

Stage 3 Eligible Hospitals, Critical Access Hospitals, and Dual-Eligible Hospitals Attesting to CMS Health Information Exchange Fact Sheet

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The Health Information Exchange (HIE) objective (formerly known as “Summary of Care”) is required for all eligible hospitals and critical access hospitals (CAHs) in the Medicare Promoting Interoperability (PI) Program. For Stage 3, the objective includes three measures for all participants. Providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective.

Overview of HIE

Objective: The eligible hospital, or CAH provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their electronic health record (EHR) using the functions of certified EHR technology (CEHRT).

Measures:

Send a Summary of Care: For more than 10 percent of transitions of care and referrals, the eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care: (1) Creates a summary of care record using CEHRT; and (2) electronically exchanges the summary of care record.

Request/Accept Summary of Care: For more than 10 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the eligible hospital or CAH incorporates into the patient’s EHR an electronic summary of care document.

Clinical Information Reconciliation: For more than 50 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the eligible hospital, or CAH performs a clinical information reconciliation. The provider must implement clinical information reconciliation for the following three clinical information sets:

- (1) Medication. Review of the patient’s medication, including the name, dosage, frequency, and route of each medication.
- (2) Medication allergy. Review of the patient’s known medication allergies.
- (3) Current Problem list. Review of the patient’s current and active diagnoses.

Attestation Requirements:

Send a Summary of Care:

- **Denominator:** Number of transitions of care and referrals during the PI reporting period for which the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) was the transferring or referring provider.
- **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.
- **Threshold:** The percentage must be more than 10 percent in order for an eligible hospital or CAH to meet this measure.

Exclusion: A provider may exclude from the measure if any of the following apply:



Any eligible hospital or CAH will be excluded from the measure if it is located in a county that does not have 50 percent or more of their housing units with 4Mbps broadband availability according to the latest information available from the FCC at the start of the PI reporting period.

Request/Accept Summary of Care

- **Denominator:** Number of patient encounters during the PI reporting period for which an eligible hospital or CAH 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.
- **Numerator:** The number of patient encounters in the denominator where an electronic summary of care record received is incorporated by the provider into the CEHRT.
- **Threshold:** The percentage must be more than 10 percent in order for an eligible hospital or CAH to meet this measure.

Exclusion: A provider may exclude from the measure if any of the following apply:

Any eligible hospital or CAH for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the PI reporting period is excluded from this measure.

Any eligible hospital or CAH will be excluded from the measure if it is located in a county that does not have 50 percent or more of their housing units with 4Mbps broadband availability according to the latest information available from the FCC at the start of the PI reporting period.

Clinical Information Reconciliation

- **Denominator:** Number of transitions of care and referrals during the PI reporting period for which the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) was the recipient of the transition or referral or has never before encountered the patient.
- **Numerator:** The number of transitions of care or referrals in the denominator where the following three clinical information reconciliations were performed: Medication list, medication allergy list, and current problem list.
- **Threshold:** The percentage must be more than 50 percent in order for an eligible hospital or CAH to meet this measure.

Exclusion: Any eligible hospital or CAH for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the PI reporting period is excluded from this measure.

NOTE: There are changes to the measure calculations policy, which specifies that actions included the numerator must occur within the PI reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the PI reporting period occurs.

Summary of Care Documents

All summary of care documents used to meet this objective must include the information outlined in **Table 1** (if the provider knows it). In circumstances where there is no information available to populate one or more of the fields listed, either because the provider can be excluded from recording such information or because there is no information to record (e.g., laboratory tests), the provider may leave the field(s) blank and still meet the objective and its associated measure.

Note: The **current problem list**, **current medication list**, and **current medication allergy list** may not be left blank. These fields must include the most recent information known by the eligible hospital as of the time of generating the summary of care document, or include a notation of no current problem, medication and/or medication allergies.

