

## How Health Reform is Transforming U.S. Healthcare: Implications for Cancer Care Providers

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Cancer care is evolving. Fueled by passage of the Patient Protection and Affordable Care Act (ACA), healthcare delivery systems are being transformed to ensure care is more patient-centered and integrated. At the same time, barriers that once stood in the way of patients accessing needed care are being removed. Read on to learn how the ACA is impacting cancer care delivery for patients and providers.

### Why the Patient Protection and Affordable Care Act (ACA)?

While the U.S. healthcare system has often been touted as among the best in the world, there have long been rumblings from those operating within the system as well as those experiencing the system from the outside that change is necessary to create a more cost-effective, high-quality and accessible system that eliminates barriers to care. Healthcare providers, including cancer care practitioners, are intimately familiar with many of the barriers to healthcare such as:

- No insurance
- Underinsurance
- Deductibles
- Co-Pays
- Pre-Existing Conditions
- Medicare Eligibility Regulations
- Medicaid Eligibility Regulations
- Loss of Health Insurance Secondary to Job Loss Due to Illness
- Insurance Lifetime Limits
- Insurance Annual Limits
- Insurance Exclusions

These barriers, in addition to cultural and travel barriers, negatively impact the health of our patients. The Patient Protection and Affordable Care Act, commonly referred to as the ACA, was crafted in part to address barriers to healthcare while also controlling rising Medicare and Medicaid expenditures. As the ACA continues to be implemented, it is essential for those in the cancer care field to understand how the law is transforming U.S. healthcare for both patients and providers.

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### Cancer Care Practitioners:

- Hematologist/Oncologist
  - Pathologist
  - Diagnostic Radiologist
  - Radiation Oncologist
  - Surgeon
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## Patient Protection and Affordable Care Act Overview

The ACA is a lengthy, far-reaching federal statute signed into law by President Obama on March 23, 2010. It is complex and still evolving with some experts likening it to an academic thesis more than a piece of legislation.

Implementation of the law has been underway for several years with momentum gaining steam in 2014 when many of the law's key provisions kick in. The ACA brings together many prior pieces of legislation and implements key concepts to hold down costs while improving healthcare quality.

In broad terms, the law seeks to improve access to health care and decrease the ranks of the uninsured, uninsurable and the underinsured. Insurance coverage will be expanded using a combination of insurance mandates impacting both individuals and employers, insurance marketplaces to help consumers compare coverage options, and an optional state expansion of the Medicaid program. Furthermore, tax credits and subsidies were included in the law to help low-income individuals and small businesses afford coverage.

Improving healthcare quality is a focus of the federal health reform law and numerous ACA provisions accelerate the promotion of value-based healthcare purchasing. The notion is that paying providers only for quality care will help drive down costs. The law aims to improve healthcare system quality while driving down costs by testing a variety of innovative payment and service delivery models. Many of the pilot and demonstration projects that are being explored aim

to integrate service delivery and improve care coordination, ensure patient-centered care, create greater efficiencies and generate cost savings. By improving quality of care and providing care in a more coordinated fashion, it is hoped that the ACA will also succeed in reducing healthcare costs.

Data collection and analysis of providers' compliance with evidence-based quality measures play a key role in measuring success, impacting providers' reimbursement, and eventually facilitating the patient's choice of providers when the results are made public. Harnessing the power of technology to help facilitate data collection and analysis, through the promotion of the electronic health record and electronic prescribing, is another tool the ACA uses to boost quality and efficiency.

An overview of the ACA would be incomplete without acknowledging how controversial the law has been. Advocates hailed passage of the law as an overdue victory for the uninsured and uninsurable. Opponents decried both the method in which the law passed as well as its substance, arguing that the law's mandates on individuals to purchase insurance is unconstitutional and that healthcare costs will continue to soar. While passionate arguments from both sides of the political aisle can still be heard whenever the topic of the ACA arises, what most people can agree on is that reform is necessary, despite disagreements on the mechanisms used to achieve change.

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“Politicizing ObamaCare... hampers the effort to get some people on board with the accountable care organization (ACO) concept.”

Eric Bieber, MD

President, UH Accountable Care Organization  
System Chief Medical Officer, University Hospitals  
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## ACA Key Elements for Transforming Care Delivery

Many of the concepts that are being tested under the ACA aim to experiment with various quality improvement and payment reforms to evaluate their effectiveness. Put another way, from a satellite view the ACA has authorized The Centers for Medicare and Medicaid Services (CMS) to create countless pilot projects testing various cost and quality mechanisms that together form a virtual Rubik’s Cube. For cancer care providers, looking at the Rubik’s Cube from the outside and trying to figure out the best way to unravel the puzzle is no small task.

To help solve this puzzle, we will highlight a few significant provisions that hold the power to transform the delivery of healthcare. Among the most important of these provisions are the many that authorize reimbursement incentives and payment adjustments and penalties. These provisions are found throughout the law and directly tie payment to quality.

Other key elements authorized by the ACA to transform the healthcare delivery system for Medicare and Medicaid that directly impact the cancer care field include:

- Physician Quality Reporting System (PQRS)
- Public Reporting of Quality Measures
- Value-Based Payment Modifier (VBPM)
- PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program
- Electronic Health Records (EHRs)
- Electronic Prescribing (E-Prescribing or eRx)
- Accountable Care Organizations (ACOs)

In this paper we attempt to describe each of the above key elements concisely. Additional resources are provided at the end of the paper to allow the reader to explore each of these complex topics in-depth. We will try to present how each of these elements are essential building blocks that support a transformed healthcare system that drives quality improvements and healthcare expenditure reductions. In particular, we highlight how the ideal accountable care organization (ACO) as envisioned by CMS embodies all of the concepts of the transformed healthcare system. We will discuss how specialty care, such as oncology, remains a critical piece of healthcare delivery and how it needs to comply with ACA requirements if it is to be compatible with ACO structures. Along the way we analyze how these key ACA elements will impact cancer care today and in the future.

