



Electronic Health Record (EHR)

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I. Questions about Getting Started

EHR Incentive Programs 101

1) How will eligible professionals (EPs) and eligible hospitals apply for incentives under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program?

Registration for the Medicare and Medicaid EHR Incentive Program is open and available online at <https://ehrincentives.cms.gov>. Please note that while most Medicaid EHR Incentive Programs are accepting registrations, launch dates will vary by State. Information on when registration will be available for Medicaid EHR Incentive Programs in specific States is posted at http://www.cms.gov/EHRIncentivePrograms/40_MedicaidStateInfo.asp.

Date Updated: 9/23/2012

New ID #2633 Old ID #9814

2) If a hospital is eligible to participate in both the Medicare and Medicaid EHR Incentive Programs, how should they register?

If your hospital meets all of the following qualifications, it is dually-eligible for the Medicare and Medicaid EHR Incentive Programs:

- You are a subsection(d) hospital in the 50 U.S. States or the District of Columbia, or you are a Critical Access Hospital (CAH); and
- You have a CMS Certification Number ending in 0001-0879 or 1300-1399; and
- You have 10% of your patient volume derived from Medicaid encounters.

If your hospital falls into this category, you must register for "Both Medicare & Medicaid" when registering for the program. Please select your state from the drop-down menu on the registration screen. If your state's program has not yet launched at the time of your registration, your file will be placed into a pending status (which means you cannot complete the eligibility verification or get paid) until your state's program launches. For a list of expected program launch dates, please go to <http://www.cms.gov/apps/files/statecontacts.pdf>.

Date Updated: 4/26/2011

New ID #2961 Old ID #10317

3) Do I need to have an electronic health record (EHR) system in order to register for the Medicare and Medicaid EHR Incentive Programs?

You do not need to have a certified EHR in order to register for the Medicare and Medicaid EHR Incentive Programs. However, to receive an incentive payment under the Medicare program, you must attest that you have demonstrated meaningful use of certified EHR technology during the EHR reporting period. For the first year of payment, the EHR reporting period is 90 consecutive days within the calendar year

for eligible professionals (EPs) or within the Federal fiscal year for eligible hospitals and critical access hospitals (CAHs).

With regard to the Medicaid EHR Incentive program, for the first year of payment, EPs and hospitals must have adopted, implemented, upgraded certified EHR technology before they can receive an EHR incentive payment from the State. As an alternative to demonstrating that they have adopted, implemented or upgraded certified EHR technology, for the first year of payment, the EP or hospital may demonstrate that they are meaningful users of certified EHR technology for the 90-day EHR reporting period.

Date Updated: 2/17/2011

New ID #2791 Old ID #10083

4) What is meaningful use, and how does it apply to the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

Under the Health Information Technology for Economic and Clinical Health (HITECH Act), which was enacted under the American Recovery and Reinvestment Act of 2009 (Recovery Act), incentive payments are available to eligible professionals (EPs), critical access hospitals (CAHs), and eligible hospitals that successfully demonstrate are meaningful use of certified EHR technology.

The Recovery Act specifies three main components of meaningful use:

- The use of a certified EHR in a meaningful manner (e.g.: e-Prescribing);
- The use of certified EHR technology for electronic exchange of health information to improve quality of health care;
- The use of certified EHR technology to submit clinical quality and other measures.

In the Stage 1 final rule Medicare and Medicaid EHR Incentive Program, CMS has defined first stage of meaningful use.

To view the Stage 1 final rule, please visit:

<http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

In August 2012, CMS issued a final rule that outlines the criteria that EPs, eligible hospitals and CAHs must meet for Stage 2.

To view the Stage 2 final rule, please visit:

[http://www.ofr.gov/\(X\(1\)S\(uzclbwrx5fwqm2w2mipkysrh\)\)/OFRUpload/OFRData/2012-21050_PI.pdf](http://www.ofr.gov/(X(1)S(uzclbwrx5fwqm2w2mipkysrh))/OFRUpload/OFRData/2012-21050_PI.pdf)

Date Updated: 9/23/2012

New ID #2793 Old ID #10084

5) Where can I get answers to my privacy and security questions about electronic health records (EHRs)?

Last Updated: January, 2015

The Office for Civil Rights (OCR) is responsible for enforcing the Privacy and Security rules related to the HITECH program. More information is available at OCR's website at <http://www.hhs.gov/ocr/>.

Date Updated: 2/17/2011

New ID #2807 Old ID #10092

6) 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 attest that they have either adopted, implemented or upgraded (first participation year for Medicaid), or successfully demonstrated meaningful use of 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.

Date Updated: 9/23/2012

New ID #2861 Old ID #10140

7) If an eligible provider (EP) practices at an outpatient location, a location other than an inpatient (place of service 21) or emergency department (place of service 23), and that location is only equipped with Certified Electronic Health Records (EHR) Technology certified to the criteria applicable to an inpatient setting, must the EP include that location in their meaningful use calculations?

No, this location is not equipped with Certified EHR Technology with all the capabilities necessary for an EP to satisfy the meaningful use objectives and measures. Accordingly, this location (like all outpatient locations) would be in the denominator of the calculation to determine whether the EP's outpatient encounters meet the 50 percent threshold, but not in the numerator as the location is not equipped with Certified EHR Technology. Also the location would not be included in the calculations of the EP's meaningful use measures in either the denominator or the numerator.

However, an EP can consider the location equipped with Certified EHR Technology if they have access to Certified EHR Technology certified to the criteria applicable to an ambulatory setting, which fills the gaps between inpatient and ambulatory.

FAQ#3077 explains access to Certified EHR Technology, and ONC FAQ #6-12-025-2 outlines the gaps between inpatient and ambulatory Certified EHR Technology.

If the EP chooses to equip the location with Certified EHR Technology with the applicable criteria, the EP must then include that location in all calculations including both the 50 percent threshold calculation and the meaningful use measures calculations.

Date Updated: 10/23/2013

New ID#7811 Old ID# N/A

Payment Questions

8) Can eligible professionals (EPs) receive electronic health record (EHR) incentive payments from both the Medicare and Medicaid programs?

Not for the same year. If an EP meets the requirements of both programs, they must choose to receive an EHR incentive payment under either the Medicare program or the Medicaid program. After a payment has been made, the EP may only switch programs once before 2015.

Date Updated: 7/30/2010

New ID #2621 Old ID #9808

9) What if my electronic health record (EHR) system costs much more than the incentive the government will pay? May I request additional funds?

The Medicare and Medicaid EHR Incentive Programs provide incentives for the meaningful use of certified EHR technology. Under the Medicaid program, there is also an incentive for the adoption, implementation, or upgrade of certified EHR technology in the first year of participation. The incentives are not a reimbursement of costs, and maximum payments have been set.

Date Updated: 7/30/2010

New ID #2629 Old ID #9812

10) Do recipients of Medicare or Medicaid electronic health record (EHR) incentive payments need to file reports under Section 1512 of the American Recovery and Reinvestment Act of 2009 (Recovery Act)? Section 1512 of the Recovery Act outlines reporting requirements for use of funds.

No. The Medicare and Medicaid EHR incentive payments made to providers are not subject to Recovery Act 1512 reporting because they are not made available from appropriations made under the Act; however, the Health Information Technology for Clinical and Economic Health (HITECH) Act does require that information about eligible professionals (EPs), eligible hospitals and CAHs participating in the Medicare fee-for-service (FFS) or Medicare Advantage (MA) EHR incentive programs be posted on our website.

Date Updated: 2/17/2011

New ID #2775 Old ID #10073

11) How much are the Medicare and Medicaid Electronic Health Record (EHR) incentive payments to eligible professionals (EPs)?

Under the Medicare EHR Incentive Program, EPs who demonstrate meaningful use of certified EHR technology can receive up to a total of \$44,000 over 5 consecutive years. Additional incentives are available for Medicare EPs who practice in a Health Provider Shortage Area (HPSA) and meet the maximum allowed charge threshold. Under the Medicaid EHR Incentive Program, EPs can receive up to a total \$63,750 over the 6 years that they choose to participate in program. EPs may switch once between programs after a payment has been made and only before 2015.

Date Updated: 2/17/2011

New ID #2803 Old ID #10089

12) Are there any special incentives for rural providers in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

Under the Medicare EHR Incentive Program, the maximum allowed charge threshold for the annual incentive payment limit for each payment year will be increased by 10 percent for eligible professionals (EPs) who predominantly furnish services in a rural or urban geographic Health Professional Shortage Area (HPSA). Critical access hospitals (CAHs) can receive an incentive payment amount equal to the product of its reasonable costs incurred for the purchase of certified EHR technology and the Medicare share percentage. Under the Medicaid EHR Incentive Program, there are no additional incentives for rural providers, beyond the incentives already available.

Date Updated: 2/17/2011

New ID #2805 Old ID #10090

13) How and when will incentive payments for the Medicare Electronic Health Record (EHR) Incentive Programs be made?

For eligible professionals (EPs), incentive payments for the Medicare EHR Incentive Program will be made approximately eight to twelve weeks after an EP successfully attests that they have demonstrated meaningful use of certified EHR technology. However, EPs will not receive incentive payments within that timeframe if they have not yet met the threshold for allowed charges for covered professional services furnished by the EP during the year. Payments will be held until the EP meets the threshold in allowed charges for the calendar year (\$24,000 in the EP's first year) in order to maximize the amount of the EHR incentive payment they receive. Medicare EHR incentive payments are based on 75% of the estimated allowed charges for covered professional services furnished by the EP during the entire calendar year. If the EP has not met the threshold in allowed charges by the end of calendar year, CMS expects to issue an incentive payment for the EP in March of the following year (allowing two months after the end of the calendar year for all pending claims to be processed).

Payments to Medicare EPs will be made to the taxpayer identification number (TIN) selected at the time of registration, through the same channels their claims payments are made. The form of payment (electronic funds transfer or check) will be the same as claims payments.

Bonus payments for EPs who practice predominantly in a geographic Health Professional Shortage Area (HPSA) will be made as separate lump-sum payments no later than the end of the calendar year following the year in which the EP was eligible for the bonus payment.

Medicare EHR incentive payments to eligible hospitals and critical access hospitals (CAHs) will also be made approximately four to eight weeks after the eligible hospital or CAH successfully attests to having demonstrated meaningful use of certified EHR technology. Eligible hospitals and CAHs will receive an initial payment and a final payment. Final payment will be determined at the time of settling the hospital cost report. CAHs will be paid after they submit their reasonable cost data to their Medicare Administrative Contractor (MAC).

Please note that the Medicaid incentives will be paid by the States, but the timing will vary according to State. Please contact your State Medicaid Agency for more details about payment.

Date Updated: 2/26/2013

New ID #2899 Old ID #10160

14) 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 Internal Revenue Service regarding how to properly report this income on their filings.

Date Updated: 9/24/2010

New ID #2859 Old ID #10138

15) In order to receive payments under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, does a provider have to be enrolled in the Provider Enrollment, Chain, and Ownership System (PECOS)?

In order to receive Medicare EHR incentive payments, EPs, eligible hospitals, and critical access hospitals must have an enrollment record in PECOS with an APPROVED status. Medicaid EPs do not have to be in PECOS. It is possible to receive payment for Medicare claims and not be in approved status. We encourage all providers to verify their status as soon as possible.

There are three ways to verify that you have an enrollment record in PECOS:

1. Check the Ordering Referring Report on the CMS website. If you are on that report, you have a current enrollment record in PECOS. Go to <http://www.cms.gov/MedicareProviderSupEnroll/>, click on "Ordering Referring Report" on the left.
2. Use Internet-based PECOS to look for your PECOS enrollment record. If no record is displayed, you do not have an enrollment record in PECOS. Go to <http://www.cms.gov/MedicareProviderSupEnroll/>, click on "Internet-based PECOS" on the left.
3. Contact your designated Medicare enrollment contractor and ask if you have an enrollment record in PECOS. Go to <http://www.cms.gov/MedicareProviderSupEnroll/>, click on "Medicare Fee-For-Service Contact Information" under "Downloads."

If you are not in PECOS, the best way to submit your application is through internet-based PECOS. For more information go to:
http://questions.cms.hhs.gov/app/answers/detail/a_id/10038/kw/pecos/session/L3NpZC9qeG1GdDliaw%3D%3D

Indian Health Service (IHS) providers who submit a paper CMS-855 will have their enrollment information entered into PECOS.

Date Updated: 8/23/2012

New ID #2887 Old ID #10154

16) For the Medicare Electronic Health Record (EHR) Incentive Program, how are incentive payments determined for eligible professionals practicing in a Health Professional Shortage Area (HPSA)?

Health Professional Shortage Area (HPSA) refers to an area determined to have a shortage of health professional(s). Medicare eligible professionals (EPs) participating in the EHR Incentive Program who predominantly furnish services in a geographic HPSA are entitled to an incentive payment limit increase for each payment year. In the Medicare EHR Incentive Program, an EP is considered eligible for the HPSA incentive if more than 50% of his or her covered professional services (e.g., Medicare Part B payments) are furnished in an area that is determined to be a geographic HPSA as of December 31st of the prior year.

Per the statute and the final rule, EPs who predominately furnish their services in a geographic HPSA and who have received the maximum non-HPSA incentive payment have their annual EHR incentive payment limit increased by 10%. The calculated allowed charge amount of the incentive payment for an EP who has predominantly furnished services in a geographic HPSA is 75% of the total allowed charges minus the non-HPSA incentive payment amount.

The EP who has predominantly furnished services in a geographic HPSA will earn a HPSA payment incentive of either the full payment increase amount or the calculated total allowed charge amount, whichever is the lesser amount.

EXAMPLE:

For 2011, if an EP who has predominantly furnished services in a geographic HPSA receives the maximum non-HPSA incentive payment of \$18,000, the will receive a payment limit increase of \$1,800.

Scenario 1: If this EP has \$30,000 in total allowed charges for 2011, their calculated allowed charge amount would be \$4,500. This amount exceeds the full payment increase amount of \$1,800. Therefore, the EP will receive HPSA incentive payment of \$1800.

Scenario 2: If this EP has \$25,000 in total allowed charges for 2011, their calculated allowed charge amount would be \$750. This amount is less than the full payment increase amount of \$1,800. Therefore, the EP will receive the calculated allowed charge amount of \$750.

Scenario 3: If this EP has \$20,000 in total allowed charges for 2011, their calculated allowed charge amount would be less than \$0. This amount is less than the full payment increase amount of \$1,800. Therefore, the EP will not receive a HPSA incentive payment.

In 2011 CMS made the HPSA eligibility determination using the provider's office location rather than the place of service for each individual claim. Payments for 2012 and later will use the place of service in the line item claim to determine HPSA eligibility.

Date Updated: 2/7/2013

New ID #7733 Old ID N/A

Other Getting Started Questions

17) Can eligible professionals (EPs) allow another person to register or attest for them?

Yes. Users registering or attesting on behalf of an EP must have an Identity and Access Management System (I&A) web user account (User ID/Password) and be associated to the EP's NPI. If you are working on behalf of an EP(s) and do not have an I&A web user account, please visit

<https://nppes.cms.hhs.gov/NPPES/IASecurityCheck.do> to create one.

Date Updated: 4/22/2011

New ID#3169 Old ID #10565

18) Is there an assumption or expectation from CMS that States identify local Regional Extension Centers (RECs) as adoption entities for the Medicaid EHR Incentive Program?

States are not required to identify RECs as EHR adoption entities. Under the Medicaid EHR Incentive Program, it is entirely up to States to determine who they wish to designate as a permissible adoption entity, if any, in accordance with CMS regulations at 495.310(k) and 495.332(c)(9). It is entirely voluntary for an eligible professional to choose to reassign his/her incentive payments to a State-designated adoption entity.

Date Updated: 3/28/2011

New ID #3097 Old ID #10521

19) Do providers have to contribute a minimum dollar amount toward their certified EHR technology for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

There is no general requirement under the Medicare and Medicaid EHR Incentive Programs for providers to contribute a minimum dollar amount toward the certified EHR technology that they use.

The Medicare and Medicaid EHR Incentive Programs provide incentives to eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) for the meaningful use of certified EHR technology. Under the Medicaid program, EPs and eligible hospitals may receive an incentive for the adoption, implementation, or upgrade of certified EHR technology in their first year of participation. The incentives are not a reimbursement of costs, and providers are not required to contribute a minimum amount toward the purchase or maintenance of their certified EHR technology in order to participate in the EHR Incentive Programs.

In addition, physicians must comply with the Physician Self-Referral Law, commonly referred to as the "Stark Law." Under the EHR exception to the Stark Law, physicians who receive a donation of EHR items and services from a DHS entity must satisfy each element of the exception at 42 CFR 411.357(w), which includes paying 15 percent of the donor's cost for the items and services.

Date Updated: 10/20/2011

New ID #3603 Old ID #10840

20) Can providers participating in the Medicare or Medicaid EHR Incentive Programs update their information (for example, if an address was mistakenly entered)? If so, will the State receive an update or full refresh of this information for its Medicaid EHR Incentive Program?

Yes, providers who have registered for the Medicare or Medicaid EHR Incentive Programs may correct errors or update information through the registration module on the CMS registration website (<https://ehrincentives.cms.gov/hitech/login.action>). The updated registration information will be sent to the State.

Date Updated: 3/28/2011

New ID #3087 Old ID #10516

21) How will I attest for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

Medicare eligible professionals and eligible hospitals will have to demonstrate meaningful use through CMS' web-based Medicare and Medicaid EHR Incentive Program Registration and Attestation System. In the Registration and Attestation System, providers will fill in numerators and denominators for the meaningful use objectives and clinical quality measures, indicate if they qualify for exclusions to specific objectives, and legally attest that they have successfully demonstrated meaningful use. Once providers have completed a successful online submission through the Attestation System, they will qualify for a Medicare EHR incentive payment. The Attestation System for the Medicare EHR Incentive Program will open in April. CMS plans to release additional information about the attestation process soon.

For the Medicaid EHR Incentive Program, providers will follow a similar process using their State's Attestation System. Check here to see states' scheduled launch dates for their Medicaid EHR Incentive Programs: <http://www.cms.gov/apps/files/medicaid-HIT-sites/>.

Date Updated: 5/4/2012

New ID #3059 Old ID #10463

22) 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? Can EPs allow another person to register or attest for them?

In April 2011, CMS implemented functionality that allows an EP to designate a third party to register and attest on his or her behalf. To do so, users working on behalf of an EP must have an Identity and Access Management System (I&A) web user account (User ID/Password) and be associated to the EP's NPI.

If you are working on behalf of an EP(s) and do not have an I&A web user account, please visit <https://nppes.cms.hhs.gov/NPPES/IASecurityCheck.do> to create one. States will not necessarily offer the same functionality for attestation in the Medicaid EHR Incentive Program. Check with your State to see what functionality will be offered.

Date Updated: 4/18/2011

New ID #2863 Old ID #10141

23) How will the public know who has received EHR incentive payments under Medicare and Medicaid EHR Incentive Program?

As required by the American Recovery and Reinvestment Act of 2009, CMS will post the names, business addresses, and business phone numbers of all Medicare eligible professionals, eligible hospitals and critical access hospitals (CAHs) that receive EHR incentive payments. There is no such requirement for CMS to publish information on

eligible professionals and eligible hospitals receiving Medicaid EHR incentive payments, though individual States may opt to do so.

To view a list of eligible professionals, eligible hospitals, and CAHs that have received Medicare EHR Incentive Payments, please http://www.cms.gov/EHRIncentivePrograms/56_DataAndReports.asp. We expect to update this list on a quarterly basis.

Date Updated: 11/14/2011

New ID #2635 Old ID #9815

24) How does CMS define Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) for the purposes of the Medicaid EHR Incentive Program?

The Social Security Act at section 1905(l)(2) defines an FQHC as an entity which, "(i) is receiving a grant under section 330 of the Public Health Service Act, or (ii) (I) is receiving funding from such a grant under a contract with the recipient of such a grant and (II) meets the requirements to receive a grant under section 330 of the Public Health Service Act, (iii) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, and is determined by the Secretary to meet the requirements for receiving such a grant including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity; or (iv) was treated by the Secretary, for purposes of Part B of title XVIII, as a comprehensive Federally-funded health center as of January 1, 1990, and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act for the provision of primary health services."

