Merit-Based Incentive Payment System (MIPS) Advancing Care Information Performance Category Request/Accept Summary of Care Measure Specifications

Objective:	**Health Information Exchange**
Measure:	**Request/Accept Summary of Care** For at least one transition of care or referral received or patient encounter in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician receives or retrieves and incorporates into the patient's record an electronic summary of care document.

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 provider's name and office contact information
- 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
- 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.*

Reporting Requirements

NUMERATOR/DENOMINATOR

- NUMERATOR: Number of patient encounters in the denominator where an electronic summary of care record received is incorporated by the clinician into the CEHRT.

- DENOMINATOR: Number of patient encounters during the performance period for which a MIPS eligible clinician was the receiving party of a transition or referral or has never before encountered the patient and for which an electronic summary of care record is available.

Scoring Information

BASE SCORE/PERFORMANCE SCORE/BONUS SCORE

- Required for Base Score (50%): **Yes**
- Percentage of Performance Score (up to 90%): **Up to 10%**
- Eligible for bonus score: **No**

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

- MIPS eligible clinicians can report the Advancing Care Information 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 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 measure. The measure is also worth up to 10 percentage points toward the performance score. More information about Advancing Care Information scoring is available on the QPP website.
- For the purposes of defining the cases in the denominator for the measure, we stated that what constitutes "unavailable" and, therefore, may be excluded from the denominator, will be that a MIPS eligible clinician—
    - Requested an electronic summary of care record to be sent and did not receive an electronic summary of care document; and
    - The MIPS eligible clinician either:
        - Queried at least one external source via HIE functionality and did not locate a summary of care for the patient, or the clinician does not have access to HIE functionality to support such a query, or
        - Confirmed that HIE functionality supporting query for summary of care documents was not operational in the MIPS eligible clinician's geographic region and not available within the clinician's EHR network as of the start of the MIPS performance period.
- For the measure, a record cannot be considered to be incorporated if it is discarded without the reconciliation of clinical information or if it is stored in a manner that is not accessible for clinician use within the EHR.
- 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 77228.
- In order to meet this measure, MIPS eligible clinician must use the capabilities and standards of CEHRT at 45 CFR 170.314(b)(1) or (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)(1) Care Coordination	(1) *Transitions of care—receive, display, and incorporate transition of care/referral summaries*—(i) *Receive.* EHR technology must be able to electronically receive transition of care/referral summaries 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). (ii) *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), §170.205(a)(2), and §170.205(a)(3). (iii) *Incorporate.* Upon receipt of a transition of care/referral summary formatted according to the standard adopted at §170.205(a)(3), EHR technology must be able to: (A) *Correct patient.* Demonstrate that the transition of care/referral summary received is or can be properly matched to the correct patient. (B) *Data incorporation.* Electronically incorporate the following data expressed according to the specified standard(s): (*1*) *Medications.* At a minimum, the version of the standard specified in §170.207(d)(2);

	(*2*) *Problems.* At a minimum, the version of the standard specified in §170.207(a)(3); (*3*) *Medication allergies.* At a minimum, the version of the standard specified in §170.207(d)(2). (C) *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).
§ 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 speciied 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 170.315(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).*