Medicaid EHR Incentive Program in 2017 Health Information Exchange Objective (Modified Stage 2)

Updated: November 2016

The Health Information Exchange (HIE) objective (formerly known as "Summary of Care") is required for all eligible hospitals participating in the Medicaid Electronic Health Record (EHR) Incentive Programs, as well as for eligible professionals (EPs) participating in the Medicaid EHR Incentive Program. For 2017, the HIE objective includes one required measure.

Overview of Health Information Exchange

Objective: The EP, eligible hospital or CAH who transitions their patient to another setting of care or provider of care, or refers their patient to another provider of care, provides a summary care record for each transition of care or referral.

Measures: The EP, eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care must—
(1) Use certified EHR technology (CEHRT) to create a summary of care record; and
(2) Electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.

Attestation Requirements:

- Denominator**:** Number of transitions of care and referrals during the EHR reporting period for which the EP or eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider.
- Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically.
- Threshold**:** The percentage must be more than 10 percent in order for an EP, eligible hospital or CAH to meet this measure.

Exclusion: Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period.

NOTE: There are changes to the measure calculations policy, which specifies that actions included the numerator 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.

Summary of Care Documents

All summary of care documents used to meet this objective must include the information outlined in **Table 1** (if the provider knows it). In circumstances where there is no information available to populate one or more of the fields listed, either because the provider can be excluded from recording such information or because there is no information to record (e.g., laboratory tests), the provider may leave the field(s) blank and still meet the objective and its associated measure.

Note: The **current problem list**, **current medication list**, and **current medication allergy list** may not be left blank. These fields must include the most recent information known by the EP or eligible hospital as of the time of generating the summary of care document, or include a notation of no current problem, medication and/or medication allergies.

Table 1:
What to Include in Summary of Care Documents

- Patient name
- Referring or transitioning provider's name and office contact information (EP only)
- Procedures
- Encounter diagnosis
- Immunizations
- Laboratory test results
- Vital signs (height, weight, blood pressure, BMI)
- Smoking status
- Functional status, including activities of daily living, cognitive and disability status
- Demographic information (preferred language, sex, race, ethnicity, date of birth)
- Care plan field, including goals and instructions
- Care team, including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider.
- Discharge instructions (Hospital Only)
- Reason for referral (EP only)

*Summary of care documents must also include:**

- Current problem list (providers may also include historical problems at their discretion)
- Current medication list (a list of medications that a patient is currently taking)
- Current medication allergy list (a list of medications to which a given patient has known allergies)

** An EP or eligible hospital must verify these three 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 or hospital as of the time of generating the summary of care document*

Note about Lab Results: The final rule for Modified Stage 2 of the EHR Incentive Programs in 2015 through 2017 requires a provider to have the ability to send all laboratory test results in the summary of care document. However, the provider may work with their system developer to establish clinically relevant parameters based on their specialty, patient population, or for certain transitions and referrals that allow for clinical relevance to determine the most appropriate results for given transition or referral. A provider who limits the results in a summary of care document must send the full results upon the request of the receiving provider or upon the request of the patient.

The **Consolidated Clinical Document Architecture (C-CDA)** is the standard adopted for EHR technology certification for summary of care documents. In this final rule, all the required data elements for the C-CDA remain as previously finalized.

Transitions of Care and Referrals

A **transition of care** is defined as 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 includes all discharges from the inpatient department and after admissions to the emergency department when follow-up care is ordered by an authorized provider of the hospital.

Referrals are cases where one provider refers a patient to another, but the referring provider maintains their care of the patient as well. In addition:

- Transition of care for electronic exchange has been further defined as one where the referring provider is *under a different billing identity* within the Medicare and Medicaid EHR Incentive Programs (such as a different National Provider Identifier [NPI] or hospital CMS Certification Number [CCN]) than the receiving provider and where the providers do not share access to the EHR.

- In cases where the providers do share access to the EHR, a transition or referral may still count toward the measure if the referring providers creates the summary of care document using CEHRT and sends the summary of care document electronically. If a provider chooses to include such transitions to providers where access to the EHR is shared, they must do so universally for all patients and all transitions or referrals.

- In cases where a provider has a patient who seeks out and receives care from another provider without a prior referral, the first provider may include that transition as a referral if the patient subsequently identifies the other provider of care.

Electronic Transmission of Summary of Care Documents

For the EHR Incentive Programs in 2017, the HIE measure simply states that a provider is required to create the summary of care records using CEHRT and to transmit the summary of care record electronically. The intent is to promote and facilitate a wide range of options for the transmission of an electronic summary of care document. The summary of care record must still be created using C-CDA that is certified by the CEHRT; however, it does not need to be sent using a certified transfer mechanism. The provider may use a third party to send the summary of care record, but it is not required.

In instances where a "third party organization that plays a role in determining the next provider of care and ultimately delivers the summary of care document" is involved, the service the third party provides does not have to be certified for the transmission to be counted in the numerator for measure 2. There are also no specific requirements around the technical standards or methods by which the third party delivers the summary of care document to the receiving provider (e.g., SOAP, secure email, fax).

Acceptable Electronic Transmission Methods

Examples of acceptable transmission methods include **secure email**, **Health Information Service Provider (HISP), query-based exchange** or use of third party HIE. There are many other options in addition to the examples listed, as well as opportunities for developers and vendors to utilize innovation and creativity. The provider must ensure that the transmission methods are in compliance with HIPAA requirements.

Note: Faxing in general is not acceptable since it is not in C-CDA format. It is only acceptable when a third party is used to transmit the summary of care record and they must convert the transmission to fax because that is the only way the receiving provider can accept the transmission. Additionally, the conversion to fax by the third party must not be a default approach.

To count in the numerator, the sending provider must have reasonable certainty of receipt of the summary of care document. This means that a ''push'' to an HIE, which might be queried by the recipient, is insufficient. Instead, the referring provider must have confirmation that a query was made to count the action toward the measure. (This could be a call to the receiving provider or email confirmation from the HIE itself in instances where a third party is used.) The exchange must comply with the privacy and security protocols for ePHI under HIPAA.

An EP or eligible hospital must use the capabilities and standards of as defined in CEHRT at § 495.4.

For More Information

Visit the CMS EHR Incentive Programs website to learn more about the requirements for the EHR Incentive Programs.