RHCs are defined as clinics that are certified under section 1861(aa)(2) of the Social Security Act to provide care in underserved areas, and therefore, to receive cost-based Medicare and Medicaid reimbursements.

In considering these definitions, it should be noted that programs meeting the FQHC requirements commonly include the following (but must be certified and meet all requirements stated above): Community Health Centers, Migrant Health Centers, Healthcare for the Homeless Programs, Public Housing Primary Care Programs, Federally Qualified Health Center Look-Alikes, and Tribal Health Centers.

Date Updated: 3/16/2011

New ID #2845 Old ID #10127

25) Will EHR Incentive Payments be subject to audits under OMB Circular A-133?

Incentive payments made to eligible professionals, eligible hospitals and critical access hospitals under the Medicare and Medicaid EHR Incentive Programs are not subject to audit under OMB Circular A-133. However, these payments are subject to audit by the EHR Incentive Programs.

Federal funding received by states following CMS approval of their Health Information Technology Planning Advance Planning Documents (HIT PAPDs) and Health Information Technology Implementation Advance Planning Documents (HIT IAPDs) for the planning and implementation of Medicaid EHR Incentive Programs is subject to audit under OMB Circular A-133. Federal funding that states receive to disburse as Medicaid EHR incentive payments is also subject to audit under OMB Circular A-133.

Additional guidance on how OMB Circular A-133 applies to the Medicare and Medicaid EHR Incentive Programs is available in the Regulations and Notices section of the EHR Incentive Programs website (http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/OMB_Circular_-_A-133_Guidance_EHR_Incentive_Programs.pdf).

Date Updated: 8/23/2011

New ID #3677

Old ID #10886

26) If an eligible provider fails to meet meaningful use (MU) during a participation year in the Medicare Electronic Health Records (EHR) Incentive Program, can he/she continue to participate and earn incentives?

An Eligible Professional (EP), Eligible Hospital or Critical Access Hospital (CAH) that participates in the Medicare EHR Incentive Program and does not meet MU for one participation year is highly encouraged to continue to attest and earn incentive payments for future participation years.

If a participating provider does not successfully attest for a given year, he/she will not be eligible to receive an incentive payment for that year. However, attesting and receiving an incentive payment for a future participation year is based on the provider's ability to meet MU during that year and not based on success or failure in previous years.

When a provider continues to participate and submit attestation information in subsequent years, the progression through the stages of MU will continue to follow the CMS-established timeline of meeting the MU criteria of each stage for two program years, regardless of whether he/she demonstrates MU in each consecutive year.

For example, if an EP demonstrates the stage 1 criteria for the 1st payment year, but does not meet the stage 1 criteria in the 2nd payment year, the EP will receive an incentive payment for the 1st payment year but not receive the associated incentive payment for the 2nd year.

When the EP proceeds to attest for the 3rd payment year, he/she may be eligible to receive the associated incentive payment if MU is met. However, since the EP has completed the 1st and 2nd program years, the EP will be expected to demonstrate the stage 2 meaningful use criteria to receive payment in the 3rd year, even if he/she did not meet the stage 1 criteria in the 2nd year.

If a provider registers to participate in the EHR Incentive Program for the first year but chooses to withdraw their attestation, the provider may have the opportunity to start over and “repeat” their first year of participation in the Incentive Program if a CMS post payment or prepayment audit has not been initiated. If the provider withdraws their attestation during or after a CMS audit has been conducted, the provider forfeits the ability to reattest as a Year 1 participant and must attest as a Year 2 participant in the next year. Once the provider has withdrawn and the audit has been initiated, the progression along the EHR Incentive Program timeline has begun and the provider would need to meet MU along this schedule in order to earn the associated incentive payments.

Please see FAQ 7737 for information about the meaningful use progression in the Medicaid EHR Incentive Program.

For more information about the EHR Incentive Program timeline, please visit:
<http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Basics.html>

To use the interactive “My EHR Participation Timeline” tool, please visit:
<http://cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Participation-Timeline.html>
Date Updated: 11/19/2013
New ID# 9220 Old ID# N/A

27) What are the specific medical specialty codes associated with anesthesiology, radiology and pathology for the specialty-based determination for the granting of a hardship exception from the payment adjustments in the Medicare Electronic Health Record (EHR) Incentive Program?

The included Medicare Specialty Codes are diagnostic radiology (30), nuclear medicine (36), interventional radiology (94), anesthesiology (30), and pathology (22).

We note that current practice guidelines issued by the American College of Radiology for interventional radiology (94) indicate that both face-to-face patient contact (pre and post procedure) and follow-up care (longitudinal care) are expected as part of the scope of practice, and we may need to revisit this issue in future rulemaking.

Radiation oncology, together with surgical and medical oncology, is one of the 3 primary disciplines involved in cancer treatment according to the American College of Radiology practice guidelines. Radiation oncologists are therefore specialized oncologists as opposed to specialized radiologists and are not eligible for the specialty-based exception. If a radiation oncologist believes they meet the hardship exception criteria for lack of face-to-face patient interaction and lack of need for

follow-up care they may apply for that exception, as can any eligible professional regardless of specialty.

Date Updated: 1/30/2013

New ID #7731 Old ID #N/A

II. Questions about Eligibility for the Programs

Eligibility Questions for Hospitals

28) Can a federally-owned Indian Health Service facility qualify as an eligible hospital for the Medicaid EHR Incentive Program?

Acute care hospitals under the Medicaid EHR Incentive Program must:

- Have an average length of stay of 25 days or fewer; AND
- have a CMS Certification Number (CCN) that ends with a number between 0001-0879 or 1300-1399.

To determine whether an Indian Health Service-owned hospital meets the certification requirements to have a CCN in these ranges, reference should be made to the certification or conditions of participation (see 42 CFR Part 482). Such facilities would also need to have 10% Medicaid patient volume.

Date Updated: 9/23/2012

New ID #3115 Old ID #10530

29) Can hospitals in the U.S. Territories (Puerto Rico, Guam, Virgin Islands, Northern Mariana Islands, and American Samoa) qualify for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program?

Hospitals in the U.S. Territories cannot receive incentive payments under the Medicare EHR Incentive Program. For the purposes of the Medicare EHR Incentive Program, the Social Security Act defines an eligible hospital as a "subsection (d) hospital" that is located in "one of the fifty States or the District of Columbia." This does not include hospitals located in the U.S. territories.

Therefore, hospitals in the U.S. territories do not qualify for the Medicare EHR Incentive Program. However, under the Medicaid EHR Incentive Program, hospitals located in the U.S. Territories are eligible to participate in the Medicaid incentive program as long as they meet all other eligibility requirements.

Date Updated: 7/30/2010

New ID #2717 Old ID #9963

Eligibility Questions for Providers: Who Can Participate

30) Can Indian Health Service (IHS) clinics or group practices qualify for the panel threshold for the Medicaid EHR Incentive Program?

Yes, the Indian Health Service (IHS) has managed care and/or primary care patient panels and would be able to qualify for an incentive payment under the Medicaid EHR Incentive Program. Patient panels are very common for IHS clinics and group practices.

Date Updated: 3/28/2011
New ID #3105 Old ID #10525

31) Do Federally Qualified Health Center (FQHC) sites have to meet the 30% minimum Medicaid patient volume threshold to receive payment under the Medicaid EHR Incentive Program?

Eligible professionals may participate in the Medicaid EHR Incentive Program if: 1) They meet Medicaid patient volume thresholds; or 2) They practice predominantly in an FQHC or Rural Health Clinic (RHC) and have 30% needy individual patient volume. FQHCs and RHCs are not eligible to receive payment under the program. Please contact your State Medicaid agency for more information on which types of encounters qualify as Medicaid/needy individual patient volume.

Date Updated: 5/9/2011
New ID #3099 Old ID #10522

32) Under the Medicaid EHR Incentive Program, is there a minimum number of hours per week that an eligible professional (EP) must practice in order to qualify for an incentive payment? Could a part-time EP qualify for Medicaid incentive payments if the EP meets all other eligibility criteria?

Yes, a part-time EP who meets all other eligibility requirements could qualify for payments under the Medicaid EHR Incentive Program. There are no restrictions on employment type (e.g., contractual, permanent, or temporary) in order to be a Medicaid eligible professional.

Date Updated: 3/28/2011
New ID #3095 Old ID #10520

33) Are physicians who are employed directly by a tribally-operated facility and who meet all other eligibility requirements eligible for payments under the Medicaid EHR Incentive Program?

Physicians are one of the categories of eligible professionals under the Medicaid EHR Incentive Program. If they meet the other program eligibility requirements (they can demonstrate 30% Medicaid patient volume, they've adopted, implemented, upgraded or meaningfully used certified Electronic Health Record technology, they are not hospital-based, etc.) then the fact that they are employed by a tribally-operated facility is irrelevant.

Date Updated: 3/28/2011
New ID #3089 Old ID #10517

34) Are physicians who work in hospitals eligible to receive Medicare or Medicaid electronic health record (EHR) incentive payments?

Physicians who furnish substantially all, defined as 90% or more, of their covered professional services in either an inpatient (POS 21) or emergency department (POS 23) of a hospital are not eligible for incentive payments under the Medicare and Medicaid EHR Incentive Programs.

Date Updated: 2/17/2011
New ID #2777 Old ID #10074

35) Will long term care providers such as nursing homes be eligible for incentive payments under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program?

Nursing homes, per se, are not eligible. The following types of institutional providers are eligible for EHR incentive payments under Medicare and/or Medicaid, provided they meet the applicable criteria.

Under Medicare, institutional providers eligible for the EHR incentive payments include "subsection (d) hospitals," as defined under section 1886(d) of the Social Security Act, and critical access hospitals (CAHs).

Under Medicaid, institutional providers eligible for the EHR incentive payments are acute care hospitals (which include CAHs and cancer hospitals) and children's hospitals. However, under Medicare, eligible professionals (EPs) may choose to assign their incentive payments to their employer or entity with which the EP has a contractual arrangement.

Under Medicaid, EPs also can choose to assign their incentive payments to their employer or to other state-designated entities.

Date Updated: 7/30/2010
New ID #2637 Old ID #9843

36) Are physicians who practice in hospital-based ambulatory clinics eligible to receive Medicare or Medicaid electronic health record (EHR) incentive payments?

A hospital-based eligible professional (EP) is defined as an EP who furnishes 90% or more of their services in either inpatient or emergency department of a hospital. Hospital-based EPs do not qualify for Medicare or Medicaid EHR incentive payments.

Date Updated: 7/30/2010
New ID #2639 Old ID #9844

37) Will ambulatory surgical centers be eligible for incentive payments under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program?

Ambulatory surgical centers are not eligible for EHR incentive payments. The following types of institutional providers are eligible for EHR incentive payments under Medicare and/or Medicaid, provided they meet the applicable criteria.

Under Medicare, institutional providers eligible for the EHR incentive payments include "subsection (d) hospitals," as defined under section 1886(d) of the Social Security Act, and critical access hospitals.

Under Medicaid, institutional providers eligible for the EHR incentive payments are acute care hospitals (which include critical access hospitals and cancer hospitals) and children's hospitals.

Date Updated: 7/30/2010

New ID #2641 Old ID #9845

38) Are eligible professionals (EPs) who practice in State Mental Health and Long Term Care Facilities eligible for Medicaid electronic health record (EHR) 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 practices is generally irrelevant to determining eligibility for the Medicaid EHR Incentive Program (except for purposes of determining whether an EP can qualify through "needy individual" patient volume). Setting is relevant for physician assistants (PA), 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.)

Date Updated: 2/17/2011

New ID #2767 Old ID #10069

39) Are mental health practitioners eligible to participate in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

Mental health providers would only be eligible for incentive payments if they meet the criteria of a Medicare or Medicaid eligible professionals (EPs).

For more complete information about eligibility requirements, please refer to the Eligibility section of the CMS website at

http://www.cms.gov/EHRIncentivePrograms/15_Eligibility.asp#TopOfPage.

Date Updated: 2/17/2011

New ID #2789 Old ID #10082

40) Will the resident physicians be eligible to participate in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

For the Medicaid EHR Incentive Program, all eligible professionals must meet their state's scope of practice rules to participate. For physicians, this typically includes education, licensure, and board certification.

For the Medicare EHR Incentive Program, a resident must meet the definition of a Medicare eligible professional, be in the Provider Enrollment and Chain Ownership System (PECOS), with an enrollment status of APPROVED and have Part B allowed charges to be eligible for the Medicare EHR incentives.

Date Updated: 3/22/2011

New ID #2877 Old ID #10148

41) Will academic physicians employed by an academic medical center billing under the same CMS facility number as the hospital be allowed to participate as eligible professionals (EPs) in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs if they qualify in all other aspects?

Physicians who furnish substantially all, defined as 90% or more, of their covered professional services in either an inpatient (POS 21) or emergency department (POS 23) of a hospital are considered to be hospital-based and are therefore not eligible for incentive payments under the Medicare and Medicaid EHR Incentive Programs. If an academic physician is employed by an academic medical center, bills under the same CCN, and is considered hospital-based according to the definition above, then the academic physician would not be eligible to participate as an eligible professional in the Medicare and Medicaid EHR Incentive Programs.

Date Updated: 9/29/2010

New ID #2879 Old ID #10149

42) Is my practice eligible to receive incentive payments through the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

Incentive payments are not made to practices but to individual eligible professionals (EPs). For more information about who is eligible to participate, please visit

http://www.cms.gov/EHRIncentivePrograms/15_Eligibility.asp#TopOfPage.

Date Updated: 1/3/2011

New ID #2889 Old ID #10155

43) Can tribal clinics be treated as Federally Qualified Health Centers (FQHCs) for the Medicaid EHR Incentive Program?

CMS previously issued guidance stating that health care facilities owned and operated by American Indian and Alaska Native tribes and tribal organizations ("tribal clinics") with funding authorized by the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended) must be reimbursed as FQHCs in order to be considered FQHCs in the Medicaid EHR Incentive Program. CMS revised this policy and will allow any such tribal clinics to be considered as FQHCs for the Medicaid EHR Incentive Program, regardless of their reimbursement arrangements. For more information on how FQHCs are defined, please see FAQ #2845.

Date Updated: 9/23/2012

New ID #3017 Old ID #10417

Other Eligibility Questions for Providers

44) What are the requirements for dentists participating in the Medicaid EHR Incentive Program?

Dentists must meet the same eligibility requirements as other eligible professionals (EP) in order to qualify for payments under the Medicaid EHR Incentive Program. This also means that they must demonstrate all 15 of the core meaningful use objectives and five from the menu of their choosing. The core set includes reporting of six clinical quality measures (three core and three from the menu 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 as there is no blanket exclusion by type of EP.

Date Updated: 9/19/2012

New ID #3109 Old ID #10527

45) Are the criteria for needy patient volumes under the Medicaid EHR Incentive Program only applied to eligible professionals (EPs) practicing predominantly in Federally Qualified Health Centers (FQHCs) and/or Rural Health Clinics (RHCs), or can they also apply to hospital patient volumes?

Criteria for minimum patient volumes attributable to needy individuals apply only to EPs practicing predominantly in an FQHC or RHC. These criteria do not apply to hospital patient volumes.

Date Updated: 3/28/2011

New ID #3107 Old ID #10526

46) If an eligible professional (EP) meets the criteria for both the Medicare and Medicaid electronic health record (EHR) incentive programs, can they choose which program to participate in?

Yes. EPs who meet the eligibility requirements for both the Medicare and Medicaid incentive programs must elect the program in which they wish to participate when they register. After the initial designation, EPs can only change their program selection once after they have received payment before 2015.

Date Updated: 7/30/2010

New ID #2707 Old ID #9957

47) Are professional services rendered by physicians or other eligible professional that are billed by the Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) included in the calculation of the Medicare eligible professional (EP) electronic health record (EHR) incentive payment?

No. The Health Information Technology for Economic and Clinical Health (HITECH) Act created an EHR incentive payment for EPs under Medicare based on the allowed charges for covered professional services furnished by the EP. Since services provided by eligible professionals while working in RHCs are not billed under the Part B physician fee schedule, they do not meet the HITECH Act definition of "covered professional services." As the HITECH Act bases the Medicare EHR incentive payment on a percentage of allowed charges for "covered professional services," services provided in the RHC by the eligible professional would not be included in the calculation for the Medicare EHR incentive. As the Medicaid EHR incentive payment

is based on a different methodology, the eligible professionals in RHCs may still qualify for the Medicaid EHR incentive payment if they, or the whole RHC as a proxy, meet the 30 percent threshold for "needy individuals" as defined in statute and other program requirements.

Date Updated: 10/5/2010

New ID #2895 Old ID #10158

48) What provisions are there for tribal clinics to receive payments from the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program, rather than the physicians themselves - especially when it is a family medicine practice? I heard there were certain percentages of patients that had to be either Medicare or Medicaid and that a physician had to decide which they were going to apply for. What if their practice includes both types of patients?

Clinics are not eligible for EHR incentive payments. However, eligible professionals who qualify for an EHR incentive payment may reassign that payment to the taxpayer identification number (TIN) of their employer, if they so choose. You are correct that eligible professionals must choose either the Medicare or the Medicaid EHR Incentive Program, and may not simultaneously receive payments from both programs if they qualify for both. They may make a one-time switch after having received an incentive payment, but the switch must occur before 2015.

Date Updated: 3/16/2011

New ID #2849 Old ID #10129

49) How is hospital-based status determined for eligible professionals in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

A hospital-based eligible professional (EP) is defined as an EP who furnishes 90% or more of their covered professional services in either the inpatient (Place of Service 21) or emergency department (Place of Service 23) of a hospital. Covered professional services are physician fee schedule (PFS) services paid under Section 1848 of the Social Security Act. CMS uses PFS data from the Federal fiscal year immediately preceding the calendar year for which the EHR incentive payment is made (that is, the "payment year") to determine what percentage of covered professional services occurred in either the inpatient (Place of Service 21) or emergency department (Place of Service 23) of a hospital. The percentage determination is made based on total number of Medicare allowed services for which the EP was reimbursed, with each unit of a CPT billing code counting as a single service. States will use claims and/or encounter data (or equivalent data sources at the State's option) to make this determination for Medicaid. States may use data from either the prior fiscal or calendar year.

EPs can learn whether or not they are considered hospital based for the Medicare EHR Incentive Program by registering now for the Medicare EHR Incentive Program. For the Medicaid EHR Incentive Program, EPs should contact their states for more information.

Date Updated: 6/13/2011

50) Can eligible professionals participate in the 2011 Physician Quality Reporting System (formerly called PQRI), 2011 Electronic Prescribing (eRx) Incentive Program, and the EHR Incentive Program (aka Meaningful Use) at the same time and earn incentives for each?

The Physician Quality Reporting System, eRx Incentive Program, and EHR Incentive Program are three distinctly separate CMS programs.

The Physician Quality Reporting System incentive can be received regardless of an eligible professional's participation in the other programs.

There are three ways to participate in the EHR Incentive Program: through Medicare, Medicare Advantage, or Medicaid.

- If participating in the EHR Incentive Program through the Medicaid option, eligible professionals are also able to receive the eRx incentive.
- If participating in the Medicare or Medicare Advantage options for the EHR Incentive Program, eligible professionals must still report the eRx measure to avoid the penalty but are only eligible to receive one incentive payment. Eligible professionals successfully participating in both programs will receive the EHR incentive payment.

Eligible professionals should continue to report the eRx measure in 2011 even if their practice is also participating in the Medicare or Medicare Advantage EHR Incentive Program because claims data for the first six months of 2011 will be analyzed to determine if a 2012 eRx Payment Adjustment will apply to the eligible professional. If an eligible professional successfully generates and reports electronically prescribing 25 times (at least 10 of which are in the first 6 months of 2011 and submitted via claims to CMS) for eRx measure denominator eligible services, (s)he would also be exempt from the 2013 eRx payment adjustment.

