

# Medicare Promoting Interoperability Program Eligible Hospitals, Critical Access Hospitals, and Dual-Eligible Hospitals Attesting to CMS Objectives and Measures for the 2021 Reporting Period

The following information is for eligible hospitals, critical access hospitals (CAHs), and dual-eligible hospitals attesting to CMS for their participation in the Medicare Promoting Interoperability Program in 2021. Those attesting to their State should refer to the [2021 Promoting Interoperability Medicaid](#) specification sheets.

Objective	Health Information Exchange
Measure	<p><b>Support Electronic Referral Loops by Sending Health Information</b></p> <p>For at least one transition of care or referral, 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 certified electronic health record technology (CEHRT); and (2) electronically exchanges the summary of care record.</p>

## 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 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.

## Reporting Requirements

- **DENOMINATOR:** Number of transitions of care and referrals during the electronic health record (EHR) reporting period for which the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) was the transitioning or referring provider.
- **NUMERATOR:** Number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically.
- The EHR reporting period in 2021 for new and returning participants attesting to CMS is a minimum of any continuous 90-day period within the calendar year.

## Scoring Information

- Total points available for this measure: 20 points.
- 100 total points will be available for the required objectives and measures of the Medicare Promoting Interoperability Program.

- In order to earn a score greater than zero, an eligible hospital or CAH must complete the activities required by the Security Risk Analysis measure, submit their complete numerator and denominator or Yes/No data for all required measures, attest to program questions on the Prevention of Information Blocking and the ONC Direct Review, as well as report on the required electronic clinical quality measure data.
- Failure to report at least a “1” in all required measures with a numerator or reporting a “No” for a Yes/No response measure will result in a total score of 0 points for the Promoting Interoperability Program. Such eligible hospitals or CAHs who fail to achieve a minimum total score of 50 points are not considered meaningful users and may undergo a downward payment adjustment.
- *Rounding:* When calculating the performance rates and measure and objective scores, scores will be rounded to the nearest whole number.

### **Additional Information**

- In 2021, eligible hospitals and CAHs may use technology meeting the existing 2015 Edition certification criteria, the 2015 Edition Cures Update criteria, or a combination of the two to meet the CEHRT definition.
- To learn more about the 2015 Edition Cures Update and the changes to 2015 Edition certification criteria finalized in the 21<sup>st</sup> Century Cures Act final rule (85 FR 25642), we encourage hospitals to visit <https://www.healthit.gov/curesrule/final-rule-policy/2015-edition-cures-update>.
- To check whether a health IT product that has been certified to the 2015 Edition Cures Update criteria, visit the Certified Health IT Product List (CHPL) at <https://chpl.healthit.gov/>.
- 2015 Edition or 2015 Edition Cures Update functionality must be used as needed for a measure action to count in the numerator during an EHR reporting period. However, in some situations the product may be deployed during the EHR reporting period but pending certification. In such cases, the product must be certified to the 2015 Edition or 2015 Edition Cures Update criteria by the last day of the EHR reporting period.
- Patients whose records are maintained using CEHRT must be included in the denominator for transitions of care.
- The referring provider must have reasonable certainty of receipt by the receiving provider to count the action toward the measure. This may include confirmation of receipt or that a query of the summary of care record has occurred in order to count the action in the numerator.
- 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, either because the eligible hospital/CAH does not record such information or because there is no information to record, the eligible hospital/CAH may leave the field(s) blank and still meet the objective and its associated measure.
- An eligible hospital or CAH 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.

- An eligible hospital or CAH 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 electronic protected health information under the Health Insurance Portability and Accountability Act (HIPAA).
- In cases where the eligible hospitals or CAHs 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 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.
- The initiating eligible hospital or CAH must send a C–CDA document that the receiving provider would be capable of electronically incorporating as a C–CDA on the receiving end. We are not continuing the policy of allowing a third party to convert the summary of care record transmission to fax as it does not drive toward the overall goal of sending, receiving, or retrieving an electronic summary of care document for this objective. Therefore, 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 (80 FR 62859).
- MIPS eligible clinicians may use any document template within the C-CDA standard for purposes of the measures under the Health Information Exchange objective.

### Regulatory References

- The measure’s objective may be found in Title 42 of the Code of Federal Regulations at 495.24 (e)(6)(i). For further discussion, please see [83 FR 41634 through 41677](#).
- In order to meet this measure, an eligible hospital or CAH must use technology certified to the criteria at 45 CFR 170.315 (b)(1).

### Certification Criteria

Below are the corresponding certification criteria for EHR technology that supports this measure.

#### Certification Criteria

Information about certification for 2015 Edition CEHRT can be found at:  
[§170.315 \(b\)\(1\) Transitions of care](#)