Quality Payment PROGRAM

Merit-Based Incentive Payment System (MIPS) Advancing Care Information Performance Category Transition Measure 2018 Performance Period

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 provider (1) uses certified electronic health record technology (CEHRT) to create a summary of care record; and (2) electronically transmits such summary to a receiving health care provider for at least one transition of care or referral.
Measure ID:	**ACI_TRANS_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:	**ACI_TRANS_LVTOC_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.

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

- Patient name
- Referring or transitioning 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
- 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 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 health care provider.

Scoring Information

BASE SCORE/PERFORMANCE SCORE/BONUS SCORE

- Required for Base Score: **Yes**
- Percentage of Performance Score: **Up to 20%**
- Eligible for Bonus Score: **No**

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 Advancing Care Information 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

- In 2018, MIPS eligible clinicians can alternatively report the 2017 Advancing Care Information transition objectives and measures if they have technology certified to the 2015 Edition, or technology certified to the 2014 Edition, or a combination of technologies certified to the 2014 and 2015 Editions.
- This measure contributes to the 50% base score for the Advancing Care Information 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 20 percentage points towards the performance category score. More information about Advancing Care Information scoring is available on the QPP website.
- Only patients whose records are maintained using CEHRT must be included in the denominator for transitions of care.
- 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.

- 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.
- 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 Advancing Care Information performance category. If these MIPS eligible clinicians choose to report as part of a group practice, they will be scored on the Advancing Care Information 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 77230.
- In order to meet this objective and measure, MIPS eligible clinicians must use the capabilities and standards of CEHRT at 45 CFR 170.314(b)(1), (b)(2), (a)(5), (a)(6) and (a)(7).

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*	
§ 170.314 (b) (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). (B) Optional. The standards specified in § 170.202(a) 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): • Medications. At a minimum, the version of the standard specified in § 170.207(d)(2); • Problems. At a minimum, the version of the standard specified in § 170.207(a)(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)(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 MU 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). (B) Optional. The standards specified in § 170.202(a) and (b). (C) Optional. The standards specified in § 170.202(b) and (c).
§ 170.314(a)(5) Problem list	Enable a user to electronically record, change, and access a patient's problem list: (i) Ambulatory setting. Over multiple encounters in accordance with, at a minimum, the version of the standard specified in § 170.207(a)(3); or (ii) Inpatient setting. For the duration of an entire hospitalization in accordance with, at a minimum, the version of the standard specified in § 170.207(a)(3).
§ 170.314(a)(6) Medication list	Enable a user to electronically record, change, and access a patient's active medication list as well as medication history.

§ 170.314(a)(7) Medication Allergy List	Enable a user to electronically record, change, and access a patient's active medication allergy list as well as medication allergy history: (i) Ambulatory setting. Over multiple encounters; or (ii) Inpatient setting. For the duration of an entire hospitalization.

**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 (incorporated by reference in § 170.299).
§ 170.202(b) Transport standards	ONC XDR and XDM for Direct Messaging Specification (incorporated by reference in § 170.299).
§ 170.202(c) Transport standards	ONC Transport and Security Specification (incorporated by reference in § 170.299).
§ 170.205(a)(1)	HL7 Implementation Guide for CDA® Release 2, CCD. Implementation specifications: HITSP Summary Documents Using HL7 CCD Component HITSP/C32.
§ 170.205(a)(2)	ASTM E2369 Standard Specification for Continuity of Care Record and Adjunct to ASTM E2369.
§ 170.205(a)(3)	HL7 Implementation Guide for CDA Release 2: IHE Health Story Consolidation. The use of the "unstructured document" document-level template is prohibited.

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