Merit-Based Incentive Payment System (MIPS) Promoting Interoperability Performance Category Measure 2018 Performance Period

Objective:	**Health Information Exchange**
Measure:	**Send a Summary of Care** For at least one transition of care or referral, the MIPS eligible clinician that transitions or refers their patient to another setting of care or health care provider—(1) creates a summary of care record using certified electronic health record technology (CEHRT); and (2) electronically exchanges the summary of care record.
Measure ID:	**PI_HIE_1**
Exclusion:	Any MIPS eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.
Measure Exclusion ID:	**PI_LVOTC_1**

Definition of Terms

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 includes all transitions of care and referrals that are ordered by the MIPS eligible clinician.

Referral – Cases where one provider refers a patient to another, but the referring provider maintains his or her care of the patient as well.

Summary of Care Record – All summary of care documents used to meet this objective must include the following information if the MIPS eligible clinician knows it:

- Patient name
- Demographic information (preferred language, sex, race, ethnicity, date of birth)

- Smoking status
- Current problem list (eligible clinicians may also include historical problems at their discretion)*
- Current medication list*
- Current medication allergy list*
- Laboratory test(s)
- Laboratory value(s)/result(s)
- Vital signs (height, weight, blood pressure, 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 clinician and the receiving clinician)*
- Immunizations
- Unique device identifier(s) for a patient's implantable device(s)
- Care plan, including goals, health concerns, and assessment and plan of treatment
- Referring or transitioning clinician's name and office contact information
- Encounter diagnosis
- Functional status, including activities of daily living, cognitive and disability status
- Reason for referral

**Note: A MIPS eligible clinician must verify that the 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 MIPS eligible clinician as of the time of generating the summary of care document or include a notation of no current problem, medication and/or medication allergies.*

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: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome).

Reporting Requirements

NUMERATOR/DENOMINATOR

- **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.

- **DENOMINATOR:** The number of transitions of care and referrals during the performance period for which the MIPS eligible clinician was the transferring or referring clinician.

Scoring Information

BASE SCORE/PERFORMANCE SCORE/BONUS SCORE

- Required for Base Score: **Yes**
- Percentage of Performance Score: **Up to 10%**
- Eligible for Bonus Score: **One-time bonus of 10% for MIPS eligible clinicians and groups who report using 2015 Edition CEHRT exclusively for the 2018 performance period and submit only Promoting Interoperability measures**

Note: MIPS eligible clinicians must fulfill the requirements of base score measures to earn a base score in order to earn any score in the Promoting Interoperability performance category. In addition to the base score, MIPS eligible clinicians have the opportunity to earn additional credit through the submission of performance measures and a bonus measure and/or activity.

Additional Information

- MIPS eligible clinicians can report the Promoting Interoperability objectives and measures if they have technology certified to the 2015 Edition, or a combination of technologies from the 2014 and 2015 Editions that support these measures.
- This measure contributes to the 50% base score for the Promoting Interoperability performance category. MIPS eligible clinicians must submit a “yes” for the security risk analysis measure, and at least a 1 in the numerator for the numerator/denominator of the remaining measures or claim exclusions. The measure is also worth up to 10 percentage points towards the performance category score. More information about Promoting Interoperability scoring is available on the QPP website.
- For the measure, only patients whose records are maintained using CEHRT must be included in the denominator for transitions of care.
- In order to count in the numerator, the exchange must occur within the performance period.

- A MIPS eligible clinician must have confirmation of receipt or that a query of the summary of care record has occurred in order to count the action in the numerator.
- 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 MIPS eligible clinician does not record such information or because there is no information to record), the MIPS eligible clinician may leave the field(s) blank and still meet the measure.
- A MIPS eligible clinician 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. This policy is limited to laboratory test results.
- A MIPS eligible clinician 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 referring clinician must have reasonable certainty of receipt by the receiving clinician to count the action toward the measure.
- The exchange must comply with the privacy and security protocols for ePHI under HIPAA.
- In cases where the MIPS eligible clinicians 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 a MIPS eligible clinician chooses to include such transitions to clinicians where access to the EHR is shared, they must do so universally for all patient and all transitions or referrals.
- The initiating MIPS eligible clinician must send a C–CDA document that the receiving clinician would be capable of electronically incorporating as a C–CDA on the receiving end. In other words, if a MIPS eligible clinician sends a C–CDA and the receiving clinician converts the C–CDA into a pdf or a fax or some other format, the sending provider may still count the transition or referral in the numerator. If the sending MIPS eligible clinician converts the file to a format the receiving clinician could not electronically receive and incorporate as a C–CDA, the initiating clinician may not count the transition in their numerator.
- The Send a Summary of Care measure remains a required measure for the base score in the Promoting Interoperability performance category. For required measures in the base score, CMS requires a one in the numerator or a “yes” response to yes/no measures or claim exclusions. Measures included in the base score are required in order for a MIPS eligible clinician to earn any score in the Promoting Interoperability performance category.
- MIPS eligible clinicians may claim the exclusions if they are reporting as a group. However, the group must meet the requirements of the exclusion as a group.
  When MIPS eligible clinicians choose to report as a group, data should be aggregated for all MIPS eligible clinicians under one Taxpayer Identification Number (TIN). This includes those MIPS eligible clinicians who may qualify for reweighting such as a significant hardship exception, hospital or ASC-based status, or in a specialty which is not required to report data to the Promoting Interoperability performance category. If these MIPS eligible clinicians

choose to report as part of a group practice, they will be scored on the Promoting Interoperability performance category like all other MIPS eligible clinicians.