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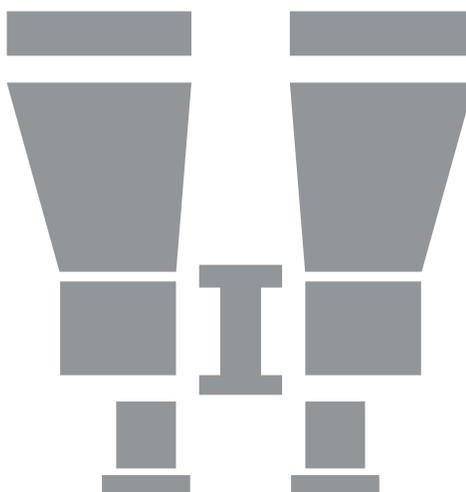
As the ACA continues to be implemented, additional regulatory changes and adjustments will change the healthcare delivery system for Medicare and Medicaid. The Centers for Medicare and Medicaid Services (CMS) website should be actively monitored by healthcare providers for phased out programs, adjustments and deadlines.

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## Physician Quality Reporting System (PQRS)<sup>1</sup>

### PQRS Background Information

One of the ACA's key elements for transforming care delivery is a provision in the law that encourages greater accountability of physician quality and cost using the Physician Quality Reporting System (PQRS). As with many of the ACA's key provisions, PQRS builds upon an initiative from a prior piece of legislation. Wanting more information about compliance to standards of care and cost effectiveness, Congress passed the Tax Relief and Health Care Act of 2006 which created the Physician Quality Reporting Initiative (PQRI). Under this voluntary pay-for-reporting initiative, physicians and other eligible professionals that met the criteria for reporting quality of care information for their Medicare patients received payment incentives.



Fast forward to passage of the federal health reform law and the underlying goals of the PQRI remain the same, but the acronym has changed to PQRS. As structured under the ACA, PQRS uses a combination of incentive payments and, for the first time, payment penalties to encourage physicians and other eligible professionals to report compliance with quality of care measures to CMS. This quality information is coupled with Medicare cost data specific to individual providers or groups creating a cost and quality database.

### PQRS Measures

In 2013 the PQRS includes 259 quality measures. Individual physicians and groups of providers can select one or more practice-relevant individual measure(s) to report on from this vast menu or they can report on a measures group. A measures group is a subset of four or more individual measures that are applicable to a particular clinical condition or focus.

## PQRS Measures and Cancer Care

PQRS provides quality reporting measures for individual cancer care practitioners and group practice cancer care organizations. Of the 259 PQRS measures for 2013 there are more than 35 *individual* measures that relate to cancer care. In 2013, an oncology measures group was added as one of the 22 *measures groups* included in the PQRS. Eight quality measures from the PQRS menu comprise the oncology measures group. The oncology measures group is primarily applicable to hematology/oncology practices. Starting in 2014 CMS has proposed to add optimizing patient exposure to ionizing radiation to the list of reportable *measures groups*.<sup>2</sup> For a list of select PQRS cancer care quality measures, including the eight measures that comprise the oncology measures group, please see appendix B.

## PQRS Data Submission Methods

Physicians and other eligible professionals have four different ways to submit PQRS quality measures data to CMS. It is important to note that CMS rules govern the reporting methods available to individual physicians versus group practices:

- Medicare Part B claims
- Registry
- Electronic health record (EHR)
- Group practice reporting option (GPRO)
  - Group practices choosing this option report either through a CMS-vetted registry or via a CMS web interface (for group practices of 25 or more providers)

## PQRS Data Submission and the Oncology Measures Group

An additional layer of complexity is created by the fact that not all data submission methods are available for all individual measures or measure groups. For example, the *oncology measures group*, which contains eight measures, is *only reportable via a registry in 2013*. CMS has approved more than 70 registry vendors that are able to submit PQRS data to CMS on behalf of individuals or group practices for the 2013 program year.<sup>3</sup> Some registry vendors support just the reporting of certain individual measures, others support only the reporting of certain measures groups and some support both.

## PQRS Reporting Requirements to Earn an Incentive Payment

For the years 2013 and 2014, individual physicians and certain group practices that submit satisfactory PQRS quality measures data will earn an incentive payment of 0.5 percent based on their Medicare Part B Physician Fee Schedule (PFS) allowed charges for covered professional services provided during that same reporting period.<sup>4</sup> PQRS incentive payments have not been authorized beyond 2014.



## PQRS Reporting Requirements to Solely Avoid a Payment Penalty

CMS will begin penalizing physicians who do not satisfactorily report their 2013 quality measures data by making payment penalties to 2015 reimbursement. Penalties for individual physicians and group practices that don't report quality measures will be -1.5 percent of their Medicare Part B Physician Fee Schedule allowed charges in 2015 and increase to -2 percent starting in 2016 and for years beyond.

For 2013 there are three ways *individual physicians* can **avoid** the payment penalty impacting 2015 reimbursement:

- Meet the requirements for satisfactorily reporting for incentive payment
- Report at least one valid individual measure via claims, participating registry or participating EHR or one valid measures group via claims or registry
- Participate in the CMS-calculated administrative claims-based reporting mechanism which is only available via the web from July 15, 2013 through October 15, 2013.<sup>5</sup>

For 2013 there are also currently three ways *group practices* participating in the PQRS GPRO can **avoid** the payment penalty impacting 2015 reimbursement:

- Meet the requirements for satisfactorily reporting for incentive payment

- Report at least one valid measure via web interface (if a group practice of 25 or more professionals) or registry
- Participate in the CMS-calculated administrative claims-based reporting mechanism which is only available via the web from July 15, 2013 through October 15, 2013.<sup>6</sup>

## PQRS Complexity

Clearly some type of reporting of quality measures to CMS must be initiated by the end of 2013 or there will be a financial penalty. Yet navigating PQRS reporting options is not without its challenges. Layers of complexity are created by the following considerations:

- Which individual measures or measures group pertains(s) to the physician or group practice applies
- Which data submission method is available for each individual measure or measures group
- Which data submission method is available for individual physicians versus group practices (and size of the group practice)
- Whether a PQRS incentive payment is sought
- Whether PQRS data submission is only to avoid a PQRS non-reporting penalty
- Whether the reporting period is for 12-months or 6-months.
- PQRS quality measures and reporting criteria are in a dynamic state and undergo frequent revisions, additions and deletions.

