Medicaid Questions on the CMS EHR Incentive Program Final Rule

November 10, 2010

1. If an eligible professional (EP) adopts, implements or upgrades to certified EHR technology (AIU) in Jan 2012 and gets the AIU payment in 2012, can the EP use a 90-day period in 2012 to report on EHR meaningful use (MU) for a 2013 Year 1 MU payment? Or, does the 90-day period have to be in the next calendar year 2013? Then they would have to show Year 2 MU in calendar year 2014 and not get their next incentive payment until sometime in 2015.

First, it is important to note that when discussing 2013, CMS stated that it expects to engage in another cycle of rulemaking for that year. Under our current rules, the 90-day period has to be in the next calendar year 2013. Payment year is defined in 42 CFR 495.4 as a calendar year beginning with CY 2011, and for Medicaid, the first payment year is the first calendar year for which the EP receives an incentive payment. The second payment year is then the second calendar year for which the EP receives the incentive payment. Because each payment year is tied to a separate calendar year, and because for Medicaid, for the first year of demonstrating MU the EHR reporting period must be a continuous 90-day within the calendar year (with all subsequent years having an EHR reporting period equal to the full CY), the EHR reporting period must occur within the year of payment. Thus, the EHR reporting period is any 90-day period within CY 2013 in the example provided above. As for what stage of meaningful use the EP must show in CY 2014, CMS stated that it expects to engage in future rulemaking to address this issue.

2. The billing provider on a claim is an EP but the performing provider type is not an EP. If we use claims to validate patient volume or meaningful use, should we count performing providers (person rendering the service) or the billing provider?

In establishing an encounter for purposes of patient volume, please see the regulations at 495.306(e)(2)(i)-(ii) at 75 FR 44579 . Furthermore, in estimating patient volume for any EP or hospital, we do not specify any requirements around billing, but rather we discuss patients. E.g., if a Physician's Assistant (PA) provides services, but they are billed through the supervising physician, it seems reasonable that a State has the discretion to consider the patient as part of the patient volume for both professionals. However, this policy would need to be applied consistently. In this scenario, using services provided by the PA but billed under the physician in the physician's numerator (e.g., Medicaid encounters) also would increase the physician's denominator (all encounters), because the State would need to adequately reflect the total universe of patients (both Medicaid and non-Medicaid) who the PA saw, but for whom the physician billed.

In terms of meaningful use, because each eligible professional must demonstrate meaningful use him/herself, if the State could not distinguish between the physician's claims and the PA's individual claims, then this would not be an adequate audit methodology.

3. I am interested in finding out how we should determine the cost of an EHR system to a provider in order for them to demonstrate their 15% of the net average allowable costs for an EHR in the following scenarios:

a. It is a group practice, owned by the clinicians. The cost of purchasing and implementing an EHR system was $300,000 and there are 30 clinicians.

i. Each eligible clinician reports $300,000; or

ii. Each eligible clinician reports $10,000 ($300,000/30 clinicians = $10,000) as their contribution. This is the correct approach.

b. It is a group practice, privately owned. The cost of purchasing and implementing an EHR system was $300,000 and there are 30 employee clinicians.

i. Each eligible clinician reports $300,000; or

ii. Each eligible clinician reports $10,000 ($300,000/30 clinicians = $10,000) as their contribution. This is the correct approach.

c. The cost of purchasing and implementing an EHR system was $300,000 and there are 30 employee clinicians at an FQHC/RHC. These costs were paid for through a Federal grant.

i. Each eligible clinician reports that the system cost $300,000; or

ii. Each eligible clinician reports the sum of the costs that s/he personally incurred to connect to the system, internet access, or any hardware, or software, or training expenses; or

iii. If all of the EHR software, licensing, training, hardware, internet and related software costs were paid by the FQHC with Federal funds, the eligible clinicians would report $0 as their contribution; or

iv. Each eligible clinician reports $10,000 ($300,000/30 eligible clinicians = $10,000) as their contribution. This is the correct approach.

4. Is it acceptable to borrow material from the slide deck that was used during the 7-19 CMS HITECH call?

They may be reused, but some of the slides had minor modifications needed. CMS will post a corrected, 508-compliant version on our website as soon as possible. It is not permissible to reproduce the CMS logo or the CMS EHR Incentive Program logo.

5. Do States need to verify the "installation" or "a signed contract" for AIU?

States should make clear to providers when they attest for AIU what documentation they must maintain, and for how long, in case of audit. If States determine that certain provider types are a high risk for potential fraud/abuse for AIU, then they can ask for some verification of adopting, implementation or upgrading but CMS encourages that this be done in a targeted manner, with the most electronic and simple means possible and not in such a way that would be burdensome to providers. For AIU, a provider does not have to have installed certified EHR technology. The definition of AIU in 42 CFR 495.302 allows the provider to demonstrate AIU through any of the following: (a) acquiring, purchasing or securing access to certified EHR technology; (b) installing or commencing utilization of certified EHR technology capable of meeting meaningful use requirements; or (c) expanding the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria. Thus, a signed contract indicating that the provider has adopted or upgraded would be sufficient.

6. When we count encounters in a clinic or medical group (or medical home model) are we able to include the encounters of ancillary providers such as pharmacists, educators, etc. when determining if the EPs are eligible, per patient volume requirements?

Our regulations did not address whether these non-EP encounters could be considered in the estimate of patient volume for the clinic. However, we believe a State would have the discretion to include such non-EP encounters in its estimates. Again, if these non-EP encounters are included in the numerator, they must be included in the denominator as well. States also must ensure that their methodology adheres to the conditions in 42 CFR 495.306(h), and specifically t 495.306(h)(4), which says: “(4) The clinic or group practice uses the entire practice or clinic’s patient volume and does not limit patient volume in any way.”

7. If the EHR Reporting Period is CY 2013, then the Payment Year also refers to 2013 even though an EP may receive the actual incentive payment in early 2014, correct? If this is the case, does “preceding year” mean that the number of patient encounters in any 90 day period in CY 2012 will be used? If so, why not use the number of patient encounters during CY 2013?

