Health Information Exchange
Coordinating Committee (HIECC)
Meeting Minutes

Date: February 12, 2010
Start Time: 10:00 a.m.
Venue: Agency for Health Care Administration
Conference Room A
2727 Mahan Drive
Tallahassee, FL 32308-5403

HIECC Members Present: Tom Arnold, Chair; Allen Byington; Robert Burns, D. O.; Nadine Dexter; Matt Doster; Linda Fuchs; Meade Grigg for Robert Harmon, M. D.; Bill Bell for Kathy Holzer; Kevin Kearns; Linda McMullen; Catherine Peper; Ebrahim Randeree, Ph.D.; Dennis Saver, M.D.; Reginald Smith; Duane Steward, Ph.D.; and Phil Williams.

HIECC Members Absent: Julie Meadows-Keefe; and Karen Koch.

Staff Present: Christine Nye; Jessica Bishop-Royce; Nick Blake; Fors Gregg; Patrick Kennedy; Diane Leiva, Ph.D.; Victoria Prescott; Bill Roberts; Christopher Sullivan, Ph.D.; Carolyn H. Turner and Quantara Williams.

Interested Parties Present: Stephanie Blay, Tampa Bay RHIO; Erwin Bodo, Ph.D, Florida Association of Homes and Services for the Aging; Robert Brooks, M.D., University of South Florida Health; Josh Chapman, Availity; Diane B. Chronis, Florida Medical Quality Assurance, Inc.; Melissa Dice, 180 Consulting; Bill Dillon, Messer, Caparello, and Self; Roderic R. Dugger, FSU Institute of Government; Charles Eckel, North Florida Medical Centers, Inc.; Dawn Emerick, Health Planning Councils; Joy Fulton, Availity; Diane Gaddis, Community Health Center Alliance; Louis Galterio, Suncoast RHIO; Jan Gorrie, Tampa Bay RHIO; Meade Grigg, Florida Department of Health; Tom Herring, Florida Department of Health; Nikole Helvey, Health Planning Council of North East Florida; William Hightower, Florida Osteopathic Medical Association; Christine Isham, Florida Association of RHIOs; Dawn Johnson, MedPlus; Erik Kirk, Kirk Consulting; Debralee LaSeur, FSU College of Medicine; Maureen Levy, M. D.; Eduardo Gonzalez Loumiet, Uber Operations LLC; Nick Magdaleno, Florida Justice Association; Sheree McFarland , Hospital Corporation of America; Jeff Nowak, Informed Decisions; Charles Phelps, Medx Solutions; Bob Reynolds, Fresenius Medical Care North America; Julia Smith, Amundsen & Smith; Sandra Stovall, Florida Senate; Angela Strain, Community Health Centers Alliance; Jen Verheyden, Availity; Ron Watson, Florida Dental Association; Cameron Yarbrough, Tsamoutales Strategies/Harris Corp; and Rick Zelznak, Maximus.

Meeting Materials: Agenda; Draft Minutes of the December 10, 2009 HIECC Meeting; AHCA Assessment of Meaningful Use for HIE; Meaningful Use for Hospitals and Providers; Presentation on the Medicare and Medicaid EHR Incentives Program; Presentation on the Proposed HIE Services of the Florida Health Information Network; Letter to the Office of the

National Coordinator for Health IT; Strategic and Operational Plans for a State Level HIE; Grant Requirements for Florida's State Level Health Information Organization; Request for Letters of Interest in Applying to be the State Level Health Information Organization; Request for Information for Florida's Statewide HIE; Map of Regional Extension Centers; Medicaid EHR Provider Incentives Payment and Eligibility; Background on the State Medicaid Health IT Plan Environmental Scan; Update on the Medicaid Health Information Network; Proposed Legislation on HIE in the 2010 Legislative Session; and Updates on the Florida Center's HIE Program. Copies of meeting materials are posted at:
http://www.fhin.net/FHIN/workgroups/HIECCmeetings.shtml and
http://www.fhin.net/eprescribe/ePrescribeWG/meetings.shtml

Call to Order

Ms. Christine Nye, Director, Florida Center for Health Information and Policy Analysis within the Agency for Health Care Administration (the Agency), chaired the meeting on behalf of Tom Arnold. She called the meeting of the Health Information Exchange Coordinating Committee to order at 10:00 a.m. and welcomed members and guests and introduced Robert Burns, D.O., a pending member of the Health Information Exchange Advisory Committee.

Due to a lack of quorum, the minutes were unanimously approved at a later point in the meeting once a quorum was attained.

Ms. Nye reported to the committee that the awards for the first round Extension Center applicants were announced. She also said that approximately 40 states would receive notice of their funding awards for the state health information exchange cooperative agreement program. (Florida was not one of the 40 states in the announcement because it is implementing directly instead of planning and its award will come later in March.)

