Quality Payment
PROGRAM

Merit-Based Incentive Payment System (MIPS)
Promoting Interoperability Performance Category Measure
2026 Performance Period

Objective:	**Health Information Exchange** The MIPS eligible clinician 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 reconciles summary of care information from other healthcare providers into their electronic health record (EHR) using the functions of certified EHR technology (CEHRT).
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 CEHRT; and (2) electronically exchanges the summary of care record.
Measure ID:	**PI_HIE_1**
Exclusion:	Any MIPS eligible clinician who transfers patients to another setting or refers patients 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 MIPS eligible clinician refers a patient to another, but the referring MIPS eligible clinician maintains his or her care of the patient as well.

Current Problem List – At a minimum, a list of current and active diagnoses.

Current Medication List – A list of medications that a given patient is currently taking.

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 aren't generally harmful.

Health Information Exchange (HIE) – "HIE" broadly refers to arrangements that facilitate the exchange of health information and may include arrangements commonly denoted as exchange "frameworks", "networks", or using other terms.

NOTE: A MIPS eligible clinician must verify that the fields for Current Problem List, Current Medication List, and Current Medication Allergy List aren't 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.

Reporting Requirements

Numerator/Denominator

- **NUMERATOR:** Number of transitions of care and referrals in the denominator where the 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 MIPS Promoting Interoperability Performance Category Score: **Yes, unless submitting one of the alternative measures**: **Health Information Exchange (HIE) Bi-Directional Exchange (PI_HIE_5), or Enabling Exchange Under the Trusted Exchange Framework and Common Agreement™ (TEFCA™) (PI_HIE_6)**
- Measure Score: **15 points**
- Eligible for Bonus Score: **No**

NOTE: A MIPS eligible clinicians must use technology certified to the Office of the National Coordinator for Health Information Technology (ONC) Certification Criteria for Health Information Technology (IT) (45 CFR 170.315) necessary to meet the CEHRT definition (42 CFR 414.1305(2)), and meet the following requirements to earn a score greater than zero for the MIPS Promoting Interoperability performance category:

- Provide their CMS EHR Certification ID from the Certified Health IT Product List (CHPL);
- Submit data for a minimum of 180 consecutive days within the calendar year;
- Submit 2 "Yes" attestations for completing both components of the Security Risk Analysis measure during the calendar year in which the performance period occurs;
- Submit a "Yes" attestation for the High Priority Practices Safety Assurance Factors for EHR Resilience (SAFER) Guide measure confirming the completion of an annual self-assessment using the 2025 High Priority Practices SAFER Guide during the calendar year in which the performance period occurs;
- Submit a "Yes" response for the ONC Direct Review attestation;
- Submit a "Yes" response for the Actions to Limit or Restrict Compatibility or Interoperability of CEHRT attestation;
- Submit their complete count of numerators (report at least a "1" for all required measures with a numerator) and denominators or "Yes" response (for attestation measures) for all required measures (or claim an exclusion, if available and applicable); and
- Submit their level of active engagement for the required measures under the Public Health and Clinical Data Exchange objective.

Also, as an optional attestation, a MIPS eligible clinician can attest (if they received a request for surveillance) to work in good faith with an ONC-Authorized Certification Bodies (ACB) that conducts surveillance of their health information technology certified under the ONC Health IT Certification Program.

Additional Information

- To check whether a health IT product has been certified to ONC Certification Criteria for Health IT, visit the Certified Health IT Product List (CHPL).
- Certified functionality must be used as needed for a measure action to count in the numerator during a performance period. However, in some situations, the product may be deployed during the performance period but pending certification. In such cases, the product must be certified by the last day of the performance period.
- If the exclusion is claimed for this measure, the 15 points will be redistributed to the Provide Patients Electronic Access to Their Health Information measure.
- Actions included in the numerator must occur within the performance period.
- Only patients whose records are maintained using CEHRT must be included in the denominator.
- The referring MIPS eligible clinician must have reasonable certainty of receipt by the receiving clinician to count the action toward the measure. This may include confirmation of receipt, not receiving a bounce back, or receiving a message, fax, phone call or other communication to the referring MIPS eligible clinician that the summary of care document has been received in order to count the action in the numerator.
- Apart from the 3 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 of care or referral.
- 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 electronic protected health information (ePHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- In cases where the MIPS eligible clinicians share access to an EHR, a transition of care or referral may still count toward the measure if the referring MIPS eligible 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 patients and all transitions or referrals.
- The referring MIPS eligible clinician must send a Consolidated Clinical Document Architecture (C-CDA) document that the receiving clinician would be capable of electronically incorporating as a C-CDA on the receiving end. If the referring MIPS eligible clinician converts the file to a format the receiving clinician could not electronically receive and incorporate as a C-CDA (including through a third party), the referring MIPS eligible 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 HIE objective.
- The exclusion is the sum total of fewer than 100 referrals or transitions by the MIPS eligible provider during the 180-day performance period.
- MIPS eligible clinicians may claim the exclusion if they are reporting as a group, virtual group, or Alternative Payment Model (APM) Entity. However, the group, virtual group, or APM Entity must meet the requirements of the exclusion as a group, virtual group, or APM Entity.

- When reporting as a group, virtual group, or APM Entity, data should be aggregated across all instances of CEHRT used by all MIPS eligible clinicians within a group/under one Taxpayer Identification Number (TIN), across all instances of CEHRT used by all TINs within a virtual group, or across all instances of CEHRT used by all participant TINs within an APM Entity. Such aggregation includes MIPS eligible clinicians who may qualify for a MIPS Promoting Interoperability Performance Category Hardship Exception due to being part of a small practice, being a non-patient facing MIPS eligible clinician, or having a hospital-based or ambulatory surgery center (ASC)-based status. For additional information, please review the 2026 MIPS Promoting Interoperability Performance Category Hardship Exception Application Guide available in the Quality Payment Program Resource Library.
- When reporting as a subgroup (MIPS Value Pathway), aggregated data of the affiliated group should be submitted.
- APM Entities can choose to report MIPS Promoting Interoperability performance category data at the individual, group, virtual group, or APM Entity level when participating in MIPS. Review the Frequently Asked Questions on the Shared Savings Program Requirement to Report Objectives and Measures for the MIPS Promoting Interoperability Performance Category (PDF, 271KB) for more information.

Regulatory References

The most recent regulatory references can be found in the Calendar Year (CY) 2023 Physician Fee Schedule final rule (87 FR 70071).

Certification Criteria

Below are the corresponding certification criteria for health IT that currently support this measure.

Certification Criteria
§170.315(b)(1) Transitions of Care

Version History Table

Date	Change Description
12/15/2025	Original posting.