The payment year is the year for which the payment is made (see 42 CFR 495.4 and the definition of “First, second, third, fourth, fifth, or sixth payment years.”). So, the questioner is correct that if the EHR reporting period is in CY 2013, the payment year also refers to 2013. Using the patient encounters from the year preceding the payment year, when the EP is AIU, or in the first year of MU, when the EHR reporting period is 90 days, allows the EP to receive an

incentive early in the payment year, such as when their EHR reporting period occurs during the first 90 days of CY 2012).

8. Can EPs count their costs towards the initial purchase of the EHR, not just what they will spend to upgrade it to the newly certified version, for purposes of 15% of the net average allowable cost? How far back in time can an EP count his/her contribution towards EHR technology for the purposes of demonstrating 15% of the net average allowable cost (NAAC) ($3750 in year 1; $1500 in years 2-6)? Can they "carry-over" those expenses for the subsequent years?

Yes, a State may, in its SMHP, use a methodology that allows the EP to count their initial costs, as one cannot upgrade that which one does not have (i.e. you have to have "version 1.0" in order to upgrade to "version 2.0") There is no prescribed timeframe. For example, if an EP expended $5000 in 2007 on an EHR and spends $2000 in 2010 for the newly certified version, his/her total costs would be $7,000. As the rule indicates that an EP must demonstrate 15% of the NAAC, which for the first participation year is $3,750, that EP would have clearly met that requirement. However, the EP cannot "carry-over" from year to year, and must demonstrate that s/he has met the 15% of the NAAC for each year. So, for participation years 2-6, the EP would need to attest to the State that they have expended at least $1500 towards their meaningful use of certified EHR technology. We provide examples in the preamble of the final rule (75 FR 44492-4), such as health information exchange transaction fees/monthly dues; costs associated with internet access; computer hardware; additional software upgrades; training/technical assistance fees, etc.

9. When should we expect to receive the hospital interface attestation info.....same day, next day, weekly etc.?

Almost all file transfers are daily. However, at first, States will just receive confirmation that the dually-eligible hospital attested, not the underlying info. Once we have a user interface for States, you will be able to look at the attestation module.

10. Can NLR information be updated by the provider at the NLR level (i.e. an address was transposed)? If so, will the States receive an update or full refresh of this information?

Yes, if there are errors like that, a provider will need to correct at the registration module in the NLR. An updated file will be sent to the State.

11. How can the state determine what, if any, other funds a provider may have received for adopting EHR technology?

a. What data sources can we utilize to determine that information?

One option is that States can employ an attestation model. We believe this might be similar to individuals reporting deductions on income taxes, for example. Providers could use worksheets to make a qualification determination, but are still subject to an audit by the State. CMS plans to develop templates for these worksheets to share with States.

12. What's been CMS's general turnaround time for feedback on informal SMHP drafts?

ASAP, but no guaranteed timeframe.

13. It seems that each State has the latitude to define the 12-month period from which to derive the Medicaid share data. Neither the preamble nor the regulatory text explicitly stipulate that the 12-month period selected by the state for the Medicaid share data needs to be in the federal FY before the hospital's FY that serves as the first payment year. Am I correct in this interpretation? In other words, a state could use two different 12-month periods to calculate the discharge-related amount and the Medicaid share?

No, this is not correct. The regulation is clear that the discharge-related amount must be calculated using a 12-month period that ends in the Federal fiscal year before the hospital's fiscal year that serves as the first payment year. 42 CFR 495.310(g)(1)((i)(B). This statement also was made in the preamble, where we stated: "For purposes of administrative simplicity and timeliness, we require that States use data on the hospital discharges from the hospital fiscal year that ends during the Federal fiscal year prior to the fiscal year that serves as the first payment year" 75 FR 44498. In addition, the regulation indicates that the period that is used for the Medicaid share is the same period as that used for the discharge-related amount. See 42 CFR 495.310(g)(2)(i) referring to "the 12-month period selected by the State." Use of "the" in 495.310(g)(2) indicates that this is the same 12-month period that is used under 495.310(g)(1). In addition, we believe that using different periods for the Medicaid share versus the discharge-related amount would lead to inaccurate estimates, as data would be drawn from inconsistent periods.

14. On Table 19 (75 FR 44499) - It seems that the table should say FY rather than CY; which is correct?

Yes, it should say FY, which is what is used throughout the preamble and regulation.

15. Are EPs who practice in State Mental Health and Long Term Care Facilities eligible for Medicaid incentive payments if they meet the eligibility criteria (e.g., patient volume, non-hospital based, certified EHR)?

The setting in which a physician, nurse practitioner, certified nurse midwife, or dentist provides care is generally irrelevant to determining eligibility for the incentive program (except for purposes of determining whether an EP can qualify through "needy individual" patient volume). Setting is relevant for physician assistants, as they are eligible only when they are practicing at a Federally Qualified Health Center (FQHC) that is led by a PA or a Rural Health Center (RHC) that is so led. All providers must meet all program requirements prior to receiving an incentive payment (e.g. adopt, implement or meaningfully use certified EHR technology, patient volume, etc.).

16. If a State had their incentive payment program approved and ready to go by 1/1/2011, could a provider use for their 90-day patient volume period 10/1-12/31/2010 to qualify for a payment as of 1/1/2011?

Yes. We specify that the volume period needs to be any 90-day period in the preceding calendar year. The provider would also need to demonstrate A/I/U in order to qualify for an incentive payment.

17. If a provider AIU in their first year, the provider will not have to demonstrate meaningful use in order to receive payment; in the second year they will have to demonstrate MU for a 90 day period only. Whereas a provider that is already a meaningful user would have to demonstrate for a 90 day period the first year and subsequent years they would have to demonstrate it for the full year. Is this correct?

This is correct.

18. If patients are dually eligible, Medicare and Medicaid, can they be counted twice by hospitals in their calculations for incentive payment if they are applying for both Medicare and Medicaid?

For purposes of calculating the Medicaid share, a patient cannot be counted in the numerator if they would count for purposes of calculating the Medicare share. Thus, in this respect the inpatient bed day of a dually eligible patient could not be counted in the Medicaid share numerator. (See 1903(t)(5)(C), stating that the numerator of the Medicaid share does not include individuals "described in section 1886(n)(2)(D)(i).") In other respects; however, the patient would count twice. For example, in both cases, the individual would count in the total discharges of the hospital.