Regional Extension Centers

Ms. Tina Nye directed the committee to a Florida map of the proposed Regional Extension Center coverage areas. She noted that the second and final applications were submitted several weeks ago. She stated that the Rural /North Florida Regional Extension Center group covered the Panhandle over to Jacksonville and down to the Gulf Coast. The PaperFree Florida Collaborative Health Information Technology Extension Center group covers the counties north and east of the Tampa area, up to the Florida-Georgia border and includes counties claimed by the Rural/North Florida group. The Central Florida Health Information Technology Initiative includes the counties around Orlando. Ms. Nye said that Health Choice Network (HCN) in Miami-Dade had received its funding award for $8.5 million and other Florida awards were expected. She also commented on the overlapping counties, included in more than one application. The counties include: Hamilton, Columbia, Suwannee, Dixie, Gilchrist, Union, Bradford, Alachua, and Polk. Ms. Nye stated that counties not yet included (Glades, Hendry, Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie) should be covered by

the extension centers. She told the committee that while she was in Washington D.C. she spoke with the staff at the Office of the National Coordinator for Health Information Technology (ONC) and noted that if Florida's Extension Center applications are satisfactory, they should receive funding. The second round applicants should hear from the ONC by the end of March.

Ms. Nye reported that there would be a meeting with the four applicants in March in Orlando to discuss how the extension centers will coordinate with the Medicaid Electronic Health Records (EHR) Incentive Program, the State HIE Cooperative Agreement program and other ARRA health information technology programs.

Mr. Kevin Kearns added that extended coverage areas were not yet determined. He said that he and Diane Gaddis from the Rural /North Florida Regional Extension Center were discussing coverage for the counties in South West Florida. While Manatee, Sarasota, Charlotte, Lee and Collier were included in the Rural/ North Florida Regional Extension Center application, the ONC may want the regions to be geographically connected. Ms. Nye responded that the orphan counties will ultimately be included as determined by ONC and the extension centers.

Dr. Bob Harmon asked the present applicants how many clinicians they were able to sign up with their National Provider Identifier (NPI) numbers. Mr. Kearns responded that Health Choice Network had received between 1,600 and 1,700. Ms. Gaddis responded that the Rural/North Florida had set its goal at 2,000 signatures, and had received 960. Dr. Brooks reported that the PaperFree Florida Collaborative Health Information Technology Extension Center in Tampa had over 1,000 NPI numbers and Ms. Nadine Dexter said that the Central Florida Health Information Technology Regional Extension Center submitted over 400 letters of support.

Approval of Minutes

Upon attaining a quorum, Ms. Nye asked the committee for a motion on the minutes. Dr. Harmon moved the minutes and Ms. Catherine Peper seconded the minutes and they were unanimously approved by the committee.

Conflict of Interest

Mr. Bill Roberts provided a Memorandum explaining that the committee is considered an advisory body under the ethics laws and falls under the Sunshine Law. He directed the committee to a listing in the Memo of the most pertinent laws, such as misuse of public position, disclosure of information, and voting on conflicts. He clarified that the misuse of public position means that a member cannot vote on a matter that will benefit themselves or someone else. He explained that information that committee members gather at the meetings cannot be used to benefit themselves or someone else. Regarding voting on conflicts Mr. Roberts stated that committee members must disclose their conflict of interest in writing prior to a vote being taken. If a member feels like the conflict is too strong, he or she should abstain from voting.

Dr. Harmon inquired if members should recuse themselves from the issue in this case. Mr. Roberts explained that abstaining and recusing are very similar. If a member abstains, he or she is still at the table, taking part in discussions, but not voting. If members recuse themselves, they are no longer involved in the discussions or the voting.

Ms. Kathy Holzer gave the example that in the event that hospitals joined with the Florida Hospital Association (FHA) to apply for the Health Information Organization (HIO) grant, committee members would not be allowed to work on the application. The hospitals would need to be sure that HIECC members were not working on the application.

Ms. Linda Fuchs asked about financial or other interests. She asked if there was a threshold similar to the financial disclosure forms that some of the state workers sign. Mr. Roberts responded that the disclosure is not the same and all potential conflicts should be disclosed. He stated that he would need to do some research on the topic to give a more specific answer.

Ms. Peper commented that half of the committee is currently working on Regional Extension Center Applications. She inquired if that meant that the members should recuse themselves and not participate in votes taken regarding Extension Center letters of support. Mr. Roberts suggested the fact that if a member's organization is working on any of the programs overseen by the HIECC, he or she should have someone other than themselves work on the programs. Ms. Nye noted that if a member was an applicant, he or she would need to abstain from voting.

Dr. Harmon asked about members discussing the matters before the committee outside of the meetings. He inquired if two members discussing the issues is a violation of the sunshine law, or if more than two members were required. Mr. Roberts responded that it only takes two members discussing the issues to break the law.

Meaningful Use Panel

Ms. Nye explained to the committee that since the Centers for Medicare & Medicaid Services (CMS) released the proposed regulations on meaningful use in December 2009 and comments are due on March 15, 2010, it was thought that a panel discussion on the proposed rule would be timely. She introduced committee member Mr. Reginald Smith as the panel moderator and introduced the panelists: Ms. Diane Gaddis, Community Health Center Alliance; Mr. Meade Gregg, Florida Department of Health; Ms. Kathy Holzer, Florida Hospital Association; and Dr. Dennis Saver, Florida Academy of Family Physicians. Ms. Nye noted that the proposed rules include regulations for the Medicaid EHR Incentive programs.

Ms. Nye stated that the panel can accomplish two things. The first is to help educate the committee on what is in the regulations so that the committee can discuss its concerns; and the second is to help develop comments that the Agency, the National Governors Association and the National Association of State Medicaid Directors will be making to the federal government relative to the regulations.