For questions on the Physician Quality Reporting System and eRx Incentive Program, contact the QualityNet Help Desk at 1-866-288-8912 (TTY 1-877-715-6222) from 7:00 a.m. - 7:00 pm. CST Monday through Friday or via Qnetsupport@sdps.org.

For more information, please see the CMS EHR Incentive Programs website at

<http://www.cms.gov/EHRIncentivePrograms>.

Date Updated: 3/7/2011

New ID #3075

Old ID #10474

51) Can eligible professionals (EPs) or eligible hospitals round their patient volume percentage when calculating patient volume in the Medicaid Electronic Health Records (EHR) incentive program?

To participate in the Medicaid EHR incentive program, EPs are required to demonstrate a patient volume of at least 30% Medicaid patients over a 90-day period in the prior calendar year or in the 12 months before attestation. The Centers for Medicare and Medicaid Services allow rounding 29.5% and higher to 30% for

purposes of determining patient volume. Similarly, pediatric patient volume may be rounded from 19.5% and higher to 20%. Finally, acute care hospitals are required to demonstrate a patient volume of at least 10% Medicaid patients over a 90-day period in the prior fiscal year preceding the hospital's payment year or in the 12 months before attestation. Hospitals' patient volume may be rounded from 9.5% and higher to 10%.

Date Updated: 3/13/2013

New ID# 8037

Old ID# N/A

III. Medicaid EHR Program for EPs

Program Requirements

52) What are the Stage 1 requirements for dentists participating in the Medicaid EHR Incentive Program?

Dentists must meet the same eligibility requirements as other eligible professionals (EP) in order to qualify for payments under the Medicaid EHR Incentive Program. This also means that for Stage 1 they must demonstrate all 15 of the core meaningful use objectives and five from the menu of their choosing. The core set for Stage 1 includes reporting of six clinical quality measures (three core and three from the menu 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 as there is no blanket exclusion by type of EP.

Date Updated: 9/19/2012

New ID #3109 Old ID #10527

53) How will eligible professionals (EPs) be required to show that they are meeting the Medicaid or needy individual patient volume thresholds of 30% for the Medicaid EHR Incentive Program?

To show that EPs are meeting the Medicaid or needy individual patient volume thresholds of 30% for the Medicaid EHR Incentive Program, States will need to propose one or more methods of calculating patient volume to CMS in their State Medicaid Health Information Technology Plans and would need to identify verifiable data sources available to the provider and/or the State. Please contact your State Medicaid Agency for more information on how your state is calculating patient volume.

Date Updated: 5/9/2011

New ID #3101 Old ID #10523

54) When calculating Medicaid patient volume or needy patient volume for the Medicaid EHR Incentive Program, are eligible professionals (EPs) required to use visits, or unique patients?

There are multiple definitions of encounter in terms of how it applies to the various requirements for patient volume. Generally stated, a patient encounter is any one day where an individual enrolled in a Medicaid program receives service. The requirements differ for EPs and hospitals. In general, the same concept applies to needy individuals. Please contact your State Medicaid agency for more information on which types of encounters qualify as Medicaid/needy individual patient volume.

Date Updated: 8/23/2012

New ID #3103 Old ID #10524

55) Under the Medicaid Electronic Health Record (EHR) Incentive Program, if an eligible professional (EP) adopts, implements or upgrades to certified EHR technology (AIU) in January 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.

Date Updated: 8/23/2012

New ID #2815 Old ID #10097

56) How does CMS define pediatrician for purposes of the Medicaid EHR Incentive Program?

CMS does not define pediatrician for this program. Pediatricians have special eligibility and payment flexibilities offered under the program and it is up to States to define pediatrician, consistent with other areas of their Medicaid programs. You can find your State's contact information [here](#).

Date Updated: 7/11/2011

New ID #3373 Old ID # 10715

57) In order to qualify for payment under the Medicaid EHR Incentive Program for having adopted, implemented, or upgraded to (AIU) certified EHR technology, an eligible professional (EP) working at an Indian Health Services (IHS) clinic may be asked to submit to their State Medicaid Agency an official letter containing information about the clinic's electronic health record from IHS (which is an Operating Division of the United States Department of Health and Human Services). The information in this letter identifies the EHR vendor, the ONC Certified Health IT Product List (CHPL) number of the EHR, as well as other information regarding the EHR product version and licensure. Does this letter meet states' documentation requirements for AIU?

Yes. This is an official letter from the United States Department of Health and Human Services and the IHS clinic generating this letter uses a certified EHR system created for the IHS. The state does not need to collect additional documentation for AIU (pre-payment or post-payment, or in the event of an audit) in instances where one of these letters is provided.

Date Updated: 1/23/2012

New ID #5993 Old ID # 10956

58) Under the Medicaid Electronic Health Record (EHR) Incentive Program, if a provider adopts, implements or upgrades (AIU) certified EHR technology 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. 24 CFR 495.4 establishes a one-time exception for providers attesting to meaningful use in 2014 during which the reporting period for Medicaid providers is any continuous 90-day period within the reporting year.

Date Updated: 8/23/2012

New ID #2839 Old ID #10112

59) Can EPs who are not anesthesiologists, pathologists and radiologists apply for or the exception for lack of face to face patient interaction and lack of need for follow-up?

Yes this exception is open to any EP who meets both of these criteria (lack of face to face interactions and lack the to follow up with patients). We consider lack of face-to-face and need for follow up care to be situations where the EP has no or nearly no face to face patient interactions or need for follow up care. The EP would need to demonstrate either a complete lack of face-to-face interactions and follow-up or that cases of face-to-face interaction and follow-up are extremely rare and not part of normal scope of practice for that EP. EPs need to apply no later than July 1, 2014 to avoid the payment adjustment in 2015 although we encourage EPs to apply well before the deadline.

Date Updated: 11/5/2012

New ID #7691 Old ID #N/A

60) If I participated in the Medicaid Electronic Health Records (EHR) Incentive Program last year, am I required to participate in the following year?

No. Medicaid providers are not required to participate in consecutive years of the EHR Incentive Program. Providers who skip years of participation will resume the progression of Meaningful Use (MU) where they left off. All providers are required to meet two years of Stage 1 in their first two years of MU and then proceed to Stage 2, regardless of not participating in consecutive years. (Note that there is an exception to that general rule for providers who demonstrated MU in 2011. These providers need not move to Stage 2 until 2014.)

Last Updated: January, 2015

Note that eligible professionals who wish to maximize their incentive payments must qualify for an incentive payment for six years, but they can begin receiving payments no later than 2016, and may not receive payments after 2021. Also note that after 2016, eligible hospitals must have participated in the previous year in order to receive a payment. For more information on what your meaningful use and incentive payment timeline will be, please see the timeline widget at <http://cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Participation-Timeline.html>.

Date Updated: 2/27/2013

New ID # 7737 Old ID #N/A

61) How can an eligible provider (EP) that is new to a practice meet the patient volume/practice predominantly criteria to be eligible for the Medicaid Electronic Health Records (EHR) Incentive Program?

There are three ways an EP could meet the patient volume/practice predominantly criteria to potentially qualify for an incentive payment. For illustrative purposes, assume the EP in the below example joined the practice in 2013:

- Next year (2014), after the EP establishes his/her own 90-day patient volume period as an EP from the prior calendar year (2013) or 12-month period prior to attestation, if this option is allowed by his/her state.
- This year (2013), if he/she is part of a group using the group patient volume proxy and it is appropriate to include him/her (i.e., he/she see Medicaid patients*). It is not a requirement that he/she was in the group for the period that is the basis for the proxy. However, using the group patient volume proxy is distinct from whether an EP practices predominantly in a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC). To meet the "practice predominantly" criterion, an EP must use individualized data; there is no group proxy (see below bullet).
- If the EP is working in an FQHC or RHC, next year (2014), after the EP practiced predominately in his/her the FQHC/RHC for at least 6 months. The EP could then use either individual or group proxy needing individual patient volume. FQHCs/RHCs using the group proxy must follow the regulations, including ensuring all EPs in the clinic use the proxy, and counting only encounters associated with the clinic (not an EP's outside encounters).

Each state has a method to determine whether or not an EP is considered hospital-based. Generally, the state uses data from the prior fiscal or calendar year to make this determination.

*Note that it is within the state's discretion to require validation of an EP's status as a Medicaid provider in the form of a paid encounter from the previous year. If the EP is new to practicing medicine (e.g., a recent graduate of an appropriate training program), he/she is not required to provide such information.

Also, see FAQ #2993.
Date Updated: 3/13/2013
New ID# 7817 Old ID# N/A

Payment Questions for Medicaid EHR Incentive Program EPs

62) What is the maximum incentive an eligible professional (EP) can receive under the Medicaid Electronic Health Record (EHR) Incentive Program?

EPs who adopt, implement, upgrade, and meaningfully use EHRs can receive a maximum of \$63,750 in incentive payments from Medicaid over a six year period (Note: There are special eligibility and payment rules for pediatricians). EPs must begin receiving incentive payments by calendar year 2016.

Date Updated: 7/30/2010
New ID #2625 Old ID #9810

63) Are Medicaid eligible professionals (EPs) and eligible hospitals subject to payment adjustments or penalties if they do not adopt electronic health record (EHR) technology or fail to demonstrate meaningful use?

There are no payment adjustments or penalties for Medicaid providers who fail to demonstrate meaningful use.

Date Updated: 7/30/2010
New ID #2709 Old ID #9958

64) What safeguards are in place to ensure that Medicaid electronic health record (EHR) incentive payments are used for their intended purpose?

Like the Medicare EHR incentive program, neither the statute nor the CMS Stage 1 final rule dictates how a Medicaid provider must use their EHR incentive payment. The incentives are not a reimbursement and are at the providers' discretion, similar to a bonus payment.

Date Updated: 8/23/2012
New ID #2711 Old ID #9959

65) The billing provider on a claim is an eligible professional (EP) but the performing provider type is not an EP. If we use claims to validate patient volume or meaningful use for the Medicaid Electronic Health Record (EHR) Incentive Program, 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. For example, 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 of certified EHR technology him or herself, if the State cannot not distinguish between the physician's claims and the PA's individual claims, then this would not be an adequate audit methodology. To view the final rule, please visit:

<http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

Date Updated: 2/24/2011

New ID #2817 Old ID #10098

66) Under the Medicaid EHR Incentive Program, can a qualifying eligible professional (EP) who is an employee of a federally-owned Indian Health Services facility (other than a tribally-owned facility or Federally Qualified Health Center) assign his/her incentive payment to the federally-owned facility in the same way as other EPs?

Yes, EPs are permitted to reassign their incentive payments to their employer or to an entity with which they have a contractual arrangement allowing the employer or entity to bill and receive payment for the EP's covered professional services, including a federally-owned Indian Health Services facility.

Date Updated: 3/28/2011

New ID #3117 Old ID #10531

67) Per CMS FAQ #3017 (or old FAQ #10417), my tribal clinic is considered a Federally-qualified health center for the Medicaid EHR Incentive Program. So our eligible professionals (EPs) need to have 30% "needy individual" patient volume in order to qualify. I understand that needy individual encounters include encounters covered by Medicaid, the Children's Health Insurance Program (CHIP), a sliding fee scale or uncompensated care. My clinic receives Indian Health Services (IHS) funding which only partially offsets the cost of these encounters that are not covered by Medicaid or CHIP, but my clinic does not impose costs on these individuals and does not have a sliding fee scale, so how do I count them?

Since your clinic receives IHS funding, the encounters are not truly "uncompensated", but the encounters would be considered services furnished at no cost (even if your clinic does not have a sliding fee scale), and therefore can be counted towards needy individual patient volume for tribal clinic-based EPs applying for the Medicaid EHR Incentive Program.

Date Updated: 8/23/2012

New ID #3501 Old ID #10787

68) For the Medicaid EHR Incentive Program, can a non-hospital based eligible professional (EP) include their in-patient encounters for purposes of calculating Medicaid patient volume even if the patient is included in the eligible hospital's patient volume for the same 90-day period?

Yes, an EP who sees patients in an in-patient setting, and is not hospital based, can include the in-patient encounter in their Medicaid patient volume calculation. Both an eligible hospital and an EP can include an encounter from the same patient in their Medicaid patient volume calculations, respectively. This is because the services performed by the EP are distinct from those performed by the eligible hospital. Section 495.306 defines an encounter as a service rendered to an individual enrolled in a Medicaid program by either an EP or an eligible hospital. An EP who sees patients in an in-patient setting bills Medicaid for the services personally rendered by the EP, while at same time the hospital bills Medicaid for the services rendered by the hospital, such as the bed and medications. Given that these are two distinct sets of services for the same patient, both the eligible hospital and the EP can count them as an encounter for Medicaid patient volume if they happened to select the same 90-day period.

Date Updated: 9/23/2012

New ID #3585

Old ID #10831

Meaningful Use Questions

69) When we count encounters in a clinic or medical group (or medical home model) for purposes of the Medicaid Electronic Health Record (EHR) Incentive Program, are we able to include the encounters of ancillary providers such as pharmacists, educators, etc. when determining if the eligible professionals (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 † 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." To view the Stage 1 final rule, please visit: <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

Date Updated: 9/23/2012

New ID #2821

Old ID #10101

70) For the Medicaid Electronic Health Record (EHR) Incentive Program, if the EHR Reporting Period is calendar year (CY) 2013, then the payment year also refers to 2013 even though an eligible professional (EP) may receive the actual incentive payment in early 2014, correct?

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.

Date Updated: 9/23/2012

New ID #2823

Old ID #10102

71) 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) for the Medicaid Electronic Health Record (EHR) Incentive Program?

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 Stage 1 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 Stage 1 final rule, prior to proposing only an alternative in their State Medicaid Health Information Technology Plans (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.

Date Updated: 9/23/2012

New ID #2835

Old ID #10110

72) Are pediatric subspecialists considered pediatricians for purposes of qualifying under the Medicaid Electronic Health Record (EHR) Incentive Program? 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.

Date Updated: 2/24/2011

New ID #2837

Old ID #10111

73) We are a tribal clinic with: one full-time physician, one part-time pediatrician, one part-time physicians assistant (PA). Are we going to receive electronic health record (EHR) incentive payments directly from Medicaid?

Clinics are not directly eligible for the Medicaid EHR Incentive Program payments, however if the practitioners at your clinic meet the eligibility criteria and successfully adopt, implement, upgrade or meaningfully use certified EHR technology, they may choose to reassign their incentive payments to your clinic. Your clinic would need to have a taxpayer identification number (TIN) that is already established with the State Medicaid agency. A PA is eligible only if your FQHC or RHC is led by a PA. Our Stage 1 final rule preamble discusses what it means for a PA to have lead role in an FQHC or RHC at page 44483.

Date Updated: 9/23/2012

New ID #2847

Old ID #10128

74) Are optometrists considered eligible professionals for the Medicaid EHR Incentive Program?

Under Medicare, a doctor of optometry is considered a physician (and therefore an EP) with respect to all services the optometrist is authorized to perform under State law or regulation. It is currently unlikely that optometrists would be eligible for the Medicaid EHR Incentive Program, as the definition of "physician" for the Medicaid program is primarily limited to doctors of medicine and osteopathy (MDs and DOs). Some states are looking at how to leverage an option in their Medicaid State plan that allows them, under special circumstances, to treat adult optometrist services as physician services. Only then could an optometrist could be eligible for the Medicaid EHR Incentive Program. Please note that this change would only impact the EHR Incentive Program and not other areas of the Medicaid program. CMS is providing guidance to states that currently cover adult optometry services in order to possibly make optometrists eligible for the Medicaid EHR Incentive Program, but it would move optometry services for adults from an optional to mandatory benefit. If you have further questions about the Medicaid State Plan, please contact your State Medicaid agency or local trade organization for more information.

Date Updated: 2/9/2011

New ID #2983

Old ID #10341

75) If an eligible professional in the Medicaid EHR Incentive Program wants to leverage a clinic or group practice's patient volume as a proxy for the individual eligible professional (EP), how should a clinic or group practice account for EPs practicing with us part-time and/or applying for the incentive through a different location (e.g., where an EP is practicing both inside and outside the clinic/group practice, such as part-time in two clinics)?

EPs may use a clinic or group practice's patient volume as a proxy for their own under three conditions:

1. The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
2. There is an auditable data source to support the clinic's patient volume determination; and
3. So long as the practice and EPs decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data). The clinic or practice must use the entire practice's patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice.

In order to provide examples of this answer, please refer to Clinics A and B, and assume that these clinics are legally separate entities.

If Clinic A uses the clinic's patient volume as a proxy for all EPs practicing in Clinic A, this would not preclude the part-time EP from using the patient volume associated with Clinic B and claiming the incentive for the work performed in Clinic B. In other words, such an EP would not be required to use the patient volume of Clinic A simply because Clinic A chose to invoke the option to use the proxy patient volume. However, such EP's Clinic A patient encounters are still counted in Clinic A's overall patient volume calculation. In addition, the EP could not use his or her patient encounters from clinic A in calculating his or her individual patient volume. The intent of the flexibility for the proxy volume (requiring all EPs in the group practice or clinic to use the same methodology for the payment year) was to ensure against EPs within the same clinic/group practice measuring patient volume from that same clinic/group practice in different ways. The intent of these conditions was to prevent high Medicaid volume EPs from applying using their individual patient volume, where the lower Medicaid patient volume EPs then use the clinic volume, which would of course be inflated for these lower-volume EPs.

CLINIC A (with a fictional EP and provider type)

- EP #1 (physician): individually had 40% Medicaid encounters (80/200 encounters)
- EP #2 (nurse practitioner): individually had 50% Medicaid encounters (50/100 encounters)
- Practitioner at the clinic, but not an EP (registered nurse): individually had 75% Medicaid encounters (150/200)
- Practitioner at the clinic, but not an EP (pharmacist): individually had 80% Medicaid encounters (80/100)
- EP #3 (physician): individually had 10% Medicaid encounters (30/300)
- EP #4 (dentist): individually had 5% Medicaid encounters (5/100)
- EP #5 (dentist): individually had 10% Medicaid encounters (20/200)

In this scenario, there are 1200 encounters in the selected 90-day period for Clinic A. There are 415 encounters attributable to Medicaid, which is 35% of the clinic's volume. This means that 5 of the 7 professionals would meet the Medicaid patient volume criteria under the rules for the EHR Incentive Program. (Two of the professionals are not eligible for the program on their own, but their clinical encounters at Clinic A should be included.)

The purpose of these rules is to prevent duplication of encounters. For example, if the two highest volume Medicaid EPs in this clinic (EPs #1 and #2) were to apply on their own (they have enough Medicaid patients to do that), the clinic's 35% Medicaid patient volume is no longer an appropriate proxy for the low-volume providers (e.g., EPs #4 and #5).

If EP #2 is practicing part-time at both Clinic A, and another clinic, Clinic B, and both Clinics are using the clinic-level proxy option, each such clinic would use the encounters associated with the respective clinics when developing a proxy value for the entire clinic. EP #2 could then apply for an incentive using data from one clinic or the other.

Similarly, if EP #4 is practicing both at Clinic A, and has her own practice, EP # 4 could choose to use the proxy-level Clinic A patient volume data, or the patient volume associated with her individual practice. She could not, however, include the Clinic A patient encounters in determining her individual practice's Medicaid patient volume. In addition, her Clinic A patient encounters would be included in determining such clinic's overall Medicaid patient volume.

Date Updated: 5/20/2011

New ID #2993 Old ID #10362

76) For the Medicaid EHR Incentive Program, how do we determine Medicaid patient volume for procedures that are billed globally, such as obstetrician (OB) visits or some surgeries? Such procedures are billed to Medicaid at a global rate where one global rate might cover several visits.