## Top 5 Most Frequently Reported PQRS Individual Measures in 2011, By Specialty<sup>12</sup>

#	Oncology/Hematology	Radiation Oncology
1st	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR) (Measure 124)	Prostate Cancer: Three-Dimensional (3D) Radiotherapy (Measure 105)
2nd	Multiple Myeloma: Treatment with Bisphosphonates (Measure 69)	Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients (Measure 104)
3rd	Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry (Measure 70)	Oncology: Radiation Dose Limits to Normal Tissues (Measure 156)
4th	Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients (Measure 72)	Oncology: Cancer Stage Documented (Measure 194)
5th	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer (Measure 71)	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients (Measure 102)

## Participation in Cancer Registries

Cancer care providers may soon be able to meet their PQRS reporting requirements if they are participating in an **independent** clinical cancer data registry, such as the American Society of Clinical Oncology’s Quality Oncology Practice Initiative (QOPI).<sup>7</sup> Under the **proposed** rule – that stems from a provision in the American Taxpayer Act of 2012 – cancer care providers would report the measures used by the clinical data registry instead of those on the PQRS measures list.<sup>8</sup>

## PQRS Participation Rates

At this time physicians are still not *required* to submit quality information, but PQRS is likely the precursor to a mandatory pay-for-performance program.<sup>9</sup> Low participation rates in PQRS have plagued the program from the outset. Of the more than one million physicians who could have participated in PQRS in 2011, just 320,422 physicians (29 percent) did. Of those who participated, 83 percent met the criteria for incentive eligibility that same year.<sup>10</sup> However, financial penalties are likely to boost participation. In 2015, radiation oncologists can expect an average penalty of \$6,029 according to a recent study.<sup>11</sup>

## Value-Based Payment Modifier (VBPM)

Implementation of the Value-Based Payment Modifier (VBPM) program is likely to cure the low participation rates that have plagued the PQRS. Considered by some to be the crown jewel of the ACA implementation, the VBPM aims to speed adoption of PQRS reporting while continuing to tie payment to quality. According to CMS, “this program supports the transformation of Medicare from a passive payer to an active purchaser of higher quality, more efficient health care through the value-based purchasing (VBP) initiative.”<sup>13</sup>

The CMS-calculated value modifier will be used in 2015 to adjust eligible physician reimbursement based on 2013 cost and quality data for physician groups of 100 or more. The value modifier will be implemented for ALL physicians who bill Medicare for services under the physician fee schedule by 2017.

How can group practices, including cancer care providers, avoid a negative payment adjustment under the VBPM? In 2013, groups of 100 physicians or more must self-nominate and choose one of three PQRS reporting methods (web interface, registry or claims-based). Group practices that choose the GPRO or registry option must also report on at least one PQRS measure. By taking these steps in 2013, group practices of 100 or more physicians can avoid a -1 percent value modifier payment adjustment in 2015 (in addition to the -1.5 percent non-reporting PQRS payment penalty).<sup>14</sup> Also, it is important to note that for 2015 and 2016 the Value-Based Payment Modifier does not apply to groups of physicians in which any of the physicians are participating in the Medicare Shared Savings Program ACO or the Pioneer ACO model (discussed later).<sup>15</sup>

## Quality Tiering Option

Adding another wrinkle, group practices with 100 or more physicians have the option of participating in quality tiering under the value modifier. In the tiering process, practices with high-quality, low-cost results will receive a positive adjustment to reimbursement whereas practices demonstrating low-quality, high-cost results will receive a negative adjustment to reimbursement. Practices that have average quality and costs will have no payment adjustment made to their reimbursement. Since the timelines and participation periods have significant influence on incentives, penalties and reimbursement, the actual program details are important to review.<sup>16</sup>

In order to determine whether or not a practice choosing to participate in the tiering option qualifies for a positive, negative, or neutral payment adjustment, compliance with Medicare Part B costs and PQRS quality measures for each practice will be compared to a baseline calculated by CMS. For the quality domain, practices that exceed the mean of the performance rate for similar practices are considered high quality while those that fall below the mean are considered low quality. A similar calculation, which also includes allowances for geography and patient acuity, is used for the cost evaluation.<sup>17</sup>

In the fall of 2013, CMS will be providing practices with 25 or more providers with reports, known as Quality and Resource Use Reports (QRURs) or Physician Feedback reports, highlighting compliance to quality measures and cost profiles. These reports, which include comparison data and benchmarks, allow practices to evaluate their performance and determine if the tiering option is a good choice.<sup>18</sup>

## PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program



### Public Reporting of Quality Measures

#### Physician Compare

The publicly-available [Physician Compare website](#) currently only contains information about whether or not physicians are participating in the PQRS. In addition, information on the website includes physicians' and other healthcare professionals' contact information and training, gender, languages spoken other than English, hospital affiliations and whether or not they accept the Medicare payment amount as payment in full. Similar information will be available about provider groups.

In the future, it is likely that quality performance data for individual physicians, groups and other healthcare professionals will be added to the Physician Compare site, similar to the more robust data currently available on the [Hospital Compare site](#).

#### Hospital Compare

The [Hospital Compare site](#) currently contains publicly-available information on hospital demographics, such as location and type of hospital, as well as quality of care measures. In the future, quality of care information for the 11 cancer care hospitals participating under the PCHQR program is expected to be added to the Hospital Compare site.

#### Relevant ACA Provision

Assessing quality of care under the Medicare program is a key goal of the ACA and the PQRS and VBPM address various ways to accomplish this for *physicians*, including those involved in the delivery of cancer care. The ACA also contains a lesser-known provision that will enable the collecting and reporting of quality measures for a select group of *cancer hospitals*. Section 3005 of the ACA requires CMS to establish a quality reporting program specifically for cancer hospitals that receive cost-based Medicare reimbursement, rather than reimbursement under the prospective payment system (PPS).

This program, commonly referred to as the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program, facilitates reporting of quality information for 11 cancer care hospitals.<sup>19</sup> Beginning in fiscal year (FY) 2014, these 11 PPS-exempt cancer hospitals are required to submit cancer quality of care measures. Public reporting on the Hospital Compare website is slated to begin in 2014 for certain measures.<sup>20</sup>

#### Rapid Quality Reporting System (RQRS)

How are these 11 cancer hospitals to submit their cancer quality of care measures to CMS? Under the PCHQR program, CMS has contracted with the American College of Surgeons to implement the reporting of at least three cancer care measures using the Rapid Quality Reporting System (RQRS) for fiscal year (FY) 2014.<sup>21</sup> Additional cancer care measures have been added for fiscal years 2016 and beyond, offering the possibility that RQRS could be used to report more cancer care measures in the coming years.

