Proposed CMS and ONC EHR Incentive Rules for Stage 2

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Conflict of Interest

- Dr. Kleeberg is the Clinical Director for the Minnesota - North Dakota Regional Extension Assistance Center for HIT (REACH) – a federally subsidized non-profit entity designed to assist Hospitals and Professionals in becoming meaningful users of EHRs.

- Dr Kleeberg also serves on the Physician Advisory Board for Elsevier

- No other conflict of interest

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Objectives

- Become familiar with the meaningful use and penalty timeline as proposed in the CMS Proposed rule

- Identify the Meaningful Use criteria that will be required for Stage 2

- Understand the changes to the Stage 1 Criteria

- Understand the proposed changes to the EHR incentive quality reporting

- Be able to describe the proposed differences between 2011 and 2014 Certified EHRs

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Outline

- **CMS EHR Incentive Proposed Rule**
  - **Rewards, Penalties and Timeline**
  - Stage 2
  - Changes to Stage 1
  - Clinical Quality Measures
  - Changes to Medicaid
- ONC Standards & Certification Proposed Rule
  - Redefining Certified EHR Technology
  - EHR Standards
  - EHR Certification Program

Stages of Meaningful Use

1st Year	Stage of Meaningful Use										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	1	1	1	2	2	3	3	TBD	TBD	TBD	TBD
2012		1	1	2	2	3	3	TBD	TBD	TBD	TBD
2013			1	1	2	2	3	3	TBD	TBD	TBD
2014				1	1	2	2	3	3	TBD	TBD
2015					1	1	2	2	3	3	TBD
2016						1	1	2	2	3	3
2017							1	1	2	2	3

Maximum Medicare Incentives for EPs in a non shortage area[1]

| 2010	2011	2012	2013	2014	2015	2016	2017	Total
	Stage 1 $18k	Stage 1 $12k	Stage 1 $8k	Stage 2 $4k	Stage 2 $2k	Stage 3	Stage 3	$44k
		Stage 1 $18k	Stage 1 $12k	Stage 2 $8k	Stage 2 $4k	Stage 3 $2k	Stage 3	$44k
			Stage 1 $15k	Stage 1 $12k	Stage 2 $8k	Stage 2 $4k	Stage 3	$39k
				Stage 1 $12k[2]	Stage 1 $8k	Stage 2 $4k	Stage 2	$24k
					Stage 1	Stage 1	Stage 2	0
Penalty (deduction from Medicare charges) if not at stage 3 by January 1 of that year:					1%	2%	3%	

1. Professionals with >50% Medicare services (as opposed to charges) in a health professional shortage area see a 10% increase in the maximum payment
2. Must demonstrate and attest to MU by October 1 2014 to avoid the 2015 penalty

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Maximum Medicaid Incentives for EPs with ≥ 30% volume

		First Year of Adopt, implement, Upgrade or MU Demonstration						
		2011	2012	2013	2014	2015	2016	2011
Calendar Year	2011	$21,250						$21,250
	2012	$8,500	$21,250					
	2013	$8,500	$8,500	$21,250				$8,500
	2014	$8,500	$8,500	$8,500	$21,250			
	2015[1]	$8,500	$8,500	$8,500	$8,500	$21,250		$8,500
	2016[1]	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250	$8,500
	2017[1]		$8,500	$8,500	$8,500	$8,500	$8,500	
	2018[1]			$8,500	$8,500	$8,500	$8,500	
	2019[1]				$8,500	$8,500	$8,500	$8,500
	2020[1]					$8,500	$8,500	
	2021[1]						$8,500	$8,500
	Total	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

1. Note: Medicare penalties will apply for any of the professional's billing to Medicare part B if not a meaningful user

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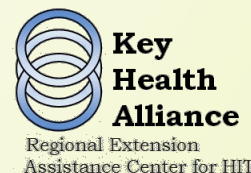
Professional EHR Reporting Period

- Professionals who have demonstrated meaningful use in 2011 through 2013 (fiscal years)

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
EHR Reporting Period	2013	2014	2015	2016	2017	2018

- Professional who demonstrates meaningful use in 2014 for the first time

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
90 day EHR Reporting Period	2014*	2014				
Full Year EHR Reporting Period			2015	2016	2017	2018

* In order to avoid the 2015 payment adjustment the professional must attest no later than October 1, 2014

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EP Medicare Payment Adjustments

% adjustment assuming <u>less than</u> 75 percent of EPs are meaningful EHR users for CY 2018 and subsequent years

	2015	2016	2017	2018	2019	2020+
EP is not subject to the payment adjustment for e-Rx in 2014	99%	98%	97%	96%	95%	95%
EP is subject to the payment adjustment for e-Rx in 2014	98%	98%	97%	96%	95%	95%