CMS leaves it up to the states how to operationalize the patient volume considerations of global payments with the following guidance: the numerator and denominator must be incorporated consistently. The total encounters can be kept global, or broken down into individual visits. If a global payment is broken down into separate visits in the numerator, then for purposes of the denominator, the state must break down any other global payments received from other payers. We recognize this could be administratively challenging and are open to reviewing strategies for doing this that may involve sampling (e.g., if the Medicaid global payment for OB averages 12 visits, we would expect to see the numerator expanded to 12 visits for Medicaid encounters, and a denominator constructed using sample data from a random file review that similarly breaks down any global payments into separate visits for Medicaid and non-Medicaid payers).

Additionally, if the state's approach to global payments excludes providers from the Medicaid EHR Incentive Program who would otherwise be eligible, the state must create a mechanism to re-review their eligibility.

Date Updated: 1/23/2012

New ID #5995 Old ID #10957

77) Is data sharing with neighboring States permitted regarding total Medicaid days for purposes of paying full incentives to hospitals or eligible professionals (EPs) with utilization in multiple states under the Medicaid Electronic Health Record (EHR) Incentive Program?

Yes. The CMS Stage 1 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 Stage 1 final rule, EPs and hospitals are permitted to receive payment from only one State in a payment year (495.310(e)). To view the Stage 1 final rule, please visit:

<http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

Date Updated: 8/23/2012

New ID #2833

Old ID #10109

78) Do States need to verify the "installation" or "a signed contract" for adopt, implement, or upgrade (AIU) in the Medicaid EHR Incentive Program?

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 capable of meeting meaningful use; (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 EHR certification criteria published by the Office of the National Coordinator of Health Information Technology (ONC). Thus, a signed contract indicating that the provider has adopted or upgraded would generally be sufficient.

However, if a provider has been identified as high risk, states could further investigate the provider's intention (or lack thereof) to AIU. While a signed contract indicating that the provider has adopted or upgraded might generally be sufficient to establish an intent to AIU, the state could still determine that other, contradictory evidence demonstrated that the provider in fact had no intent to AIU. In such cases, that contradictory evidence might outweigh the presence of a signed contract.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit <http://www.cms.gov/EHRIncentivePrograms>.

Date Updated: 4/2/2014

New ID #2819

Old ID #10100

79) Does the provision requiring that States pay the incentive "without deduction or rebate" still allow a State to offset mandatory public debt collection (e.g., wage garnishment and claims overpayments) with the incentive?

The requirement that the incentives be passed to providers "without deduction or rebate" refers to requiring that the State not use the incentive payment to pay for its own program administration or to fund other State priorities. However, where there are public debts under a collection mandate, CMS considers the incentive as paid to the provider, even when part or all of the incentive may offset, under two scenarios:

1. Where it is authorized specifically by the Medicaid program (a civil monetary penalty, for example, or a Medicare debt); or
2. Where there is a court-ordered garnishment for a specific purpose.

Date Updated: 5/9/2011

New ID #2985 Old ID #10342

80) When eligible professionals work at more than one clinical site of practice, are they required to use data from all sites of practice to support their demonstration of meaningful use and the minimum patient volume thresholds for the Medicaid EHR Incentive Program?

CMS considers these two separate, but related issues.

Meaningful use: Any eligible professional demonstrating meaningful use must have at least 50% of their of their patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with certified EHR technology capable of meeting all of the meaningful use objectives. Therefore, States should collect information on meaningful users' practice locations in order to validate this requirement in an audit.

Patient volume: Eligible professionals may choose one (or more) clinical sites of practice in order to calculate their patient volume. This calculation does not need to be across all of an eligible professional's sites of practice. However, at least one of the locations where the eligible professional is adopting or meaningfully using certified EHR technology should be included in the patient volume. In other words, if an eligible professional practices in two locations, one with certified EHR technology and one without, the eligible professional should include the patient volume at least at the site that includes the certified EHR technology. When making an individual patient volume calculation (i.e., not using the group/clinic proxy option), a professional may calculate across all practice sites, or just at the one site. For more information on applying the group/clinic proxy option, see FAQ #10362 or click [here](#).

Date Updated: 2/9/2011

New ID #3015 Old ID #10416

81) If a State utilizes the option to include patient panels when looking at patient volume for the Medicaid EHR Incentive Program, what does it mean to have "unduplicated encounters"?

The requirements for this option to calculate patient volume are to account for eligible professionals treating patients in a care management role (often managed care or a medical home), as well as any additional encounters outside of a care management arrangement (often fee-for-service). When a State has leveraged this option, the calculation is:

[Total Medicaid patients* assigned to the provider in any representative continuous 90-day period in the preceding calendar year with at least one encounter in the calendar year preceding the start of the 90-day period] -PLUS- [Unduplicated Medicaid encounters* in that same 90-day period]

-DIVIDED BY-

[Total patients assigned to the provider in the same 90-day with at least one encounter in the calendar year preceding the start of the 90-day period] -PLUS- [All unduplicated encounters in that same 90-day period]

**Note that this same equation applies to making a determination for Needy Individual patient volume, where "Medicaid" is substituted by "Needy Individuals."*

In this calculation, "unduplicated" simply means that an eligible professional may not include the same encounters more than once. There may be multiple encounters with patients (even with patients included on the panel), but these may not be counted in more than one place in the equation. In addition, as noted in the preamble of the July 28, 2010 Federal Register (page 44488), the "unduplicated encounters" would only be encounters with non-panel Medicaid patients that occurred during the representative 90-day period.

As the question notes, not all States will use this option in determining patient volume. Please talk to your State or visit their website (found here and updated monthly) to get more information on how patient volume is calculated in each State.

Date Updated: 3/7/2011

New ID #3079 Old ID #10476

IV. Medicaid EHR Program for Hospitals

Program Requirements and Registration Questions

82) Do States need to verify the "installation" or "a signed contract" for adopt, implement, or upgrade (AIU) in the Medicaid EHR Incentive Program?

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 capable of meeting meaningful use; (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 EHR certification criteria published by the Office of the National Coordinator of Health Information Technology (ONC). Thus, a signed contract indicating that the provider has adopted or upgraded would generally be sufficient.

However, if a provider has been identified as high risk, states could further investigate the provider's intention (or lack thereof) to AIU. While a signed contract indicating that the provider has adopted or upgraded might generally be sufficient to establish an intent to AIU, the state could still determine that other, contradictory evidence demonstrated that the provider in fact had no intent to AIU. In such cases, that contradictory evidence might outweigh the presence of a signed contract.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit <http://www.cms.gov/EHRIncentivePrograms>.

Date Updated: 4/2/2014

New ID #2819 Old ID #10100

83) If a dually-eligible hospital initially registers only for the Medicaid EHR Incentive Program, but later decides that it wants to also register for the Medicare EHR Incentive Program, can it go back and change its registration from Medicaid only to both Medicare and Medicaid?

Hospitals that are eligible for EHR incentive payments under both Medicare and Medicaid should select "Both Medicare and Medicaid" during the registration process, even if they plan to apply only for a Medicaid EHR incentive payment by adopting, implementing, or upgrading certified EHR technology. Dually-eligible hospitals can then attest through CMS for their Medicare EHR incentive payment at a later date, if they so desire. It is important for a dually-eligible hospital to select "Both Medicare and Medicaid" from the start of registration in order to maintain this option. Hospitals that register only for the Medicaid program (or only the Medicare program) will not be able to manually change their registration (i.e., change to "Both Medicare and Medicaid" or from one program to the other) after a payment is initiated and this may cause significant delays in receiving a Medicare EHR incentive payment.

Date Updated: 12/9/2010

New ID #2931

Old ID #10267

84) What is the reporting period for eligible hospitals participating in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program?

For an eligible hospital or critical access hospital's first payment year, the EHR reporting period is a continuous 90-day period within a Federal fiscal year. In subsequent years (except 2014), the EHR reporting period for eligible hospitals and critical access hospitals (CAHs) is the entire Federal fiscal year. In 2014, an eligible hospital or CAH can use either the entire Federal fiscal year or a 3-month period aligned with the quarters of the Federal fiscal year.

Date Updated: 08/23/2012

New ID #2715

Old ID #9962

85) If I participated in the Medicaid Electronic Health Records (EHR) Incentive Program last year, am I required to participate in the following year?

No. Medicaid providers are not required to participate in consecutive years of the EHR Incentive Program. Providers who skip years of participation will resume the progression of Meaningful Use (MU) where they left off. All providers are required to meet two years of Stage 1 in their first two years of MU and then proceed to Stage 2, regardless of not participating in consecutive years. (Note that there is an exception to that general rule for providers who demonstrated MU in 2011. These providers need not move to Stage 2 until 2014.)

Note that eligible professionals who wish to maximize their incentive payments must qualify for an incentive payment for six years, but they can begin receiving payments no later than 2016, and may not receive payments after 2021. Also note that after 2016, eligible hospitals must have participated in the previous year in order to receive a payment. For more information on what your meaningful use and incentive payment timeline will be, please see the timeline widget at

<http://cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Participation-Timeline.html>.

Date Updated: 2/27/2013

New ID # 7737

Old ID #N/A

Payment and Penalty Questions

86) Are Medicaid eligible professionals (EPs) and eligible hospitals subject to payment adjustments or penalties if they do not adopt electronic health record (EHR) technology or fail to demonstrate meaningful use?

There are no payment adjustments or penalties for Medicaid providers who fail to demonstrate meaningful use.

Date Updated: 7/30/2010

New ID #2709

Old ID #9958

87) What safeguards are in place to ensure that Medicaid electronic health record (EHR) incentive payments are used for their intended purpose?

Like the Medicare EHR incentive program, neither the statute nor the CMS Stage 1 final rule dictates how a Medicaid provider must use their EHR incentive payment. The incentives are not a reimbursement and are at the providers' discretion, similar to a bonus payment.

Date Updated: 8/23/2012

New ID #2711 Old ID #9959

88) May a hospital include zero pay Medicaid eligible days in the Medicaid hospital EHR Incentive Program payment calculation?

No, zero pay Medicaid eligible days must be excluded from the Medicaid hospital incentive calculation.

Section 1903(t)(5)(C) of the Act requires the Medicaid share to be calculated "in the same manner as the Medicare share." In all ways possible, the Medicaid hospital incentive calculation is similar to Medicare, based on this language. Medicare retrieves data for the calculation exclusively from the Medicare cost report. Although Medicaid offers additional flexibility in data sources, the data parameters for Medicaid are the same as Medicare. This is cited in the Stage 1 final rule where CMS said:

"The statute requires us to calculate the Medicaid share 'in the same manner' as the Medicare share under section 1886(n)(2)(D) of the Act and such substitute service days would not be considered 'in the same manner.' Thus, we proposed that for purposes of the Medicaid formula, we would count only those days that would count as inpatient-bed-days for Medicare purposes under section 1886(n)(2)(D) of the Act."

In the CMS Stage 1 final rule, CMS also made clear: "[T]he EHR hospital incentive payment calculation requires the inclusion of only paid inpatient-bed-days." 75 Fed. Reg. at 44500.

Given this, a joint FAQ was published (FAQ # 3471) that mirrored cost report data sources for the calculation. Per the cost report instructions, all acute inpatient days must be paid. While CMS uses line 2 of worksheet S-3 part 1, which contains HMO data as well as other data used to calculate the Disproportionate Share Hospital (DSH) calculation (including zero pay days), Medicare is removing all of the DSH data from line 2 and using only the paid managed care days. Medicare does not include unpaid days as acute inpatient days, so following the same manner for Medicaid means using only paid days as well.

Additionally, 1903(t)(5)(C) states that the Secretary establishes how the "inpatient bed-days" used in the Medicaid numerator are counted. The statute specifically says that the Medicaid share has as its numerator "the amount that is equal to the

number of inpatient-bed-days (as established by the Secretary) which are attributable to individuals who are receiving medical assistance under this title." By using only paid inpatient Medicaid days, the Secretary has "established" how she counts the number of inpatient bed days per statutory authority.

Date Updated: 10/25/2012

New ID # 7649 Old ID #N/A

Meaningful Use Questions

89) Under the Medicaid Electronic Health Record (EHR) Incentive Program, if a provider adopts, implements or upgrades (AIU) certified EHR technology 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. 24 CFR 495.4 establishes a one-time exception for providers attesting to meaningful use in 2014 during which the reporting period for Medicaid providers is any continuous 90-day period within the reporting year.

Date Updated: 8/23/2012

New ID #2839 Old ID #10112

90) Are nursery days and nursery discharges (for newborns) included as acute-inpatient services in the calculation of hospital incentives for the Medicare and Medicaid EHR Incentive Programs?

No, nursery days and discharges are not included in inpatient bed-day or discharge counts in calculating hospital incentives. We exclude nursery days and discharges because they are not considered acute inpatient services based on the level of care provided during a normal nursery stay.

Pages 44450 and 44453 of the Stage 1 final rule preamble explain that for the Medicare calculation, the statutory language clearly restricts discharges and inpatient bed-days to those from the acute care portion of a hospital. This is because of the definition of "eligible hospital" in section 1886(n)(6)(B) of the Social Security Act.

Page 44497 of the Stage 1 final rule explains that statutory parameters placed on Medicaid incentive payments to hospitals are largely based on the methodology applied to Medicare incentive payments. Therefore, as Medicaid is held to the same parameters as Medicare, the same limitations on counting inpatient bed-days and total discharges apply to Medicaid hospital incentive calculations.

To view the Stage 1 final rule for the Medicare and Medicaid EHR incentive programs, please visit: <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

Date Updated: 8/23/2012

New ID #2991

Old ID #10361

91) If the State chooses to use the cost report in the Medicaid EHR incentive hospital payment calculation, what data elements should be used in the Medicare cost report, Form CMS 2552-96 and the Form CMS 2552-10?

Based on the Medicare cost report guidance, Form CMS 2552-96 will be used until the implementation of the new Medicare cost report, Form CMS 2552-10. Although the State may choose to use the following data elements, it is the States' and hospitals' responsibility to ensure the integrity and regulatory compliance of the data.

The CMS 2552-96 data elements are as follows:

- Total Discharges - Worksheet S-3 Part 1, Column 15, Line 12
- Medicaid Days - Worksheet S-3, Part I, Column 5, Line 1 + Lines 6-10
- Medicaid HMO Days - Worksheet S-3, Part I, Column 5, Line 2
- Total Inpatient Days - Worksheet S-3 Part 1, Column 6, Line 1, 2 + Lines 6 -10
- Total Hospital Charges - Worksheet C Part 1, Column 8, Line 101
- Charity Care Charges - Worksheet S-10, Column 1, Line 30

The CMS 2552-10 data elements are as follows:

- Total Discharges - Worksheet S-3 Part 1, Column 15, Line 14
- Medicaid Days - Worksheet S-3, Part I, Column 7, Line 1 + Lines 8-12
- Medicaid HMO Days - Worksheet S-3, Part I, Column 7, Line 2
- Total Inpatient Days - Worksheet S-3 Part 1, Column 8, Line 1, 2 + Lines 8 - 12
- Total Hospital Charges - Worksheet C Part 1, Column 8, Line 200
- Charity Care Charges - Worksheet S-10, Column 3, Line 20

For information about the cost report data elements that are used in the Medicare hospital incentive calculation, please see FAQ #10717.

Date Updated: 8/9/2011

New ID #3471

Old ID #10771

92) What are the EHR reporting periods for eligible hospitals participating in both the Medicare and Medicaid EHR Incentive Programs, as well as the requirements for receiving an EHR incentive payment?

There are two factors that determine the EHR reporting period for hospitals eligible for both the Medicare and Medicaid EHR Incentive Programs:

- Whether the hospital is attesting to Medicaid only; Medicaid first, then Medicare in the same fiscal year; Medicaid first, then Medicare in a later fiscal year; or Medicare and Medicaid simultaneously/Medicare first, then Medicaid in a later fiscal year.
- The payment year for which the hospital is attesting (first, second, third etc.)

See the table below (where having adopted, implemented, or upgraded to certified EHR technology for Medicaid is abbreviated as AIU and meaningful use is abbreviated as MU):

Hospital Participating In:			
Payment Year	Medicaid Incentive Program Only	Medicaid 1 st , then Medicare in same FY	Medicare and Medicaid Simultaneously / Medicare 1 st , then Medicaid in a later FY
1 st payment year	AIU	AIU (Medicaid);	MU, 90 day reporting period
		MU, 90 day reporting period (Medicare)	
2 nd payment year	MU, 90 day reporting period	MU, 12 month reporting period	MU, 12 month reporting period
3 rd payment year	MU, 12 month reporting period	MU, 12 month reporting period	MU, 12 month reporting period

Relevant points to remember regarding eligible hospitals:

- Hospitals that are eligible for EHR incentive payments under both Medicare and Medicaid should select "Both Medicare and Medicaid" during the registration process, even if they initially plan to apply for an incentive under only one program.
- A hospital that is a meaningful EHR user under the Medicare EHR Incentive Program is deemed to be a meaningful user for Medicaid. CMS will audit hospitals eligible for both the Medicare and Medicaid EHR Incentive Programs for compliance with the meaningful use requirements under the Medicare program. The states are responsible for auditing AIU and other requirements for receiving an EHR incentive payment, such as patient volume.
- There will never be two consecutive years of 90-day reporting periods for meaningful use. The 90-day reporting period is always followed by a 12-month reporting period the following year, irrespective of when attestation occurred and whether to Medicare or Medicaid.
- The reporting period must begin and end in the Federal Fiscal Year that constitutes the payment year.
- There is no reporting period for adopt/implement/upgrade.
- A hospital participating in the Medicaid EHR incentive program must meet all Medicaid requirements, including patient volume requirements.
- See p. 44323 of the Stage 1 Final Rule for Stages of meaningful use by payment year.

Date Updated: 1/19/2012

New ID #3575

Old ID #10826

93) 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) for the Medicaid Electronic Health Record (EHR) Incentive Program?

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 Stage 1 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 Stage 1 final rule, prior to proposing only an alternative in their State Medicaid Health Information Technology Plans (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.

Date Updated: 8/23/2012

New ID #2835 Old ID #10110

94) Is data sharing with neighboring States permitted regarding total Medicaid days for purposes of paying full incentives to hospitals or eligible professionals (EPs) with utilization in multiple states under the Medicaid Electronic Health Record (EHR) Incentive Program?

Yes. The CMS Stage 1 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 Stage 1 final rule, EPs and hospitals are permitted to receive payment from only one State in a payment year (495.310(e)). To view the Stage 1 final rule, please visit: <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

Date Updated: 8/23/2012

New ID #2833 Old ID #10109

95) It seems that each State has the latitude to define the 12-month period from which to derive the Medicaid share data for the purposes of the Medicaid Electronic Health Record (EHR) Incentive Program. Neither the preamble nor the regulatory text of the Stage 1 final rule explicitly stipulate that the 12-month period selected by the state for the Medicaid share data needs to be in the federal fiscal year (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. To view the Stage 1 final rule, please visit: <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

Date Updated: 8/23/2012

New ID #2825 Old ID #10104

96) Can a hospital receive credit for any of the Inpatient Quality Reporting (IQR) Program requirements by electronically submitting the Clinical Quality Measures (CQMs) for the EHR Incentive Program?

Yes, a hospital will be able to receive credit for the EHR Incentive Program and IQR by electronically submitting the CQMs (also referred to as eCQMs) for the EHR Incentive Program, using the IQR system (Qualitynet.org). There are 16 CQMs that are shared by the two programs, and these shared measures are organized into four measure sets, stroke (seven measures), venous thromboembolism (six measures), emergency department (two measures) and perinatal care (one measure). Hospitals choosing to report the specified measure sets electronically to meet the CQM requirements for the Medicare EHR Incentive Program and the IQR Program, may report one quarter of data (either January – March 2014, April – June 2014, or July – September 2014). If a provider reports measures electronically, they are not required to report the same measures by via chart abstraction or attestation. Please note that both the IQR Program and the EHR Incentive Program have additional requirements which must be reported

IQR Program

For the IQR Program, a hospital must continue to submit all 13 of the remaining IQR measure sets each quarter if it wishes to fulfill the requirements for the IQR program. The 13 measure sets include data for the following: Clinical, HCAHPS, Aggregate Population and Sample size counts, HAI, Claims, and Structural Measures. Hospitals participating in the IQR program must also sign a notice of participation, provide a security administrator and complete the Data Accuracy and Completeness Acknowledgement (DACA).