What is the RQRS? The RQRS is an invaluable tool in the cancer quality movement. First, daily updating of information allows for real-time benchmarking. Next, its Web-based design means that RQRS is an integral, structural piece of a cancer program's work flow rather than just an extraneous reporting tool. Most significantly, the RQRS actively promotes evidence-based care at the local level by alerting care providers of care expectations that align with clinical guidelines in real time. If, for instance, a patient requires chemotherapy within 90 days of diagnosis, RQRS will alert care providers that this guideline has not yet been fulfilled – as well as how much time is left before the requirement must be met – when they check the RQRS Web site (e.g. Mrs. Smith requires chemotherapy within 47 days).<sup>22</sup>

While reporting using the RQRS is currently a requirement only for the 11 PPS-exempt cancer hospitals that are submitting cancer care measures for the PCHQR program, there are signs that the use of RQRS is growing in the cancer field. In fact, effective January 1, 2014 cancer programs that wish to receive Commission on Cancer accreditation with commendation – the highest award given – will need to be participating in RQRS.<sup>23</sup>

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Three Cancer Care Measures to be Reported Using RQRS for FY 2014 Program and Subsequent Years for the PCHQR Program<sup>24</sup>

Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1, or Stage II or III hormone receptor negative breast cancer.

Adjuvant hormonal therapy.

Adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery for patients under the age of 80 with AJCC Stage III (lymph node positive) colon cancer.

Finalized New Clinical Process and Cancer Care Measures for the PCHQR Program Beginning with the FY 2016 Program Year<sup>25</sup>

Oncology: Radiation Dose Limits to Normal Tissues

Oncology: Plan of Care for Pain

Oncology: Pain Intensity Quantified

Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients

Prostate Cancer: Avoidance of Overuse Measure-Bone Scan for Staging Low-Risk Patients

## How Technology Fits In

The RQRS provides an excellent example of how technology is helping to improve the quality of cancer care. In addition to RQRS, countless technological advances are modernizing the healthcare sector – chief among them the electronic health record (EHR) and electronic prescribing (E-prescribing or eRx).

With payers increasingly requiring documentation from healthcare records that clearly describes compliance to evidence-based practice guidelines as well as information about the patient’s evaluation of their healthcare experience, one thing has become clear: paper documentation cannot fulfill this vision.

Conceptually, the provision of healthcare requires readable documentation describing the comprehensive evaluation of the patient and the detailed, planned management of the patient’s illness, such as colon cancer, including collated prescriptions. The medical record should be readily accessible to other healthcare providers on the patient’s healthcare team to help coordinate care. Some appropriate portions of the healthcare record should be available to the patient, thereby engaging the patient in their care. The medical records must also be secure.<sup>26</sup>

## Electronic Health Records and Electronic Prescribing

The Affordable Care Act enforces the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act. HITECH encouraged the adoption and meaningful use of electronic health records (EHR) and electronic prescribing (E-Prescribing or eRx) by healthcare providers. The phrase “meaningful use” is what CMS considers appropriate integration of the EHR and eRx into clinical practice.<sup>27</sup>

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### *Electronic Health Record (EHR)*

An EHR is an electronic collection of patient information such as demographic data, progress notes, medications and medical histories that enables providers to share information between specialists, primary care practitioners, other providers and payers.<sup>28</sup> Having an EHR also enables providers to document and report quality data to CMS, track patient care, and provide care coordination.

### *Electronic Prescribing (E-Prescribing or eRx)*

Electronic prescribing, commonly referred to as E-Prescribing or eRx “is a prescriber’s ability to electronically send an accurate, error-free and understandable prescription directly to a pharmacy from the point-of-care.”<sup>29</sup> E-Prescribing is considered an important element in reducing medication errors and enhancing patient safety.

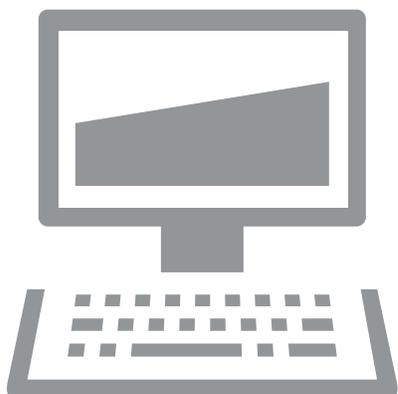
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## Meaningful Use

The phrase “meaningful use” is what CMS considers appropriate integration of the EHR and eRx into clinical practice. To achieve “meaningful use,” CMS-defined core objectives, menu objectives and clinical quality measures must be met.

The U.S. Department of Health and Human Services (HHS) was empowered by the ACA to mandate through incentives and payment adjustments that providers adopt secure, CMS-compatible electronic health records and electronic prescribing, thereby creating an electronic infrastructure that will enable:

- Sharing of medical information among providers
- Appropriate patient access to their medical record
- CMS to evaluate provider meaningful use of EHR and eRx
- CMS to assess and evaluate quality of care (i.e. PQRS )
- CMS to create a comparative database linking quality and cost
- CMS to create individual provider quality and cost profiles



## EHR Benefits

There is a multifaceted benefit to installation and progressive utilization of an electronic health record (EHR):

- Enables complete and timely documentation of patient care
- Facilitates coordination of care
- Demonstrates compliance to meaningful use of the EHR
- Provides a system for electronic prescribing (eRx)
- Facilitates the documentation of compliance to selected PQRS Quality Measures
- Enables compatible interfacing with an ACO
- Enables compatible interfacing with CMS

## Information Technology and Cancer Care

Information technology, in particular EHR and eRx, will need to be incorporated into any cancer care practice to allow for tracking quality of care, easier reporting of meaningful use of EHR and eRx, and as one vehicle for reporting of PQRS quality measures to CMS. The integration of the electronic infrastructure into clinical practice should provide real data on the quality of care delivered. Moreover, it should allow for better coordination and continuity of care between members of the care team by providing common access to the patient’s medical record – an essential component of an accountable care organization, which we describe in detail in the next section of the paper.