Mr. Smith asked each panelist to give a short presentation; once each of the panelists had spoken, the committee would have an opportunity to ask questions. He stated that he would hold his comments to the end and suggested that the speakers clarify whether the comments would be on meaningful use objectives or meaningful use measurements. He gave the example of the requirement that the provider meets all of the meaningful use requirements to get the financial incentives. Then he described more specific concerns for a referral center. Mr. Smith suggested that the panelists begin with the more global topics of the meaningful use rules and then focus on the specifics. He introduced Dr. Saver, who was on the conference line.

Dr. Dennis Saver stated that the idea of meaningful use remains very important and it provides the only leverage physicians have on vendors who will not provide services otherwise. He stated that as an individual physician, he may be unable to get the vendors to provide the services that he needs for meaningful use. However, he said, if the ONC requires the specific criteria in the rule, the vendors will make the necessary changes. He noted the administratively burdensome nature of the meaningful use on physicians. He stated that the electronic record should improve workflow, efficiency, and safety. Many aspects of the reporting requirements only add to the workload.

Dr. Saver next discussed computerized order entry, and stated that the rule refers to it as physician order entry. He stated that it will be burdensome for physicians to be responsible for order entry at 80%, which he feels is unreasonable. Other members of the medical team, besides the provider, would be better suited to do certain kinds of recording and this should be made clear in the rule.

Dr. Saver next spoke to the capacity issue for information exchange with multiple external entities. He noted the requirement that the electronic record must be able to communicate with registries, such as the immunization registry. He stated that there is inadequate support for interfaces. The rule should not be requiring such a high bar when the current EMR systems do not enable providers to perform the required activities. He stated that it is counterproductive to adoption.

Dr. Saver noted that providers cannot receive any incentive payments unless all of the meaningful use requirements are met. He suggested that the ONC require that 50% of the meaningful use requirements be met in the first year for partial payment and allow physicians to start slowly. He went on to say that when providers see the reporting requirements included in meaningful use, and they realize that they have to meet all of the meaningful use requirements, they may feel disincentivized.

Ms. Diane Gaddis, CEO of the Community Health Center Alliance stated that she agrees with Dr. Saver on many of his points. She said that she represents Federally Qualified Health Centers (FQHC). Many of the FQHCs are members of the two health center controlled networks in this state and as such have been ahead of the curve in adopting and advancing health information technology (HIT). She stated that the FQHCs are on track to meet the meaningful use requirements. There is a concern that many FQHCs still not be affiliated with one of the health center controlled networks and are not sure what they should do. She also stated that there are a lot of vendors making a lot of promises about meaningful use. Health

centers, as well as the private industry providers, may not be well-versed in negotiating with vendors. She warned that vendors may tell the provider that their solutions will meet the meaningful use requirements, but there are no consequences to the vendors for not meeting deliverables. She stated that there may be a lot of providers and health centers who are not ready for this implementation.

Ms. Gaddis said that in regard to health information exchange (HIE) another concern is the requirement that providers be able to provide their patients a copy of their records in an electronic format. There needs to be additional clarification on what that format will be and how it will be accomplished. She noted that there are many different models of HIE and that there is not one standardized model. She said there are many considerations such as the cost and what is being exchanged. There is a question as to whether or not making this information available to patients will be accomplished by the HIE or whether providers will have to stand up their own solutions. Her final concern was how the health centers would receive the incentive dollars. All of the FQHCs will fall under the Medicaid Incentive Program, which will be administered by the State. There is no indication as yet of exactly when or how that money will be dispersed for meeting the meaningful use criteria.

Ms. Kathy Holzer, Florida Hospital Association (FHA), outlined the approach the FHA is taking in regard to HIE, addressed the state of HIT adoption in hospitals and presented their goals for communicating these issues to CMS. Ms. Holzer reported that prior to the release of the meaningful use rules the FHA had begun communicating with Florida's congressional delegation and with members of the ONC committees. Florida's hospitals have to have HIT adoption and issues around receiving incentive payments and purchasing a certified EHR system need to be clarified. She noted that the FHA has been working with the American Hospital Association (AHA), other hospital associations and other groups around the country to identify available technology. FHA will be sending a draft letter in early March to the providers to send to Florida's Congressional delegation concerning the purchase of EHRs. She noted that they will request letters of support from the Agency for Health Care Administration, the Governor's office, and the House and Senate leadership.

Ms. Holzer stated that if the Healthcare Information and Management Systems Society (HIMSS) EMR adoption model is used, approximately 50% of Florida's hospitals are in Stage 3, which includes clinical documentation, the flow sheets, and a clinical decision support system. She noted that half of these 50% are on the lower end of the Stage 3 scale. She reported that about 122 hospitals are in varying stages of adoption and that the small and rural hospitals are in Stage 1 and a few are in Stage 2. Many of the large hospitals, at Stage 3, will not be able to qualify for the incentives because the requirements are too much, too fast. She stated that she thinks that once the final certification criteria are out, at least three-quarters of the 50% of hospitals at Stage 3 will not meet meaningful use criteria because their vendors will not certify the system that the hospitals have. The vendors will not be able to act quickly enough to meet meaningful use by 2011. She reported that one of the comments from the FHA will be to request that the ONC allow use of EHRs that can meet the meaningful use requirements, but are not certified.