For more information regarding IQR requirements and a checklist for providers, please go to the Inpatient Quality Reporting Program Tab > How to participate on www.QualityNet.org.

EHR Incentive Program

Electronic submission of the 16 eCQMs will meet the CQM requirement for the Medicare EHR Incentive Program. Hospitals also need to attest to the core and menu objectives for meaningful use through the Medicare EHR Incentive Program Registration and Attestation System. Critical Access Hospitals and Eligible Hospitals will need to check with their state Medicaid programs to determine all necessary requirements to participate in the Medicaid EHR Incentive Program.

For more information on program details, please visit the CMS EHR Incentive Programs page. www.cms.gov/ehrincentiveprograms.

Date Updated: 11/22/2013

New ID# 9276 **Old ID# N/A**

97) Can SCIP INF-9 (CMS178v4 / NQF0453) still be used to meet the reporting requirements of the EHR Incentive Program (Meaningful Use) for Eligible Hospitals and the Hospital Inpatient Quality Reporting Program?

CMS suggests eligible hospitals participating in the Medicare & Medicaid EHR Incentive Programs and/or choosing the voluntary electronic reporting option under the Hospital Inpatient Quality Reporting (IQR) Program not select SCIP INF-9 (CMS 178v4/NQF 0453) as one of their electronic clinical quality measures (eCQMs) and choose another eCQM for Meaningful Use reporting and/or Hospital IQR reporting in 2015. A critical error identified in the measure (CMS 178v4/NQF 0453) renders a zero denominator.

The denominator error noted in the SCIP INF-9 (CMS 178v4/NQF 0453) was identified after the 2014 Annual Update posting. If the measure is used for reporting, a zero in the denominator will count as a successful submission for that CQM for both the Medicare EHR Incentive Program and the Hospital IQR Program.

Eligible hospitals and CAHs reporting CQMs using certified EHR technology are required to report on a minimum of 16 CQMs across 3 National Quality Strategy Domains. If an eligible hospital or CAH reports on a CQM generating a zero denominator, it will count toward the required 16 CQMS for the Medicare EHR Incentive Program and the Hospital IQR Program.

For additional clarification on reporting zero denominators, please see the page 50323 of the FY 2015 IPPS Final Rule:

<http://www.gpo.gov/fdsys/pkg/FR-2014-08-22/pdf/2014-18545.pdf>.

Date Updated: 10/9/2014

New ID# 10786 **Old ID# N/A**

Critical Access Hospital Questions

98) What is the definition of "reasonable cost" for critical access hospitals (CAHs) under the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs?

The reasonable costs for which a CAH may receive an EHR incentive payment are the reasonable acquisition costs for the purchase of certified EHR technology to which purchase depreciation (excluding interest) would otherwise apply. Section 495.106(a) of the regulations states that reasonable costs incurred for the purchase of certified EHR technology for a qualifying CAH means the reasonable acquisition costs incurred for the purchase of depreciable assets as described in part 413 subpart G of the regulations, such as computers and associated hardware and software, necessary to administer certified EHR technology as defined in section 495.4 excluding any depreciation and interest expenses associated with the acquisition. This EHR incentive payment provision allows a qualifying CAH to expense the acquisition costs of a qualifying asset in a single payment year instead of depreciating the acquisition costs over the useful life of the asset. If a qualifying CAH incurs non-depreciable expenses related to implementing/maintaining its EHR system, those expenses cannot be included in the EHR incentive payment. However, those expenses may be an allowable cost for Medicare payment purposes, under the current reasonable cost payment methodology for CAHs, in the cost reporting period in which such expenses are incurred. For example, if a qualifying CAH rents its EHR technology assets, instead of purchasing the assets, the rent expense cannot be included in the EHR incentive payment. However, the rent expense may be an allowable cost for Medicare payment purposes, under the current reasonable cost payment methodology for CAHs, in the cost reporting period in which such expense is incurred.

Qualifying CAHs should contact their Medicare contractor to answer questions on reasonable costs that will be included in the calculation of the EHR incentive payment.

Date Updated: 3/7/2011

New ID #2905 Old ID #10163

99) When calculating inpatient bed days for the Medicaid Electronic Health Record (EHR) Incentive Program, can Critical Access Hospitals (CAHs) exclude swing bed days from the average length of stay if this is consistent with how they complete the Medicare and Medicaid cost reports?

Swing beds days that are used to furnish skilled nursing facility (SNF) or nursing facility-level care would not normally be considered part of the inpatient acute-care part of the hospital, whereas swing bed days that are used to furnish inpatient-level care are part of the acute-care part of the hospital. However, for CAHs participating in the Medicaid EHR Incentive program, when there is no way to

distinguish between days used to furnish SNF-level care versus inpatient acute-level care, we will allow States to exclude these days, if it is consistent with how the CAH completes the Medicare and Medicaid cost report. As the Medicaid EHR Incentive Program requires eligible acute care hospitals to have an average length of stay of 25 days or fewer, exclusion of swing bed days may facilitate CAH participation in the Medicaid EHR Incentive Program.

Date Updated: 6/13/2011

New ID #3315 Old ID #10668

100) For calculation of a Medicaid hospital's electronic health record (EHR) incentive payment, 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. To view the Stage 1 final rule, please visit: <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

Date Updated: 8/23/2012

New ID #2831 Old ID #10108

V. Medicare EHR Incentive Program for Hospitals

Registration Questions

101) If a dually-eligible hospital initially registers only for the Medicaid EHR Incentive Program, but later decides that it wants to also register for the Medicare EHR Incentive Program, can it go back and change its registration from Medicaid only to both Medicare and Medicaid?

Hospitals that are eligible for EHR incentive payments under both Medicare and Medicaid should select “Both Medicare and Medicaid” during the registration process, even if they plan to apply only for a Medicaid EHR incentive payment by adopting, implementing, or upgrading certified EHR technology. Dually-eligible hospitals can then attest through CMS for their Medicare EHR incentive payment at a later date, if they so desire. It is important for a dually-eligible hospital to select “Both Medicare and Medicaid” from the start of registration in order to maintain this option. Hospitals that register only for the Medicaid program (or only the Medicare program) will not be able to manually change their registration (i.e., change to “Both Medicare and Medicaid” or from one program to the other) after a payment is initiated and this may cause significant delays in receiving a Medicare EHR incentive payment.

Date Updated: 12/9/2010

New ID #2931

Old ID #10267

Payment Questions

102) After successfully demonstrating meaningful use for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program, will incentive payments be paid as a lump sum or in multiple installments?

Eligible professionals (EPs) participating in the Medicare EHR Incentive Program will receive a single lump sum payment for each year they successfully demonstrate meaningful use of certified EHR technology. Eligible hospitals and critical access hospitals (CAHs) participating in the Medicare EHR Incentive Program will first receive an initial payment. The final payment will be determined at the time of settling the hospital cost report. Payments to Medicare providers will be made to the taxpayer identification number (TIN) selected at the time of registration, through the same channels their claims payments are made. However, for EPs practicing in a health professional shortage area (HPSA), the additional incentive payment will be paid separately to the same TIN as the incentive payment.

Medicaid incentives will be paid by the States. EPs, eligible hospitals, and CAHs participating in the Medicaid EHR Incentive Program should check with their State.

Date Updated: 4/11/2011

Meaningful Use Questions

103) What is the reporting period for eligible hospitals participating in Stage 1 of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program?

For an eligible hospital or critical access hospital's first payment year, the EHR reporting period is a continuous 90-day period within a Federal fiscal year. In subsequent years (except 2014), the EHR reporting period for eligible hospitals and critical access hospitals (CAHs) is the entire Federal fiscal year. In 2014, an eligible hospital or CAH can use either the entire Federal fiscal year or a 3-month period aligned with the quarters of the Federal fiscal year.

Date Updated: 8/23/2012

New ID #2715

Old ID #9962

104) A number of measures for Meaningful Use objectives for eligible hospitals and critical access hospitals (CAHs) include patients admitted to the Emergency Department (ED). Which ED patients should be included in the denominators of these measures for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

There are two methods for calculating ED admissions for the denominators for measures associated with Meaningful Use objectives. Eligible hospitals and CAHs must select one of the methods below for calculating ED admissions to be applied consistently to all denominators for the measures. That is, eligible hospitals and CAHs must choose either the "Observation Services method" or the "All ED Visits method" to be used with all measures. Providers cannot calculate the denominator of some measures using the "Observation Services method," while using the "All ED Visits method" for the denominator of other measures. Before attesting, eligible hospitals and CAHs will have to indicate which method they used in the calculation of denominators.

Observation Services method.

When using this method, the denominator should include the following visits to the ED:

- The patients who are admitted to the inpatient department (Place of Service (POS) 21) either directly or through the emergency department.
- The patients who are initially presented to the emergency department (POS 23) and receive observation services. Patients who receive observation services under both POS 22 and POS 23 should be included in the denominator. Details on observation services can be found in the Medicare Benefit Policy Manual, Chapter 6, Section 20.6.

All ED Visits method.

An alternate method for computing admissions to the ED is to include all ED visits (POS 23 only) in the denominator for all measures requiring inclusion of ED admissions. All actions taken in the inpatient or emergency departments (POS 21 and 23) of the hospital would count for purposes of determining meaningful use.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit <http://www.cms.gov/EHRIncentivePrograms>.

Date Updated: 2/04/2014

New ID #2843 Old ID #10126

105) When will a Medicare Subsection (d) Hospital be paid under the Medicare EHR Incentive Program?

Upon submission of a successful attestation of meaningful use, the hospital will be eligible for an EHR incentive payment. The hospital will receive a preliminary, initial payment soon after attestation (usually within 4 to 6 weeks). The initial payment will be calculated based on the data reported on the hospital's latest submitted 12-month cost report.

Final payment will then be determined at the time of settling the first 12-month hospital cost report for the hospital fiscal year that begins on or after the first day of the payment year. Preliminary payments will be reconciled to the actual amounts at final settlement of the cost report.

Example – A hospital has a December 31 fiscal year end, and attests as a meaningful user on August 1, 2011. At the time of such attestation:

- The latest filed cost report will most likely be the fiscal year end December 31, 2010 cost report. Data from that cost report will be used to calculate the initial payment (subject to review by the Medicare contractor).
- Final payment will be based on data from the fiscal year end December 31, 2011 cost report. This is the first 12-month cost reporting period that begins in payment year 2011 (which is Federal fiscal year 2011). These data will be used to “reconcile” the initial payment, at final settlement of the cost report.

The new Medicare hospital cost report, Form CMS 2552-10, will contain worksheets to accommodate the EHR incentive payments.

Note – the EHR incentive payments will be made by a single payment contractor, and not by the hospitals' Medicare contractor (Fiscal Intermediary/Medicare Administrative Contractor).

Date Updated: 7/11/2011

New ID #3375 Old ID #10716

106) What cost report data elements are used in the EHR incentive payment calculation for Medicare Subsection (d) Hospitals?

The current Medicare cost report, Form CMS 2552-96, will be used until the implementation of the new Medicare cost report, Form CMS 2552-10. The CMS 2552-96 data elements are as follows:

- Total Discharges - Worksheet S-3 Part 1, Column 15, Line 12
- Inpatient Part A Days - Worksheet S-3 Part 1, Column 4, Line 1 + Lines 6 through 10
- Inpatient Part C Days - Worksheet S-3 Part 1, Column 4, Line 2
- Total Inpatient Days - Worksheet S-3 Part 1, Column 6, Line 1 + Lines 6 through 10
- Total Charges - Worksheet C Part 1, Column 8, Line 101
- Charity Care Charges - Worksheet S-10, Column 1, Line 30

The CMS 2552-10 data elements are as follows:

- Total Discharges - Worksheet S-3 Part 1, Column 15, Line 14
- Inpatient Part A Days - Worksheet S-3 Part 1, Column 6, Line 1 + Lines 8 through 12
- Inpatient Part C Days - Worksheet S-3 Part 1, Column 6, Line 2
- Total Inpatient Days - Worksheet S-3 Part 1, Column 8, Line 1 + Lines 8 through 12
- Total Charges - Worksheet C Part 1, Column 8, Line 200
- Charity Care Charges - Worksheet S-10, Column 3, Line 20

For information about the cost report data elements that are used in the Medicaid hospital incentive calculation, please see FAQ #10771.

Date Updated: 7/11/2011

New ID #3377 Old ID #10717

107) Will nursery days (for newborns) be included as inpatient-bed-days in the calculation of hospital incentives for the Medicare and Medicaid EHR Incentive Programs?

No, nursery days and discharges are not included in inpatient bed-day or discharge counts in calculating hospital incentives. We exclude nursery days and discharges because they are not considered acute inpatient services based on the level of care provided during a normal nursery stay.

Pages 44450 and 44453 of the Stage 1 final rule preamble explain that for the Medicare calculation, the statutory language clearly restricts discharges and inpatient bed-days to those from the acute care portion of a hospital. This is because of the definition of "eligible hospital" in section 1886(n)(6)(B) of the Social Security Act.

Page 44497 of the Stage 1 final rule explains that statutory parameters placed on Medicaid incentive payments to hospitals are largely based on the methodology applied to Medicare incentive payments. Therefore, as Medicaid is held to the same parameters as Medicare, the same limitations on counting inpatient bed-days and total discharges apply to Medicaid hospital incentive calculations.

To view the Stage 1 final rule for the Medicare and Medicaid EHR incentive programs, please visit: <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

Date Updated: 8/23/2012

New ID #2991 Old ID #10361

108) If patients are dually eligible for 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 Electronic Health Record (EHR) Incentive Programs?

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. To view the Stage 1 final rule, please visit:

<http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

Date Updated: 8/23/12

New ID #2829 Old ID #10106

109) Can SCIP INF-9 (CMS178v4 / NQF0453) still be used to meet the reporting requirements of the EHR Incentive Program (Meaningful Use) for Eligible Hospitals and the Hospital Inpatient Quality Reporting Program?

CMS suggests eligible hospitals participating in the Medicare & Medicaid EHR Incentive Programs and/or choosing the voluntary electronic reporting option under the Hospital Inpatient Quality Reporting (IQR) Program not select SCIP INF-9 (CMS 178v4/NQF 0453) as one of their electronic clinical quality measures (eCQMs) and choose another eCQM for Meaningful Use reporting and/or Hospital IQR reporting in 2015. A critical error identified in the measure (CMS 178v4/NQF 0453) renders a zero denominator.

The denominator error noted in the SCIP INF-9 (CMS 178v4/NQF 0453) was identified after the 2014 Annual Update posting. If the measure is used for reporting, a zero in the denominator will count as a successful submission for that CQM for both the Medicare EHR Incentive Program and the Hospital IQR Program.

Eligible hospitals and CAHs reporting CQMs using certified EHR technology are required to report on a minimum of 16 CQMs across 3 National Quality Strategy Domains. If an eligible hospital or CAH reports on a CQM generating a zero denominator, it will count toward the required 16 CQMS for the Medicare EHR Incentive Program and the Hospital IQR Program.

For additional clarification on reporting zero denominators, please see the page 50323 of the FY 2015 IPPS Final Rule:

<http://www.gpo.gov/fdsys/pkg/FR-2014-08-22/pdf/2014-18545.pdf>.

Date Updated: 10/9/2014
New ID# 10786 Old ID# N/A

Critical Access Hospital Questions

110) What is the definition of "reasonable cost" for critical access hospitals (CAHs) under the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs?

The reasonable costs for which a CAH may receive an EHR incentive payment are the reasonable acquisition costs for the purchase of certified EHR technology to which purchase depreciation (excluding interest) would otherwise apply. Section 495.106(a) of the regulations states that reasonable costs incurred for the purchase of certified EHR technology for a qualifying CAH means the reasonable acquisition costs incurred for the purchase of depreciable assets as described in part 413 subpart G of the regulations, such as computers and associated hardware and software, necessary to administer certified EHR technology as defined in section 495.4 excluding any depreciation and interest expenses associated with the acquisition. This EHR incentive payment provision allows a qualifying CAH to expense the acquisition costs of a qualifying asset in a single payment year instead of depreciating the acquisition costs over the useful life of the asset. If a qualifying CAH incurs non-depreciable expenses related to implementing/maintaining its EHR system, those expenses cannot be included in the EHR incentive payment. However, those expenses may be an allowable cost for Medicare payment purposes, under the current reasonable cost payment methodology for CAHs, in the cost reporting period in which such expenses are incurred. For example, if a qualifying CAH rents its EHR technology assets, instead of purchasing the assets, the rent expense cannot be included in the EHR incentive payment. However, the rent expense may be an allowable cost for Medicare payment purposes, under the current reasonable cost payment methodology for CAHs, in the cost reporting period in which such expense is incurred.

Qualifying CAHs should contact their Medicare contractor to answer questions on reasonable costs that will be included in the calculation of the EHR incentive payment.

Date Updated: 3/7/2011
New ID #2905 Old ID #10163

111) What if a Critical Access Hospital (CAH) purchases certified EHR technology, but it also includes other non-EHR functionality? Can the CAH include the cost in the Medicare EHR incentive payment?

The CAH may only include the portion of the reasonable costs of the system that pertains to certified EHR technology (what is required to achieve Meaningful Use). For example, if a certified system is purchased, and it also includes a payroll or other non-EHR module, only the portion of the reasonable costs pertaining to the certified EHR technology may be included in the EHR incentive payment. The CAH must be

able to provide documentation to the Medicare contractor (FI/MAC) to support the portion that it intends to claim.

Any other costs may continue to be included in the Medicare cost report, subject to reasonable cost principles.

Date Updated: 7/11/2011
New ID #3395 **Old ID #10726**

112) What if a Critical Access Hospital (CAH) purchases certified EHR technology, and the hardware needed to support it is shared with other systems?

The CAH may only include the portion of the reasonable costs of the hardware that pertains to certified EHR technology (what is required to achieve Meaningful Use). For example, if a certified system is purchased, and is housed on a server that contains other non-EHR systems, only the portion of the reasonable costs that pertains to the certified EHR technology may be included in the Medicare EHR incentive payment. The CAH must be able to provide documentation to the Medicare contractor (FI/MAC) to support the portion that it intends to claim.

Any other costs may continue to be included in the Medicare cost report, subject to reasonable cost principles.

Date Updated: 7/11/2011
New ID #3397 **Old ID #10727**

113) How are Medicare EHR Incentive Payments Calculated for Critical Access Hospitals (CAHs)?

CAHs are currently paid based on reasonable cost principles; therefore, their EHR incentive payments are calculated differently from the incentive payments to subsection (d) hospitals. A CAH must meet the definition of a meaningful EHR user to qualify to be paid the incentive payment for a payment year. A payment year means a Federal fiscal year beginning after FY 2010 and before FY 2016. In no case are incentive payments made with respect to cost reporting periods that begin during a payment year before FY 2011 or after FY 2015, and in no case may a CAH receive an incentive payment with respect to more than 4 consecutive payment years. The incentive payment made to a qualifying CAH equals:

[Allowable cost amount] * [Medicare Share].

The allowable cost amount equals the costs of depreciable assets purchased, such as computers and associated software, necessary to administer certified EHR technology. The incentive payment permits a qualifying CAH to expense the allowable cost amount in a single payment year rather than depreciating the costs over the useful life of the purchased asset. The allowable cost amount for a cost reporting period that begins in a payment year includes the reasonable cost incurred for the purchase of certified EHR technology in that payment year plus the

undepreciated costs for assets purchased, prior to the CAH becoming qualified, that are also being used to administer certified EHR technology in that payment year.

The Medicare Share is a fraction based on Medicare fee-for-service and managed care inpatient days, divided by total inpatient days, modified by charges for charity care:

- Numerator = (1) The number of inpatient-bed-days which are attributable to individuals with respect to whom payment may be made under Part A, including individuals enrolled in section 1876 Medicare cost plans; and (2) The number of inpatient-bed-days which are attributable to individuals who are enrolled with a Medicare Advantage organization
- Denominator = Total number of acute care inpatient-bed-days; * ((Total amount of the eligible hospital's charges – charges attributable to charity care)/Total amount of the eligible hospital's charges))

For CAHs, 20 percentage points are added to the Medicare Share calculation (not to exceed 100 percent).