19. Can organizations register for the Medicaid EHR Incentive Program on behalf of their eligible professionals?

There is nothing preventing this. Anyone doing this on behalf of providers would need to have an Identity & Account (I&A) Management user ID/pw for NPPES.

20. Can organizations request payments for the Medicaid EHR Incentive Program on behalf of their eligible professionals including attesting to required information?

The EPs are legally attesting that they meet the requirements in order to receive payments. States could consider a model similar to that used for tax preparation, where a preparer (accountant) completes the information, but the individual still signs the forms. We recommend consulting with your legal department about your current rules for claims submissions, and ensuring that the EPs remain liable under the False Claims Act and other fraud, waste and abuse provisions. Furthermore, we want to ensure providers know that an attestation is being submitted on their behalf—as there may be EPs in multiple practices that want to direct the incentive to one particular practice.

21. In the event EPs have more than allowable cost in a given year, can they carry-over excess costs to future years?

We did not set up parameters for this in the final rule. Only if there was an on-going aspect to that cost, not a one-time expenditure. States will have to define this clearly for their programs.

22. For calculation of the hospital incentive, is the estimated growth rate for hospitals most recent three years based on growth in total days or growth in discharges? (The data sources for these are different.)

The average annual growth rate should be for discharges (see 1903(t)(5)(B), referring to the annual rate of growth of the most recent 3 years for "discharge data.") We agree that the sources are different. Hospitals would probably have to use MMIS or auditable hospital records to get accurate discharge data rate of growth.

23. Is data sharing with neighboring States permitted regarding total Medicaid days for purposes of paying full incentives to hospitals or EPs with utilization in multiple states?

Yes. The CMS final rule clarifies the policy about calculating patient volume for Medicaid providers with clinical practices in more than one State, both in terms of what is "Medicaid patient volume" and about the cross-border issue. See 75 FR 44503, stating: "[W]e recommend that States consider the circumstances of border State providers when developing their policies and attestation methodologies. To afford States maximum flexibility to develop such policies, we will not be prescriptive about whether a State may allow a Medicaid EP to aggregate his/her patients across practice sites, if the State has a way to verify the patient volume attestation when necessary. States will propose their policies and attestation methodologies to CMS for approval in their State Medicaid HIT plans." However, as stated in the final rule, EPs and hospitals are permitted to receive payment from only one State in a payment year (495.310(e)).

24. Does a State have the option of solely using a state-submitted alternative methodology (pending CMS approval) for determining patient volume, or is the State additionally required to use one of the CMS specified methodologies (patient encounter or patient volume)?

Yes, the State can submit to us for approval only the alternative methodology that meets the requirements of 495.306(g). As we stated in the preamble to the final rule, we believe most States will not submit alternative methodologies until after the first year of the program, allowing for alternatives to recognize evolving State and provider experience with patient volume estimate methodologies. We recommend that States consider the methodologies that were put forward in the final rule, prior to proposing only an alternative in their SMHPs. If a State alternative methodology is approved by us, we will post this methodology on our website, so that other States may adopt the methodology as well.

25. We are trying to determine if the physicians who work in a tribally operated facility (called 638) who meet the Medicaid volume requirements and are hired directly by the facility would be eligible for Medicaid incentive payments?

Physicians are one of the categories of eligible professionals. If they meet the other Medicaid

eligibility requirements, such as patient volume, AIU or MU of certified EHR technology, non-hospital based, etc, then the fact that they work at a tribally-operated facility and are direct hires or not is not relevant. We believe the questioner may be concerned about calculating net average allowable costs and/or ensuring that the EPs working in the facility are determined to have met their 15% responsibility. However, without more information on these aspects of the question, we cannot provide a response.

26. Are pediatric subspecialists considered pediatricians for purposes of qualifying under Medicaid meaningful use? In other words, if I am an otolaryngologist who only sees children, can I qualify under Medicaid if I only have 20% of patient volume as Medicaid?

For the Medicaid EHR Incentive Program, States will define "pediatrician" in a manner consistent with how they define the term for other purposes of their Medicaid programs.

27. Will the CMS Communications Plan include "key messages" that we should incorporate into the statewide communications materials that we'll be producing?

CMS has already developed and continues to develop a number of HITECH products conveying important information about the EHR incentive programs that should be used by the States in their own HITECH communications and outreach plans. These products can be found in downloadable form at the CMS Medicare and Medicaid EHR Incentive Programs website (https://www.cms.gov/EHRIncentivePrograms/). In addition to overviews of the Medicare & Medicaid EHR incentive programs, fact sheets addressing EHRs and "meaningful use", tip sheets with detailed information about eligible provider and hospital participation in the Medicaid EHR incentive program and Medicaid specific FAQs (such as this one) are on our web site. The biweekly HITECH conference calls between CMCS and the States are another good source of information for States' HITECH communications with providers and other stakeholders. Recordings of these calls will soon be available at the CMS website.

28. Is CMS asking us to include the new eHR logo and tagline (as they've been using on recent PowerPoint presentations) in our statewide materials that we'll be producing?

No, CMS is not currently requesting that State Medicaid Agencies (or other organizations) use the eHR logo and tagline, however State Medicaid Agencies may request the logo to help identify their program as the "official" source for their state's Medicaid EHR incentive program. Please note that the eHR logo and tagline may only be used by external entities with permission by CMS Office of External Affairs and Beneficiary Services. To request the logo, please submit an email via logos@cms.hhs.gov to start the process. External entities must sign a license agreement to use any CMS logo/mark prior to receiving the logo artwork. This arrangement prevents non-CMS entities from using CMS logos without permission and misrepresenting CMS and its programs.

29. I am particularly interested in getting clarification on "Implementation" criteria. On July 13th CMS did a call/presentation and indicated providers could submit a "signed contract" for AIU payment. Every presentation since that time has indicated the EH record must be "installed." This makes a

difference in our strategy for verification and payment. Can you please get an answer as we are moving along with policy and system development?

