

Medicaid Promoting Interoperability (PI) Program Frequently Asked Questions: Program Year 2020 Health Information Exchange

| # | Question and Answer | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1 | <p>Q: How does an eligible professional (EP) meet the health information exchange objective^A?</p> <p>A: An EP must meet the minimum threshold for 2 of the 3 measures or meet the available exclusions.</p> <ul style="list-style-type: none"> • If the EP meets the criteria for exclusion from two measures, they must meet the threshold for the one remaining measure. • If the EP meets the criteria for exclusion from all three measures, they may be excluded from meeting this objective. <p>Some examples of possible combinations are included below:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;">Pass or Fail</th> <th style="text-align: center;">Measure 1</th> <th style="text-align: center;">Measure 2</th> <th style="text-align: center;">Measure 3</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">Pass</td> <td style="text-align: center;">Meets Threshold</td> <td style="text-align: center;">Meets Threshold</td> <td style="text-align: center;">Does Not Meet Threshold or Exclusion</td> </tr> <tr> <td style="text-align: center;">Pass</td> <td style="text-align: center;">Meets Threshold</td> <td style="text-align: center;">Meets Exclusion</td> <td style="text-align: center;">Meets Exclusion</td> </tr> <tr> <td style="text-align: center;">Pass</td> <td style="text-align: center;">Meets Exclusion</td> <td style="text-align: center;">Meets Exclusion</td> <td style="text-align: center;">Meets Exclusion</td> </tr> <tr> <td style="text-align: center;">Fail</td> <td style="text-align: center;">Meets Threshold</td> <td style="text-align: center;">Meets Exclusion</td> <td style="text-align: center;">Does Not Meet Threshold or Exclusion</td> </tr> <tr> <td style="text-align: center;">Fail</td> <td style="text-align: center;">Meets Exclusion</td> <td style="text-align: center;">Meets Exclusion</td> <td style="text-align: center;">Does Not Meet Threshold or Exclusion</td> </tr> </tbody> </table> | Pass or Fail | Measure 1 | Measure 2 | Measure 3 | Pass | Meets Threshold | Meets Threshold | Does Not Meet Threshold or Exclusion | Pass | Meets Threshold | Meets Exclusion | Meets Exclusion | Pass | Meets Exclusion | Meets Exclusion | Meets Exclusion | Fail | Meets Threshold | Meets Exclusion | Does Not Meet Threshold or Exclusion | Fail | Meets Exclusion | Meets Exclusion | Does Not Meet Threshold or Exclusion |
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| Pass | Meets Threshold | Meets Threshold | Does Not Meet Threshold or Exclusion | | | | | | | | | | | | | | | | | | | | | | |
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| 2 | <p>Q: What is a current problem list?</p> <p>A: A current problem list is at a minimum a list of current and active diagnoses.</p> | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 | <p>Q: What is an active or current medication list?</p> <p>A: An active or current medication list is a list of medications that a given patient is currently taking.</p> | | | | | | | | | | | | | | | | | | | | | | | | |
| 4 | <p>Q: What is an active or current medication allergy list?</p> <p>A: An active or current medication allergy list is a list of medications to which a given patient has known allergies.</p> | | | | | | | | | | | | | | | | | | | | | | | | |

^A [AHCCCS Program Year 2020 – Health Information Exchange](#)

| # | Question and Answer |
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| 5 | Q: What is an allergy? |
| | A: An allergy is an exaggerated immune response or reaction to substances that are generally not harmful. |
| 6 | Q: What is a care plan? |
| | A: A care plan is the structure used to define the management actions for the various conditions, problems, or issues. A care plan must include at a minimum the following components: goals, health concerns, assessment, and plan of treatment. |
| 7 | Q: What is a transition of care? |
| | A: A transition of care is the movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory, specialty care practice, long-term care, home health, rehabilitation facility) to another. At a minimum, this <u>includes all transitions of care and referrals</u> that are ordered by the EP. |
| 8 | Q: What is a referral? |
| | A: A referral is a case where one provider refers a patient to another provider, but the referring provider also continues to provide care to the patient. |
| 9 | Q: Is an EP able to transition a patient to himself or herself at another practice location to meet objective 7? |
| | A: No, the transition of care must take place between providers which have, at a minimum, different billing identities within the Medicaid PI Program, such as different National Provider Identifiers (NPI) or hospital CMS Certification Numbers (CCN) to count toward this objective. |
| 10 | Q: Is an EP able to transition a patient to another EP using the same CEHRT to meet objective 7? |
| | <p>A: Yes, if the receiving provider already has access to the CEHRT of the initiating provider of the transition or referral, and the initiating provider also creates and sends a summary of care document, this transition can be included in the denominator and the numerator, as long as this transition is <u>counted consistently across the organization</u>. The summary of care document must be created and sent electronically using CEHRT.</p> <p>If the receiving provider already has access to the CEHRT of the initiating provider of the transition or referral, simply accessing the patient’s health information (PHI) does not count toward meeting the numerator of this objective.</p> |