In order for the CAH to receive its interim incentive payment, upon attestation, it must submit supporting documentation for its incurred costs of purchasing certified EHR technology to its Medicare contractor (Fiscal Intermediary/Medicare Administrative Contractor). The Medicare contractor will then calculate the allowable amount. The interim incentive payment is then subject to reconciliation to determine the final incentive payment amount. The final payment amount constitutes payment in full for the reasonable costs incurred for the purchase of certified EHR technology in the single payment year.

Date Updated: 7/11/2011

New ID #3379 Old ID #10718

114) What costs can be included in the Critical Access Hospital's Medicare EHR incentive payment?

The EHR incentive payment shall only include reasonable costs for the purchase of certified EHR technology to which purchase depreciation would apply. This would include the computers, and associated hardware and software, necessary to administer certified EHR technology.

If the cost cannot be included as a depreciable asset under normal Medicare cost reporting principles, it cannot be included in the EHR incentive payment. However, the CAH may continue to report all other costs on the Medicare Cost Report, and be reimbursed under reasonable costs principles.

Since the reasonable costs of the depreciable assets being included in the EHR incentive payment are allowed to be expensed in their entirety in the year incurred, the CAH must ensure that the resulting depreciation on those assets is not included in subsequent cost reports.

Date Updated: 7/11/2011

115) Can a Critical Access Hospital (CAH) include costs to lease/rent certified EHR technology in the Medicare EHR incentive payment?

Under the statute and the regulations, the CAHs EHR incentive payment shall only include reasonable costs for the purchase of certified EHR technology to which purchase depreciation (excluding interest) would apply. There are two types of lease agreements that a CAH may enter into to administer their EHR system... an operating lease or a capital lease.

OPERATING LEASE

An operating lease is merely a lease that involves an asset that is purchased, owned, and depreciated by the lessor and the lessee (the CAH) signs the lease agreement with the lessor to use the asset by paying a lease/rental fee for the term of the lease. The asset is returned to the lessor at the end of the lease without further obligation. Generally, the CAH can claim the entire lease/rental payment under an operating lease as an operating expense, unrelated to depreciation expenses. With an operating lease, the CAH does not purchase, own, or depreciate the asset, and the lease/rental expense does not meet the intent of the statute and regulations. Therefore, operating lease/rental expenses are not included in the CAH incentive payment. The CAH may, however, continue to include the operating lease expenses on its cost report, subject to reasonable cost principles.

CAPITAL LEASE

A capital lease agreement is essentially the same as a virtual purchase agreement, as defined in 42 CFR 413.130(b)(8) of the regulations and the Medicare Provider Reimbursement Manual (PRM), (CMS Pub. 15-1) section 110.B.1.b. A capital lease is treated as though the CAH (lessee) purchased the asset and the capital-related costs may not exceed the amount that the lessee would have included in capital-related costs if it had legal title to the asset (the cost of ownership). The cost of ownership includes straight-line depreciation, insurance and interest for computing the limitation. To be a capital lease, the agreement must satisfy at least one of the four conditions established by the Federal Accounting Standards Board (FASB). Similar to the FASB conditions, under CMS Pub. 15-1, section 110.B.1.b., a lease that meets any one of the following four conditions establishes a virtual purchase (otherwise the lease is considered an operating lease).

- The lease transfers title of the facilities or equipment to the lessee during the lease term,
- The lease contains a bargain purchase option,
- The lease term is 75 percent or more of the useful life of the facilities or equipment. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment, or
- The present value of the minimum lease payments (that is, payments to be made during the lease term, including bargain purchase option, guaranteed residual value, or penalties for failure to renew) equal 90 percent or more of

the fair market value of the leased property. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment. The present value is computed using the lessee's incremental borrowing rate, unless the interest rate implicit in the lease is known and is less than the lessee's incremental borrowing rate, in which case, the interest rate implicit in the lease is used.

Based on these criteria, a capital lease or virtual purchase meets the intent of the statute and regulation to qualify the leased asset as a purchased asset. Therefore, the CAHs' incentive payment may include the "cost" of such leased asset which must be based on the fair market value of the asset (see 42 CFR 413.134(b)(2)) at the date the lease was initiated. Other costs of ownership such as interest and insurance related to the virtual purchase lease shall not be included in the asset's cost for the purpose of the EHR incentive payment.

However, the portion of the rental expense which relates to the interest and insurance portion of the cost of ownership of such virtual purchase asset (see CMS Pub. 15-1, section 110.B.1.b.) may continue to be included on the cost report as reimbursable cost subject to the limitation on rental charges which are allowed under a virtual purchase lease (see CMS Pub. 15-1, section 110.B.1.b.2.). (See also the instructions for Form CMS-2552-10, W/S A-8, Line 32 describing the computation of the limitation.)

In order to include the reasonable cost of the leased asset in its incentive payment, the CAH will be required to provide its Medicare Administrative Contractor (MAC) with sufficient, appropriate documentation to establish that the lease meets the criteria of a virtual purchase lease as described above and that the "cost" of the asset was determined using the fair market value at the date the lease was initiated.

Date Updated: 7/17/2012

New ID #3387 Old ID #10722

116) What if the Home Office purchases the certified EHR technology for the Critical Access Hospital (CAH)?

If the certified EHR technology assets were purchased by the Home Office for the CAH, and the CAH meets the Meaningful Use criteria, the cost may be included in the Medicare EHR incentive payment calculation for the CAH. The cost must be directly attributable to the CAH, separately identifiable, and cannot be included in a pooled allocation of cost to the CAH on the Home Office Cost Statement. The CAH must be able to separately identify the assets to ensure that subsequent depreciation is not included. The CAH must maintain documentation to support the direct or functional allocation and to ensure that subsequent depreciation is not included in pooled allocations, as the Medicare contractor may need to review it to determine the allowable amount.

Date Updated: 7/11/2011

New ID #3389 Old ID #10723

117) What if the Home Office leases the certified EHR technology and allocates it to the Critical Access Hospital (CAH)?

If the Home Office is leasing the certified EHR technology, and allocating cost to the CAH, it cannot be included in the Medicare EHR incentive payments. The costs allowable for the EHR incentive payment are only the reasonable costs to which purchase depreciation would apply.

The CAH may, however, continue to include the lease costs on its cost report, subject to reasonable cost principles.

Date Updated: 7/11/2011

New ID #3391 Old ID #10724

118) What if a group of providers purchase and share certified EHR technology? Can the Critical Access Hospital (CAH) include the cost in the Medicare EHR incentive payment?

Yes, but only the portion that pertains to the specific CAH.

If there is a special arrangement where a group of providers purchase and share certified EHR technology, the specific CAH may only include the actual costs it incurred. For EHR incentive payments, the CAH may only include the costs of certified EHR technology to which purchase depreciation would apply. The CAH must maintain documentation to support the process of allocating the costs, as the Medicare contractor may need to review it to determine the allowable amount. The CAH must also have documentation to support that it has ownership in the assets, and is not renting/leasing the certified EHR technology.

Date Updated: 7/11/2011

New ID #3393 Old ID #10725

119) Can Critical Access Hospital (CAH) costs only be included in the first year for Medicare EHR incentive payments?

No, if the CAH incurs reasonable costs for certified EHR technology in subsequent payment years, it may receive additional incentive payments. The documentation to support the cost may be sent to the Medicare contractor (FI/MAC) after the attestation for that payment year.

Date Updated: 7/11/2011

New ID #3385 Old ID #10721

120) When will a Critical Access Hospital (CAH) receive its Medicare EHR incentive payment?

Upon submission of a successful attestation, the CAH will be eligible for an EHR incentive payment. In order for the incentive payment to be calculated, the CAH must submit documentation to its Medicare contractor (Fiscal Intermediary/Medicare Administrative Contractor) to support the costs incurred for

certified EHR technology. Once the Medicare contractor calculates the allowable amount and Medicare Share the CAH should expect its interim incentive payment within 4 to 6 weeks.

The CAH will receive an interim incentive payment that will later be reconciled on the Medicare cost report. The interim payment will be calculated using the Medicare Share based on the data reported on the hospital's latest submitted 12-month cost report.

The interim payment will be included on the CAH's cost report that begins during the payment year, and will be reconciled to the actual amounts at final settlement of the cost report.

Example – If a hospital has a December 31 fiscal year end, and attests as a meaningful user on August 1, 2011:

- The latest filed cost report when the CAH attests will most likely be the fiscal year end December 31, 2010 cost report. The data on that cost report will be used to calculate the Medicare Share for the initial payment.
- The cost reporting period that begins during the HITECH payment year (which is the federal fiscal year) is the fiscal year ending December 31, 2011 cost reporting period (since the begin date of January 1, 2011 falls within the fiscal year 2011 HITECH year). The interim payment will be reconciled at final settlement of the cost report for this period.

The new Medicare hospital cost report, Form CMS 2552-10, will contain worksheets to accommodate the EHR incentive payments.

Note – the EHR incentive payments will be made by a single payment contractor, and not by the hospitals' Medicare contractor (Fiscal Intermediary/Medicare Administrative Contractor).

Date Updated: 7/11/2011

New ID #3381 Old ID #10719

VI. Questions about Certified EHR Technology

121) What is the purpose of certified electronic health record (EHR) technology?

Certification of EHR technology will provide assurance to purchasers and other users that an EHR system or product offers the necessary technological capability, functionality, and security to help them satisfy the meaningful use objectives for the Medicare and Medicaid EHR Incentive Programs. Providers and patients must also be confident that the electronic health information technology (IT) products and systems they use are secure, can maintain data confidentially, and can work with other systems to share information. Confidence in health IT systems is an important part of advancing health IT system adoption and realizing the benefits of improved patient care.

For more information, please visit the Office of the National Coordinator's website at <http://healthit.hhs.gov/certification>.

Date Updated: 2/17/2011

New ID #2809 Old ID #10093

122) What if a Critical Access Hospital (CAH) purchases certified EHR technology, and the hardware needed to support it is shared with other systems?

The CAH may only include the portion of the reasonable costs of the hardware that pertains to certified EHR technology (what is required to achieve Meaningful Use). For example, if a certified system is purchased, and is housed on a server that contains other non-EHR systems, only the portion of the reasonable costs that pertains to the certified EHR technology may be included in the Medicare EHR incentive payment. The CAH must be able to provide documentation to the Medicare contractor (FI/MAC) to support the portion that it intends to claim.

Any other costs may continue to be included in the Medicare cost report, subject to reasonable cost principles.

Date Updated: 7/11/2011

New ID #3397 Old ID #10727

123) What if a group of providers purchase and share certified EHR technology? Can the Critical Access Hospital (CAH) include the cost in the Medicare EHR incentive payment?

Yes, but only the portion that pertains to the specific CAH.

If there is a special arrangement where a group of providers purchase and share certified EHR technology, the specific CAH may only include the actual costs it incurred. For EHR incentive payments, the CAH may only include the costs of certified EHR technology to which purchase depreciation would apply. The CAH must maintain documentation to support the process of allocating the costs, as the

Medicare contractor may need to review it to determine the allowable amount. The CAH must also have documentation to support that it has ownership in the assets, and is not renting/leasing the certified EHR technology.

Date Updated: 7/11/2011

New ID #3393 Old ID #10725

124) Do I need to have an electronic health record (EHR) system in order to register for the Medicare and Medicaid EHR Incentive Programs?

You do not need to have a certified EHR in order to register for the Medicare and Medicaid EHR Incentive Programs. However, to receive an incentive payment under the Medicare program, you must attest that you have demonstrated meaningful use of certified EHR technology during the EHR reporting period. For the first year of payment, the EHR reporting period is 90 consecutive days within the calendar year for eligible professionals (EPs) or within the Federal fiscal year for eligible hospitals and critical access hospitals (CAHs).

With regard to the Medicaid EHR Incentive program, for the first year of payment, EPs and hospitals must have adopted, implemented, upgraded certified EHR technology before they can receive an EHR incentive payment from the State. As an alternative to demonstrating that they have adopted, implemented or upgraded certified EHR technology, for the first year of payment, the EP or hospital may demonstrate that they are meaningful users of certified EHR technology for the 90-day EHR reporting period.

Date Updated: 2/17/2011

New ID #2791 Old ID #10083

125) Can two separate practices with two different Tax Identification Numbers (TINs) purchase a single certified electronic health record (EHR) system and share it in order to participate in the Medicare and Medicaid EHR Incentive Programs?

Yes. Incentive payments are made based on the demonstration of meaningful use by individual eligible professionals (EPs). Certified EHR technology will track each EP's performance on the individual meaningful use objectives. Multiple practices that do not share a business affiliation could use the same certified EHR technology for their respective EPs.

Date Updated: 10/20/2011

New ID #3607 Old ID #10842

126) Must providers have their electronic health record (EHR) technology certified prior to beginning the EHR reporting period in order to demonstrate Meaningful Use under the Medicare and Medicaid EHR Incentive Programs?

No. An EP or hospital may begin the EHR reporting period for demonstrating Meaningful Use before their EHR technology is certified. Certification need only be obtained prior to the end of the EHR reporting period. However, Meaningful Use

must be completed using the capabilities and standards outlined in the ONC Standards and Certification Regulation for certified EHR technology.

Any changes to the EHR technology after the beginning of the EHR reporting period that are made in order to get the EHR technology certified would be evidence that the provider was not using the capabilities and standards necessary to accomplish Meaningful Use because those capabilities and standards would not have been available, and thus, any such change (no matter how minimal) would disqualify the provider from being a meaningful EHR user. If providers begin the EHR reporting period prior to certification of their EHR technology, they are taking the risk that their EHR technology will not require any changes for certification.

Any changes made to gain certification must be done prior to the beginning of the EHR reporting period during which Meaningful Use will be demonstrated. This does not apply to changes made to EHR technology that were not necessary for certification.

Date Updated: 9/29/2010

New ID #2893 Old ID #10157

127) How do I know if my electronic health record (EHR) system is certified? How can I get my EHR system certified?

The Medicare and Medicaid EHR Incentive Programs require the use of certified EHR technology, as established by a new set of standards and certification criteria. Existing EHR technology needs to be certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB) to meet these new criteria in order to qualify for the incentive payments. The Certified Health IT Product List (CHPL) is available at <http://www.healthit.hhs.gov/CHPL>. This is a list of complete EHRs and EHR modules that have been certified for the purposed of this program.

Through the temporary certification program, new certification bodies have been established to test and certify EHR technology. Vendors can submit their EHR products to the certifying bodies to be tested and certified. Hospitals and practices who have developed their own EHR systems or products can also seek to have their existing systems or products tested and certified. Complete EHRs may be certified as well as EHR modules that meet at least one of the certification criteria. Once a product is certified, the name of the product will be published on the ONC web site: <http://www.healthit.hhs.gov/CHPL>.

For more information, please visit the Office of the National Coordinator's website at <http://healthit.hhs.gov/certification>.

Date Updated: 2/17/2011

New ID #2811 Old ID #10094

128) My electronic health record (EHR) system is CCHIT certified. Does that mean it is certified for the Medicare and Medicaid EHR Incentive Programs?

No. All EHR systems and technology must be certified specifically for this program. The Certified Health IT Product List is available at <http://www.healthit.gov/CHPL>. This is a list of all complete EHRs and EHR modules that have been certified for the purposes of this program.

The Medicare and Medicaid EHR Incentive Programs require the use of certified EHR technology, as established by a new set of standards and certification criteria. Existing EHR technology needs to be certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB) to meet these new criteria in order to qualify for the incentive payments.

Through the temporary certification program, new certification bodies have been established to test and certify EHR technology. Vendors can submit their EHR products to the certifying bodies to be tested and certified. Hospitals and practices who have developed their own EHR systems or products can also seek to have their existing systems or products tested and certified. Complete EHRs may be certified as well as EHR modules that meet at least one of the certification criteria. Once a product is certified, the name of the product will be published on the ONC web site – <http://www.healthit.gov/CHPL>.

For more information, please visit the Office of the National Coordinator's website at <http://healthit.hhs.gov/>. For more information about the Medicare and Medicaid EHR Incentive Program, please visit: <http://www.cms.gov/EHRIncentivePrograms>.

Date Updated: 8/17/2010

New ID #2623 Old ID #9809

129) For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, if the certified EHR technology possessed by an eligible professional (EP) generates zero denominators for all clinical quality measures (CQMs) in the additional set that it can calculate, is the EP responsible for determining whether they have zero denominators or data for any remaining CQMs in the additional set that their certified EHR technology is not capable of calculating?

This FAQ applies to providers who are reporting 2013 CQMs.

No, the EP is not responsible for determining the status of CQMs that their certified EHR technology is not capable of calculating. The certification criterion for ambulatory CQMs sets a minimum threshold in order for the certification criterion to be met. A 2011 edition EHR technology must be certified to the 6 core CQMs (3 core and 3 alternate core CQMs in Table 7 of the Stage 1 final rule) and at least 3 CQMs from the additional set (Table 6 of the Stage 1 final rule). In the Stage 1 final rule, we stated that it was our expectation that EPs would seek out certified EHR technologies that include and were certified for CQMs relevant to their scope of practice. Starting in 2014, EPs will have 2014 edition EHR technology which has different criteria. This FAQ applies only through the end of 2013.

To view the Stage 1 final rule for the Medicare and Medicaid EHR incentive programs, please visit: <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

To view the Stage 1 final rule for the Medicare and Medicaid EHR incentive programs, please visit: <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

Date Updated: 11/14/2014

New ID #3275

Old ID #10648

130) For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, if certified EHR technology possessed by an eligible professional (EP) includes the ability to calculate clinical quality measures (CQMs) from the additional set that are not indicated by the EHR developer or on the Certified Health Information Technology Product List (CHPL) as tested and certified by an ONC - Authorized Testing and Certification Body (ONC-ATCB), can the EP submit the results of those CQMs to CMS as part of their meaningful use attestation?

Through 2013, yes, the EP can submit results for CQMs in the additional set (Table 6 of the Stage 1 final rule) calculated by certified EHR technology, even if those CQMs were not individually tested and certified by an ONC-ATCB. We expect to revisit CQM requirements in more detail for later stages of meaningful use as well as the corresponding certification requirements. Starting in 2014, the EP must have 2014 edition Certified EHR Technology and will be required to only submit results generated by EHR technologies certified to the 2014 edition criteria.

To view the Stage 1 final rule for the Medicare and Medicaid EHR incentive programs, please visit: <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

Date Updated: 5/23/2011

New ID #3277

Old ID #10649

131) 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.

Date Updated: 9/24/2010
New ID #2853 Old ID #10135

132) To meet the Stage 1 meaningful use objective "use certified EHR technology to identify patient-specific resources and provide those resources to the patient" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, does the certified EHR have to generate the education resources or can the EHR simply alert the provider of available resources?

In the patient-specific education resources objective, education resources or materials do not have to be stored within or generated by the certified EHR. However, the provider should utilize certified EHR technology in a manner where the technology suggests patient-specific educational resources based on the information stored in the certified EHR technology. The provider can make a final decision on whether the education resource is useful and relevant to a specific patient.

Date Updated: 10/18/2010
New ID #2907 Old ID #10164

133) If my certified electronic health record (EHR) technology is capable of submitting batch files to an immunization registry using the standards adopted by the Office of the National Coordinator of Health Information Technology (HL7 2.3.1 or 2.5.1, and CVX), is that sufficient to meet the Stage 1 Meaningful Use objective "submit electronic data to immunization registries" for the Medicare and Medicaid EHR Incentive Programs?

Submitting batch files to an immunization registry, provided that they are formatted according to the standards adopted by the Office of the National Coordinator of Health Information Technology, is sufficient to meet the Meaningful Use objective "submit electronic data to immunization registries."