Our regulations at 42 CFR 495.302 define "adopt, implement or upgrade," and include in the definition that the eligible provider "acquire, purchase, or secure access to certified EHR technology." The preamble to the final rule also states that while the States will provide details to CMS on how they will audit and oversee Medicaid providers' adoption, implementation or upgrading to certified EHR technology . . . a proof of purchase or signed contract would likely be an acceptable indicator of EHR adoption per the States." Please refer to the final rule preamble page 44504 last column for this discussion. A provider is not required to have installed certified EHR technology in order to meet AIU. Please note that the PowerPoint presentations are meant to provide an overview of the final rule but do not substitute for the actual language in the final rule.

30. I have seen that the EP must participate at the site that they practice at least 51% of their time and that has a certified EHR rolled out. But is there a minimum amount of time/week that they must practice. Does a part-time EP qualify for the Medicaid program? For instance: if a MD only works 2 days total/week at a practice that has a qualified EHR, do they qualify since that is 100% of their practice but they are a part-time provider. And do contracted clinicians qualify?

Please refer to page 44491 of the preamble to the final rule where we address this issue. As stated on that page: "Full or part-time status does not affect patient volume calculations. . . There is no mention of requisite number of hours in the statute or this final rule as a pre-condition for eligibility." Patient volume is calculated as a proportion and there is no minimum denominator or minimum full-time equivalency in order to qualify. Therefore yes, a part-time provider could be eligible. Likewise, there are no restrictions on employment type, e.g., contractual, permanent, temporary, in order to be an eligible professional.

31. We were told there are three options for testing a state connection to the NLR: one this fall for a January launch; then one in February for a launch no later than May; and one in May, to launch no later than August. What will happen if a state is not prepared to test by May? Will there be other opportunities?

Yes. The CMS Contractor, Paragon, that is charged with working with each State to successfully establish an interface with the NLR will provide individualized support and additional details for States that are not ready to test by May 2011. Paragon will also be working out the testing and launching details for Groups 2 and 3.

32. CMS staff has said that they expect every provider to receive the maximum incentive benefit for both AIU and for meeting MU. However, we know that there are products that may not cost enough to adopt to qualify a provider for the full benefit. Even the Wall Street Journal on 8-9-10 talked about an EHR for certain Humana providers where 85% of the products implementation costs are roughly $4,000. So that said, why is the response on calls

consistently 'we expect providers to get the full benefit' or 'the payment is XX'. Will we get any additional guidance on the documentation needed to prove costs?

We understand providers' concerns. Just to clarify though, 15% of the NAAC in Year 1 is $3750 and $1500 in Years 2-5. We are taking into consideration all the costs for adopting, implementing, upgrading or meaningfully using certified EHR technology, and not just the cost of the EHR system, as described on page 44494 of the final rule preamble: "States should consider costs related to the providers' efforts to address workflow redesign and training as contributing to the providers' 15 share." Similarly, in the preamble we note that providers can reflect their initial costs for the original EHR, as well as their new costs for the upgraded version as part of their 15%. So in the Humana example, the providers would be able to report the $4,000 for the costs to date, plus any new expenditures once their current EHR upgrades to the newly certified version under the ONC final rule standards released on 7/28/2010. Please also be sure that outreach materials note that "EHR costs" are inclusive of purchase/lease of software, hardware, staff training, system support and maintenance.

33. Understanding that ONC has worked to develop the REC model, is there an assumption/expectation from CMS that States identify the RECs as an adoption entity?

It is entirely up to States to determine who they wish to designate as a permissible adoption entity, if any, in accordance with our regulations at 495.310(k) and 495.332(c)(9). Likewise it is entirely voluntary for an eligible professional to choose to reassign his/her incentive payments to a State-designated adoption entity.

34. Are hospitals able to apply for an incentive payment under Medicaid before applying for a Medicare incentive payment in Year 1?

Yes, they may do so. Participation in either program is voluntary, as is the timing of registration for either program. So yes, a hospital eligible for both incentive programs could choose to participate in one program and not the other in any given year through 2016. However, there may be a number of considerations involved: including but not limited to: (1) to maximize the Medicare hospital incentives, a hospital must begin in Medicare no later than 2013; (2) to take advantage of "deeming" for purposes of demonstrating it is a meaningful EHR user, a hospital must participate in both programs simultaneously; (3) we intend to publish Stage 2 meaningful use criteria for 2013; and (4) hospitals may initiate Medicaid incentive payments no later than 2016, and subsequent to 2016 may receive a Medicaid payment only if the hospital received an incentive payment in the year prior.

35. Which clinical quality measures are applicable to dentists?

Each dentist/oral surgeon would need to look at the clinical quality measures him/herself to determine which ones s/he has applicable patient populations in their certified EHR system.

36. Do FQHC sites have to meet the same 30% criteria for Medicaid? It states in one of the Power Points...Or if the Medicaid Eligible Provider practices predominantly in an FQHC or RHC - 30% "Needy Individuals" patient

volume threshold... What does this mean?

EPs may participate in this program if: 1) They meet Medicaid patient volume thresholds; or 2) They practice predominantly in an FQHC or RHC and have 30% needy individual patient volume. Please see the final rule preamble starting on page 44487 for an explanation of which eligible professionals could meet the required patient volume thresholds at FQHCs or RHCs. The definition of "needy individual" is included in the HITECH Act at 1903(t)(3)(F). It also is included in our regulations at 42 CFR 495.302.

37. How will we be required to show that we're meeting the Medicaid and/or Needy Thresholds of 30%?

Please see the preamble to the final rule, starting on page 44486, as well as our regulations on establishing patient volume at 42 CFR 495.306. States will need to propose one or more methods of calculating patient volume to CMS in their State Medicaid HIT Plans and would need to identify verifiable data sources available to the provider and/or the State. Many States are indicating that providers may attest and/or the State will use a data match and verify.

38. When calculating the Medicaid (or needy patient) threshold, are we looking at visits, or unique patients?

Please see the preamble to the final rule, starting on page 44486, as well as our regulations on establishing patient volume at 42 CFR 495.306. There are multiple definitions of encounter in terms of how it applies to the various requirements for patient volume (see 495.306(e)). Generally stated, the EP is looking at a patient encounter on any one day where Medicaid paid for all or part of the service or Medicaid paid for the co-pays, cost-sharing, or premiums for the encounter. The details are in the final rule and different requirements for EPs and hospitals and this same concept generally applies to needy individuals.