% adjustment assuming <u>more than</u> 75 percent of EPs are meaningful EHR users for CY 2018 and subsequent years

	2015	2016	2017	2018	2019	2020+
EP is not subject to the payment adjustment for e-Rx in 2014	99%	98%	97%	97%	97%	97%
EP is subject to the payment adjustment for e-Rx in 2014	98%	98%	97%	97%	97%	97%

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EP Hardship Exception

- Proposed Exception on an application basis submitted by July 1 before the payment year
  - Insufficient internet access for the two years prior
  - Newly practicing EPs for two years
  - Extreme circumstances such as unexpected closures, natural disaster, EHR vendor going out of business, etc.
- Proposed combination of 3 barriers would constitute a significant hardship
  - Lack of direct interaction with patients
  - Lack of need for follow-up care for patients
  - Lack of control over the availability of Certified EHR Technology

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Medicare Incentives for Prospective Payment System (PPS) Hospitals[1]

2010	2011	2012	2013	2014	2015	2016	2017	% Max Payment
	Stage 1 100%	Stage 1 75%	Stage 1 50%	Stage 2 25%	Stage 2	Stage 3	Stage 3	100%
		Stage 1 100%	Stage 1 75%	Stage 2 50%	Stage 2 25%	Stage 3	Stage 3	100%
			Stage 1 100%	Stage 1 75%	Stage 2 50%	Stage 2 25%	Stage 3	100%
				Stage 1[2] 75%	Stage 1 50%	Stage 2 25%	Stage 2	60%
					Stage 1 50%	Stage 1 25%	Stage 2	30%
						Stage 1	Stage 1	0%
Penalties: Market basket update would be reduced by:					-25%	-50%	-75%	

1. Percentages in the cells indicate the transition factor for the Medicare Share incentive
2. Must demonstrate and attest to MU by July 1, 2014 to avoid the 2015 penalty

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# Subsection (d) (PPS) Hospital EHR Reporting Period

- Hospital which has demonstrated meaningful use in 2011 through 2013 (fiscal years)

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Meaningful User Year	2013	2014	2015	2016	2017	2018

- Hospital which demonstrates meaningful use in 2014 for the first time

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
90 day EHR Reporting Period	2014*	2014				
Full Year EHR Reporting Period			2015	2016	2017	2018

* In order to avoid the 2015 payment adjustment the hospital must attest no later than July 1, 2014

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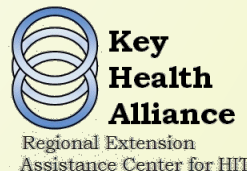
Subsection (d) (PPS) Hospital Payment Adjustments

% Decrease in the Percentage Increase to the IPPS Payment Rate that the hospital would otherwise receive for that year

	2015	2016	2017	2018	2019	2020+
% Decrease	25%	50%	75%	75%	75%	75%

- For example if the increase to IPPS for 2015 was 2% than a hospital subject to the payment adjustment would only receive a 1.5% increase

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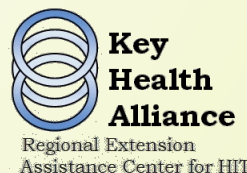
Subsection (d) (PPS) Hospital Hardship Exception

- Proposed Exception on an application basis
  - Insufficient internet access two years prior to the payment adjustment year
  - New hospitals for at least 1 full year cost reporting period
  - Extreme circumstances such as unexpected closures, natural disaster, EHR vendor going out of business, etc.
- Applications need to be submitted no later than April 1 of year before the payment adjustment year

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Medicare Incentives for Eligible Critical Access Hospitals (CAHs)

2010	2011	2012	2013	2014	2015	2016	2017	# of Payments
	Stage 1 Payment	Stage 1 Payment	Stage 1 Payment	Stage 2 Payment	Stage 2	Stage 3	Stage 3	4
		Stage 1 Payment	Stage 1 Payment	Stage 2 Payment	Stage 2 Payment	Stage 3	Stage 3	4
			Stage 1 Payment	Stage 1 Payment	Stage 2 Payment	Stage 2	Stage 3	3
				Stage 1 Payment	Stage 1 Payment	Stage 2	Stage 2	2
					Stage 1 Payment	Stage 1	Stage 2	1
						Stage 1	Stage 1	0
Penalties: Reasonable cost reimbursement of 101% would be reduced to:					100.66%	100.33%	100%	

Incentive payments calculation based on the Medicare Share of the EHR cost

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CAH EHR Reporting Period

- CAH which has demonstrated meaningful use prior to the 2015 fiscal year

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Full Year EHR Reporting Period	2015	2016	2017	2018	2019	2020

- CAH which demonstrates meaningful use in 2015 for the first time

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
90 day EHR Reporting Period	2015					
Full Year EHR Reporting Period		2016	2017	2018	2019	2020

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Critical Access Hospital Payment Adjustments

Applicable % of reasonable costs reimbursement which without payment adjustments is 101%

	2015	2016	2017	2018	2019	2020+
% of reasonable costs	100.66%	100.33%	100%	100%	100%	100%

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CAH Hardship Exception

- Proposed Exemptions on an application basis

  - Insufficient internet access for the payment adjustment year

  - New CAHs for one year after they accept their first patient

  - Extreme circumstances such as unexpected closures, natural disaster, EHR vendor going out of business, etc.

