# Merit-Based Incentive Payment System (MIPS) Advancing Care Information Performance Category Measure

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| **Objective:** | **Health Information Exchange** |
| **Measure:** | **Request/Accept Summary of Care**<br>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. |

## 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%**
- No bonus points available.

**Note**: 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, eligible clinicians have the opportunity to earn additional credit through a performance score and the bonus score.

# 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 clinician must use the capabilities and standards of CEHRT at 45 CFR 170.315 (b)(1) through (b)(3) and (a)(6) through (a)(8).

# 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*** | |
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| **§ 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<br><br>(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).<br><br>(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.<br><br>(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.

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| | (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.<br><br>(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.<br><br>(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** | |
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| **§ 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).<br><br>(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 criteria may apply. Review the ONC 2015 Edition Final Rule for more information.*