39. Does IHS have any managed care or the like to qualify for the panel threshold?

Yes, IHS has managed care and/or primary care patient panels. This is very common for clinics and group practices.

40. My first read of the Final Rule leads me to believe that calculations of needy patient volumes only apply to EPs practicing predominantly in FQHCs and/or RHCs. However, further review suggests "needy individual" may also apply to hospital patient volumes.

That is, section 495.306, Establishing Patient Volume, is clear that it applies to both EPs and Hospitals. Subsection 495.306(e) states, "For purposes of this section, the following rules apply:" It then goes on in number (1) to define EP encounters, in number (2) to define hospital encounters, and in number (3) for "calculating needy individual patient volume."

Both 495.306(c)(1), (2) & (3) and 495.306(e)(1), (2) & (3) seem to define "needy individual patient volume" as it would apply to both EPs and hospitals.

There is also a CMS Fact Sheet on the subject at the following website that implies the same conclusion:

http://www.cms.gov/apps/media/press/factsheet.asp?Counter=3793&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date

Under the heading Eligibility, the fact sheet states in paragraph 2, "[The Final Rule] specifies that eligible professionals and hospitals must meet patient volume thresholds, measured by a methodology selected by the state. The two options offered in the final rule include: 1) a ratio where the numerator is the total number of Medicaid patient encounters (or needy individuals) treated in any 90-day period in the previous calendar year and the denominator is all patient encounters over the same period..." Please advise if my reading of the needy individual patient volumes, as it applies to hospitals, is accurate.

It applies only to EPs practicing predominantly in an FQHC or RHC.

41. I would like more information on the Dental staff requirements for MU. Example - What measures would apply? Obviously CPOE, but what about the others? Is there a minimum that they need to meet? Example – 20 of 25.

Dentists must meet the same requirements as other eligible professionals in order to qualify for the EHR incentive payments under Medicaid. That means that they must demonstrate all 15 of the core meaningful use objectives and 5 from the menu set of their choosing. The core set includes reporting of a total of 6 clinical quality measures (3 core and 3 from the menu set of their choosing.)Several meaningful use objectives have exclusion criteria that are unique to each

objective. EPs will have to evaluate whether they individually meet the exclusion criteria for each applicable objective. There is not a blanket exclusion by type of EP.

42. What about "FQHC look-alike" tribal health programs? Are these programs exempt from the 30% Medicaid patient requirement in order to qualify for the EHR financial incentive?

See above for clarification on what types of clinics meet FQHC or RHC requirements. Eligible professionals working at FQHC look-alikes are considered the same as eligible professionals working at an FQHC/RHC. If they practice predominantly at that site, they must demonstrate 30% needy individual patient volume.

43. Who can enter medication orders in order to meet the measure for the computerized provider order entry (CPOE) Meaningful Use objective under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs? When must these medication orders be entered?

Any licensed healthcare professional can enter orders into the medical record for purposes of including the order in the numerator for the measure of the CPOE objective if they can originate the order per state, local, and professional guidelines. The order must be entered by someone who could exercise clinical judgment in the case that the entry generates any alerts about possible interactions or other clinical decision support aides. This necessitates that CPOE occurs when the order first becomes part of the patient's medical record and before any action can be taken on the order. Each provider will have to evaluate on a case-by-case basis whether a given situation is entered according to state, local, and professional guidelines, allows for clinical judgment before the medication is given, and is the first time the order becomes part of the patient's medical record.

44. If a provider purchases a Complete Electronic Health Record (EHR) but opts to use alternate certified EHR modules for certain Meaningful Use functionality, will that provider qualify as a Meaningful User under the Medicare and Medicaid EHR Incentive Programs?

To successfully demonstrate meaningful use a provider must do three things:

1. Have certified EHR technology capable of demonstrating meaningful use, either through a complete certified EHR or a combination of certified EHR modules;

2. Meet the measures or exclusions for 20 Meaningful Use objectives (19 objectives for eligible hospitals and Critical Access Hospitals (CAHs)); and

3. Meet those measures using the capabilities and standards that were certified to accomplish each objective.

If a provider can meet all of these requirements, that provider may qualify for an incentive payment under the Medicare and Medicaid EHR Incentive Programs.

45. One of the menu set Meaningful Use objectives for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs requires eligible hospitals and Critical Access Hospitals (CAHs) to incorporate clinical lab-test results into EHR as structured data. Must there be an explicit linking between structured lab results received into the EHR and the order placed by the physician for the lab test in order to count a structured lab result in the numerator for the measure of this objective?

The only requirement to meet the measure of this objective is that more than 40 percent of all clinical lab tests results ordered during the EHR reporting are incorporated in certified EHR technology as structured data. Provided the lab result is recorded as structured data and uses the standards to which certified EHR technology is certified, there does not need to be an explicit linking between the lab result and the order placed by the physician in order to count it in the numerator for the measure of this objective in the Medicare and Medicaid EHR Incentive Programs.

46. In order to satisfy the Meaningful Use objective for electronic prescribing in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, can providers use intermediary networks that convert information from the certified EHR into a computer-based fax for sending to the pharmacy? Should these transactions be included in the numerator for the measure of this objective?

The meaningful use measure for e-prescribing is the electronic transmission of 40 percent of all permissible prescriptions. If the EP generates an electronic prescription and transmits it electronically using the standards of certified EHR technology to either a pharmacy or an intermediary network, and this results in the prescription being filled without the need for the provider to communicate the prescription in an alternative manner, then the prescription would be included in the numerator.

47. Are payments from the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs subject to federal income tax?

We note that nothing in the Act excludes such payments from taxation or as tax-free income. Therefore, it is our belief that incentive payments would be treated like any other income. Providers should consult with a tax advisor or the IRS regarding how to properly report this income on their filings.