Date Updated: 7/11/2011
New ID #3369 Old ID #10713

134) If my certified EHR technology only includes the capability to submit information to an immunization registry using the HL7 2.3.1 standard but the immunization registry only accepts information formatted in the HL7 2.5.1 or some other standard, will I qualify for an exclusion because the immunization registry does not have the capacity to receive the information electronically? What if the immunization registry has a waiting list or is unable to test for other reasons but can accept information formatted in HL7 2.3.1, is that still a valid exclusion for Stage 1?

If the immunization registry does not accept information in the standard to which your EHR technology has been certified—that is, if your EHR is certified to the HL7 2.3.1 standard and the immunization registry only accepts HL7 2.5.1, or vice versa—and if the immunization registry is the only immunization registry to which you can submit such information, then you can claim an exclusion to this Meaningful Use objective because the immunization registry does not have the capacity to receive the

information electronically. The capacity of the immunization registry is determined by the ability of the immunization registry to test with an individual EP or eligible hospital.

An immunization registry may have the capacity to accept immunization data from another EP or hospital, but if for any reason (e.g. waiting list, on-boarding process, other requirements, etc) the registry cannot test with a specific EP or hospital, that EP or hospital can exclude the objective. It is the responsibility of the EP or hospital to document the justification for their exclusion (including making clear that the immunization registry in question is the only one it can submit information to). If the immunization registry, due to State law or policy, would not accept immunization data from you (e.g., not a lifespan registry, etc), you can also claim the exclusion for this objective. Please note, this FAQ applies in principle to all of the Stage 1 public health meaningful use measures (syndromic surveillance and reportable lab conditions).

Date Updated: 7/11/2011

New ID #3371 Old ID #10714

135) If a provider purchases a certified Complete Electronic Health Record (EHR) or has a combination of certified EHR Modules that collectively satisfy the definition of certified EHR technology, but opts to use a different, uncertified EHR technology to meet certain meaningful use core or menu set objectives and measures, will that provider be able to successfully demonstrate meaningful use under the Medicare and Medicaid EHR Incentive Programs?

No, the provider would not be able to successfully demonstrate meaningful use. 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.

A provider using uncertified EHR technology to meet one or more of the core or menu set measures would not be using the capabilities and standards that were certified to accomplish each objective. Please note that this does not apply to the use of uncertified EHR technology and/or paper-based records for purposes of reporting on certain meaningful use measures (i.e., measures other than clinical quality measures), which is addressed in FAQ #10589.

Date Updated: 4/22/2011

New ID #3211 Old ID #10590

136) Can an eligible professional (EP) use EHR technology certified for an inpatient setting to meet a meaningful use objective and measure?

Yes. For objectives and measures where the capabilities and standards of EHR technology designed and certified for an inpatient setting are equivalent to or require more information than EHR technology designed and certified for an ambulatory setting, an EP can use the EHR technology designed and certified for an inpatient setting to meet an objective and measure. There are some EP objectives, however, that have no corollary on the inpatient side. As a result, an EP must possess Certified EHR Technology designed for an ambulatory setting for such objectives. Please reference ONC FAQ 12-10-021-1 and 9-10-017-2 and CMS FAQ 10162 for discussions on what it means to possess Certified EHR Technology, ONC FAQ 6-12-025-1 for a list of affected capabilities and standards, and how that relates to the exclusion and deferral options of meaningful use.

To view the ONC FAQs, please visit:

http://healthit.hhs.gov/portal/server.pt/community/onc_regulations_faqs/

Date Updated: 6/21/2012

New ID #6421

Old ID #N/A

137) If data is captured using certified electronic health record (EHR) technology, can an eligible professional or eligible hospital use a different system to generate reports used to demonstrate meaningful use for the Medicare and Medicaid EHR Incentive Programs?

By definition, certified EHR technology must include the capability to electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage for all percentage-based meaningful use measures (specified in the certification criterion adopted at 45 CFR 170.302(n)). However, the meaningful use measures do not specify that this capability must be used to calculate the numerators and denominators. Eligible professionals and eligible hospitals may use a separate, non-certified system to calculate numerators and denominators and to generate reports on the measures of the core and menu set meaningful use objectives.

Eligible professionals and eligible hospitals will then enter this information in CMS' web-based Medicare and Medicaid EHR Incentive Program Registration and Attestation System. Eligible professionals and eligible hospitals will fill in numerators and denominators for meaningful use objectives, indicate if they qualify for exclusions to specific objectives, report on clinical quality measures, and legally attest that they have successfully demonstrated meaningful use.

Please note that eligible professionals and eligible hospitals cannot use a non-certified system to calculate the numerators, denominators, and exclusion information for clinical quality measures. Numerator, denominator, and exclusion information for clinical quality measures must be reported directly from certified EHR technology. For additional clarification about this, please refer to the following FAQ from the Office of the National Coordinator of Health Information Technology: http://healthit.hhs.gov/portal/server.pt/community/onc_regulations_faqs/3163/faq_13/20775.

Last Updated: January, 2015

138) What certification approaches would satisfy the 2014 Edition transitions of care certification criteria adopted at 45 CFR 170.314(b)(1) and (b)(2) as well as permit an eligible provider to have EHR technology that meets the Certified EHR Technology (CEHRT) definition? Please emphasize how the adopted transport standards fit in.

In general, EHR technology developers can take the three approaches outlined in the table below to meet the transitions of care certification criteria and their included transport standard(s). EHR technology certified according to any one of these three approaches could then be used by eligible providers to meet the CEHRT definition.

As additional context, it is important to keep in mind the "scope of a certification criterion" in the 2014 Edition EHR certification criteria (see 77 FR 54168). In the final rule, we describe that in order for a certification criterion to be met, all specific capabilities expressed under the second regulation text paragraph (e.g., everything under 170.314(b)(1)) would need to be demonstrated for certification. In other words, if EHR technology was presented for certification and could only perform the specific "create a CCDA" capability expressed in 170.314(b)(2)(i), that EHR technology would not meet this certification criterion.

With respect to transport standards, both certification criteria at 170.314(b)(1) and (b)(2) follow the same framework. At a minimum, EHR technology presented for certification must be able to electronically receive and transmit (in the respective certification criteria) transitions of care/referral summaries according to the Applicability Statement for Secure Health Transport. EHR technology developers are also able to seek certification to two optional transport standards:

- The Applicability Statement for Secure Health Transport specification and the XDR and XDM for Direct Messaging specification; and
- The Simple Object Access Protocol (SOAP)-Based Secure Transport Requirements Traceability Matrix (RTM) version 1.0 standard and the XDR and XDM for Direct Messaging specification.

Approach Descriptions

Approaches 1 and 2: The EHR technology presented for certification can perform all of the specific capabilities expressed by the certification criterion, including the required capabilities for content and transport standard (and any optional transport standards) (e.g., for 170.314(b)(1), receipt according to transport standards, display of CCD/C32, CCR, and CCDA, and incorporation of CCDA sections). The EHR technology presented for certification could either be from an EHR technology developer that likely includes other clinical capabilities or from an EHR technology developer (e.g., HIE/HISP) that focuses on transition of care/transmission related capabilities.

Approach 3: The EHR technology presented for certification can perform most of the capabilities expressed by the certification criterion (e.g., CCDA creation for 170.314(b)(2)), but also relies on a health information exchange (HIE) organization, health information service provider (HISP), or other 3rd party's technology to perform the required transport standard capability (and any optional transport standards). Under this approach and to meet the certification criterion:

1. The EHR technology must be presented for certification together with the technology supplied by the other entity to perform the transport capability (this other technology would be treated as "relied upon" software under ONC's certification rules (see FAQ 16))
2. The certification issued would represent the unique pairing of the EHR technology and the other entity's transport technology.

Finally, we note that these certification approaches could also be pursued in combination so long as the full scope of the certification criterion is met. For example, in order for an EHR technology developer to get its EHR technology certified to meet the required transport standard capability it could pursue the second approach and also seek certification for its EHR technology's native capability to perform to the second optional transport requirement (i.e., the SOAP-based RTM + XDR/XDM), which would enable its customers to have additional transport capabilities as part of their CEHRT.

Date Updated: 11/5/2012

New ID #7699

Old ID #N/A

139) When maintaining an up-to-date problem list as part of achieving meaningful use in the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs, can both SNOMED CT as well as non-SNOMED CT (for example ICD-9 or ICD-10) elements be included to meet the measure?

Prior to 2014, the Medicare and Medicaid EHR Incentive Programs permitted either SNOMED CT or ICD-9 to be used when a patient's problems were recorded by 2011 Edition Certified EHR Technology (CEHRT) as structured data. However, when an eligible professional (EP), eligible hospital, or critical access hospital (CAH) begins its 2014 EHR reporting period (for Stage 1 or Stage 2) it will need to use 2014 Edition CEHRT which only permits recording patient problems in SNOMED-CT®.

Therefore, beginning with the 2014 EHR reporting period, EPs, eligible hospitals, and CAHs will need to use the capabilities and standards included in 2014 Edition CEHRT to maintain the problem list using SNOMED-CT® as structured data. This policy also applies to other Stage 1 and Stage 2 objectives and measures in which problems

data is required, such as creating a Consolidated Clinical Document Architecture (CCDA) formatted summary record for the purposes of meeting the Stage 2 “transitions of care” measure #2 (10% electronic transmissions).

If the provider uses other code sets to identify/select problems for the problem list as part of a user interface (which is permitted), such codes will need to be mapped to the corresponding SNOMED-CT® codes when recorded in the CEHRT. For example, if the CEHRT is certified and uses both ICD and SNOMED-CT® codes, the ICD codes need to be “cross-walked” to the appropriate SNOMED-CT® codes to be included in the problem list to meet this measure.

Date Updated: 11/21/2013

New ID# 9274

Old ID# N/A

140) If an eligible provider (EP) practices at an outpatient location, a location other than an inpatient (place of service 21) or emergency department (place of service 23), and that location is only equipped with Certified Electronic Health Records (EHR) Technology certified to the criteria applicable to an inpatient setting, must the EP include that location in their meaningful use calculations?

No, this location is not equipped with Certified EHR Technology with all the capabilities necessary for an EP to satisfy the meaningful use objectives and measures. Accordingly, this location (like all outpatient locations) would be in the denominator of the calculation to determine whether the EP's outpatient encounters meet the 50 percent threshold, but not in the numerator as the location is not equipped with Certified EHR Technology. Also the location would not be included in the calculations of the EP's meaningful use measures in either the denominator or the numerator.

However, an EP can consider the location equipped with Certified EHR Technology if they have access to Certified EHR Technology certified to the criteria applicable to an ambulatory setting, which fills the gaps between inpatient and ambulatory. FAQ#3077 explains access to Certified EHR Technology, and ONC FAQ #6-12-025-2 outlines the gaps between inpatient and ambulatory Certified EHR Technology.

If the EP chooses to equip the location with Certified EHR Technology with the applicable criteria, the EP must then include that location in all calculations including both the 50 percent threshold calculation and the meaningful use measures calculations.

Date Updated: 10/23/2013

New ID#7811

Old ID# N/A

141) When new versions of clinical quality measure (CQM) specifications are released by the Centers for Medicare and Medicaid Services (CMS), do developers of Electronic Health Records (EHR) technology need to seek retesting/recertification of their certified complete EHR or certified EHR module in order to keep its certification valid?

No. The minimum version required for 2014 Edition certification is the version of CQM specifications released by CMS in December 2012. EHR technology that has been issued a certification based on the December 2012 version will remain certified even when CMS releases new versions of CQM specifications.

We strongly encourage EHR technology developers to update to the newest CQMs specifications as they become available since those updates include new codes, logic corrections and clarifications. We also recommend EHR technology developers consider that other CMS programs (beyond the EHR Incentive Programs) and other private sector programs generally update CQMs on an annual basis. As a result, an EHR technology developer's customers continued ability to successfully participate and report in those other programs could be impacted if the CQM data generated by the EHR technology is based on older specification versions (and no longer accepted by the other programs).

Please see FAQ 8898 and 8900 for additional information pertaining to the relationship between EHR certification and the CQM specification updates.

For more information on the 2014 CQM specifications, please visit:
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html

For more information on ONC Health Information Technology (HIT) Certification, please visit:

<http://www.healthit.gov/policy-researchers-implementers/about-certification>

Date Updated: 8/22/2013

New ID# 8896 Old ID# N/A

142) If the Electronic Health Records (EHR) technology "Product A" is already certified to the December 2012 clinical quality measure (CQM) specifications, can it be updated to include the Center for Medicare and Medicaid Service's (CMS) updated June 2013 specifications without seeking retesting/recertification?

Yes, you can update the EHR technology "Product A" to the new version of the CQM specifications without seeking additional testing and certification unless it is relabeled.

If Product A is relabeled to call it "Product A+2013 CQMs" and an EHR technology developer also wants "Product A+2013 CQMs" listed on the Certified Health IT Product List (CHPL) for its customers to select, the EHR technology developer will need to contact your Office of the National Coordinator - Authorized Certification Body (ONC-ACB) and, at a minimum, submit an inherited certified status request to get this new labeled version of Product A issued a certification. Upon receipt of the inherited certified status request an ONC-ACB would have discretion to require additional testing

Please see FAQ 8896 and 8900 for additional information pertaining to the relationship between EHR certification and the CQM specification updates.

For more information on the 2014 CQM specifications, please visit:
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html

For more information on ONC Health Information Technology (HIT) Certification, please visit:

<http://www.healthit.gov/policy-researchers-implementers/about-certification>

Date Updated: 8/22/2013

New ID# 8898 Old ID# N/A

143) If Electronic Health Records (EHR) technology is not yet certified to the clinical quality measure (CQM) criteria (45 CFR 170.314(c)(1) through (3)), can the EHR technology be tested and certified to only the newest available version of the CQM specifications or must it be tested and certified to the December 2012 specifications (first or as well)?

Yes, EHR technology may be presented for testing and certification to only newest CQM specifications. We strongly encourage EHR technology developers to test and certify to the newest CQMs specifications as they become available since those updates include new codes, logic corrections and clarifications. In addition, other CMS programs (beyond the EHR Incentive Programs) and other private sector programs generally update CQMs on an annual basis. Updating EHR technology to the newest CQM version specifications enables providers to participate and report in those other programs for which they are eligible as well.

Please see FAQ 8896 and 8898 for additional information pertaining to the relationship between EHR certification and the CQM specification updates.

For more information on the 2014 CQM specifications, please visit:

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html

For more information on ONC Health Information Technology (HIT) Certification, please visit:

<http://www.healthit.gov/policy-researchers-implementers/about-certification>

Date Updated: 8/22/2013

New ID# 8900 Old ID# N/A

144) How does a provider attest to a meaningful use objective (e.g., the “transitions of care,” “view/download patient data,” and public health objectives) where the provider electronically transmits data using technical capabilities provided by a health information exchange (HIE)?

Several meaningful use objectives require eligible professionals, eligible hospitals, and Critical Access Hospitals (CAH) to conduct electronic transmissions. In general, eligible professionals, eligible hospitals, and CAHs may use an HIE's services or technology to meet a particular meaningful use objective if the HIE technology used by the eligible professional, eligible hospital, or CAH has been certified to support that objective. If an eligible professional, eligible hospital, or CAH uses an HIE to satisfy a particular meaningful use objective, the provider will need to include the HIE technology's certification number, as a certified Electronic Health Records (EHR) Module, in their attestation.

A provider can determine whether the HIE technology they intend to use has been certified to support meaningful use objectives by using the Certified Health Information Technology (HIT) Products List (CHPL), available at <http://www.healthit.gov/CHPL>. This is a list of all EHR technology issued a "Complete EHR" or "EHR Module" certification for the purposes of the EHR Incentive Program.

Date Updated: 8/20/2013

New ID# 8908 Old ID# N/A

145) For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, how should an eligible professional (EP), eligible hospital, or critical access hospital (CAH) attest if the certified EHR vendor uses 2011 edition Certified EHR Technology for the first part of 2013 and 2014 edition Certified EHR Technology for the remainder of 2013?

If an EP, eligible hospital or CAH switches from 2011 edition Certified EHR Technology to 2014 Edition Certified EHR Technology during the program year, the data collected for the selected menu objectives and quality measures should be combined from both of the EHR systems for attestation. The count of unique patients does not need to be reconciled when combining from the two EHR systems.

If the menu objectives and/or clinical quality measures used are also being changed when switching certified editions, the menu objectives and/or quality measures collected from the EHR system that was used for the majority of the EHR reporting period should be reported.

Date Updated: 8/20/2013

New ID# 9060 Old ID# N/A

146) If a provider utilizes a health information organization that participates with the eHealth Exchange but is not connected to public health entities in the provider's state, does the provider still need to connect to those entities for purposes of participating in the Medicare and Medicaid EHR Incentive Program?

Yes, to meet the requirements for meaningful use, the provider must connect to the appropriate public health entities in his or her state, even if the provider has connected to an eHealth Exchange participant for other reasons. This can be accomplished by expanding the eHealth Exchange participant connections to

include public health agencies, or through direct connections from the provider to the public health agency, or through a different third-party interface.

The information required by a public health meaningful use objective must originate from the provider's Certified Electronic Health Records Technology (CEHRT), and the information sent from that technology must be formatted according to the standards and implementation specifications associated with the public health meaningful use objective. If a provider wishes to use an health information exchange (HIE) or other intermediary to connect to a public health agency and perform a function to meet the meaningful use requirement, the provider must use an HIE or intermediary that is certified as an EHR Module for that purpose.

CMS recognizes the variety of methods in which the exchange of public health information could take place, and therefore does not seek to limit or define the receiving capabilities of public health entities (see FAQ 3461).

Date Updated: 7/24/2013

New ID# 8906 Old ID# N/A

147) For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, how should an eligible professional (EP), eligible hospital, or critical access hospital (CAH) attest if the certified EHR vendor being used is switched to another certified EHR vendor in the middle of the program year?

If an EP, eligible hospital or CAH switches from one certified EHR vendor to another during the program year, the data collected for the selected menu objectives and quality measures should be combined from both of the EHR systems for attestation. The count of unique patients does not need to be reconciled when combining from the two EHR systems.

If the menu objectives and/or clinical quality measures used are also being changed when switching vendors, the menu objectives and/or quality measures collected from the EHR system that was used for the majority of the program year should be reported.

Date Updated: 4/22/2013

New ID# 8227 Old ID# N/A

148) If an eligible provider (EP) practices at an outpatient location that has not implemented all the functionalities necessary for the EP to meet meaningful use, is that location considered equipped with Certified Electronic Health Records (EHR) Technology? Must that location be included in the EP's meaningful use calculations? Does it matter if the location possesses ambulatory Certified EHR Technology covering the relevant meaningful use objectives, but does not implement them?

No, this location is not equipped with Certified EHR Technology and should not be used to calculate whether the EP's outpatient encounters meet the 50 percent threshold, nor would it be included in the calculations of the EP's meaningful use measures. This is true even if the location does possess ambulatory Certified EHR

Technology covering the relevant meaningful use objectives, but does not implement the functionalities.

An EP can consider the location equipped with Certified EHR Technology only if they have access to Certified EHR Technology certified to the criteria applicable to an ambulatory setting, which fills the gaps between the technology implemented by the location and the Certified EHR Technology necessary to meet the relevant meaningful use objectives. If the EP chooses to equip the location with Certified EHR Technology with the applicable criteria, the EP must then include this location in all calculations including both the 50 percent threshold calculation and the meaningful use measures calculations.

Date Updated: 2/26/2013

New ID# 7813 Old ID# N/A

149) When combining meaningful use data from multiple locations equipped with Certified Electronic Health Records (EHR) Technology, is it required to have a full meaningful use report from each location or is it acceptable to only collect denominator information from one or more locations?

An eligible provider (EP) must have accurate denominators for the meaningful use measures. If an EP is unable to access data from a location to determine whether a patient or action in the denominator should be included in the numerator for a given measure, the EP should be aware that this could negatively impact their performance on the measure, and the EP might not meet the required threshold for the measure.