Ms. Holzer went on to discuss the 23 meaningful use criteria, stating that there are too many criteria to meet and she would like to see the criteria reduced to eight flexible criteria. She reported that the AHA believes that these changes are possible.

Ms. Holzer next noted that there are two hospitals in Tallahassee that are early adopters and have been exchanging a significant amount of data through Big Bend RHIO. Neither hospital will meet meaningful use because they cannot meet the certification requirements in time or the Computer Provider Order Entry (CPOE) requirements.

Ms. Holzer said that for hospitals that have multi-campus licensure, their incentive payments would be to just one hospital rather than each hospital within the system being eligible for the incentive payments. However, the cost to communicate campus to campus is still there.

In closing she said that the FHA recommendations are:

- Reduce meaningful use objectives to eight.
- Extend the transition to 2017.
- Grandfather EHRs for certification.
- Include only quality measures that are currently being recorded and have been validated.
- Exclude non-clinical objectives.
- Recognize providers grouped under one identifier.

Ms. Holzer indicated that she would share the FHA's comments with the Florida Center or anyone interested.

Mr. Meade Grigg from the Florida Department of Health (DOH) told the committee that he would focus his comments on the population and public health goals of meaningful use. He noted that the criteria, measures, objectives and goals are important to DOH as they serve over 750,000 clinical patients per year.

Mr. Grigg began with public health provisions. He stated that the core mission of the DOH is to monitor the health of the population. EHRs offer the opportunity to expand and improve its role in health care and surveillance activities. He said that Stage 1 of the meaningful use requirements addresses three areas of public health HIE including immunization registries, the electronic laboratory surveillance of reportable diseases and syndromic surveillance. He reported that hospitals and medical providers are required in Stage 1 to attest to HIE capability and can opt out of capability testing if no public health agency has the ability to receive HIE. He noted that demonstration of actual submission will be in Stage 2. Mr. Grigg said that DOH has some concerns and issues with the public health requirements. DOH is trying to assess its capability to receive the information. He stated that when looking at quality measures relevant to public health, states should have the flexibility to set their own requirements and measures.

Mr. Grigg moved on to discuss electronic lab surveillance, noting that there is a set of reportable diseases that hospitals and laboratories are required to report. Currently, DOH receives electronic feeds from 16 partners – 10 labs and 6 hospitals. They are working with 80 hospitals

to develop the capacity to bring up their ability to report this year. He said it is expected to take a year to complete. Mr. Grigg said that another issue with meaningful use is that hospitals are required to receive lab reporting using LOINC; it does not require capability to send the data in LOINC. He said that DOH wants a change in the rule to standardize lab information.

Mr. Grigg noted that to set up and test with the hospitals takes some time and is not a trivial matter. He stated that it will require staff and time. He noted that DOH will need additional human resources, and will look for those resources from other sources such as the CDC to handle the load from all of the providers. Also, there is a lack of specification of capacity testing and the certification and verification of these types of HIEs. He noted the national process of setting up labs to report communicable diseases.

Mr. Grigg stated that there is a similar situation for the immunization registry in that it can accept, batch and direct loads of data, and there will need to be modifications to the software. He noted implications of working with EMR vendors and health plans for submission of data, stating that DOH needs more resources.

Mr. Grigg reported that DOH does not consider the syndromic surveillance requirement as a major issue. Currently, 133 hospitals are submitting syndromic data, including the data from HCA hospitals, and soon DOH will have over 170 hospitals reporting. The data is automated from the emergency departments with the patient's chief complaint and diagnosis codes reported.

Mr. Smith commented that providers must demonstrate meaningful use by their provider number. He said that when a medical clinic has more than one facility they should be able to demonstrate meaningful use as an organized campus regardless of the number of provider numbers. He suggested sending the reports in clusters, including all data to meet meaningful use.

Mr. Smith suggested that the meaningful use rules should clarify the role of Personal Health Records (PHRs). There is no mention of PHRs to be certified or HIPAA compliant or interoperable with standards that hospitals must abide by.

Dr. Harmon asked Mr. Grigg to comment on the efforts to implement a statewide EHR for the County Health Departments and how it is impacted by meaningful use. Mr. Grigg responded that the Medicaid EHR incentive program is providing funding for EHR adoption, allowing the county health departments to develop in-house capability for EHRs, using the meaningful use criteria to build. He noted the time frame and resource issues. He also stated that DOH has questions about what the process will be to certify DOH's EHR.

Ms. Nye reported that there will be a Medicaid EHR Provider Incentive Program presentation later in the meeting. She stated that the Agency is trying to make this process as simple as possible and that it needs help from the providers and stakeholders to make it happen.

Dr. Burns commented on practice management functionality and asked if physician offices can be clearinghouses. He stated that the 96-hour reporting rules for providing patient access to their electronic health records are problematic and should be better defined.

Mr. Smith commented on the 96-hour rule for notes stating that it is a very difficult task, even using automated transcription. He noted that some transcriptions are unintelligible. He suggested that the time should be at least a week.