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| 11 | <p>Q: What information must be included in the summary of care record to meet measures 1 and 2?</p> <p>A: All summary of care documents used to meet measures 1 and 2 must include the following information if the provider knows it:</p> <ul style="list-style-type: none"> • 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) - Required* • Current medication list - Required* • Current medication allergy list - Required* • 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 <p>*See questions 12 and 13 regarding additional information on these items.</p> |
| 12 | <p>Q: What should an EP do if the EP creates a summary of care for a patient that does not have a current problem list, current medication list, or current medication allergy list?</p> <p>A: An EP must verify that the required 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 <u>include a notation of no current problem, medication and/or medication allergies.</u></p> |
| 13 | <p>Q: Is an EP allowed to leave one of the items mentioned in question 11 as blank when creating the summary of care record?</p> <p>A: Yes, 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.</p> |

| # | Question and Answer |
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| 14 | <p>Q: Must an EP transmit all data pertaining to a patient’s laboratory test results in the summary of care document?</p> <p>A: No, an EP is not required to transmit all data pertaining to a patient’s laboratory test results in the summary of care record. However, an EP must have the ability to transmit all data pertaining to laboratory test results in the summary of care document, but may work with his/her system developer to establish clinically relevant parameters for the most appropriate results for the given transition or referral.</p> <p>An EP who limits the transmission of laboratory test result data in a summary of care document must send the full results upon request (i.e., all lab results as opposed to a subset).</p> <p>The exchange must comply with the privacy and security protocols for electronic protected health information (ePHI) under the Health Insurance Portability and Accountability Act (HIPAA).</p> |
| 15 | <p>Q: What format must an EP use when creating a summary of care record?</p> <p>A: While an EP’s CEHRT must be capable of sending the full consolidated clinical document architecture (C-CDA) summary of care and an EP must do so upon request, an EP may use any document template within the C-CDA HL-7 standard for purposes of meeting the health information exchange measures.</p> |
| 16 | <p>Q: Can the referring provider count the transition in the numerator if the receiving provider converts the C-CDA into a non-electronic format such as PDF or a fax?</p> <p>A: Yes, 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.</p> <p>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.</p> |
| 17 | <p>Q: When must the transition of care or referral occur for it to be included in objective 7, measure 1?</p> <p>A: To be included in the numerator, the transition of care or referral with a summary of care record must occur within the calendar year in which the PI (EHR) reporting period occurs.</p> <p>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.</p> <p>The numerator includes all transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically. A patient had to have been seen by the EP during the PI (EHR) reporting period to be included in the numerator and the denominator. Please note each transition of care should only be counted once even if the patient was seen multiple times during the PI (EHR) reporting period.</p> |

| # | Question and Answer |
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| 18 | <p>Q: What changed between Program Year (PY) 2019 to 2020 for objective 7, measure 1?</p> <p>A: No changes occurred between PY 2019 and 2020.</p> |
| 19 | <p>Q: What documentation must be submitted to demonstrate that the EP meets objective 7, measure 1?</p> <p>A: The EP should submit a CEHRT-generated dashboard* for the selected PI (EHR) reporting period that shows the following:</p> <ul style="list-style-type: none"> • Provider’s Name • Numerator • Denominator • Measure Percentage <p>*In certain situations, a non-CEHRT generated report may be necessary. The use of non-CEHRT generated reports may be permitted upon AHCCCS review and approval.</p> |
| 20 | <p>Q: How is the EP required to incorporate a summary of care document into the CEHRT to meet objective 7, measure 2 numerator?</p> <p>A: Measure 2 does not specify the manner in which EPs are required to incorporate the data. CMS does not define the word incorporate for this measure, as it may vary among recipient providers based on the providers’ HIE workflows, their patient population, and based on the referring provider.</p> <p>The record may be included as an attachment, as a link within the EHR, as imported structured data, or the provider may conduct a reconciliation of the clinical information within the record to incorporate this information into the patient record within the EHR.</p> <p>However, 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.</p> |
| 21 | <p>Q: Is an EP able to include a transition of care or referral in the objective 7, measure 2 or measure 3 numerator if the patient refers themselves to the EP?</p> <p>A: There may be circumstances when a patient refers himself or herself to a setting of care <u>without a provider’s prior knowledge</u> or intervention. These referrals may be included as a subset of the existing referral framework and they are an important part of the care coordination loop for which summary of care record exchange is integral.</p> <p>An EP should <u>include these instances in the denominator</u> for the measure if the patient subsequently identifies the provider from whom he/she received care.</p> <p>An EP may <u>count such a referral in the numerator</u> for the measure if he/she undertakes the action required to meet the measure upon disclosure and identification of the provider from whom the patient received care.</p> |