## Accountable Care Organizations (ACOs)

The key organizational structure embodying the ACA's main objectives – improving the quality of care, holding down costs, and ensuring care is patient-centered and integrated – is the formation of accountable care organizations (ACOs). ACOs tie together many of the key elements discussed in this paper – quality reporting, cost-effective care and supporting technologies.

The idea of leveraging accountable care organizations (ACOs) to help control Medicare spending gained traction during health reform conversations on Capitol Hill. The general concept behind the current ACO structure had been tested by the ten participating organizations in the Medicare Physician Group Practice (PGP) Demonstration from 2005-2010 and achieved modest success.<sup>30</sup>

Touted as a way to end fragmented, duplicative care that paid providers for the *quantity* of services provided rather than the *quality* of services provided, ACOs have been presented as a model for transforming care delivery to improve individual health, population health and contain costs. With a strong emphasis on strengthening the delivery of primary care, ACOs aim to reward providers for working together to coordinate care – which theoretically allows for patient-centered care. While on paper ACOs comprise just seven pages of the mammoth federal health reform law,<sup>31</sup> the impact they will likely have on healthcare delivery is immeasurable.

## Background Information

What are ACOs? An accountable care organization is a group of providers who come together voluntarily and can be held accountable for the cost and quality of healthcare provided to a defined population. While this concept is not new, what is unique about this reform approach is that ACOs put the locus of accountability for both the cost and quality of care on a local *group* of providers and delivery systems, rather than an *individual* provider or insurance company.<sup>32</sup>

ACOs hold the common goals of providing healthcare that is co-ordinated and efficient in the hopes of achieving better health outcomes for patients, an exceptional patient experience and cost savings. To achieve coordinated care, ACOs need to have the ability to care for patients in various institutional settings across the continuum of care. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

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**“The ACO model is always adapting and changing. Providers, including large healthcare systems, need to be nimble.”**

Eric Bieber, MD

President, UH Accountable Care Organization  
System Chief Medical Officer, University Hospitals  
Clinical Professor of Reproductive Biology,  
CWRU School of Medicine

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ACOs are often eligible to receive pay-ments for shared savings if they meet quality performance standards and reduce the rate of growth in health spending. How this is structured varies based on the way the program is set up by the payer, but ACOs that keep their patients healthy and out of the hospital are more likely to achieve cost savings and in turn receive financial rewards.<sup>33</sup> Under some programs, ACOs can also take on greater risk and receive higher shared savings amounts for their performance as well as face the risk of financial losses.

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### ACO Quick Facts

- There are 428 active ACOs operating in 49 states as of January 2013.<sup>34</sup>
- 259 ACOs, serving 4 million Medicare beneficiaries, have joined the Medicare Shared Savings Program as of January 2013.<sup>35</sup>
- Physician groups have recently overtaken hospitals as the largest sponsoring entity of ACOs.<sup>36</sup>



### ACOs in the Affordable Care Act

As structured under the ACA, Medicare accountable care organizations are defined as healthcare organizations that are primary care-focused with a CMS-defined governing body; data management systems; designated integration (medical home, patient-centered care); administrative infrastructure; and quality and cost control systems. The use of technological resources such as electronic health records and electronic prescribing are encouraged. Several primary care focused Medicare ACO reimbursement incentive models are authorized by the federal health reform law.

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- Medicare Shared Savings Program: A program to help Medicare fee-for-service program providers become organized as ACOs.
  - Advance Payment ACO Model: A supplementary incentive program for selected participants in the Medicare Shared Savings Program.
  - Pioneer ACO Model: A program designed for early adopters of coordinated care. Applications are no longer being accepted.<sup>37</sup>
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## Medicare Shared Savings Program

The Medicare Shared Savings Program (MSSP) is a voluntary ACO demonstration project that began in 2012.<sup>38</sup> Each participating ACO has at least 5,000 fee-for-service (FFS) Medicare beneficiaries assigned to it annually and agrees to participate for not less than three years. When an ACO succeeds in meeting quality care measures and reducing healthcare expenditures to benchmark levels it will **share with Medicare in the savings** it achieves.

ACOs in the Medicare Shared Savings Program can choose one of two program tracks, depending on the level of risk they want to assume:

- Shared savings only track
- Shared savings and risk of financial losses

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Approximately half of the Medicare ACOs that have formed are physician-led practices serving fewer than 10,000 beneficiaries<sup>40</sup>

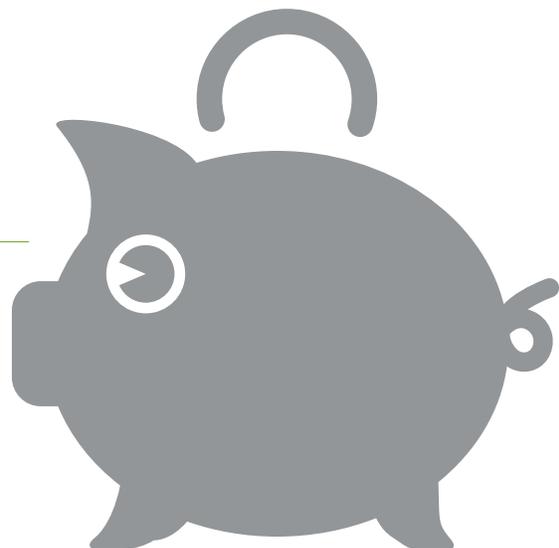
Roughly 20 percent of ACOs include critical access hospitals, rural health centers and community health centers<sup>41</sup>

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ACOs in the shared savings only program are eligible to receive shared savings payments if they meet quality performance standards and reduce their healthcare expenditures to benchmark levels and are not subject to financial risk for a cost overrun. In contrast, ACOs willing to take on additional risk can choose the second track and not only have the potential to receive a higher proportion of the shared savings, if there are any, but also have the potential to suffer financial losses based on their quality and cost overrun.