Dr. Saver stated that he does not think the patient has to get the entire content of the progress notes. He said that the patient has to receive a summary of their problems and instructions. Ms. Gaddis stated her concern with the 48-hour time frame for providing copies of encounter information to patients. She thinks that the provider must be allowed to review the report such as lab results before providing it to the patient.

Mr. Smith noted that there are two layers of complexity. Technology is one issue and workflow around technology is the other. He used the example of drug-to-drug interaction alerts on the e-prescribe systems. He stated that there is too much "White Noise" from e-prescribing systems and that they are often turned off.

Ms. Nye concluded the panel discussion and thanked the panelists, committee members and audience for their participation. She asked that everyone submit their comments within 10 days.

RHIO and HIE Outreach

Ms. Nye told the committee that after the last HIECC meeting, Secretary Arnold suggested that she go and speak with representatives from each of the Regional Health Information Organizations (RHIOs) around the state. She reported that she had met with Healthy Ocala and the Central Florida RHIO and would be meeting with Big Bend, Suncoast, and RHIOs in Jacksonville, Broward County, and Tampa. She noted that she would be meeting with RHIO representatives in Pensacola the following week. She said that the discussions are focused on what a state-level HIO will do to support and enhance the regional level effort.

Ms. Victoria Prescott presented on the proposed state-level Health Information Exchange Services and the role of RHIOs. She discussed the proposed HIE services: Secure Messaging/Communication, Patient Look-up Services and Quality Metrics Service. Ms. Prescott explained that secure messaging includes results delivery, provider-to-provider communication for electronic referrals, consults, and transitions in care and two-way communication with public health. She stated that this is concept of pushing data from one party to another.

Ms. Prescott went on to describe the patient look-up services as classical health information exchange. She stated that it is the electronic retrieval of records from multiple data sources and aggregation into a virtual, longitudinal patient record available via portal or desktop viewer, or through a direct data transmission into RHIOs local software or an EHR. Ms. Prescott explained

that quality metrics services will involve the query of multiple data sources and the aggregation of information for meaningful use and clinical decision support. The reports for the providers include patient-specific information with alerts and reminders for follow-up, as well as information about quality outcomes for selected patients. The reports to payers on behalf of providers will assist providers in quality reporting to payers.

Ms. Prescott continued her presentation to give the committee an overview of data flow and options for RHIO connectivity. She began by reviewing the potential sources of patient health data including health care providers, payers, government and other entities. She described the FHIN Gateway Prioritization Approach. She said that the State-Level HIO will target connectivity with large, national or multi-regional data sources and focus on connecting rural providers who may not be served by a RHIO; while the RHIOs will focus on connectivity of their local stakeholders. The State-Level HIO and RHIOs will work together to establish a common interface for sharing data.

Ms. Prescott completed the presentation by describing other ways that the state HIO can work with RHIOs. She stated that the Agency is open to exploring other ways to work with RHIOs. The HIO would seek to negotiate volume discount rates with vendors for data standardization and mapping services, interface development costs charged by EHR vendors, and data acquisition/transaction costs.

Ms. Holzer requested that the Agency post information about RHIOs operating in the state on its Web site. Dr. Sullivan reported that the Agency has sent out surveys to Florida RHIOs to find out their capabilities. He said that the survey results will be on the Web site by March.

Dr. Steward suggested that abstracting data into a summary is challenging. He noted the number of issues required to turn data retrieved from multiple sources into a summary. He questioned the accuracy and liability of the state for having made that aggregation. The liability and responsibility of patrons using the information would add significant cost. Finally, he questioned whether there is enough trust in the abstraction that it would be utilized at levels that would justify the investment.

Ms. Prescott responded that the plan is set up in specified stages. The first stage is clinical messaging and allows communications between providers. The second stage is patient lookup; she noted that the mass of data received might be distracting. She explained that providers would receive a summary which is a summation of latest diagnostically relevant details. She said that providers could drill down into the report for more detail. Ms. Prescott stated that there needs to be a standardization of data.

Dr. Steward noted that there needs to be care in the semantics. He said that to get utilization, the HIO cannot flood physicians with data. He stated that the HIO must be careful about professional judgment regarding what is included versus not included in a professional judgment.

Ms. Nye stated that she agrees and that there would have to be a negotiated decision on what providers find useful.

Ms. Peper stated that the report needs to include Medicare data. She inquired if there were any rules from CMS regarding data sharing. Ms. Prescott responded that she does not think that there are rules from Medicare on data sharing. Ms. Nye noted that there is interest nationwide in Medicare participation in HIE.

Ms. Holzer stated that she agrees with Dr. Steward and asked if the Agency has decided that the first stage will be clinical messaging rather than patient lookup. Ms. Nye responded that no firm decision has been made, but when speaking with representatives from other states, they made that suggestion. Ms. Nye said that she understands that some of the hospitals do not think we should do clinical messaging.

Dr. Harmon inquired if the Agency will make the Medicaid HIN a leading partner of the FHIO. Ms. Nye responded that it will be a major source of information to the FHIO. Dr. Harmon asked if the HIO will provide the common portal. Ms. Nye responded that Availity has a portal now, but the payer data would also go through the FHIO. She said that she wants to see all payer data connected through a common portal.

Dr. Levy asked about the connectivity of peer review organizations to the FHIO and if there will be a way for consumers to have access. Ms. Nye responded that to answer these questions, there needs to be further policy discussions.

