practicing;

- Extreme circumstances that make it impossible for an EP to demonstrate meaningful use through no fault of their own during the reporting period

Value-based purchasing

- CMS finalized proposal to implement value-based payment modifier for specific physicians and physician groups on 1/1/15 and all physicians and physician groups on 1/1/17

- CMS goals are to

  - Improve quality and lower per-capita growth in expenditures

- Payment modifier will be implemented with budget neutrality – as payments increase for some physicians, they will decrease for others

VBP Measures

- CMS finalized proposal to measure performance for the value-based payment modifier on
  - Measures in the core set of the PQRS for 2012 (except measure #200, heart failure, warfarin therapy)
  - All measures in the GPRO of the PQRS for 2012
  - The core measures, alternate core, and 38 additional measures in the EHR Incentive Program measures for 2012
- Initial performance period for the use of the value-based modifier will be 1/1/13 – 12/31/13

2015….

VBP modifier begins for some physicians (2017 for all)

Incentive	2012	2013	2014	2015
PQRS	0.5%	0.5%	0.5%	
eRx	1.0%	0.5%		
EHR	Y	Y	Y	Y

Penalty	2012	2013	2014	2015
PQRS				-1.5%
eRx	-1%	-1.5%	-2%	
EHR				-1%

Privacy & Security…. *New!*

- *Guide to **Privacy and Security of Health Information***

- http://www.healthit.gov/sites/default/files/pdf/privacy/privacy-and-security-guide.pdf

Guide to **Privacy and Security of Health Information**

Chapter 1: What Is Privacy & Security and Why Does It Matter

Chapter 2: Privacy & Security and Meaningful Use

Chapter 3: Privacy & Security 10 Step Plan for Meaning ful Use

Chapter 4: Integrating Privacy and Security into Your Practice

Chapter 5: Privacy and Security Resources

For more info…

- PQRS   www.cms.gov/PQRS

- eRx   www.cms.gov/erxincentive

- eRx Payment Adjustment information

  - https://www.cms.gov/MLNMattersArticles/downloads/SE1141.pdf

  - http://www.cms.gov/MLNMattersArticles/Downloads/SE1206.pdf

For more info…

- For more info
  - https://www.cms.gov/EHRIncentivePrograms/
- New CMS publication: "An Introduction to the Medicare EHR Incentive Program for Eligible Professionals"
  - https://www.cms.gov/EHRIncentivePrograms/Downloads/Beginners_Guide.pdf

Thank you for caring for people with cancer.

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