48. Under the Medicaid Electronic Health Record (EHR) Incentive Program, can States net or recoup public or private debts owed by the provider from these incentive payments before disbursing to the provider? Can the Centers for Medicare & Medicaid Services net or recoup federal debts from payments made under the Medicare EHR Incentive Program?

We believe that payments under the Medicare and Medicaid EHR Incentive Programs will be treated like all other income. The incentive payment legal authorities do not supersede any State or Federal laws requiring wage garnishment or debt recoupment. Therefore, if there is a legal

basis for the State or Federal government to net or recoup debts then we believe such authority would apply to incentive payments, just as it applies to all other income.

49. Do providers register only once for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, or must they register every year?

Providers are only required to register once for the Medicare and Medicaid EHR Incentive Programs. However, they must successfully demonstrate that they have either adopted, implemented or upgraded (first participation year for Medicaid) or meaningfully used certified EHR technology each year in order to receive an incentive payment for that year. Additionally, providers seeking the Medicaid incentive must annually re-attest to other program requirements, such as meeting the required patient volume thresholds. Providers will register using the Medicare and Medicaid EHR Incentive Program Registration & Attestation System, a web-based system. Providers who have elected to participate in the Medicare EHR Incentive Program will also use this system to attest to their program eligibility and meaningful use. Providers who select the Medicaid EHR Incentive Program will demonstrate their eligibility and attest via their State Medicaid Agency's system. If any basic registration information changes, the provider will need to update their information in the Medicare and Medicaid EHR Incentive Program Registration & Attestation System.

50. For large practices, will there be a method to register all of the Eligible Professionals (EPs) at one time for the Medicare or Medicaid Electronic Health Record (EHR) Incentive Programs?

At this time there is no method available to register multiple EPs via a single transaction for the Medicare and Medicaid EHR Incentive Programs. Each EP will have to register separately.

51. One of the measures for the core set of clinical quality measures for eligible professionals (EPs) is not applicable for my patient population. Am I excluded from reporting that measure for the Medicare or Medicaid Electronic Health Record (EHR) Incentive Programs?

An eligible professional (EP) is not excluded from reporting core clinical quality measures. However, zero is an acceptable value to report for the denominator of a clinical quality measure if there is no patient population within the EHR to whom that clinical quality measure applies. If an EP reports a zero denominator for one of the core measures, then the EP is required to report results for up to three alternate core measures (possibly reporting denominators of 0 for all three alternate core measures). We refer readers to pp. 44409-10 of the preamble to our final rule for our discussion of this issue.

52. Can I use the electronic specifications for clinical quality measures to satisfy both the Physician Quality Reporting Initiative (PQRI) and the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

No. Each program has specific specifications for reporting. In the future CMS expects to harmonize specifications between PQRI and the Medicare and Medicaid EHR Incentive Programs. Therefore if a provider is reporting under the PQRI EHR program, they must refer to the PQRI EHR specifications found at

http://www.cms.gov/PQRI/20_AlternativeReportingMechanisms.asp. Providers are required to report using the specifications for clinical quality measures found at http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage.

53. I am an eligible professional (EP) for whom none of the core, alternate core, or additional clinical quality measures adopted for the Medicare and Medicaid Electronic Health Record (EHR) incentive programs apply. Am I exempt from reporting on all clinical quality measures?

In the event that none of the 44 clinical quality measures applies to an EP's patient population, the EP is still required to report a zero for the denominators for all six of the core and alternate core clinical quality measures. If all of the remaining 44 clinical quality measures included in Table 6 of our final rule do not apply to the EP, then the EP is still required to report on at least three of the additional clinical quality measures of their choosing from Table 6 of the final rule (other than the six core/alternative core measures). If the EP reports zero values for these three additional, menu-set clinical quality measures, then for the remaining menu-set clinical quality measures, the EP will also have to attest that all the other menu-set quality measures calculated by the certified EHR technology have a value of zero in the denominator. In other words, the EP is required is required to try to find at least three measures in the menu set for which the denominator is other than zero. If s/he cannot, then the EP must still choose three menu-set measures on which to report. S/he may report zero denominators for some or all of these measures, but must accompany such "zero denominator" reporting with an attestation that all of the other menu-set measures calculated by the certified EHR technology have a value of zero in the denominator. A zero report in the menu-set is not sufficient without such accompanying attestation. We refer readers to page 44410 of the preamble to the final rule.

54. If the denominators for all three of the core clinical quality measures are zero, do I have to report on the additional clinical quality measures for eligible professionals (EPs) under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

If the denominator value for all three of the core clinical quality measures is zero, an EP must report a zero denominator for all such core measures, and then must also report on all 3 alternate core clinical quality measures. If the denominator value for all three of the alternate core clinical quality measures is also '0,' an EP still needs to report on 3 additional clinical quality measures. Zero is an acceptable denominator provided that this value was produced by certified EHR technology. Please see the above Q & A for a discussion of zero denominator reporting in the menu set.

55. For eligible hospitals and critical access hospitals (CAHS) under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, will the clinical quality measure results be calculated similar to the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program?

No. For all clinical quality measures reported for the Medicare and Medicaid EHR Incentive Programs, the certified EHR must report the numerator, denominator, and exclusion results. Providers will report their aggregate results for clinical quality measures during attestation to CMS or the States.

56. When can eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) begin to attest to meaningful use of certified electronic health record (EHR) technology for the purposes of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program?

The earliest an EP, eligible hospital, or CAH can attest to CMS that they have demonstrated meaningful use of certified EHR technology under the Medicare EHR Incentive Program is April 2011. Participants under the Medicaid EHR Incentive Program should check with their State to find out when they can begin participation. Under the Medicaid EHR Incentive Program, providers can attest that they have adopted, implemented, or upgraded certified EHR technology in their first year of participation to receive an incentive payment.

57. How are the various reporting periods (Medicaid Volume, EHR investment & Meaningful Use) affected if the EP skips a year or takes longer than 12 months between registrations?