Mr. Kearns told the committee to look at HIE in context of $20 million coming to Florida. He asked if Florida can use the funding efficiently. He said that if the Hospital CIO Council does not go along with the plans, then he has concerns as well. He suggested holding a statewide workshop of CIOs, extension centers, RHIOs and other stakeholders to discuss how to best invest the money as well as making decisions regarding technology. He stated that he is not sure of the progress that has been made in the community and that part of the $20 million should be used for the RHIOs.

Ms. Holzer stated that the FHA would support and facilitate such a workshop. Ms. Nye stated that the Agency is willing to work on and facilitate the meeting, or summit. She reminded the committee that it is important to remember that different groups have their own interests, and the state plan must reflect the sum of their interests. She stated that the Agency will plan a summit for April or May.

Mr. Kearns stated that he wants to hear from the industry and learn more about the technological aspects. Ms. Nye said that the Agency is planning to bring in experts from other states that have successful HIE to discuss their experiences of what works and what does not work, and how they overcame barriers.

Mr. Kearns stated that sustainability is key and asked Ms. Nye if while travelling the state to visit the RHIOs if any of them had any idea how to support themselves. Ms. Nye answered that there are ideas but no clear answers.

Ms. Nye suggested that the Agency ask stakeholders for input regarding the summit and then circulate the suggestions back to the members and create an agenda for the summit.

Ms. Stephanie Blay asked if anyone else has run into the issue of organizations that have approached the providers to do their data exchange. She noted that various groups are representing themselves as RHIOs. She asked if the stakeholders can collaborate to figure out a solution. Ms. Nye responded that the Agency's environmental assessment will supply a list of the RHIOs and what their capability is.

Ms. Nye noted that the committee has a pretty good vision of how we want to end up and what the HIO will do. The difficulty is in the lack of clarity from the federal government about EHR regulations and what technology is available and which entities that claim to be able to provide HIE services are able to. Unfortunately, Ms. Nye stated, this implementation will take longer than anyone wants it to.

Health Information Exchange Cooperative Agreement

Ms. Turner reported that the ONC sent comments in January for clarifications to the strategic and operational plan (SOP) of the State HIE Cooperative Agreement application. She directed the committee to the Agency's letter responding to the ONC. The letter lists the changes that were made, and the SOP is posted with the changes highlighted. She said that the changes clarify what was originally proposed. The ONC wanted clarification on the role of RHIOs. She stated that the Agency added an organizational chart and further explained the plan to issue a grant to set up the state-level HIO. She said that the ONC also wanted to see the technical change process described which was added to the application.

Ms. Turner noted that the ONC identified certain HIE requirements and wanted the Agency to specify how it would meet these requirements. A table was added to the SOP describing an initial assessment of existing HIE, gaps and how the state level HIO would address these needs. She noted the technical clarifications to the SOP, as well as additional language regarding the adoption of policies and procedures. She said that the Agency added additional detail about the budget. ONC wanted additional budget detail for core services, and for outreach services. She said that the Agency expects the budget to change and evolve as the program moves forward.

Ms. Turner next discussed the Florida Health Information Organization Grant program. She gave a brief overview of the HIO services and requirements. She reported that eligible organizations include non-profit organizations and institutions registered in Florida, units of state and local governments and public health departments. These entities also have other conditions to meet in order to be selected as the state HIO. She went through the grant program objectives, the grant requirements, required HIE services, other requirements for a technical solution, as well as operational requirements. She went through the proposed project selection criteria and the schedule of important dates and the expected award amounts and award periods. She told the committee that applicants should read the strategic and operational plan and align their application with it. If there are differences in their plan from the strategic

and operational plan, the applicant must give a detailed reason why they believe their approach to be superior. Ms. Turner stated that the general roll out is expected to begin March 1, 2011, when the different services will begin to become available. Clinical messaging is expected to be rolled out initially, because the patient look up will take longer. The applicant will be expected to include an outreach plan on how they intend to work with the other stakeholders and bring in participants. The applicant must submit a business plan including their market projections over time for engaging participants and the potential earnings.

Ms. Turner indicated that the HIO Grant Award is expected to be approximately $19.2 million over 4 years. The applicant must agree to work with the Agency to meet the cost sharing requirement that increases each year. She mentioned the review and evaluation of the submissions and went over the criteria. She stated that the Agency will be looking to some of the committee members to evaluate applicants.

Ms. Turner next discussed the Agency's request for letters of interest in applying to be the state level health information organization. She stated that the letters are due February 25, 2010. Ms. Nye stated that the Agency will be moving back the schedule for the Florida HIO funding opportunity announcement (from April 1) and the application deadline given the still pending federal grant and to allow applicants more time to prepare.

Ms. Peper inquired about required HIE services noting that the eligibility and benefits look-up as well as e-prescribing are already mature, and why would this be replicated in the HIE. Ms. Turner replied that eligibility and benefits look-up and e-prescribing are addressed because ONC asked the states to address them. She stated that the states will coordinate with what already exists.

Dr. Saver commented on financial stability over time. He said that the SOP includes language that the HIO must meet unmet needs that stakeholders will pay for. He does not see paying for anything in the future. He is unsure if he would use it for free due to the effort involved, but said he would turn down HIE if costs were involved. He stated that when there is no funding for HIEs, there is no sustainability.

