Quality Payment PROGRAM

Merit-Based Incentive Payment System (MIPS) Promoting Interoperability Performance Category Measure 2019 Performance Period

Objective:	**Health Information Exchange**
Measure:	**Support Electronic Referral Loops by Sending Health Information** 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:** 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

- Required for Promoting Interoperability Performance Category Score: **Yes**
- Measure Score: **20 points**
- Eligible for Bonus Score: **No**

Note: MIPS eligible clinicians must:

- Submit a "yes" to the Prevention of Information Blocking Attestations
- Submit a "yes" to the ONC Direct Review Attestation, if applicable
- Submit a "yes" that they have completed the Security Risk Analysis measure during the calendar year in which the MIPS performance period occurs
- Must report the required measures from each of the four objectives in order to earn a score greater than zero for the Promoting Interoperability performance category

Additional Information

- MIPS eligible clinicians must use EHR technology certified to the 2015 Edition certification criteria to support the Promoting Interoperability performance category objectives and measures.
- This measure was previously named Send a Summary of Care.
- MIPS eligible clinicians are required to report certain measures from each of the four objectives, with performance-based scoring occurring at the individual measure-level. Each measure will be scored based on the MIPS eligible clinician's performance for that measure, based on the submission of a numerator/denominator, or a "yes or no" statement.
- If an exclusion is claimed for this measure, redistribution of the points will be determined during 2019 rulemaking and will be effective retroactively to 2019.
- Actions included in the numerator must occur within the performance period.
- More information about Promoting Interoperability performance category 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.
- The referring clinician must have reasonable certainty of receipt by the receiving clinician to count the action toward the measure.
- 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 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 patients 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.
- MIPS eligible clinicians may use any document template within the C-CDA standard for purposes of the measures under the Health Information Exchange objective.
- MIPS eligible clinicians may claim the exclusion 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 through an approved Promoting Interoperability 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.
- For additional discussion, please see the 2018 Physician Fee Schedule final rule – Quality Payment Program final rule: 83 FR 59789.
- 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 Standards and Criteria

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

Certification Criteria
Information about certification for 2015 Edition CEHRT can be found at the links below: §170.315(b)(1) Transitions of care

Standards Criteria
Standards for 2015 Edition CEHRT can be found at the ONC's 2015 Standards Hub: https://www.healthit.gov/topic/certification/2015-standards-hub