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Meaningful Use Concepts

- In general:
  - Stage 1 menu items have become core
  - Percentages have increased
  - Turnaround time is shorter
  - More exchange and patient involvement
  - Some core measures incorporated into other activities

- Changes
  - Exclusions no longer count to meeting one of the menu objectives
  - All denominators include all patient encounters at outpatient locations equipped with certified EHR technology

Stage 1 to Stage 2 Meaningful Use

Eligible Professionals

15 core objectives

5 of 10 menu objectives

20 total objectives

Eligible Professionals

17 core objectives

3 of 5 menu objectives

20 total objectives

Eligible Hospitals & CAHs

14 core objectives

5 of 10 menu objectives

19 total objectives

Eligible Hospitals & CAHs

16 core objectives

2 of 4 menu objectives

18 total objectives

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Stage 2 EP Core Objectives

1. Use CPOE > ~~30~~ **60%** of **all** medication, **laboratory and radiology** orders

2. E-Rx > ~~40~~ **65%**

3. Record demographics > ~~50~~ **80%**

4. Record vital signs > ~~50~~ **80%**

5. Record smoking status > ~~50~~ **80%**

6. Implement ~~1~~ **5** clinical decision support interventions + drug/drug and drug/allergy

7. Provide office visit summaries in ~~72~~ **24 hours**

8. Conduct or review security analysis and incorporate in risk management process

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Stage 2 EP Core Objectives – No Longer Menu:

9. Incorporate lab results > ~~40~~ **55%**

10. Generate patient list by specific condition

11. Use EHR to identify and provide > 10% with reminders for preventive/follow-up

12. Provide *online access* to health information > 50% with > *10% actually accessing*

13. Use EHR to identify and provide education resources > 10%

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Stage 2 EP Core Objectives – No Longer Menu:

14. Medication reconciliation > ~~50~~ **65%** of transitions of care

15. Provide summary of care document > ~~50~~ **65%** of transitions of care and referrals with > **10% sent electronically**

16. **Successful ongoing** transmission of immunization data

New Stage 2 EP Core Objective:

17. **> 10% of patients send secure messages to their EP**

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Stage 2 EP Menu Objectives (Select 3 of 5)

1. ***Successful ongoing*** *transmission of syndromic surveillance data*

2. *> 40% of imaging results are accessible through Certified EHR Technology*

3. *Record family health history > 20%*

4. *Successful ongoing transmission of cancer case information*

5. *Successful ongoing transmission of data to a specialized registry*

Stage 2 Hospital Core Objectives

1. Use CPOE > ~~30~~ **60%** of **all** medication, **laboratory and radiology** orders

2. Record demographics > ~~50~~ **80%**

3. Record vital signs > ~~50~~ **80%**

4. Record smoking status > ~~50~~ **80%**

5. Implement ~~1~~ **5** clinical decision support interventions + drug/drug and drug/allergy

6. Conduct or review security analysis and incorporate in risk management process

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Stage 2 Hospital Core Objectives – No Longer Menu:

7. Incorporate lab results > ~~40~~ **55%**

8. Generate patient list by specific condition

9. Provide **online access** to health information > 50% with > **10% actually accessing**

10. Use EHR to identify and provide education resources > 10%

11. Medication reconciliation > **65%** of transitions of care

Stage 2 Hospital Core Objectives – No Longer Menu:

12. Provide summary of care document > ~~50~~ **65%** of transitions of care and referrals with **10% sent electronically**

13. **Successful ongoing** transmission of immunization data

14. **EH: Successful ongoing** submission of reportable laboratory results

15. **EH: Successful ongoing** submission of electronic syndromic surveillance data

New Stage 2 EP Core Objective:

16. **EMAR with barcode scanning is implemented and used for more than 10% of medication orders**

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Stage 2 Hospital Menu Objectives (Select 2 of 4)

1. Record indication of advanced directive for more than 50%

2. *More than 40% of imaging results are accessible through Certified EHR Technology*

3. *Record family health history for more than 20%*

4. *E-Rx for more than 10% of discharge prescriptions*

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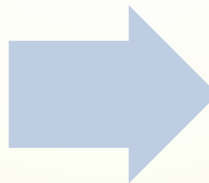Assistance Center for HIT