Ms. Turner stated that the Agency is looking at all kinds of options. She said that it is up to the HIO applicant to propose what they think will work. She said that there is no specific notion of how sustainability will be attained. There is the potential for providers already spending money now to exchange health information to save money by participating. She agreed that if the HIO cannot make the case, it will be very difficult to have folks step up and pay for something new.

Dr. Saver inquired what the state will do if there are no letters of interest received on February 26, 2010. Ms. Turner responded that the reason for soliciting letters was to encourage interested parties to collaborate. She said that it is unlikely that there will be no applicants. Dr. Saver noted that it is a mountainous job and he hopes the state can succeed in creating a sustainability model.

Ms. Nye noted that there are other areas in the United States with sustainable models. She stated that there must be a clear understanding of how this organization can bring the most value to providers.

Dr. Steward inquired what the role of the HIECC will be in relation to HIO. Ms. Nye responded that the HIO will be an organization that would get into the details of how HIE would work. The HIECC is responsible for advising the Agency on high level priorities for HIE, but HIO would convene stakeholders to make things work by contracting with technical vendors. The HIO needs a strong, stakeholder relevant, experienced Board. Ms. Nye stated that the HIECC will continue as a high level review and direction setting group.

Mr. Ron Watson representing the Florida Dental Association asked about the cost sharing responsibilities to the charter members of the HIO. Ms. Nye responded that the HIO will be responsible for a sustainability model at the end of four years. She said that the matching requirements do not necessarily have to be a cash match. Mr. Watson inquired if it will be difficult to have a start-up non-profit do this. He voiced concern that a newly formed non-profit would not have enough capital to meet the matching requirements and their ability to attain sustainability.

Ms. Christine Isham representing the Florida Association of RHIOs suggested that the Agency use a staged process with the applicants outlining their qualifications and let the committee look at the potential applicants. This will allow investigation to determine which groups can work together.

Ms. Nye stated that the Agency will take the time needed and that no one will be totally happy with this, but most will be more happy than not. She said that Florida needs organizations to step up to run this. Ms. Peper commented that there will need to be trust to make it happen.

Ms. Nye stated that it is the role of Agency to keep pushing. She asked the committee how to get the leadership in the state to step forward. Dr. Harmon responded that this is a very ambitious set of requirements. He reiterated that the HIO must make this financially sustainable. He suggested that if it is not possible for a non-profit HIO to attain sustainability, then the government must step forward. He noted an HIE tax on each claim in Vermont to create a fiscally sustainable model. He stated that we must engage government and inquired if the Legislature will fund this.

Ms. Linda Fuchs inquired what mechanism exists for exchange of ideas across the states and if any other states have any ideas. She stated that the main issue is running of the HIO and then the second issue of sustainability. The Agency is waiting for people to step up. Ms. Nye responded that there are associations such as the National Governors Association (NGA) who are bringing people and states together to discuss different options.

Dr. Steward stated that HIMSS has been actively engaged to share ideas about health information exchange. Ms. Holzer said that hospitals are doing the same activities across the country.

Next, Ms. Nye reported that at the last HIECC meeting it was determined that the Agency would issue a Request for Information (RFI) to determine what technical capabilities the different vendors have regarding clinical messaging, patient look-up and quality tools. She said that Florida looked at what other states have done and tailored the RFI to the state of Florida.

Dr. Sullivan gave a brief review of the draft RFI for the HIO. He stated that the RFI will provide a "vendor scan" to determine what services are available to the HIO. The RFI addresses Florida's needs based on the standards promulgated through the ONC. The services are grouped into 2 sections; the first section covers the core services of the HIE and second is the core products that the HIO will provide. The RFI asks about the master patient indexes and record locator, the provider index, data exchange, data source connections and interface engines. He stated that there needs to be secure connections and interfaces with every facility that uses the HIO. He stated that to develop the interfaces for all of the facilities in Florida would cost much more than $20 million. Dr. Sullivan reported that the RFI must address access, authentication, security, archiving and a backup recovery plan. He next listed four services that the RFI must address. They are secure clinical messaging, patient look-up services including a provider portal, quality metrics with meaningful use reporting and public health reporting. Dr. Sullivan explained that the RFI is in draft form and the Agency will take comments.

Dr. Saver complimented Dr. Sullivan on the RFI saying that it is well written and comprehensive. He stated that he will send Dr. Sullivan comments. Dr. Sullivan asked that comments be submitted in two weeks.

Dr. Harmon remarked that he thinks a 30-page response limit on a 10-page RFI might be too restrictive, he suggested expanding the response page limit. Ms. Nye requested that anyone interested in reviewing and commenting on the RFI inform the Agency.

Ms. Nye reported that Health Choice Network received its award announcement for its Regional Extension Center. She stated that the cooperative agreement awards were released and Florida is not on the list. [It was subsequently determined that Florida's award would be issued with a second group of states that requested implementation funding.]

