A Practical Guide to Promoting Interoperability

- In January 2019, CMS will implement new measures for EHR Meaningful Use—under the new “Promoting Interoperability” program. Hospitals and Critical Access Hospitals (CAHs) should quickly get started to ensure they will meet the new reporting targets.

- Hospitals stand to lose ~2% of Medicare income if they don’t achieve the targets (~1% for CAHs).

- Achievement of the measurement goal is binary. Medicare income will be adjusted by the maximum amount if the goal is not achieved.

- In 2019, a hospital must achieve 50 points out of 100 to be classified as a meaningful user of EHRs and avoid the lost revenue. CMS has not yet announced the point threshold for future years, but they are sure to rise.

- 40% of the “points” focus on electronic referral loops, the digital exchange of medical records for referrals and transitions in care; 40% focus on providing patients with access to their records; and 10% focus on each for e-prescribing and public health data sharing.

- The first measurement year is 2019, and hospitals can choose the best consecutive 90-day period to report performance.

- Additionally, CMS plans to aggressively pursue hospitals that “block” access to patient records with additional enforcement actions.
Key Takeaways

To maximize the number of “points” available, without any exclusions:

- Patient records must be generated using an EHR that meets the CEHRT 2015 standards.
- If a doctor orders follow-up care, that outbound patient referral or transition in care must be made digitally.
- If a referral is received by a hospital digitally, it must upload and incorporate specific sections with the related patient data in their EHR.
- A referral sent from an EHR using a fax gateway is not considered to be digital.
- A patient must be provided with digital access to their record.

Beyond the Points

There are many other benefits to focusing on the electronic referral loops that CMS prescribes:

- The process of managing outbound and inbound referrals and transitions in care will be more efficient.
- Specialists will receive the reasons for inbound referrals, which has been hampered in a paper-based system and necessitating that the patient convey crucial medical information.
- A communications channel will be established with outside healthcare organizations which will better support the coordination of care.
- Patients will benefit from greater “behind the scenes” coordination between their providers and have a greater opportunity to be a partner in their own care.
Implementers Action Plan

1- Certification

Verify with your vendor that your EHR meets the 2015 certification criteria for CEHRT. This means that it is capable of generating a patient record in a standard data format known as a C-CDA and supports electronic clinical quality measurement. Earlier versions of CEHRT standards are not acceptable even if your EHR is capable of generating a C-CDA.

2- Coding

Ensure that your EHR has been correctly implemented to meet the standards. For example, if patient encounters are not being coded “correctly”, even if they adequately support your current internal workflows, they will not properly convey in the exported C-CDA.

3- Fax Gateway

If you have an EHR fax gateway, make sure it is disabled for referrals and transitions in care. Every transaction sent this way will be added to the denominator of the outbound electronic referral measure with nothing in the numerator making the achievement of the target even more difficult.

4- Outbound Referral Loops

Partner with a third-party service if needed, to establish a process for sending every transition in care and referral digitally. Our experience is that less than 20% of healthcare organizations support receipt of referrals via the Direct protocol, and therefore relying on Direct messages sent by your EHR will not be enough—particularly to primary and specialty care providers.
5- Inbound Reconciliation of C-CDAs

Identify a third-party service that supports the receipt of C-CDAs and establish a process for reconciling and uploading the C-CDAs that are received by your hospital digitally. While CEHRT 2015 standards make C-CDAs more standardized, they only do so for certain sections (known as the Common Clinical Data Set). Instead of rejecting the entire C-CDA, a new C-CDA can be created from the source containing only the standardized sections (or an even narrower set that includes medication, medication allergies and the current problem list which are the elements that must be reconciled with your EHR) as a way to more easily meet the PI standard.

6- Patient Access

Ensure that every patient has access to their digital health record—your EHR patient portal may be capable of supporting this requirement but you need to ensure the record can also be downloaded digitally and made available to third-party applications. If this feature is not available as part of your EHR (or has not been enabled), you should identify a mechanism to interface with third-party applications and allow a patient to view, download and transmit their health information.

7- e-Prescribing

Make sure you can measure the volume of prescriptions ordered through an e-prescribing system versus a manual process. The e-prescribing measure, designed to help providers avoid inappropriate prescriptions and improve care coordination, is 10% for 2019, so an impactful component in the overall measures.
8- Opioids

Verify whether your EHR can query your state’s maintained “Prescription Drug Monitoring Program” (PDMP) each time an opioid is electronically prescribed. If you have implemented patient-provider opioid treatment agreements, be sure they can be stored and accessed in your EHR (note: Opioid measures are not required for 2019 but will become important in 2020).

9- Measurements

Establish a process for accurately capturing the “numerator” and “denominator” in each of the performance-based measures. See page 7 of this guide for an explanation of how the calculation is determined for each objective.

10- Conduct Outreach

Work with large provider groups, ACOs and other care partners in your community to reinforce your digital strategy and promote true digital interoperability, benefiting your patients and improving care coordination.
The Scoring Approach

During 2019 and 2020, hospitals will be required to report against the measures for one consecutive 90-day period. This does not need to be a calendar quarter.