Regardless of when the previous incentive payment was made, the following reporting periods apply:

- For patient volume, an EP should use any continuous, representative 90-day period in the prior calendar year.
- For demonstrating it is a meaningful EHR user, the EP should use the EHR reporting period associated with that payment year (for the first payment year that an EP is demonstrating meaningful use the reporting period is a continuous 90-day period within the calendar year; for subsequent years the period is the full calendar year).
- For ensuring that an eligible professional is responsible for 15% of NAAC, the State uses the payment year. For example, if an EP expended $5,000 in 2007 on an EHR and spends $2,000 in 2010 for the newly certified version, his/her total costs would be $7,000. As the rule indicates that an EP must demonstrate 15% of the NAAC, which for the first participation year is $3,750, that EP would have clearly met that requirement. However, the EP cannot “carry-over” from year to year, and must demonstrate that s/he has met the 15% of the NAAC for each year. So, for participation years 2-6, the EP would need to attest to the State that they have expended at least $1500 towards their meaningful use of certified EHR technology. We provide examples in the preamble of the final rule (75 FR 44492-4), such as health information exchange transaction fees/monthly dues; costs associated with internet access; computer hardware; additional software upgrades; training/technical assistance fees, etc.

58. Please clarify what the reference point is for the "preceding year." Is it the year preceding the payment year? For example, if the Medicaid EP's payment year is CY 2013, then the applicable year for the volume determination is a representative 90-day time period in CY 2012? Or, is it the year preceding when the provider is making the attestation -- therefore, the applicable year for the volume determination could actually be the payment year? So, following the above example, say it's the EP's 3rd payment year in CY 2013, therefore the EP is coming into the State sometime in 2014 to attest they have met Meaningful Use for the entirety of CY 2013.

Then, the applicable year for the volume determination is a representative 90-day time period in CY 2013.

For EPs, "the preceding year" means the calendar year preceding the payment year. For eligible hospitals, it is the Federal fiscal year preceding the payment year. The example given is incorrect. The third payment year for the EP is CY 2013, and the EP demonstrates it is a meaningful EHR user for that entire calendar year. The 90-day period associated with Medicaid patient volume derives from CY 2012.

59. Our State's Medicaid legal department has explained that their opinion is that only active Medicaid patients can have their health information made available through the health information exchange. This may be a very conservative view of the regulations and hampers the ability for providers to have accurate information at the time of treatment for those persons who have been enrolled in Medicaid but are not current patients. It would be most helpful if providers were able to see treatment history on all patients. Can you tell me if this is an accurate interpretation of the legislation?

Health Information Exchange Organizations with business associate agreements with providers can ask Medicaid to disclose records for those currently being treated by that provider.

60. CMS has said a number of times that in order to use the 90/10 EHR Incentive Payment Program planning dollars for projects that aren't 100% Medicaid, there needs to be cost allocation (collaboration with HIE, etc.). If a state wants to create an "EHR light" for all providers that are Medicaid eligible providers, both those that qualify for EHR incentive and those that don't, wouldn't that be a project for which the state could use its 90/10 FFP?

The 90/10 HITECH administrative funding is meant to directly correlate to and support the success of the Medicaid EHR Incentive Program. In order to qualify for an EHR Incentive payment, a provider must use certified EHR technology capable of meeting Meaningful Use. An "EHR light" would not meet that requirement. Therefore, use of the 90/10 funds to develop and offer such a product would be questionable strategically for Medicaid purposes, and in terms of appropriate use of the funds in a manner consistent with the statute. This is aside from the cost allocation issue.

61. We would like clarification on Enclosure C - Guiding Principles for Use of the CMS 90 Percent Administrative Matching Funds for the Medicaid EHR Incentive Program (State Medicaid Directors Letter). If a shared solution for HIE is built outside of the Medicaid Agency, it would appear that the Medicaid Agency would be limited to 50% FFP for its share of the development and operating costs, based upon current MMIS FFP rules. Enclosure C indicates CMS will consider 90 percent FFP to support the creation of the HIE as a direct accelerant to the success of the State's Medicaid EHR incentive program. Assuming that the request excludes

activities funded by ONC or other technical assistance efforts, and that the expenditures are subject to a cost allocation formula across all payers, can the HITECH 90% FFP be used to participate in the creation of a HIE that is not directly administered by Medicaid?

It depends upon whether the HIE solution is using MMIS funding or HITECH funding. Governance only is relevant under the MMIS regulations, as it pertains to determining the matching rate. We encourage States to talk to CMS about their ideas in draft, informally so that we can give a more State-specific response around appropriate funding and matching rates, etc.

62. While CAHs must have an average length of stay of 96 hours or fewer in order to be certified as a CAH, many CAHs also have acute care/NF swing bed days that could increase the average. Can CAHs exclude swing-bed days from the average length of stay if this is consistent with how they complete the Cost Report?

Yes. Since acute care hospitals must have an average length of stay of 25 days or fewer, CAHs may exclude these swing bed or NF days. This should be consistent with how they complete the Cost Report.

63. If hospitals are eligible for both the Medicaid and Medicare incentive programs, where do dual eligibles fit? Are they counted in both programs, or do facilities need to select one program or another in which to count them?

For purposes of calculating the Medicaid share, a patient cannot be counted in the numerator if they would count for purposes of calculating the Medicare share. Thus, in this respect the inpatient bed day of a dually eligible patient could not be counted in the Medicaid share numerator. (See 1903(t)(5)(C), stating that the numerator of the Medicaid share does not include individuals "described in section 1886(n)(2)(D)(i).") In other respects; however, the patient would count twice. For example, in both cases, the individual would count in the total discharges of the hospital.

64. Can a federally-owned IHS facility qualify as an eligible hospital under ARRA Section 4201?

Acute care hospitals under Medicaid (4201) must:

- Have an average length of stay of 25 days or fewer; AND
- The last four digits of their CMS Certification Number (CCN) must be 0001-0879 or 1300-1399.

We do not think that IHS-owned hospitals meet the certification requirements to have a CCN in these ranges, but reference should be made to the certification or conditions of participation (see 42 CFR Part 482). Hospitals know if they meet this requirement. Additionally, such facilities would need to have 10% Medicaid patient volume.

65. Can a qualifying EP who is an employee of a federally-owned IHS facility (other than a tribally-owned facility or FQHC) assign his/her incentive payment to the federally-owned facility in the same way as other EPs?

