Florida Medicaid
Promoting
Interoperability Program

Kim Davis-Allen,
Outreach Coordinator

September 24, 2019

Meaningful Use Objective: Health Information Exchange (HIE)

Program Year 2019 – Basics

All providers have a minimum 90 day Electronic Health Record (EHR) reporting period

All providers attest to Stage 3 requirements

Providers must have 2015 certified technology

Clinical Quality Measures (CQMs): First time attesting to Meaningful Use (MU): 90 days

2nd or later years: Full year reporting

Eligible Providers (EP) must report one outcome or priority CQM

Stage 3 Meaningful Use Objectives

- Protect Electronic Protected Health Information (ePHI)
- Electronic Prescribing
- Clinical Decision Support (CDS)
- Computerized Provider Order Entry (CPOE)
- Patient Electronic Access to Health Information
- Coordination of Care through Patient Engagement
- Health Information Exchange (HIE)
- Public Health and Clinical Data Registry Reporting

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/TableofContents_EP_Medicaid_2019.pdf

Health Information Exchange

OBJECTIVE: The eligible professional (EP) provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their electronic health record (EHR) using the functions of certified EHR technology (CEHRT).

An EP must attest to all three measures and meet the threshold for two measures for this objective. If the EP meets the criteria for exclusion from two measures, they must meet the threshold for the one remaining measure. If they meet the criteria for exclusion from all three measures, they may be excluded from meeting this objective.

Measure 1:

For more than 50 percent of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care:

(1) Creates a summary of care record using CEHRT; and

(2) Electronically exchanges the summary of care record

Measure 2:

For more than 40 percent of transitions or referrals received and patient encounters in which the EP has never before encountered the patient, he/she incorporates into the patient's EHR an electronic summary of care document.

Measure 3:

For more than 80 percent of transitions or referrals received and patient encounters in which the EP has never before encountered the patient, he/she performs a clinical information reconciliation. The EP must implement clinical information reconciliation for the following three clinical information sets:

(1) Medication. Review of the patient's medication, including the name, dosage, frequency, and route of each medication.

(2) Medication allergy. Review of the patient's known medication allergies.

(3) Current Problem list. Review of the patient's current and active diagnoses.

Measure 1 Exclusions

(1) He or she transfers a patient to another setting or refers a patient to another provider fewer than 100 times during the EHR reporting period.
(2) He or she conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the Federal Communications Commission (FCC) on the first day of the EHR reporting period.*

Measure 2 Exclusions

(1) The total transitions or referrals received and patient encounters in which he or she has never before encountered the patient, is fewer than 100 during the EHR reporting period.
(2) He or she conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period. *

Measure 3 Exclusions

An EP may take an exclusion if the total transitions or referrals received and patient encounters in which he or she has never before encountered the patient, is fewer than 100 during the EHR reporting period.

*not applicable in Florida

Summary of Care Record Elements

Must include the following information if the provider knows it:

- Patient name
- Demographic information (preferred language, sex, race, ethnicity, date of birth)
- Smoking status
- Current problem list (providers may also include historical problems at their discretion)*
- Current medication list*
- Current medication allergy list*
- Laboratory test(s)
- Laboratory value(s)/result(s)
- Vital signs (height, weight, blood pressure, Body Mass Index (BMI))
- Procedures
- Care team member(s) (including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider)*
- Immunizations
- Unique device identifier(s) for a patient's implantable device(s)
- Care plan, including goals, health concerns, and assessment and plan of treatment
- Referring or transitioning provider's name and office contact information
- Encounter diagnosis
- Functional status, including activities of daily living, cognitive and disability status
- Reason for referral

*Note: An EP must verify that the fields for current problem list, current medication list, and current medication allergy list are not blank and include the most recent information known by the EP as of the time of generating the summary of care document or include a notation of no current problem, medication and/or medication allergies.

To Meet Measure 1 . . .

For Measure 1 in order to count in the numerator, the exchange must occur within the EHR reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the EHR reporting period occurs.

For Measure 1, the referring EP must have reasonable certainty of receipt by the receiving provider to count the action toward the measure. An EP must have a confirmation of receipt or that a query of the summary of care record has occurred in order to count the action in the numerator.

Apart from the three fields noted as required for the summary of care record (i.e., current problem list, current medication list, and current medication allergy list), in circumstances where there is no information available to populate one or more of the fields listed (because the EP does not record such information or because there is no information to record), the EP may leave the field(s) blank and still meet the objective and its associated measure.

More on Measure 1

The initiating EP must send a C–CDA document that the receiving provider would be capable of electronically incorporating as a C–CDA on the receiving end.

In other words, if an EP sends a C–CDA and the receiving provider converts the C–CDA into a pdf, a fax, or some other format, the sending EP may still count the transition or referral in the numerator.

If the sending provider converts the file to a format the receiving provider could not electronically receive and incorporate as a C–CDA, the initiating EP may not count the transition in their numerator

Measure 2 – Removing Cases

PER CMS - for the purposes of defining the cases in the denominator for Measure 2, we stated what constitutes ‘‘unavailable’’ and, therefore, may be excluded from the denominator, will be that an EP:

Requested an electronic summary of care record to be sent and did not receive an electronic summary of care document
AND

The EP Either		
Queried at least one external source via HIE functionality and did not locate a summary of care for the patient, or the provider does not have access to HIE functionality to support such a query.	OR	Confirmed that HIE functionality supporting query for summary of care documents was not operational in the provider’s geographic region and not available within the EP’s EHR network as of the start of the EHR reporting period.

Before You Remove Cases From Denominator

- Determine what HIE functionality exists in your area
- Determine what functionality your system supports
- Does your system capture request information?
  - Central log of requests and those that did not comply
  - System generated report of requests
- If you do remove:
  - Document, document, document
  - Actions were taken
  - Maintain for pre-payment and post payment

Measure 2 Explanation Continued

For Measure 2, a record cannot be considered incorporated if it is discarded without the reconciliation of clinical information or if it is stored in a manner that is not accessible for EP use within the EHR.

Know how your system is capturing and reporting!!

For Measure 3:

- The process may include both automated and manual reconciliation to allow the receiving EP to work with both the electronic data provided with any necessary review, and to work directly with the patient to reconcile their health information.

- Non-medical staff may conduct reconciliation under the direction of the EP so long as the EP or other credentialed medical staff is responsible and accountable for review of the information and for the assessment of and action on any relevant clinical decision support alert.

Preparing for Program Year 2019

2015 Certification

Understand Your System

Run Your Reports

Contacts and Resources

Florida Medicaid Incentive Program
Promoting Interoperability

www.ahca.myflorida.com/medicaid/ehr

MedicaidHIT@AHCA.MyFlorida.com

Call Center 1.855.231.5472

FLORIDA HIE SERVICES

www.Florida-HIE.net

FLHII@ahca.myflorida.com

FloridaHealthFinder.gov
Connecting Florida with Health Care Information

http://www.floridahealthfinder.gov/index.html

E-FORCSE
Electronic-Florida Online Reporting of Controlled Substances Evaluation

Erika.Marshall@flhealth.gov
www.e-forcse.com

Connect with us through Social Media:

https://www.facebook.com/AHCAFlorida

@AHCA_FL