Health Information Exchange

Program Year 2021

AHCCCS
Arizona Health Care Cost Containment System

Health Information Exchange Learning Objectives

- Understand the Health Information Exchange requirements for the Medicaid PI Program.

- Understand the differences in objective 7 Health Information Exchange between Program Year (PY) 2020 and 2021.

- Learn about the Health Information Exchange documentation requirements.

Program Year 2021 Meaningful Use Reporting Period Length

- **PI (EHR) Reporting Period:**
  - The PI (EHR) reporting period is 90 days for all EPs.
  - The PI (EHR) reporting period must be within CY 2021 and the end of the PI (EHR) reporting period must fall **on or before** October 31, 2021.

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 a certified EHR technology (CEHRT).

- An EP must attest to all three measures and meet the minimum threshold for two of the three measures.

Health Information Exchange

- An EP must meet the minimum threshold for two of the three measures.
  - 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.
- Some examples of possible combinations are included below:

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

Definition of Terms

- **Current problem lists**: At a minimum a list of current and active diagnoses.
- **Active/current medication list**: A list of medications that a given patient is currently taking.
- **Active/current medication allergy list**: A list of medications to which a given patient has known allergies.
- **Allergy**: An exaggerated immune response or reaction to substances that are generally not harmful.
- **Care Plan**: 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.
- **Exclusion:** CMS allows some exceptions for EPs to omit from reporting on a measure. Exclusions vary depending on the measure. An EP must still submit documentation to support qualifying for the applicable exclusion.

Health Information Exchange
Transition of Care

- **Transition of Care**: 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.
  - 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.
    - 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.
    - However, if 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>.
  - <u>Referrals</u> are cases where one provider refers a patient to another provider, but the referring provider also continues to provide care to the patient.

Health Information Exchange
Summary of Care

- **Summary of Care Record (measure 1 and 2)**: All summary of care documents used to meet this objective 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)** *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)*

*Note: 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 include a notation of no current problem, medication and/or medication allergies.

Health Information Exchange
Summary of Care

Continued from previous slide

- o Immunizations
- o Unique device identifier(s) for a patient's implantable device(s)
- o Care plan, including goals, health concerns, and assessment and plan of treatment
- o Referring or transitioning provider's name and office contact information
- o Encounter diagnosis
- o Functional status, including activities of daily living, cognitive and disability status
- o Reason for referral

- 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.

Health Information Exchange
Summary of Care

- 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 their system developer to establish clinically relevant parameters for the most appropriate results for the given transition or referral.

- 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).

- 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).

Health Information Exchange
Summary of Care

- In cases where the providers share access to an EHR, a transition or referral may still count toward the measure if the referring provider creates the summary of care document using CEHRT and sends the summary of care document electronically.

  - If an EP chooses to include such transitions to providers where access to the EHR is shared, they must do so universally for all patient and all transitions or referrals.

- 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.

Objective 7, Measure 1

Objective 7, Measure 1

- **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.

Objective 7, Measure 1

- In order to count a transition of care or referral in the numerator, the action must occur within the calendar year in which the PI (EHR) reporting period occurs.

- 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.

Objective 7, 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.
  - o 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.
  - o 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 <u>may not</u> count the transition in their numerator.

Changes from PY 2020 to 2021

Reporting Periods	2020	2021
PI (EHR) 90-Day Reporting Period	Falls within entire CY 2020	Falls within CY 2021 but ends on or before October 31, 2021

Documentation Requirements for Measure 1

- A CEHRT-generated dashboard* for the selected PI (EHR) reporting period** that shows the following:
    - Provider's Name
    - Numerator
    - Denominator
    - Measure Percentage

*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.

**See slide 3 for more information regarding an appropriate PI (EHR) reporting period.

Objective 7, Measure 2

Objective 7, Measure 2

- **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.

Objective 7, Measure 2

- 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.

- 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.

- 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.

Objective 7, Measure 2

- 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.

  - An EP should <u>include these instances in their denominator</u>* for the measure if the patient subsequently identifies the provider from whom they received care.

  - An EP may <u>count such a referral in the numerator</u>* for the measure if they undertake the action required to meet the measure upon disclosure and identification of the provider from whom the patient received care.

*If applicable, can include in measure 3 numerator and/or denominator.

Objective 7, Measure 2

- For the purposes of defining the cases in the denominator for measure 2, CMS stated that 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 PI (EHR) reporting period.