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| 22 | <p>Q: What determines if an electronic summary of care record is unavailable and should be excluded from the objective 7, measure 2 denominator?</p> <p>A: The denominator includes the number of patient encounters during the PI (EHR) reporting period for which an EP was the receiving party of a transition or referral or has never before encountered the patient and for which an electronic summary of care record is available. For a summary of care record to be unavailable, the EP must meet both of the following:</p> <ul style="list-style-type: none"> • Requested an electronic summary of care record to be sent and did not receive an electronic summary of care document; and • The EP either: <ul style="list-style-type: none"> ○ 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 PI (EHR) reporting period. |
| 23 | <p>Q: What changed between PY 2019 to 2020 for objective 7, measure 2?</p> <p>A: No changes occurred between PY 2019 and 2020.</p> |
| 24 | <p>Q: What documentation must be submitted to demonstrate that the EP meets objective 7, measure 2?</p> <p>A: The EP should submit a CEHRT-generated dashboard* for the selected PI (EHR) reporting period that shows the following:</p> <ul style="list-style-type: none"> • Provider’s Name • Numerator • Denominator • Measure Percentage <p>*In certain situations, a non-CEHRT generated report may be necessary. The use of non-CEHRT generated reports may be permitted upon AHCCCS review and approval.</p> |
| 25 | <p>Q: Must all three clinical information reconciliations be completed through automation in order to be included in objective 7, measure 3 numerator?</p> <p>A: No, the clinical information reconciliation 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.</p> |

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| 26 | <p>Q: Must an EP update a patient’s clinical information in order to include it in objective 7, measure 3 numerator?</p> <p>A: No, if an update is not necessary, the process of reconciliation may consist of simply verifying that fact or reviewing a record received on referral and determining that such information is merely duplicative of existing information in the patient record.</p> |
| 27 | <p>Q: Is a non-medical staff allowed to conduct the clinical information reconciliations included in the objective 7, measure 3 numerator?</p> <p>A: Yes, 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.</p> |
| 28 | <p>Q: What changed between PY 2019 to 2020 for objective 7, measure 3?</p> <p>A: No changes occurred between PY 2019 and 2020.</p> |
| 29 | <p>Q: What documentation must be submitted to demonstrate that the EP meets objective 7, measure 3?</p> <p>A: The EP should submit a CEHRT-generated dashboard* for the selected PI (EHR) reporting period that shows the following:</p> <ul style="list-style-type: none"> • Provider’s Name • Numerator • Denominator • Measure Percentage <p>*In certain situations, a non-CEHRT generated report may be necessary. The use of non-CEHRT generated reports may be permitted upon AHCCCS review and approval.</p> |
| 30 | <p>Q: What exclusions are available to an EP for objective 7, measure 1?</p> <p>A: An EP may take an exclusion for objective 7, measure 1 if the appropriate exclusion applies:</p> <ul style="list-style-type: none"> • An EP transfers a patient to another setting or refers a patient to another provider fewer than 100 times during the PI (EHR) reporting period. • An EP 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 PI (EHR) reporting period. EPs in AZ are not able to meet this exclusion. |

| # | Question and Answer |
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| 31 | <p>Q: What exclusions are available to an EP for objective 7, measure 2?</p> <p>A: An EP may take an exclusion for objective 7, measure 2 if the appropriate exclusion applies:</p> <ul style="list-style-type: none"> • The total transitions or referrals received and patient encounters in which the EP has never before encountered the patient is fewer than 100 during the PI (EHR) reporting period. • An EP 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 PI (EHR) reporting period. EPs in AZ are not able to meet this exclusion. |
| 32 | <p>Q: What exclusions are available to an EP for objective 7, measure 3?</p> <p>A: An EP may take an exclusion for objective 7, measure 3 if the total transitions or referrals received and patient encounters in which the EP has never before encountered the patient is fewer than 100 during the PI (EHR) reporting period.</p> |
| 33 | <p>Q: Where do I find the latest information available from the Federal Communications Commission (FCC)?</p> <p>A: If an EP is interested in additional information from the FCC regarding broadband information, the EP can visit the FCC website. Any documentation that might be used by the EP to support meeting the exclusion must be supported by the format 4/1 Mbps, not 25/3 Mbps. The state recommends that the EP uses the Broadband Access Exclusion tip sheet from CMS to determine if the EP is in a county that is eligible for the exclusion.</p> <p>The state of Arizona does not have any counties listed. Therefore, an EP in Arizona is not able to meet this exclusion.</p> |
| 34 | <p>Q: What documentation is required to support the EP meets the appropriate exclusion discussed in questions 30 through 32?</p> <p>A: The following types of documentation would be sufficient to support that the EP meets the appropriate exclusion:</p> <ul style="list-style-type: none"> • The CEHRT dashboard shows that the EP had fewer than 100 qualifying transitions/referrals/encounters for the appropriate measure during the PI (EHR) reporting period; or • Provide supporting documentation, other than the CEHRT dashboard, that demonstrates the EP had fewer than 100 qualifying transitions/referrals/encounters for the appropriate measure. |