Yes, so long as all other requirements are met. Please see 495.10(f) of our final rule for the reassignment provisions. The passage below is from Medicare, but the same concept applies to Medicaid and Medicare incentives.

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Comment: One commenter representing American Indian and Alaska Native health providers urged CMS to require that the HITECH/EHR Meaningful Use provider incentive payments be reassigned to the Tribal outpatient clinics, because the Tribal clinics developed the infrastructure not the EPs themselves, and purchased electronic medical record systems to complement the current Registration Patient Management Systems (RPMS) of the Indian Health Service. In addition, the commenter noted that many tribal outpatient clinics have employment contracts with their EPs. Thus, the commenters urged CMS to require that incentive EHR payments should be included in employment contracts to help protect the EP as employee and the Tribe as the employer. Response: As stated above, section 1848(o)(1)(A) of the Act provides that the EP's incentive payment shall be paid to the eligible professional (or to an employer or other entity with which the physician has a valid contractual arrangement allowing the employer or other entity to bill for the physician's services). We recognize that some tribes purchased EHR systems based upon criteria established by the Indian Health Service. However, after careful consideration, we believe that the same standards concerning the incentive payments should apply. The EP and the Tribal outpatient clinic should jointly resolve whether the EP's EHR incentive payment will be reassigned to the Tribal outpatient clinic or made directly to the EP. Similarly, any decision by the Tribal outpatient clinic concerning whether to include language in its employment contract (or in the alternative, whether any pre-existing contract already requires reassignment of the payment), is a matter of contract interpretation that should be resolved by the parties themselves. This discussion is also addressed in the Medicaid section of this rule at II.D.4.a.3.

66. CMS proposed that to demonstrate an eligible hospital or CAH is a meaningful EHR user, the eligible hospital or CAH would be required to electronically submit information on each clinical quality measures for each patient to whom the clinical quality measure applies, regardless of payer, discharged from the hospital during the EHR reporting period and for whom the clinical quality measure is applicable. Is this still applicable and does this mean that a hospital is required to report quality metrics on ALL patients and if so, then how will the measurement be defined with regards to numerator/denominator?

The technical specifications issued by CMS for the clinical quality measures specify what data should be included in the numerator and the denominator. Yes, it is inclusive of all applicable patients or actions during the EHR reporting period, with no differentiation by payer.

67. We are hopeful that CMS might develop a template that could be used by all states for purposes of provider attestation that he/she has contributed 15% of the cost of the EHR. Similarly, we would like to see CMS develop a template

for purposes of provider attestation concerning any cash payments received for purchase of an EHR.

We agree that these templates would be useful and plan to have them produced by the end of CY 2010 at the latest.

68. Will the requirement that EPs and Hospitals choose at least one public health objective still apply to those states that ask CMS for approval to change the definition of Meaningful Use? That is, if a state wants to require Immunization reporting, is the provider still required to choose another public health objective or does the new Meaningful Use definition in that state supersede the general definition?

If the State required any of the public health measures as core measures, then that would fulfill the eligible provider's requirement to select at least one public health measure. If the eligible provider meets the exclusion criteria for any of the public health measures that a State has moved to the core set, with CMS approval, they would still have to select one public health measure from the menu set.

69. As I understand it, states will need to include the new definition of Meaningful Use in the State Medicaid HIT Plans. I have heard they are due November 1st. Is this true for all states or does it depend on HHS region or some other criteria?

There is no due date for State Medicaid HIT Plans. States are implementing their Medicaid EHR Incentive Programs on a rolling basis. The SMHPs are therefore expected to be iterative, as States implement their programs incrementally, especially in the early years. Yes, if a State wishes to request flexibility with the definition of Meaningful Use, to the extent permissible under the final rule, they would do so via their SMHP.

70. I heard you give criteria for how CMS should grant the request to include public health objectives. I believe they included having the public health infrastructure, the ability to implement it evenly across the state. Were there any others and have you put out any guidance on this yet?

Just what is in the final rule, on page 44325 of the preamble. CMS will need to assess each request on a case-by-case basis, depending upon that State's situation.

71. What are CMS expectations for how states will audit provider attestation concerning any cash payments received for purchase of an EHR? The final rules specifically indicate that states will be expected to audit this issue. If the provider attests, for example, that they did not receive any cash payment for purchase of an EHR, how would we audit such an attestation? Does CMS expect providers to make their financial records available to the state? If so, providers will need to be alerted to this at the point in time they sign up for

the program. This is clearly a very different matter than making information from their appointment scheduling system and/or EHR available to the State upon audit. And, even if the intent is for the state to audit the provider's financial records, I'm not sure a cash payment for an EHR would be readily identifiable.

CMS expects that States will design their audit strategies using a risk-based approach that identifies audit elements and/or providers that are at highest risk for fraud, waste, or abuse. Some audit elements should be examined pre-payment and others based upon a sampling strategy or other triggers, in a post-payment fashion. We agree that this would be a complex item to verify.

In light of the more common eligibility requirements for the incentive, States will need to determine how they prioritize verifying that a provider truthfully attested if s/he received any cash payments from sources other than employer, state or local, towards their costs for certified EHR technology.

72. If a State has a team of 6-7 staff who will be administering the Medicaid incentive payment program from 2011-2021 (answering provider questions, reporting and analysis, assisting providers with eligibility and verifying provider eligibility, appeals, etc.) would there be 90% FFP for this team on an ongoing basis (2011-2021) once we receive approval from CMS on our IAPD and SMHP?

Yes. If they are not working full-time on the EHR Incentive Program, however, their salaries would need to be cost-allocated appropriately.

73. Is there an IAPD model checklist similar to the HIT PAPD checklist that can be provided to States?

No. The content is specified in the August 17th State Medicaid Directors letter.

74. If the state wants to use its REC to comply with some of the SMHP/IAPD requirements (education and outreach, etc.) and the REC already is doing this as part of its function, what type of documentation does CMS want to see from the state regarding its collaboration with the REC in the SMHP/IAPD? Do they want a formal MOU or other legal document or something less formal, like documentation or a statement from the REC outlining their assistance?

It would be helpful to provide a copy of the actual documents that outline the roles and deliverables.