Table 1: What to Include in Summary of Care Documents	
<ul style="list-style-type: none"> • Patient name • 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) 	<ul style="list-style-type: none"> • 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. • Discharge instructions <p><i>Summary of care documents must also include:*</i></p> <ul style="list-style-type: none"> • Current problem list (providers may also include historical problems at their discretion) • Current medication list (a list of medications that a patient is currently taking) • Current medication allergy list (a list of medications to which a given patient has known allergies)
<p><i>* An eligible hospital or CAH must verify these three 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 hospital as of the time of generating the summary of care document</i></p>	

Note about Lab Results: The final rule for Modified Stage 2 of the PI Programs in 2015 through 2018 as well as for Stage 3 requires a provider to have the ability to send all laboratory test results in the summary of care document. However, the provider may work with their system developer to establish clinically relevant parameters based on their specialty, patient population, or for certain transitions and referrals that allow for clinical relevance to determine the most appropriate results for given transition or referral. A provider who limits the results in a summary of care document must send the full results upon the request of the receiving provider or upon the request of the patient.

The **Consolidated Clinical Document Architecture (C-CDA)** is the standard adopted for EHR technology certification for summary of care documents. In this final rule, all the required data elements for the C-CDA remain as previously finalized.

Transitions of Care and Referrals

A **transition of care** is defined as 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 discharges from the inpatient department and after admissions to the emergency department when follow-up care is ordered by an authorized provider of the hospital.

Referrals are cases where one provider refers a patient to another, but the referring provider maintains their care of the patient as well. In addition:

- Transition of care for electronic exchange has been further defined as one where the referring provider is *under a different billing identity* within the Medicare and Medicaid PI Programs (such as a different National Provider Identifier [NPI] or hospital CMS Certification Number [CCN]) than the receiving provider and where the providers do not share access to the EHR.
- In cases where the providers do share access to the EHR, a transition or referral may still count toward the measure if the referring providers creates the summary of care document using CEHRT and sends the summary of care document electronically. If a provider chooses to include such transitions to providers where access to the EHR is shared, they must do so universally for all patients and all transitions or referrals.
- In cases where a provider has a patient who seeks out and receives care from another provider without a prior referral, the first provider may include that transition as a referral if the patient subsequently identifies the other provider of care.

Electronic Transmission of Summary of Care Documents

For the PI Programs in 2018 the HIE measure simply states that a provider is required to create the summary of care records using CEHRT and to transmit the summary of care record electronically. The intent is to promote and facilitate a wide range of options for the transmission of an electronic summary of care document. The initiating provider must send a C–CDA document that the receiving provider would be capable of electronically incorporating as a C–CDA on the receiving end. In other words, if a provider sends a C–CDA and the receiving provider 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 provider converts the file to a format the receiving provider could not electronically receive and incorporate as a C–CDA, the initiating provider may not count the transition in their numerator. The provider may use a third party to send the summary of care record, but it is not required.

In instances where a “third party organization that plays a role in determining the next provider of care and ultimately delivers the summary of care document” is involved, the service the third party provides does not have to be certified for the transmission to be counted in the numerator for measure 2. There are also no specific requirements around the technical standards or methods by which the third party delivers the summary of care document to the receiving provider (e.g., SOAP, secure email, fax).

Acceptable Electronic Transmission Methods

Examples of acceptable transmission methods include **secure email**, **Health Information Service Provider**, **query-based exchange** or use of third party HIE. There are many other options in addition to the examples listed, as well as opportunities for developers and vendors to utilize innovation and creativity. The provider must ensure that the transmission methods are in compliance with HIPAA requirements.

Note: Faxing in general is not acceptable since it is not in C-CDA format. It is only acceptable when a third party is used to transmit the summary of care record and they must convert the transmission to fax because that is the only way the receiving provider can accept the transmission. Additionally, the conversion to fax by the third party must not be a default approach.

To count in the numerator, the sending provider must have reasonable certainty of receipt of the summary of care document. This means that a “push” to an HIE, which might be queried by the recipient, is insufficient. Instead, the referring provider must have confirmation that a query was made to count the action toward the measure. (This could be a call to the receiving provider or email confirmation from the HIE itself in instances where a third party is used.) The exchange must comply with the privacy and security protocols for electronic protected health information under HIPAA.

An eligible hospital or CAH must use the capabilities and standards of as defined in [CEHRT at § 495.4](#).

For More Information

Visit the [CMS PI Programs website](#) to learn more about the requirements for the PI Programs.