Changes to Stage 1:

| Denominator: Unique Patient with at least one medication in their med list | → | Denominator: Number of Orders during the EHR Reporting Period |

Optional in 2013 Required in 2014+
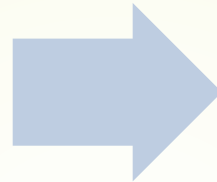
| Age Limits: Age 2 for Blood Pressure & Height/Weight | → | Age Limits: Age 3 for Blood Pressure, No age limit for Height/Weight |

Optional in 2013 Required in 2014+

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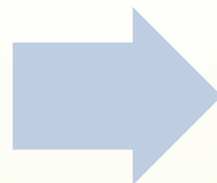
Changes to Stage 1:

Exclusion: All three elements not relevant to scope of practice	→	Exclusion: Allows BP to be separated from height/weight

Optional in 2013 Required in 2014+

One test of electronic transmission of key clinical information	→	Requirement removed effective 2013

Effective 2013

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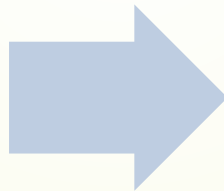
Changes to Stage 1:

Objective: Provide patients with e-copy of health information upon request

Objective: Provide electronic access to health information

→
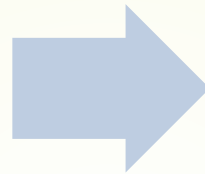
Replacement Objective:

Provide patients the ability to view online, download and transmit their health information

Required in 2014+

Immunizations

Reportable Labs

Syndromic Surveillance

→

Addition of "except where prohibited" to all three

Effective 2013

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Alignment Among Programs

- CMS is committed to aligning quality measurement and reporting among programs

- Alignment efforts on several fronts:
  - Choosing the same measures for different programs
  - Coordinating quality measurement stakeholder involvement
  - Identifying ways to minimize multiple submission requirements

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CQM - Domains

- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Population and Public Health
- Efficient Use of Healthcare Resources
- Clinical Processes/Effectiveness

CQM – Changes from Stage 1 Final Rule

2010 Final Rule

2012 Proposed Rule

<u>**Eligible Professionals**</u>

3 core <u>OR</u> 3 alt. core CQMs

+

3 menu CQMs

6 total CQMs

<u>**Eligible Professionals**</u>

1) 12 CQMs (≥1 per domain)

2) PQRS

Group Reporting

12 total CQMs

<u>**Eligible Hospitals & CAHs**</u>

15 total CQMs

<u>**Eligible Hospitals & CAHs**</u>

24 CQMs (≥1 per domain)

24 total CQMs

**Align with ONC's
2011 EHR Certification**

**Align with ONC's
2014 EHR Certification**

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CQM Reporting in 2013 EPs & Hospitals

- CQMs will remain the same through 2013
  - As published in the July 28, 2010 Final Rule
- Electronic specifications for the CQMs will be updated
- Reporting Methods:
  - Attestation
  - 2012 Electronic Reporting Pilots (PQRS for EPs and IQR for EHs) extended to 2013
  - Medicaid – State-based e-submission

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CQM Reporting for EPs Beginning in CY2014

- Option 1: EHR Incentive Program Only
  - 12 CQMs, ≥1 from each domain
  - Medicaid – State based e-submission
  - Aggregate XML-based format specified by CMS
- Option 2: EHR Incentive Program + PQRS
  - Submit and satisfactorily report CQMs under PQRS EHR Reporting option using CEHRT to satisfy MU

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CQM Reporting for EPs Beginning in CY2014

- Group Reporting (3 options):

(1) ≥ 2 EPs, each with a unique NPI under one TIN	Submit 12 CQMs from EP measures table, ≥1 from each domain
(2) EPs in an ACO (Medicare Shared Savings Program)	Satisfy requirements of Medicare Shared Savings Program using Certified EHR Technology
(3) EPs satisfactorily reporting via PQRS GPRO option	Satisfy requirements of PQRS GPRO option using Certified EHR Technology

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CQM Reporting for Hospitals Beginning in FY2014

- 24 CQMs, ≥1 from each domain
  - Includes 15 CQMs from July 28, 2010 Final Rule
  - Considering instituting a case number threshold exemption for some hospitals

- Reporting Methods
  - Aggregate XML-based format specified by CMS
  - Manner similar to 2012 Medicare EHR Incentive Program Electronic Reporting Pilot

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Medicaid- Specific Changes

- Proposed an expanded definition of a Medicaid encounter:
  - To include any encounter with an individual receiving medical assistance under 1905(b), including Medicaid expansion populations
  - To permit inclusion of patients on panels seen within 24 months instead of just 12
  - To permit patient volume to be calculated from the most recent 12 months, instead of on the CY
  - To include zero-pay Medicaid claims

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Medicaid-Specific Changes Continued

