Merit-Based Incentive Payment System (MIPS) 2017 Advancing Care Information Performance Category Health Information Exchange Transition Measure

Objective:	**Health Information Exchange**
Measure:	**Health Information Exchange** The MIPS eligible clinician that transitions or refers their patient to another setting of care or health care clinician (1) uses CEHRT to create a summary of care record; and (2) electronically transmits such summary to a receiving health care clinician for at least one transition of care or referral.

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.

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

- Patient name
- Referring or transitioning healthcare provider's name and office contact information (MIPS eligible clinician 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
- Reason for referral (MIPS eligible clinician only)
- Current problem list (Providers may also include historical problems at their discretion)*
- Current medication list*
- Current medication allergy list*

**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 MIPS eligible clinician 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: Number of transitions of care and referrals during the performance period for which the MIPS eligible clinician was the transferring or referring health care clinician.

Scoring Information

BASE SCORE/PERFORMANCE SCORE/BONUS SCORE

- Required for Base Score (50%): **Yes**
- Percentage of Performance Score (up to 90%): **Up to 20%**
- No bonus points available.

Note: MIPS eligible clinicians must earn the full base score in order to earn any score in the Advancing Care Information performance category. In addition to the base score, MIPS eligible clinicians have the opportunity to earn additional credit through a performance score and the bonus score.

Additional Information

- In 2017, MIPS eligible clinicians can report the 2017 Advancing Care Information Transition Measures if they have technology certified to the 2014 Edition, or technology certified to the 2015 Edition, or a combination of technologies certified to the 2014 and 2015 Editions.
- This measure contributes to the base score for the Advancing Care Information performance category. MIPS eligible clinicians must submit at least a 1 in the numerator for the numerator/denominator to receive credit toward the base score. The measure is also worth up to 20 percentage points toward the performance score. More information about Advancing Care Information scoring is available on the QPP website.
- Only patients whose records are maintained using certified EHR technology must be included in the denominator for transitions of care.

- This exchange may occur before, during, or after the MIPS performance period. However, it must occur within the 2017 calendar year to count in the numerator.
- Apart from the three fields noted as required (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.
- The summary of care record should be provided when transitioning or referring their patient to another setting of care, when receiving or retrieving a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient.
- 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 clinician 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.
- When reporting as a group to the Advancing Care Information performance category, the group combines their MIPS eligible clinicians' performances under one Taxpayer Identification Number (TIN). Therefore, they are not calculated based upon one MIPS eligible clinician's performance.

Regulatory References

- For further discussion, please see the Quality Payment Program final rule with comment period: 81 FR 77230.
- In order to meet this measure, MIPS eligible clinician must use the capabilities and standards of CEHRT at 45 CFR 170.314(b)(2) and (8), or 45 CFR 170.315(b)(1).

Certification and Standards Criteria

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

Certification Criteria*	
§ 170.314(b)(2) Care Coordination	(2) *Transitions of care—create and transmit transition of care/referral summaries*— (i) *Create.* Enable a user to electronically create a transition of care/referral summary formatted according to the standard adopted at §170.205(a)(3) that includes, at a minimum, the Common Clinical Data Set and the following data expressed, where applicable, according to the specified standard(s): (A) *Encounter diagnoses.* The standard specified in §170.207(i) or, at a minimum, the version of the standard specified §170.207(a)(3); (B) *Immunizations.* The standard specified in §170.207(e)(2); (C) Cognitive status; (D) Functional status; and (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. (ii) *Transmit.* Enable a user to electronically transmit the transition of care/referral summary created in paragraph (b)(2)(i) of this section in accordance with: (A) The standard specified in §170.202(a)(1). (B) *Optional.* The standards specified in §170.202(a)(1) and (b). (C) *Optional.* The standards specified in §170.202(b) and (c).

§ 170.314(b)(8) Care Coordination	(8) *Optional—Transitions of care*—(i) *Send and receive via edge protocol.* EHR technology must be able to electronically: (A) Send transitions of care/referral summaries through a method that conforms to the standard specified at §170.202(d) and that leads to such summaries being processed by a service that has implemented the standard specified in §170.202(a)(1); and (B) Receive transitions of care/referral summaries through a method that conforms to the standard specified at §170.202(d) from a service that has implemented the standard specified in §170.202(a)(1). (ii)(A) *Display.* EHR technology must be able to electronically display in human readable format the data included in transition of care/referral summaries received and formatted according to any of the following standards (and applicable implementation specifications) specified in: §170.205(a)(1) through (3). (B) *Section views.* Extract and allow for individual display each additional section or sections (and the accompanying document header information) that were included in a transition of care/referral summary received and formatted in accordance with the standard adopted at §170.205(a)(3). (iii) *Create.* Enable a user to electronically create a transition of care/referral summary formatted according to the standard adopted at §170.205(a)(3) that includes, at a minimum, the Common Clinical Data Set and the following data expressed, where applicable, according to the specified standard(s): (A) *Encounter diagnoses.* The standard specified in §170.207(i) or, at a minimum, the version of the standard specified §170.207(a)(3); (B) *Immunizations.* The standard specified in §170.207(e)(2); (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; and (F) *Inpatient setting only.* Discharge instructions.
§ 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. (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) and/or (g)(2) or 45 CFR 170.315 (g)(1) and/or (g)(2);in order to assist in the calculation of this meaningful use measure.*

For additional information, please review the ONC 2014 Standards Hub, ONC 2015 Standards Hub, and ONC Certification Companion Guides (CCGs).

Disclaimer: This document is intended only for informational purposes. It does not provide a complete summary of the applicable regulations and policies. We refer readers to the final rule with comment period titled Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, 81 Fed. Reg. 77008-77831 (Nov. 4, 2016).