Regulatory References

- For further discussion, please see the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) final rule: 81 FR 77228.
- In order to meet this objective and measure, MIPS eligible clinicians must use the capabilities and standards of CEHRT at 45 CFR 170.315 (b)(1).

Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this measure.

Certification Criteria*	
§ 170.315(b)(1) Care Coordination	(1) Transitions of care—(i) Send and receive via edge protocol—(A) Send transition of care/referral summaries through a method that conforms to the standard specified in §170.202(d) and that leads to such summaries being processed by a service that has implemented the standard specified in §170.202(a)(2); and (B) Receive transition of care/referral summaries through a method that conforms to the standard specified in §170.202(d) from a service that has implemented the standard specified in §170.202(a)(2). (C) XDM processing. Receive and make available the contents of a XDM package formatted in accordance with the standard adopted in §170.205(p)(1) when the technology is also being certified using an SMTP-based edge protocol. (ii) Validate and display—(A) Validate C-CDA conformance—system performance. Demonstrate the ability to detect valid and invalid transition of care/referral summaries received and formatted in accordance with the standards specified in §170.205(a)(3) and §170.205(a)(4) for the Continuity of Care Document, Referral Note, and (inpatient setting only) Discharge Summary document templates. This includes the ability to: (1) Parse each of the document types. (2) Detect errors in corresponding “document-templates,” “section-templates,” and “entry-templates,” including invalid vocabulary standards and codes not specified in the standards adopted in §170.205(a)(3) and §170.205(a)(4). (3) Identify valid document-templates and process the data elements required in the corresponding section-templates and entry-templates from the standards adopted in §170.205(a)(3) and §170.205(a)(4). (4) Correctly interpret empty sections and null combinations. (5) Record errors encountered and allow a user through at least one of the following ways to:

(i) Be notified of the errors produced.

(ii) Review the errors produced.

(B) Display. Display in human readable format the data included in transition of care/referral summaries received and formatted according to the standards specified in §170.205(a)(3) and §170.205(a)(4).

(C) Display section views. Allow for the individual display of each section (and the accompanying document header information) that is included in a transition of care/referral summary received and formatted in accordance with the standards adopted in §170.205(a)(3) and §170.205(a)(4) in a manner that enables the user to:

(1) Directly display only the data within a particular section;

(2) Set a preference for the display order of specific sections; and

(3) Set the initial quantity of sections to be displayed.

(iii) Create. Enable a user to create a transition of care/referral summary formatted in accordance with the standard specified in §170.205(a)(4) using the Continuity of Care Document, Referral Note, and (inpatient setting only) Discharge Summary document templates that includes, at a minimum:

(A) The Common Clinical Data Set.

(B) Encounter diagnoses. Formatted according to at least one of the following standards:

(1) The standard specified in §170.207(i).

(2) At a minimum, the version of the standard specified in §170.207(a)(4).

(C) Cognitive status.

(D) Functional status.

	(E) Ambulatory setting only. The reason for referral; and referring or transitioning provider's name and office contact information. (F) Inpatient setting only. Discharge instructions. (G) Patient matching data. First name, last name, previous name, middle name (including middle initial), suffix, date of birth, address, phone number, and sex. The following constraints apply: (1) Date of birth constraint—(i) The year, month and day of birth must be present for a date of birth. The technology must include a null value when the date of birth is unknown. (ii) Optional. When the hour, minute, and second are associated with a date of birth the technology must demonstrate that the correct time zone offset is included. (2) Phone number constraint. Represent phone number (home, business, cell) in accordance with the standards adopted in §170.207(q)(1). All phone numbers must be included when multiple phone numbers are present. (A)(3) Sex constraint. Represent sex in accordance with the standard adopted in §170.207(n)(1).

** Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this meaningful use measure.*

Standards Criteria	
§ 170.202(a) Transport standards	ONC Applicability Statement for Secure Health Transport, Version 1.0 (incorporated by reference in §170.299).
§ 170.202 (2)(b) Transport standards	ONC Applicability Statement for Secure Health Transport, Version 1.2 (incorporated by reference in §170.299). (b) Standard. ONC XDR and XDM for Direct Messaging Specification (incorporated by reference in §170.299).
§ 170.202 (2)(c) Transport standards	ONC Transport and Security Specification (incorporated by reference in §170.299).
§ 170.205(a)(1) Patient Summary Record	Health Level Seven Clinical Document Architecture (CDA) Release 2, Continuity of Care Document (CCD) (incorporated by reference in §170.299). Implementation specifications. The Healthcare Information Technology Standards Panel (HITSP) Summary Documents Using HL7 CCD Component HITSP/C32 (incorporated by reference in §170.299).

Additional certification and standards criteria may apply. Review the ONC 2015 Edition Final Rule for more information.