- Proposed the inclusion of additional children's hospitals that do not have a CMS Certification Number (CCN)

- Proposed to extend States' flexibility with the definition of meaningful use to Stage 2

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Essential Changes in EHR Certification

- EHR Certification:
  - From "Stage 1 Certified" ➔ 2011 Certification
  - New Certification criteria ➔ 2014 Certification
- All will need to have 2014 Certified EHR Technology (CERT) in payment year 2014
- ONC/CMS will not require an EP/EH CAH to purchase components they do not need
- Vendors will not need to recertify on criteria that have not changed since 2011
- New Criteria: Safety-enhanced design

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"New" Certification Criteria

Ambulatory & Inpatient	Inpatient Only	Ambulatory Only
Electronic Notes	Electronic medication administration record	Secure messaging
Imaging (access to)	eRx (for discharge)	Cancer case information
Family Health History	Transmission of electronic lab tests and values/results to ambulatory providers	Transmission to cancer registries
Amendments		
View, Download, & Transmit to 3rd party		
Auto numerator recording		
Non-%-based measure use report		
Safety-enhanced design		

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"Revised" Certification Criteria

Ambulatory & Inpatient		Ambulatory Only
Drug-drug, drug-allergy interaction checks	Incorporate lab tests and values/results	eRx
Demographics	CQMs	Clinical summaries
Problem list	Auditable events and tamper-resistance	
Clinical decision support	Audit report(s)	**Inpatient Only**
Patient-specific education resources	Encryption of data at rest	Transmission of reportable lab tests and values/results
TOC – Incorporate summary care record	Immunization Information	
TOC – Create transmit summary care record	Transmission to Immunization Registries	
Clinical information reconciliation	Automated measure calculation	

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"Unchanged" Certification Criteria

Ambulatory & Inpatient	
CPOE	Drug-formulary checks
Vital signs, BMI, & growth charts	Medication list
Smoking status	Medication allergy list
Patient reminders	Patient lists
Authentication, access control, & authorization	Accounting of disclosures
Automatic log-off	Advance directives
Emergency access	Public health surveillance
Integrity	Immunization information
Reportable lab tests and values/results	Incorporate lab test results (inpatient only)

- Roughly 40% of 2014 Edition Certification Criteria Eligible for "Gap Certification"

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Certified EHR Technology

Here's what it looks like today...   Here's what ONC is proposing...

2011 - 13   2014+

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"Base EHR"

- EHR technology that includes fundamental capabilities all providers would need to have.
- All are defined by statute as the ability to support:
  - Demographics
  - CPOE
  - CDS
  - Quality Reporting
  - Information exchange
- Security requirements, though not required by statute, were added to the base EHR

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Base EHR

Certification Criteria Required to Satisfy the Definition of a Base EHR	
Base EHR Capabilities	**Certification Criteria**
Includes patient demographic and clinical health information, such as medical history and problem lists	Demographics § 170.314(a)(3) Vital Signs § 170.314(a)(4) Problem List § 170.314(a)(5) Medication List § 170.314(a)(6) Medication Allergy List § 170.314(a)(7)
Capacity to provide clinical decision support	Drug-Drug and Drug-Allergy Interaction Checks § 170.314(a)(2) Clinical Decision Support § 170.314(a)(8)
Capacity to support physician order entry	Computerized Provider Order Entry § 170.314(a)(1)
Capacity to capture and query information relevant to health care quality	Clinical Quality Measures § 170.314(c)(1) and (2)
Capacity to exchange electronic health information with, and integrate such information from other sources	Transitions of Care § 170.314(b)(1) and (2)
	View, Download, and Transmit to 3rd Party § 170.314(e)(1)
Capacity to protect the confidentiality, integrity, and availability of health information stored and exchanged	Privacy and Security § 170.314(d)(1)-(8)