ACO structures authorized under the Medicare Shared Savings Program:

- Physicians and other practitioners in group practice arrangements
- Networks of individual practitioners
- Hospitals that partner with or employ eligible physicians, nurse practitioners, clinical nurse specialists and physician assistants
- Certain critical access hospitals, rural health clinics and federally qualified health centers<sup>39</sup>



## Comments of Two Early ACO Adopters

Healthcare experts are paying close attention to the lessons learned from the early adopters of accountable care organizations. We were able to speak to two early adopters of accountable care organizations that are participating under the Medicare Shared Savings Program – Summa Health System’s NewHealth Collaborative and the UH Coordinated Care Organization.

According to the contacts with whom we spoke, there is much to be learned from their early experiences:

- ACOs are multi-faceted.
- They are constantly evolving.
- Nobody knows exactly what the ACO model will look like in the future.
- Providers forming ACOs, including large healthcare systems, need to be nimble to rapidly adapt to changing healthcare rules, regulations and their own internal environment.

Despite uncertainty about what the ACO model will look like in the future, high quality, cost-effective and patient-centered healthcare is essential. The healthcare system is moving from providing acute and episodic care to being able to provide coordinated care across the care continuum.

Specialists, such as cancer care providers, are concerned that the heightened focus on primary care may inadvertently minimize the importance of the role they play in healthcare delivery. Our contacts emphasized that specialist care is essential, but primary care physician teams will need to be the focal point in managing medical care to ensure care coordination. ACOs are still figuring out how to bridge the different silos of care among specialists and primary care providers to ensure continuity of care.

Developing the technological infrastructure to support the ACO is an ongoing process. Implementing an EHR system has been labor intensive, but the data that the EHR systems provide improve care coordination and help identify patient needs, especially in complex high-risk patients. Quality of care and coordination of care are definitely enhanced by the formation of an ACO.

## Advance Payment ACO Model

An Advance Payment ACO Model is also being tested under the ACA as a way to help smaller ACOs that have more limited access to capital participate in the Medicare Shared Savings Program. This has accelerated the creation of ACOs. This group of ACOs includes small physician-based providers, rural providers and critical access hospitals that are given help in accessing needed capital to invest in infrastructure – such as electronic health records and staff – necessary to improve care coordination. The notion is that the up-front loans that are provided will be recouped from any possible shared savings that are achieved in the future.

## Pioneer ACO Model

An initial ACO model, the Pioneer ACO Model, signed on 32 large provider groups known as the “Pioneers” that had experience operating in configurations similar to the ACO model. The Pioneer ACO Model was designed to be a more advanced ACO model and is complementary to the Medicare Shared Savings Program. Applications are no longer being accepted for this program.



## ACO Quality Measures Reporting

Currently, ACOs authorized under the federal health reform law must report data on 33 evidence-based quality measures. It is important to note that these measures are applicable mainly to primary care providers, but two measures cover preventive cancer care screenings. Many of these measures align with current generally accepted quality initiatives that existed prior to passage of the ACA. These measures cover the following broad categories: care coordination and patient safety; appropriate use of preventive health services; improved care for at-risk populations; and patient and caregiver experience:

- **Patient and caregiver experience (7 measures)**
  - i.e. timely care, appointments and information; access to specialists
- **Care coordination and patient safety (6 measures)**
  - i.e. screening for future fall risk
- **Preventive health (8 measures)**
  - i.e. tobacco use screening and cessation intervention; **breast cancer screening, colorectal cancer screening**; body mass index (BMI) screening and follow-up, influenza immunization
- **At-risk populations:**
  - *Diabetes (1 measure and 1 composite consisting of five measures)*
    - i.e. tobacco non-use
  - *Hypertension (1 measure)*
    - i.e. controlling high blood pressure
  - *Ischemic Vascular Disease (2 measures)*
    - i.e. use of aspirin or other antithrombotic
  - *Heart Failure (1 measure)*
    - i.e. beta-blocker therapy for left ventricular systolic dysfunction (LVSD)
  - *Coronary Artery Disease (1 composite consisting of 2 measures)*
    - i.e. lipid control

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“The one comment I would like to make to the specialists:

Whenever you can and in whatever interaction you have with patients ask yourself the question, ‘How can I be an extension and a promoter of the primary care team?’”

Nancy Myers, PhD, System Director for Quality and Clinical Effectiveness, Summa Health System

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## Oncology Service Line and ACOs

There have been discussions by healthcare experts about oncology ACOs and how large oncology practices, hospitals and third party payers are exploring those. However, in the ACA the quality measures that Medicare ACOs must report data on are particularly applicable to *primary care practices*. Of the 33 quality measures, only the preventive measures of breast cancer screening and colorectal cancer screening relate specifically to cancer care – none relate to cancer care treatment. If one examines the CMS definition and the CMS-defined structure of an ACO, it does not allow for a pure cancer care ACO.

Cancer is one of the top cost drivers in healthcare and some estimates suggest that **10 percent of all healthcare costs** are attributable to cancer care, with \$124.6 billion spent on cancer treatments in 2010 alone.<sup>42</sup> Given the large chunk of the nation’s healthcare tab that cancer care comprises, many have questioned why cancer care delivery hasn’t been more specifically targeted for achieving ACO cost savings under the ACA models.

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“An oncology group practice with an EHR system, complying with quality measures, would be a more attractive provider for contracting with an ACO.”

Nancy Myers, PhD, System Director for Quality and Clinical Effectiveness, Summa Health System

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Keep in mind the distinction of a Medicare defined and registered ACO versus a non-Medicare ACO. What do we know about how oncology care is being incorporated into the ACO structure? In a 2011 survey of health plan and health system executives forming accountable care organizations, 65 percent indicated that oncology services were already employed or closely aligned with their organization and 30 percent had loose affiliations with oncology providers.<sup>43</sup>

Despite the challenges inherent in designing oncology-specific ACOs, large private insurers are actively pursuing oncology ACOs and payment redesign methodologies for oncology services. To date, oncology-specific ACOs are attempting to rein in costs, in particular drug costs, as well as better standardizing care protocols and helping patients wade through the vast amount of information available to them following a diagnosis.<sup>44</sup>

### Oncology-Specific ACOs

Florida Blue, Florida's Blue Cross and Blue Shield company, announced in December 2012 that it was launching an ACO specifically for cancer patients being cared for by the Tampa, Florida-based Moffitt Cancer Center and their 330 oncology practitioners. This move follows on the heels of the insurer's announcement that it had formed an ACO specific to the treatment of cancer between a large health system, Baptist Health South Florida, and an oncology group in the Miami-area, Advanced Medical Specialties.<sup>45</sup>

Aetna has also been exploring an oncology ACO model for the past few years in an attempt to highlight the importance of clinical pathways. Results of the insurer's shared savings partnership with U.S. Oncology Network's Texas affiliate included:

- Outcomes that were the same or better for participants than for those who were not part of the program
- Decrease in emergency department visits of 39.8 percent
- Decrease in hospital admissions of 16.5 percent
- Cost savings of roughly 12 percent among breast, colorectal and lung cancers alone.<sup>46</sup>



## Conclusion

The ACA is transforming healthcare delivery. Numerous trial endeavors, which include various financial incentives and penalties, have been started and will be analyzed. The key to these are high-quality care at the lowest possible cost. Accountable care organizations are one such endeavor.