Previous measures were “threshold-based” meaning that a certain threshold had to be met and once met, the hospital would receive all of the credit (i.e. points) for that specific measure. The new measures are “performance-based” meaning that the higher the performance against a specific measure, the higher the credit for that measure.

Under the new methodology, there are a total of 100 “points”. To avoid penalties, a hospital must score 50 or more points in 2019 and CMS has indicated this target will rise in future years. There are no rewards for achieving more than 50 points but there are penalties for achieving less than 50 points.

Prerequisites: For a hospital to earn any points at all, it must have implemented an EHR system that has been certified as CEHRT 2015 compliant and completed a HIPAA-related Security Risk Analysis (for which no points are awarded). It must then go on to demonstrate that it meets the defined standards for the “Public Health and Clinical Data Exchange” measures for which it will be awarded 10 points (unless it is exempt from this requirement).

Then, the hospital must earn an additional 40 points to achieve the goal of being a meaningful user of EHR technology and avoid the penalties.
The Actual Measures

The number of unique measures falls from the current 16 to just 5 in 2019. A hospital will be required to report on all of them, although CMS is assessing whether reporting on at least one measure from each category would be preferable (i.e. requiring a hospital to report on just 4 measures). CMS is also considering adding additional measures and will add two new measures focusing on opioid addiction in 2020.

The core 2019 measures are as follows:

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Calculation</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>e-prescribing</td>
<td>Use of e-prescribing</td>
<td># e-prescriptions / Total # prescriptions</td>
<td>10</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td>Support Electronic referral Loops by Sending Health Information</td>
<td># Referrals sent electronically / # Referrals ordered</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Support Electronic referral Loops by Receiving and Incorporating Health Information</td>
<td># Records uploaded/ reconciled / # Referrals received electronically</td>
<td>20</td>
</tr>
<tr>
<td>Provider-to-Patient Exchange</td>
<td>Provide Patients Access to their Health Information</td>
<td># Patients provided access / Total # discharged patients</td>
<td>40</td>
</tr>
<tr>
<td>Public Health</td>
<td>Syndromic Surveillance Reporting, Plus One of five Public Health Reporting Programs</td>
<td>If actively reporting, points are awarded</td>
<td>10</td>
</tr>
</tbody>
</table>

There are also 10 bonus points related to certain opioid measures although it is unlikely that many EHRs or states will have the systems in place to support these in 2019.

Below is an example of how a well-organized hospital might score today without any further action beyond establishing the measurement processes:

<table>
<thead>
<tr>
<th>Objective</th>
<th>Calculation</th>
<th>Example</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>e-prescribing</td>
<td>e-prescriptions / Total # prescriptions</td>
<td>65,700 / 73,000</td>
<td>9</td>
</tr>
<tr>
<td>Health Information Exchange</td>
<td># Referrals sent electronically / # Referrals ordered</td>
<td>1,642 / 10,950</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td># Records uploaded/ reconciled / # Referrals received electronically</td>
<td>492 / 1,642</td>
<td>6</td>
</tr>
<tr>
<td>Provider-to-Patient Exchange</td>
<td># Patients provided access / Total # discharged patients</td>
<td>5,474 / 12,166</td>
<td>18</td>
</tr>
<tr>
<td>Public Health</td>
<td>If actively reporting, points are awarded</td>
<td>N/A</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>46</td>
</tr>
</tbody>
</table>
Summary

CMS finalized its rule to overhaul the meaningful use program with an emphasis on advancing health data exchange among providers. The rule also finalizes a new scoring methodology with fewer measures, which is designed to provide a more flexible, less-burdensome structure, and allowing eligible hospitals and CAHs to place their focus back on patients.

It is our opinion that the narrower set of measures that place greater emphasis on information sharing between providers (referrals and transitions in care) will be the most challenging aspects of the new rules and those concerned about the limited time to prepare should get started now.

Healthcelerate has a range of services that support the goals of the Promoting Interoperability program. We would welcome the opportunity to show you how they can be deployed to ensure that your hospital can exceed the 50-point goal. Please contact us at info@healthcelerate.com.

About Healthcelerate
Healthcelerate’s flagship service, careMESH, makes it possible for hospitals, Accountable Care Organizations (ACOs), physician practices, and other groups to quickly and securely share digital patient information. careMESH features end-to-end encryption and allows users to share clinical records, aggregate records from multiple EHRs, close care gaps, and improve patient care in support of better outcomes. For more information, visit www.healthcelerate.com.

Disclaimer
The information contained within this guide represent Healthcelerate’s interpretation of the CMS regulations. We make no representations of the accuracy of these interpretations or the views expressed herein.

2 Health Affairs: Despite Substantial Progress in EHR Adoption, Health Information Exchange and Patient Engagement Remain Low In Office Settings. By Michael F. Furukawa, Jennifer King, Vaishali Patel, Chun-Ju Hsiao, Julia Adler-Milstein, and Ashish K. Jha
3 http://www.healthcareitnews.com/encrypted-fax-over-cloud-network