CEHRT – as defined in NPRM

MU Menu - 3

MU Core - 2

Base EHR 1
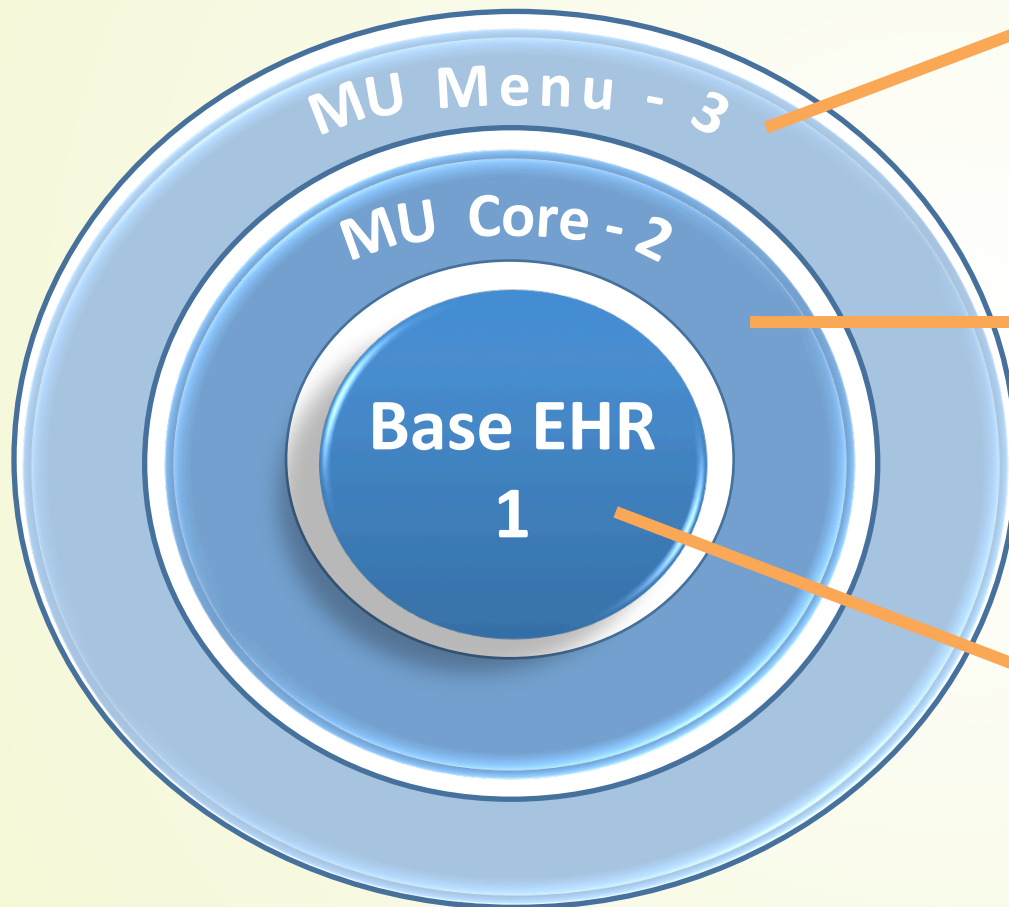
EP/EH/CAH would only need to have EHR technology with capabilities certified for the MU menu set objectives & measures for the stage of MU they seek to achieve.

EP/EH/CAH would need to have EHR technology with capabilities certified for the MU core set objectives & measures for the stage of MU they seek to achieve unless the EP/EH/CAH can meet an exclusion.

EP/EH/CAH must have EHR technology with capabilities certified to meet the definition of Base EHR.

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3 proposed ways to meet CEHRT Definition

- Complete EHR
- EHR Module(s):
  - Combination of EHR Modules
  - Single EHR Module
- The new proposal would allow an eligible professional or hospital to have only the 2014 certified EHR modules they needed to meet the definition of CEHRT