Changes from PY 2020 to 2021

Reporting Periods	2020	2021
PI (EHR) 90-Day Reporting Period	Falls within entire CY 2020	Falls within CY 2021 but ends on or before October 31, 2021

Documentation Requirements for Measure 2

- A CEHRT-generated dashboard* for the selected PI (EHR) reporting period** that shows the following:
  - Provider's Name
  - Numerator
  - Denominator
  - Measure Percentage

*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.

**See slide 3 for more information regarding an appropriate PI (EHR) reporting period.

Objective 7, Measure 3

Objective 7, Measure 3

- **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:

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

  - Medication allergy. Review of the patient's known medication allergies.

  - Current Problem list. Review of the patient's current and active diagnoses.

Objective 7, 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.

- If no update is 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.

- 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.

- There may be circumstances when a patient refers himself or herself to a setting of care without a provider's prior knowledge or intervention. An EP can include the patient in the numerator or denominator if all actions are met.
  - See slide 21 for more information.

Changes from PY 2020 to 2021

Reporting Periods	2020	2021
PI (EHR) 90-Day Reporting Period	Falls within entire CY 2020	Falls within CY 2021 but ends on or before October 31, 2021

Documentation Requirements for Measure 3

- A CEHRT-generated dashboard* for the selected PI (EHR) reporting period that shows the following:
  - o Provider's Name
  - o Numerator
  - o Denominator
  - o Measure Percentage

*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.

**See slide 3 for more information regarding an appropriate PI (EHR) reporting period.

Objective 7 Exclusions

Exclusions

- **Exclusion:**
  - EP is not required to submit data or meet the measure.
  - EP must submit documentation of how he/she met the exclusion(s).

- **Exclusion for Objective 7 Health Information Exchange:**
  - Number of patient transfers criteria (EP is sender)
  - Broadband criteria
  - Number of patient transitions and referrals criteria (EP is receiver)

Health Information Exchange Exclusions

- An EP may take an exclusion if the EP meets the exclusion criteria applicable to the measure in the table below.

Applicable Measure(s)	HIE Objective Exclusions
Measure 1	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.
Measures 1 and 2	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.*
Measures 2 and 3	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.

Broadband Access Exclusion

- For Program Years 2015-2017 CMS identified the counties in the U.S. who conducted 50 percent or more patient encounters in a county where 50 percent or more of its housing units do not have 4Mbps broadband availability and therefore meet the broadband exclusion.

  o The state of Arizona does not have any counties listed;

  o Therefore, an EP in AZ is not able to meet this exclusion.

- CMS has not published an updated list of the counties; however, the majority of counties in the U.S. has increased their broadband availability and still do not meet the requirements for the exclusion. It is unlikely the broadband availability would have decreased since the CMS tip sheet was published.

CMS Broadband Access Exclusion

Exclusion Documentation Required

- **Measure 1 only:** EP transfers a patient to another setting or refers a patient to another provider fewer than 100 times during the PI (EHR) reporting period.

- **Measures 2 and 3:** Total transitions or referrals received and patient encounters in which EP has never before encountered the patient, is fewer than 100 during the PI (EHR) reporting period.

- Documentation supporting exclusions for measures 1, 2, and 3 above:
  - 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.

- Broadband access exclusion for measures 1 and 2.
  - Arizona EPs are unable to meet this exclusion per CMS.
  - CMS Broadband Access Exclusion

AHCCCS
Arizona Health Care Cost Containment System

Audit Findings

What Happens During an Audit?

- All providers that receive a Medicaid PI Program incentive payment could potentially be selected by AHCCCS for post-payment audit.

- If selected, AHCCCS post-payment analysts will conduct a thorough review of the documentation attached to the EP's attestation in ePIP to determine if it meets the program requirements.

- AHCCCS may have follow-up questions or make additional documentation requests.

Common Audit Findings

- The CEHRT dashboard does not show the PI (EHR) reporting period or EP name.

- Failure to maintain documentation and practice no longer has access to the CEHRT.

- Including data for the entire practice in the CEHRT dashboard report rather than data for the individual EP.

- Not uploading the CEHRT dashboard during attestation.

Resources

- CMS Objective 7 Tip Sheet

- Federal Final Rule - Modified Stage 2 and Stage 3

- CMS Broadband Access Exclusion

- AHCCCS Health Information Exchange Frequently Asked Questions*

*To access the AHCCCS Health Information Exchange Frequently Asked Questions click on the link above, then click on the drop down arrow labeled "Frequently Asked Questions".

Contact Information

Agency	Help With	Email	Phone
AHCCCS	PI Program	EHRIncentivePayments@azahcccs.gov	(602) 417-4333
Health Current	Educational Assistance & Support	ehr@healthcurrent.org	(602) 688-7210

Questions?

Thank You.