Medicaid EHR Incentive Program

Ms. Nye reported that the program's purpose is to provide funding to hospitals and eligible professionals to adopt and engage in the meaningful use of HIT. She stated that the Medicaid and Medicare programs are slightly different. She told the committee that the program is very planning intensive with CMS oversight. She said that Florida received approval from CMS to begin planning the program. The Agency submitted a Pre-Advanced Planning Document

(PAPD) which was approved on February 9, 2010. The HIECC will be very involved in the whole process. Ms. Nye stated that the goal is to make this as simple as possible for providers to obtain their incentive payment. The Agency needs to be sure that the funding is being used for EHRs and will monitor for fraudulent activities.

Ms. Heidi Fox reported that the Agency has begun to move forward with planning. She stated that while the Agency does not yet have budget authority, the Agency is able to conduct the environmental scan to develop an "as is" assessment of HIE in the state. The scan will determine who the potentially eligible professionals and eligible hospitals are and the level of HIE that currently exists. She reported that DOH will do an environmental scan of the county health departments, children's medical services, and all of the public health reporting that is available in their systems. The Agency will hire a vendor to help pull the program together and will survey the Medicaid Management Information Systems (MMIS) about its current operations and its capacity for supporting HIE as envisioned. She stated that this is a big change for the use of Medicaid data, explaining that it has historically been used for claims and payments and not for the exchange of data among clinicians. She stated that the plan will include information on the current state of HIE in Florida, the envisioned state for 2014 and the specific steps of how it will be implemented. The implementation plan will describe how to identify the eligible providers, through their volume of Medicaid patients. It will include how the payments will be made and tracked and how Florida will be sure that the eligible professional is not also receiving Medicare incentive payments. The Agency will develop the state Medicaid Health Information Technology plan and the implementation plan to submit to CMS for approval.

Dr. Sullivan reviewed the details of the environmental scan to assess provider's technological capabilities across the state and to identify where there is need. The scan will include hospitals, federally qualified health centers, rural clinics and eligible professionals. He stated that the Agency will work with the hospital CIOs to determine where the hospitals stand today in regards to having a certified EMR. He said that the scan will determine what the health centers and rural clinics' capabilities are in regards to exchanging data. The scan will examine the Medicaid database to identify eligible professionals and survey a portion of them to assess their technological abilities as well as their willingness to participate. The Agency will then use the results to map the hospital and providers' technological capabilities.

Ms. Nye stated that the scan is a requirement from the CMS to receive the funding. She said that there will be two contracts out of the planning process; one is for the environmental scan; and the other is to develop the State Medicaid HIT Plan. Ms. Fuchs inquired how the program is funded. Ms. Nye responded that the program has funding for administration which is 90% federally funded and separate funding for the incentive payments which is 100% federally funded. The state provides a 10% match for administration. Ms. Nye reported that Florida will receive almost $1.8 million for administration and planning in 2010.

Ms. Holzer offered to assist the Agency in arranging a conference call with the hospital CIOs. Dr. Sullivan replied that the first step is to determine what questions the scan will need to ask.

Florida Medicaid Health Information Network

Ms. Nye reported that the Florida Medicaid Health Information Network powered by Availity (MHIN) went live late last year. Providers can, with proper authorization, view the patient's Medicaid claims records from the past 18 months using a secure provider portal. She stated that there has been no marketing of this and the Agency realizes that the only way this will be used is if providers decide to bring it into their workflow. She noted that the MHIN provides a free e-prescribing tool for the providers which will be easier to access through a single sign-on in the near future.

Ms. Peper, representing Blue Cross Blue Shield reported that Availity receives about 1,200 hits per month and that it continues to grow. Dr. Harmon asked how clinicians sign up to use the Availity portal. Ms. Fox directed him to the Availity Web site registration. Ms. Peper commented that there is training available to the providers and that each office has a provider administrator who must authorize access to the Availity portal at each location. She added that this application alone meets seven or eight of the proposed meaningful use criteria. Dr. Sullivan stated that this will be very useful to the county health departments.

Health Information Exchange Legislation

Ms. Turner reported that bills containing the Agency's proposed HIE legislation for 2010 have been filed. Representative Hudson is sponsoring HB 911 and Senator Ring has filed SB 958. Ms. Turner pointed out that there are differences between the House and Senate versions of the bill. She said that the House bill includes the language suggested by the Advisory Council to not put the entire data sharing agreement in rule. The revised language directs the Agency to adopt elements of the agreement in the rule. Ms. Nye explained that the agreement is to be between the providers and the HIO. Ms. Turner noted that the legislation includes provisions for the state to work with the regional extension centers and puts responsibility for HIE strategic planning under the State Consumer Health Information and Policy Advisory Council.

HIE Update

Ms. Nye directed the committee to the HIE Update materials provided. She gave a quick review, most of which had already been discussed in the meeting. Mr. Phil Williams inquired if the Agency received any requests for letters of support for the Beacon Grant program that were *not* provided. Ms. Nye responded that the Agency had received six requests and provided letters of support for each.

Ms. Nye reported that Florida has been awarded one grant for Broadband mapping in the first round of grants and there are several applications that have moved on to the second round of grants.

Ms. Turner reported that the Legal Working Group will meet on April 23, 2010 to look at developing a standard health information exchange data sharing agreement. Ms. Nye stated

that the Agency held a rule workshop on the Universal Patient Authorization Form rules on February 5, 2010 and the summary is posted on www.FHIN.net. Ms. Turner stated that the Agency will file the proposed rules next month.

There being no further discussions the committee adjourned at 1:45 P.M.