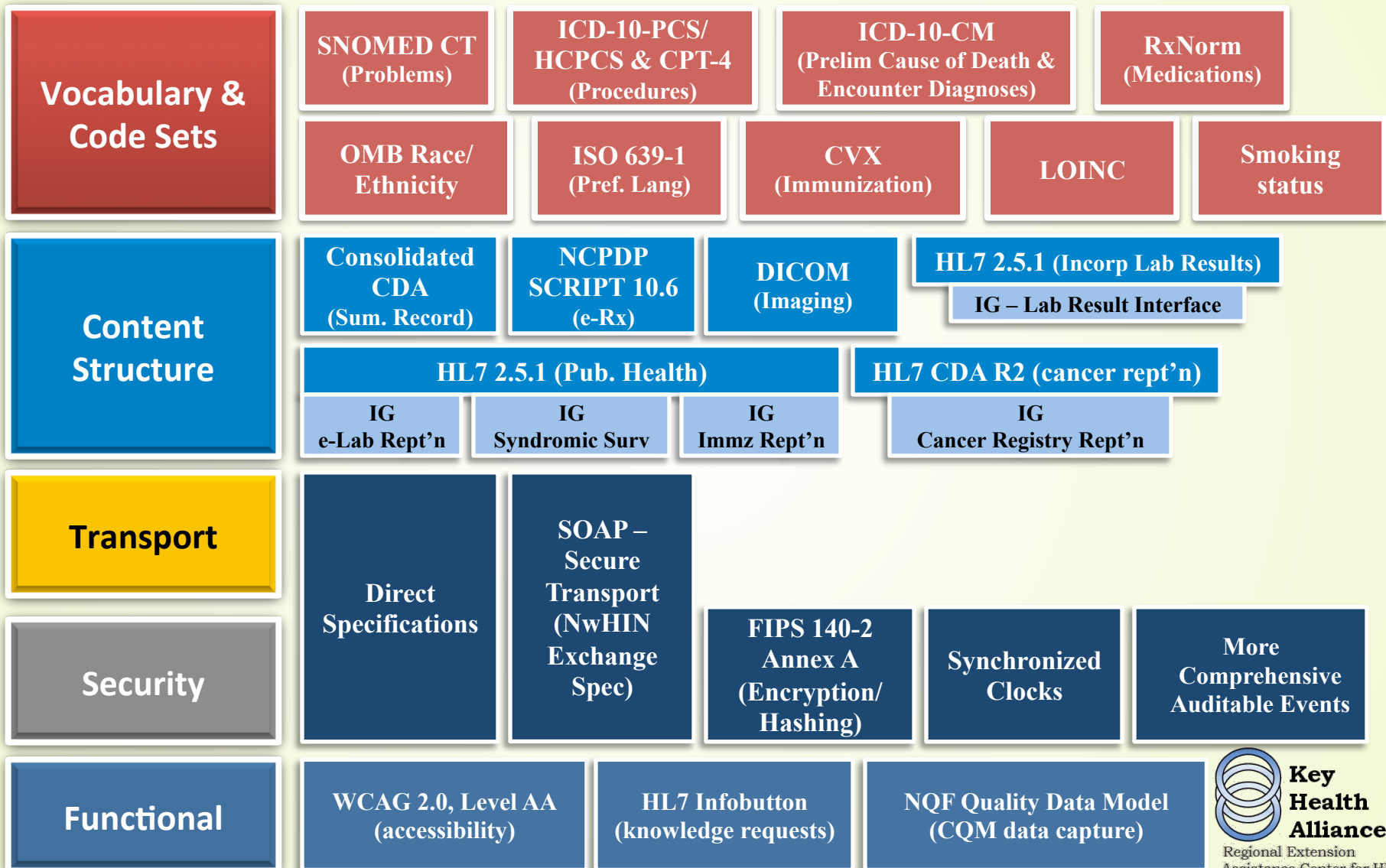# Proposed Revised Definition of CEHRT Compliance

EHR Reporting Period			
FY/CY 2011	**FY/CY 2012**	**FY/CY 2013**	**FY/CY2014**
MU Stage 1	MU Stage 1	MU Stage 1	MU Stage 1 <u>or</u> MU Stage 2
All EPs, EHs, and CAHs must have EHR technology certified to all applicable 2011 Edition EHR certification criteria or equivalent 2014 Edition EHR certification criteria			All EPs, EHs, and CAHs must have EHR technology (including a Base EHR) that has been certified to the 2014 Edition EHR certification criteria that would support the objectives and measures, and their ability to successfully report the CQMs, for the MU stage that they seek to achieve.

Outline

- CMS EHR Incentive Proposed Rule
  - Rewards, Penalties and Timeline
  - Stage 2
  - Changes to Stage 1
  - Clinical Quality Measures
  - Changes to Medicaid
- **ONC Standards & Certification Proposed Rule**
  - Redefining Certified EHR Technology
  - **EHR Standards**
  - EHR Certification Program

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2014 Edition Standards

Vocabulary & Code Sets

- SNOMED CT (Problems)
- ICD-10-PCS/ HCPCS & CPT-4 (Procedures)
- ICD-10-CM (Prelim Cause of Death & Encounter Diagnoses)
- RxNorm (Medications)
- OMB Race/ Ethnicity
- ISO 639-1 (Pref. Lang)
- CVX (Immunization)
- LOINC
- Smoking status

Content Structure

- Consolidated CDA (Sum. Record)
- NCPDP SCRIPT 10.6 (e-Rx)
- DICOM (Imaging)
- HL7 2.5.1 (Incorp Lab Results)
  - IG – Lab Result Interface
- HL7 2.5.1 (Pub. Health)
  - IG e-Lab Rept'n
  - IG Syndromic Surv
  - IG Immz Rept'n
- HL7 CDA R2 (cancer rept'n)
  - IG Cancer Registry Rept'n

Transport

- Direct Specifications
- SOAP – Secure Transport (NwHIN Exchange Spec)

Security

- FIPS 140-2 Annex A (Encryption/ Hashing)
- Synchronized Clocks
- More Comprehensive Auditable Events

Functional

- WCAG 2.0, Level AA (accessibility)
- HL7 Infobutton (knowledge requests)
- NQF Quality Data Model (CQM data capture)

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Vocabulary/Code Sets

Data	2011 Edition	2014 Edition (proposed)
Immunizations	CVX – July 30, 2009	CVX – Aug 15, 2011
Problems	ICD-9 -CM/ IHTSDO SNOMED CT – July 2009	IHTSDO SNOMED CT – Jan 2012
Procedures	ICD-9 -CM/ CPT-4	ICD-10-PCS/HCPCS & CPT-4
Lab Tests	LOINC 2.27	LOINC 2.38
Medications	Any source vocabulary in RxNorm	RxNorm – Feb 6, 2012
Race & Ethnicity	OMB standards	OMB standards
Preferred Language	N/A	ISO 639-1:2002
Preliminary Determination of Cause of Death and Encounter Diagnoses	N/A	ICD-10-CM
Smoking Status	N/A	Current every day; current some day; former; never; smoker, current status unknown; and unknown if ever smoked