While the ACA is the law of the land, countless implementation details remain to be sorted out. The Secretary of Health and Human Services has ultimate discretionary power over most implementation aspects of the law, therefore healthcare providers, including cancer care providers, will need to stay abreast of the many changes and details that are forthcoming.<sup>47</sup>

With more than 200 diseases comprising cancer, the ACA's impact on cancer care delivery for countless patients and providers is important to assess.<sup>48</sup> How should the oncology field adapt to these changes and continue to provide high-quality, comprehensive, multidisciplinary, cost-effective, innovative, compassionate cancer care as requested? Based on the information available it seems the best course of action for cancer care providers is to:

- Participate in PQRS reporting (for eligible providers)
- Participate in PCHQR (if a PPS-exempt cancer hospital)
- Adopt electronic health records
- Adopt electronic prescribing
- Self-monitor quality, cost and patient satisfaction

Cancer care professionals will want to familiarize themselves with the rules and regulations that impact ACOs, to determine how and whether they want to implement this model.<sup>49</sup> Oncology, which is responsible for at least 10 percent of healthcare expenditures, should not be left behind.

## Acknowledgements

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- Nancy Myers, PhD, System Director for Quality and Clinical Effectiveness, Summa Health System
- Janice Guhl Hammer, Director of Media Relations and News Services, University Hospitals
- Nate Hunt, Director of Operations, UH Coordinated Care Organization

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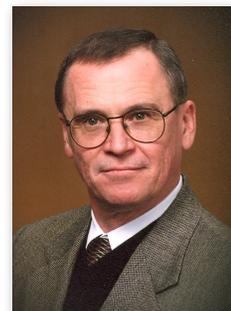
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### V. Moysaenko, MD, FACS

Dr. Valeriy Moysaenko, a graduate of the Ohio State University Medical School, is a Board Certified General Surgeon who had been in a solo general surgical practice for almost 30 years. He served as the Medical Director of the Cancer Program at Upper Valley Medical Center in Troy, Ohio and as a member of the Board of Trustees, Hospice of Miami County. Dr. Moysaenko serves on the Board of the American Cancer Society, Ohio Division.



Dr. Moysaenko believes that carefully developed cancer control strategies are extremely important in the fight against cancer. Toward that end, Dr. Moysaenko is the Chairman of the American College of Surgeons, Ohio Chapter Cancer Committee, working to coordinate control efforts among the American College of Surgeons Physician Liaisons in Ohio.

Dr. Moysaenko also sits on the Executive Committee of the Ohio Partners for Cancer Control. This organization has formulated and is currently implementing a statewide cancer control plan for Ohio.

A champion for progress in the cancer care quality movement, Dr. Moysaenko is also a surveyor for the American College of Surgeons' Commission on Cancer, which sets the standards for quality cancer care delivered primarily through hospital settings. Dr. Moysaenko surveys hospitals to assess compliance with those standards and uses data to improve cancer care outcomes at the national and local level.

In March of 2010, Moysaenko collaborated with T. Hare, RHIT, CTR, vice president of CHAMPS Oncology to write a white paper on quality cancer care entitled "The Continuing Pursuit of Excellence: Advancing Cancer Care through Quality Improvement."

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### Toni Hare, RHIT, CTR

Under Hare's leadership, the cancer information specialists of CHAMPS Oncology strategically partner with cancer programs nationwide to transform quality cancer data into valuable information – information that can be used to achieve accreditation, administrative planning, community outreach and cancer care objectives.



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With a degree in Health Information Management and 30 years of experience in the cancer registry profession, Hare is a progressive enthusiast for quality cancer information. She never stops promoting the importance of education in the profession, and quality within the cancer registry. As a Commission on Cancer-trained Consultant, she provides guidance and expertise to hospitals going through the CoC accreditation process. She has experience:

- Assisting administrative and cancer care leadership at new and existing cancer programs to achieve/maintain CoC accreditation
- Providing pre-survey cancer program needs assessment (gap analysis)
- Developing and assisting in the implementation of action plans for cancer programs to meet compliance with CoC standards
- Managing the creation of cancer registry database and operations for new cancer programs
- Developing a formal educational program in cancer data management
- Conducting and facilitating consultative evaluations (mock surveys)

She has published articles in Executive Healthcare Management; Advance for Health Information Professionals; and ACCC's Oncology Issues, including Hare's most recent article, "Multiple Program Accreditations: Mastering the Juggling Act." In March of 2010, Hare collaborated with V. Moysaenko, MD, FACS, vice-chair of Ohio's Cancer Liaison Physicians, and a CoC cancer program surveyor, to write a white paper on quality cancer care entitled "The Continuing Pursuit of Excellence: Advancing Cancer Care through Quality Improvement."