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Content Exchange

Purpose	2011 Edition	2014 Edition (proposed)
Summary Record	HL7 CDA R2, CCD *HITSP Summary Doc using HL7 CCD Component HITSP/C32* ASTM E2369 Standard Spec for CCR and Adjunct to ASTM E2369	Consolidated CDA
eRx	NCPDP SCRIPT 8.1 / 10.6	NCPDP SCRIPT 10.6
Electronic submission of lab results to PH agencies	HL7 2.5.1 *HL7 2.5.1 IG electronic lab reporting to PH, R1 (US Realm)*	HL7 2.5.1 *HL7 2.5.1 IG: electronic lab reporting to PH, R1 (US Realm)*
Electronic submission to PH agencies for surveillance or reporting	HL7 2.3.1 / 2.5.1	HL7 2.5.1 *PHIN Messaging Guide for Syndromic Surveillance: Emergency Dept and Urgent Care Data HL7 Version 2.5.1.*

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Content Exchange (cont.)

Purpose	2011 Edition	2014 Edition (proposed)
Electronic submission to immunization registries	HL7 2.3.1 / 2.5.1 *IG for immunization Data Transactions using Version 2.3.1 of HL7 Standard Protocol Implementation Guide Version 2.2 HL7 2.5.1 Implementation Guide for Immunization Messaging Release 1.0*	HL7 2.5.1 *HL7 2.5.1 IG for Immunization Messaging Release 1.3*
Quality Reporting	CMS PQRI Registry XML Spec *PQRI Measure Specs Manual for Claims and Registry*	TBD XML Spec
Cancer information	N/A	HL7 CDA, R2 *IG for Healthcare Provider Reporting to Central Cancer Registries, Draft, Feb 2012*
Imaging	N/A	DICOM PS3 – 2011
Electronic incorporation and transmission of lab results	N/A	HL7 2.5.1 *HL7 2.5.1 IG: S&I Framework Lab Results Interface, Release 1 (US Realm)*

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Transport

Purpose	2011 Edition	2014 Edition (proposed)
Direct Specifications	N/A	Applicability Statement for Secure Health Transport
SOAP-Secure Transport	N/A	External Data Representation and Cross-Enterprise Document Media Interchange for Direct Messaging
NwHIN Exchange Modular Specification	N/A	Simple Object Access Protocol (SOAP)-Based Secure Transport Requirements Traceability Matrix (RTM) version 1.0

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Security

Purpose	2011 Edition	2014 Edition (proposed)
Auditable events	The date, time, patient identification, and user identification must be recorded when electronic health information is created, modified, accessed, or deleted; and an indication of which action(s) occurred and by whom must also be recorded.	The 2011 specs plus: 1. The electronic health information affected by the action(s) 2. When audit log is enabled and disabled 3. When encryption of electronic health information managed by EHR technology on end-user devices is enabled and disabled
Encryption and hashing	N/A	FIPS 140-2 Annex A
Synchronized clocks	N/A	NTPv3 or NTPv4

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Functional

Purpose	2011 Edition	2014 Edition (proposed)
Accessibility	N/A	WCAG 2.0, Level AA Conformance
Reference Source	N/A	Infobutton, International Normative Ed 2010
CQM - data capture and export	N/A	NQF Quality Data Model, 2011

Clinical Quality Measure (CQMs) Standards

- Focuses on the CQM lifecycle
  - Data capture (+ export)
  - Calculation (+ incorporation of external sources)
  - Reporting

- Identified Challenges from Stage 1
  - "EHR-Ready" CQMs
  - Exclusions
  - Workflow

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Outline

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Permanent Certification Program Proposed Changes

- Vendors may use newer versions of certain identified minimum code sets standards that have been identified without adversely affecting certification status *unless:*

  - The Secretary *expressly prohibits* the use of a newer version of a "minimum standard" code set

- Two methods to identify newer versions of adopted minimum standards:

  - Anyone can notify the National Coordinator, or

  - The Secretary of HHS identifies a new version

In Closing:

- Summary of Stage 2:
    - Increased provider use of Certified EHRs
    - Increased involvement of patients
    - Increased electronic exchange of information
    - Continued pay-for-reporting of Clinical Quality Measures; pay-for-performance is coming
    - Penalties for non-use are slated to come sooner than we thought

- The direction is clear – we will need to wait until later this summer to know the specifics

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