## Appendix A: Abbreviations Table

Abbreviation	Description
ACA	Patient Protection and Affordable Care Act
ACO	Accountable care organization
CMS	Centers for Medicare and Medicaid Services
EHR	Electronic health record
eRx or E-Prescribing	Electronic prescribing
FFS	Fee-for-service
FY	Fiscal year
GPRO	Group practice reporting option
HHS	U.S. Department of Health and Human Services
HITECH	Health Information Technology for Economic and Clinical Health Act
MSSP	Medicare Shared Savings Program
PCHQR	PPS-Exempt Cancer Hospital Quality Reporting Program
PFS	Physician fee schedule
PGP	Medicare Physician Group Practice Demonstration
PPS	Prospective payment system
PQRI	Physician Quality Reporting Initiative
PQRS	Physician Quality Reporting System
QOPI	Quality Oncology Practice Initiative
QRUR	Quality and Resource Use Report
RQRS	Rapid Quality Reporting System
VBP	Value-Based Purchasing
VBPM	Value-Based Payment Modifier

## Appendix B: Select 2013 PQRS Cancer Care Quality Measures

PQRS Measure Number	Measure Title
67	Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow
68	Hematology: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy
69	Hematology: Multiple Myeloma: Treatment with Bisphosphonates
70	Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry
<b>71</b>	<b>Breast Cancer: Hormonal Therapy for Stage IC - IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer*</b>
<b>72</b>	<b>Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients*</b>
76	Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol
99	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade
100	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade
102	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
104	Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Prostate Cancer Patients
<b>110</b>	<b>Preventive Care and Screening: Influenza Immunization*</b>
112	Preventive Care and Screening: Breast Cancer Screening
113	Preventive Care and Screening: Colorectal Cancer Screening

PQRS Measure Number	Measure Title
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
<b>130</b>	<b>Documentation of Current Medications in the Medical Record*</b>
131	Pain Assessment and Follow-Up
134	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
137	Melanoma: Continuity of Care – Recall System
138	Melanoma: Coordination of Care
<b>143</b>	<b>Oncology: Medical and Radiation – Pain Intensity Quantified*</b>
<b>144</b>	<b>Oncology: Medical and Radiation – Plan of Care for Pain*</b>
145	Radiology: Exposure Time Reported for Procedures Using Fluoroscopy
146	Radiology: Inappropriate Use of “Probably Benign” Assessment Category in Mammography Screening
147	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy
156	Oncology: Radiation Dose Limits to Normal Tissues
157	Thoracic Surgery: Recording of Clinical Stage Prior to Lung Cancer or Esophageal Cancer Resection
185	Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use
<b>194</b>	<b>Oncology: Cancer Stage Documented*</b>
224	Melanoma: Overutilization of Imaging Studies in Melanoma
225	Radiology: Reminder System for Mammograms

PQRS Measure Number	Measure Title
<b>226</b>	<b>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention*</b>
233	Thoracic Surgery: Recording of Performance Status Prior to Lung or Esophageal Cancer Resection
234	Thoracic Surgery: Pulmonary Function Tests Before Major Anatomic Lung Resection (Pneumonectomy, Lobectomy, or Formal Segmentectomy)
250	Radical Prostatectomy Pathology Reporting
251	Immunohistochemical (IHC) Evaluation of Human Epidermal Growth Factor Receptor 2 Testing (HER2) for Breast Cancer Patients
262	Image Confirmation of Successful Excision of Image-Localized Breast Lesion
263	Preoperative Diagnosis of Breast Cancer
264	Sentinel Lymph Node Biopsy for Invasive Breast Cancer
265	Biopsy Follow-Up
320	Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
321	Participation by a Hospital, Physician or Other Clinician in a Systematic Clinical Database Registry that Includes Consensus Endorsed Quality

**\*Eight measures comprising the oncology measures group.**

## Appendix C: Web Link Resource Guide

All links below can be accessed in our online version at [championcology.com](http://championcology.com).

### ACA Additional Resources

- [Patient Protection and Affordable Care Act Law](#)  
(including the Supreme Court's ruling to uphold the bulk of the law)

### PQRS Additional Resources

Background Information on PQRS:

- [American Medical Association: PQRS](#)
- [American Society of Clinical Oncology: PQRS](#)

### CMS PQRS Resources

- [How to Get Started with PQRS](#)
- [2013 PQRS Participation for Incentive Decision Tree](#)  
(Provides information on PQRS Measures Selection and Reporting Options)
- [PQRS Measures Codes](#)
- [PQRS Analysis and Payment](#)
- [PQRS Payment Adjustment Information](#)
- [2013 PQRS: 2015 Payment Adjustment](#)
- [PQRS Registry Reporting](#)
- [PQRS Electronic Health Record Reporting](#)
- [PQRS Educational Resources](#)

### Value-Based Payment Modifier (VBPM) Additional Resources

- [VBPM Background Information](#)
- [VBPM Overview](#)
- [Description of VBPM Reporting and Calculations](#)

### PCHQR Additional Resources

- [PPS-Exempt Hospitals Quality Reporting Program \(PCHQR\)](#)
- [Rapid Quality Reporting System \(RQRS\)](#)

### EHR Additional Resources

- [Overview of CMS EHR Incentive Programs](#)
- [EHR Incentive Program: Getting Started](#)
- [The CMS Electronic Health Record Reporting page](#) provides a Clinical Decision Tool to help you decide about applying for the incentive payments. A clinical practice utilizing an EHR in some cases directly submits compliance to quality measures to CMS. See [here](#).
- [Meaningful Use](#)
- [Eligible Professional Meaningful Use Core and Menu Set Objectives](#)
- [Certified EHR Technology](#)
- [A listing of the certified EHRs](#)
- [Clinical Quality Measures](#)
- [Moving Toward HITECH Healthcare: EHR Adoption at the Dawn of a New Era](#)

## eRx Additional Resources

- [E-Prescribing Overview](#)
- [Electronic Prescribing \(eRx\) Incentive Program](#)
- [Electronic Prescribing \(eRx\) Incentive Program: How to Get Started](#)
- [Electronic Prescribing \(eRx\) Payment Adjustment Information](#)
- [Registry reporting for eRx](#)
- [List of eRx Participating Registry Vendors](#)
- [EHR-Based Reporting](#)
- [List of EHR Direct Vendors](#)
- [eRx Measures](#)

## ACO Additional Resources

- [ACO Overview](#)
- [Accountable Care Organization Provisions in the \*Patient Protection and Affordable Care Act\*](#)
- [Medicare Shared Savings Program Shared Savings and Losses and Assignment Methodology](#)
- [2013 ACO Narrative Measure Specifications](#)
- [Summary of Final Rule Provisions for Accountable Care Organizations under the Medicare Shared Savings Program](#)
- [FAQ on ACOs: Accountable Care Organizations, Explained](#)
- [Medicare Shared Savings Program: Frequently Asked Questions](#)

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