Date Updated: 2/26/2013

New ID# 7815 Old ID# N/A

150) For the certification criteria that providers must have in place to meet the Clinical Decision Support (CDS) objective, what type of interventions must the EHR technology trigger to meet the criteria? For this and for the Eligible Provider and Eligible Hospital Core Measures related to the Objective “use clinical decision support to improve performance on high-priority health conditions,” are “pop-up” alerts the only type of intervention that a provider can use to meet the CDS objective?

The intention of the CDS intervention certification requirement is to ensure certified EHR technology helps providers make timely and informed decisions. The certification requirement that CDS interventions be ‘triggered’ means that a CDS intervention – which may come in many forms other than “pop-ups” – be based on relevant, timely patient and care process information and that it may appear in ‘real time’ when it is most relevant to improve care provision.

CDS is not simply an alert, notification, or explicit care suggestion. Providers can meet the objective by using other kinds of CDS, including, but not limited to clinical guidelines; condition-specific order sets; focused patient data reports and summaries; documentation templates; diagnostic support; and contextually relevant

reference information. In addition, CDS interventions are not only for doctors or nurses, but also for support staff, patients, and other caregivers, and may be delivered outside of the examination room or treatment setting.

Date Updated: 7/21/2014

New ID# 10228 Old ID# N/A

VII. Questions about Stage 1 Meaningful Use and Clinical Quality Measures

General Questions about Meaningful Use & Reporting Period

151) Under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program, who is responsible for demonstrating meaningful use of certified EHR technology, the provider or the vendor?

To receive an EHR incentive payment, the provider (eligible professional (EP), eligible hospital or critical access hospital (CAH)) is responsible for demonstrating meaningful use of certified EHR technology under both the Medicare and Medicaid EHR incentive programs.

Date Updated: 7/30/2010

New ID #2719 Old ID #9967

152) Is the physician the only person who can enter information in the electronic health record (EHR) in order to qualify for the Medicare and Medicaid EHR Incentive Programs?

No. The Stage 1 Final Rule for the Medicare and Medicaid EHR incentive programs, specifies that in order to meet the meaningful use objective for computerized provider order entry (CPOE) for medication orders, any licensed healthcare professional can enter orders into the medical record per state, local, and professional guidelines. The remaining meaningful use objectives do not specify any requirement for who must enter information.

To view the Stage 1 final rule, please visit:

<http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>

Date Updated: 2/17/2011

New ID #2771 Old ID #10071

153) Can an eligible professional (EP) implement an electronic health record (EHR) system and satisfy meaningful use requirements at any time within the calendar year for the Medicare and Medicaid EHR Incentive Program?

For a Medicare EP's first payment year, the EHR reporting period is a continuous 90-day period within a calendar year, so an EP must satisfy the meaningful use requirements for 90 consecutive days within their first year of participating in the program to qualify for an EHR incentive payment. In subsequent years (except 2014), the EHR reporting period for EPs will be the entire calendar year. With regard to the Medicaid EHR Incentive program, EPs must have adopted, implemented, upgraded, or meaningfully used certified EHR technology during the first calendar year. In 2014, a Medicare EP can use either the entire calendar fiscal year or a 3-month period aligned with the quarters of the calendar year. If the Medicaid EP

adopts, implements or upgrades in the first year of payment, and demonstrates meaningful use in the second year of payment, then the EHR reporting period in the second year is a continuous 90-day period within the calendar year; subsequent to that, the EHR reporting period is then the entire calendar year except in 2014 where it is any continuous 90 day period.

Date Updated: 2/17/2011

New ID #2797 Old ID #10086

154) Where can I find a list of public health agencies and immunization registries to submit my data as required by the public health objectives for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

For information and/or instructions on where to submit your public health-related data, please contact your local or state public health agencies and immunization registries. The EHR Incentive Programs include public health objectives for submitting electronic data to immunization registries or immunization information systems, submitting electronic syndromic surveillance data to public health agencies, and (for eligible hospitals and CAHs only) submitting electronic data on reportable lab results to public health agencies.

Date Updated: 10/20/2011

New ID #3605 Old ID #10841

155) Can an eligible hospital implement an electronic health record (EHR) system and satisfy meaningful use requirements at any time within the Federal fiscal year for the Medicare and Medicaid EHR Incentive Program?

For an eligible hospital's first payment year, the EHR reporting period is a continuous 90-day period within a Federal Fiscal Year, so an eligible hospital must satisfy the meaningful use requirements for 90 consecutive days within their first Federal Fiscal Year of participating in the program to qualify for an EHR incentive payment. In subsequent years (except 2014), the EHR reporting period for eligible hospitals will be the entire Federal Fiscal Year. In 2014, an eligible hospital or CAH can use either the entire Federal fiscal year or a 3-month period aligned with the quarters of the Federal fiscal year. With regard to the Medicaid EHR Incentive program, eligible hospitals must have adopted, implemented, upgraded, or meaningfully used certified EHR technology during the first Federal Fiscal Year. If the Medicaid eligible hospital adopts, implements or upgrades in the first year of payment, and demonstrates meaningful use in the second year of payment, then the EHR reporting period in the second year is a continuous 90-day period within the Federal fiscal year; subsequent to that, the EHR reporting period is then the entire Federal fiscal year.

Date Updated: 2/17/2011

New ID #2799 Old ID #10087

156) What is the reporting period for eligible professionals (EPs) participating in the electronic health record (EHR) incentive programs?

For demonstrating meaningful use through both the Medicare and Medicaid EHR Incentive Programs, the EHR reporting period for an EP's first year is any continuous 90-day period within the calendar year. In subsequent years, the EHR reporting period for EPs is the entire calendar year. Under the Medicaid program, there is also an incentive for the adoption, implementation, or upgrade of certified EHR technology, which does not have a reporting period.

Date Updated: 7/30/2010

New ID #2713 Old ID #9961

157) What is the reporting period for eligible hospitals participating in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program?

For an eligible hospital or critical access hospital's first payment year, the EHR reporting period is a continuous 90-day period within a Federal fiscal year. In subsequent years (except 2014), the EHR reporting period for eligible hospitals and critical access hospitals (CAHs) is the entire Federal fiscal year. In 2014, an eligible hospital or CAH can use either the entire Federal fiscal year or a 3-month period aligned with the quarters of the Federal fiscal year.

Date Updated: 8/23/2012

New ID #2715 Old ID #9962

158) Does a provider have to record all clinical data in their certified EHR technology in order to accurately report complete clinical quality measure data for the Medicare and Medicaid EHR Incentive Programs?

We recognize that providers are continuing to implement new workflow processes to accurately capture clinical data in their certified EHR technology, but many providers are not able to capture all data at this time. Although we encourage providers to capture complete clinical data in order to provide the best care possible for their patients, for the purpose of reporting clinical quality measure data, CMS does not require providers to record all clinical data in their certified EHR technology at this time. CMS recognizes that this may yield numerator, denominator, and exclusion values for clinical quality measures in the certified EHR technology that are not identical to the values generated from other methods (such as record extraction). However, at this time CMS requires providers to report the clinical quality measure data exactly as it is generated as output from the certified EHR technology in order to successfully demonstrate meaningful use. We will continue to collaborate with our partners in the Office of the National Coordinator for Health Information Technology and with industry stakeholders to make further headways in system interoperability, standards for EHR data, as well as certification of vendor products.

Date Updated: 10/20/2011

New ID #3601 Old ID #10839

159) Do specialty providers have to meet all of the meaningful use objectives for the Medicare and Medicaid EHR Incentive Programs, or can they ignore the objectives that are not relevant to their scope of practice?

For eligible professionals (EPs) who participate in the Medicare and Medicaid EHR Incentive Programs, there are a total of 25 meaningful use objectives. To qualify for an incentive payment, 20 of these 25 objectives must be met. There are 15 required core objectives. The remaining 5 objectives may be chosen from the list of 10 menu set objectives. Certain objectives do provide exclusions. If an EP meets the criteria for that exclusion, then the EP can claim that exclusion during attestation. However, if an exclusion is not provided, or if the EP does not meet the criteria for an existing exclusion, then the EP must meet the measure of the objective in order to successfully demonstrate meaningful use and receive an EHR incentive payment. Failure to meet the measure of an objective or to qualify for an exclusion for the objective will prevent an EP from successfully demonstrating meaningful use and receiving an incentive payment.

Date Updated: 7/11/2011

New ID #3069

Old ID #10469

160) Under the Medicaid EHR Incentive Program, will the requirement that eligible professionals and eligible hospitals choose at least one public health objective among the meaningful use measures 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 for the Medicaid EHR Incentive Program, then that would fulfill the eligible professional's (EP) requirement to select at least one public health measure. If the EP 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 at least one public health measure from the menu set.

Date Updated: 3/28/2011

New ID #3119

Old ID #10532

161) For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, is an eligible professional or eligible hospital limited to demonstrating meaningful use in the exact way that EHR technology was tested and certified? For example, if a Complete EHR has been tested and certified using a specific workflow, is an eligible professional or eligible hospital required to use that specific workflow when it demonstrates meaningful use? Similarly, if the EHR technology was tested and certified with certain clinical decision support rules, are those the only clinical decision support rules an eligible health care provider is permitted to use when demonstrating meaningful use?

In most cases, an eligible professional or eligible hospital is not limited to demonstrating meaningful use to the exact way in which the Complete EHR or EHR Module was tested and certified. As long as an eligible professional or eligible hospital uses the certified Complete EHR or certified EHR Module's capabilities and, where applicable, the associated standard(s) and implementation specifications

that correlate with the respective meaningful use objective and measure, they can successfully demonstrate meaningful use even if their exact method differs from the way in which the Complete EHR or EHR Module was tested and certified.

It is important to remember the purpose of certification. Certification is intended to provide assurance that a Complete EHR or EHR Module will properly perform a capability or capabilities according to the adopted certification criterion or criteria to which it was tested and certified (and according to the applicable adopted standard(s) and implementation specifications, if any). The Temporary Certification Program and Permanent Certification Program Final Rules (75 FR 36188 and 76 FR 1301, respectively), published by the Office of the National Coordinator for Health IT (ONC), acknowledged that eligible professionals and eligible hospitals could, where appropriate, modify their certified Complete EHR or certified EHR Module to meet local health care delivery needs and to take full advantage of the capabilities that the certified Complete EHR or certified EHR Module includes.

These rules also cautioned that modifications made to a Complete EHR or EHR Module post-certification have the potential to adversely affect the technology's capabilities such that it no longer performs as it did when it was tested and certified, which could ultimately compromise an eligible professional or eligible hospital's ability to successfully demonstrate meaningful use.

In instances where a certification criterion expresses a capability which could potentially be added to or enhanced by an eligible professional or eligible hospital, the way in which EHR technology was tested and certified generally would not limit a provider's ability to modify the EHR technology in an effort to maximize the utility of that capability. Examples of this could include adding clinical decision support rules, adjusting or adding drug-drug notifications, or generating patient lists or patient reminders based on additional data elements beyond those that were initially required for certification. Modifications that adversely affect the EHR technology's capability to perform in accordance with the relevant certification criterion could, however, ultimately compromise an eligible professional or eligible hospital's ability to successfully demonstrate meaningful use.

In instances where the EHR technology was tested and certified using a sample workflow and/or generic forms/templates, an eligible professional or eligible hospital generally is not limited to using that sample workflow and/or those generic forms/templates. In this context, the "workflow" would constitute the specific steps, methods, processes, or tasks an eligible professional or eligible hospital would follow when using one or more capabilities of the certified Complete EHR or certified EHR Module to meet meaningful use objectives and associated measures. An eligible health care provider could use a different workflow and/or substitute different forms/templates for those that are included in the certified Complete EHR or certified EHR Module. Again, care should be taken to ensure that such actions do not adversely affect the Complete EHR's or EHR Module's performance of the capabilities for which it was tested and certified, which could ultimately compromise

an eligible professional or eligible hospital's ability to successfully demonstrate meaningful use.

Date Updated: 3/7/2011

New ID #3073

Old ID #10473

162) To meet the Stage 1 public health meaningful use objectives (submitting information to an immunization registry, reporting lab results to a public health agency, or reporting syndromic surveillance information) for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, does a provider have to send information directly from their certified EHR technology to the appropriate receiving entity or can they use an intermediary such as a health information exchange (HIE) or another third-party software vendor?

CMS recognizes that there are a variety of methods in which the exchange of public health information could take place. In order to promote the submission of public health information to appropriate entities, we do not seek to limit or define the receiving capacities of said entities. In order to satisfy the public health meaningful use objectives, a provider must conduct one test of information exchange according to the following criteria:

- The information required for the public health meaningful use objective must originate from the provider's certified EHR technology; and
- The information sent from the provider's certified EHR technology must be formatted according to the standards and implementation specifications associated with the public health meaningful use objective.

If an intermediary performs a capability specified in an adopted certification criterion and a provider intends to use the capability the intermediary provides to satisfy a correlated meaningful use requirement (submission to public health according to adopted standards), the capability provided by the intermediary would need to be certified as an EHR Module (see ONC FAQ 18 for more information).

Date Updated: 8/23/2012

New ID #3461

Old ID #10764

163) What are the EHR reporting periods for eligible hospitals participating in both the Medicare and Medicaid EHR Incentive Programs, as well as the requirements for receiving an EHR incentive payment?

There are two factors that determine the EHR reporting period for hospitals eligible for both the Medicare and Medicaid EHR Incentive Programs:

- Whether the hospital is attesting to Medicaid only; Medicaid first, then Medicare in the same fiscal year; Medicaid first, then Medicare in a later fiscal year; or Medicare and Medicaid simultaneously/Medicare first, then Medicaid in a later fiscal year.
- The payment year for which the hospital is attesting (first, second, third etc.)

See the table below (where having adopted, implemented, or upgraded to certified EHR technology for Medicaid is abbreviated as AIU and meaningful use is abbreviated as MU):

Payment Year	Hospital Participating In:		
	Medicaid Incentive Program Only	Medicaid 1 st , then Medicare in same FY	Medicare and Medicaid Simultaneously / Medicare 1 st , then Medicaid in a later FY
1 st payment year	AIU	AIU (Medicaid); MU, 90 day reporting period (Medicare)	MU, 90 day reporting period
2 nd payment year	MU, 90 day reporting period	MU, 12 month reporting period	MU, 12 month reporting period
3 rd payment year	MU, 12 month reporting period	MU, 12 month reporting period	MU, 12 month reporting period

Relevant points to remember regarding eligible hospitals:

- Hospitals that are eligible for EHR incentive payments under both Medicare and Medicaid should select "Both Medicare and Medicaid" during the registration process, even if they initially plan to apply for an incentive under only one program.
- A hospital that is a meaningful EHR user under the Medicare EHR Incentive Program is deemed to be a meaningful user for Medicaid. CMS will audit hospitals eligible for both the Medicare and Medicaid EHR Incentive Programs for compliance with the meaningful use requirements under the Medicare program. The states are responsible for auditing AIU and other requirements for receiving an EHR incentive payment, such as patient volume.
- There will never be two consecutive years of 90-day reporting periods for meaningful use. The 90-day reporting period is always followed by a 12-month reporting period the following year, irrespective of when attestation occurred and whether to Medicare or Medicaid.
- The reporting period must begin and end in the Federal Fiscal Year that constitutes the payment year.
- There is no reporting period for adopt/implement/upgrade.
- A hospital participating in the Medicaid EHR incentive program must meet all Medicaid requirements, including patient volume requirements.
- See p. 44323 of the Stage 1 Final Rule for Stages of meaningful use by payment year.

Date Updated: 1/19/2012

New ID #3575

Old ID #10826

164) If a provider purchases a certified Complete Electronic Health Record (EHR) or has a combination of certified EHR Modules that collectively satisfy the definition of certified EHR technology, but opts to use a different, uncertified EHR technology to meet certain meaningful use core or menu set objectives and measures, will that

provider be able to successfully demonstrate meaningful use under the Medicare and Medicaid EHR Incentive Programs?

No, the provider would not be able to successfully demonstrate meaningful use. 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.

A provider using uncertified EHR technology to meet one or more of the core or menu set measures would not be using the capabilities and standards that were certified to accomplish each objective. Please note that this does not apply to the use of uncertified EHR technology and/or paper-based records for purposes of reporting on certain meaningful use measures (i.e., measures other than clinical quality measures), which is addressed in FAQ #10589.

Date Updated: 4/22/2011

New ID #3211 Old ID #10590

165) Under the Medicaid EHR Incentive Program, will the requirement that eligible professionals and eligible hospitals choose at least one public health objective among the meaningful use measures 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 for the Medicaid EHR Incentive Program, then that would fulfill the eligible professional's (EP) requirement to select at least one public health measure. If the EP 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 at least one public health measure from the menu set.

Date Updated: 3/28/2011

New ID #3119 Old ID #10532

166) If an eligible professional (EP) sees a patient in a setting that does not have certified electronic health record (EHR) technology but enters all of the patient's information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of meaningful use measures for the Medicare and Medicaid EHR Incentive Programs?

Starting in 2013, an EP must have access to Certified EHR Technology at a location in order to include patients seen in locations in the determination of whether they

meet the threshold of 50% of patient encounters at locations equipped with Certified EHR Technology to be eligible for the EHR Incentive Program. However, if the EP meets this threshold and also includes information on patient encounters at locations where they do not have access to Certified EHR Technology, information about those encounters can be included when calculating the numerators and denominators for the meaningful use measures.

For information about the patient encounters threshold, please visit FAQ 3215.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit <http://www.cms.gov/EHRIncentivePrograms>.

Date Updated: 8/20/2013

New ID #3077 Old ID #10475

167) Does the inclusion of certified Medical Assistant in the list of professionals who can enter orders into the EHR using CPOE and have them count in the numerator?

We have revised the description of who can enter orders into the EHR and have it count as CPOE and have it count for purposes of the CPOE measure. This revision is available for EHR reporting periods in 2013 and beyond regardless of what stage of meaningful use the provider is attesting to.

Date Updated: 11/5/2012

New ID #7693 Old ID #N/A

168) For some of the eligible professional (EP) clinical quality measures (CQMs), there are look back periods or look forward periods for which data was not available. How are these CQMs calculated for the reporting period?

CQMs that include look back periods or look forward periods may require data outside of the reporting period of a CMS quality reporting program.

Look Back Period – Example CQM:

An example of a CQM that includes a look back period is CMS130 (NQF 0034) Colorectal Cancer Screening. The CQM assesses performance on the percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer. If the screening occurred within the reporting period and through the EP's practice, it should be captured in the calculated performance rate. However, if the screening took place before the reporting period and/or occurred outside of the EP's practice, it is possible that the screening would be omitted from the calculated performance rate.

Look Forward Period – Example CQM:

An example of a CQM that includes a look forward period is CMS159 (NQF 0710) Depression Remission at Twelve Months. The CQM assesses performance on adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score >9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5 (includes newly diagnosed and existing patients with depression or

dysthymia). If the assessment for remission at twelve months occurs within the reporting period and through the EP's practice, it should be captured in the calculated performance rate. However, if the assessment takes place after the reporting period and/or occurred outside of the EP's practice, it is possible that the occurrence of the remission would be omitted from the calculated performance rate.

General Guidelines:

We recommend that the information needed from the look back periods be requested from the patient as part of the encounter and recorded in the Electronic Health Records (EHR) technology, for example, as part of the patient's history. For EHR vendors, we recommend that EHRs include the capability of capturing the type of information needed for the look back periods as part of the encounter (e.g., in the history section of an encounter note) and then extract data from this entry for purposes of reporting CQMs with look back periods.

There is no practical way to capture information for look forward periods that go into the next reporting period. In most cases, this should affect the performance rates of all EPs similarly. For CQM data reporting to CMS that may be used for a pay for performance program, the collective EP performance rates should be reflected in the benchmark for each respective CQM that contains a look forward period. Since EPs who are subject to the value-based payment modifier would be assessed, in part, based on the performance rate of the CQMs they report through the Physician Quality Reporting System (PQRS), those EPs may review the CQMs available and try to report on CQMs that are not affected by look back or look forward periods to help mitigate the issues described above for programs that have the option to select CQMs.

Date Updated: 2/06/2014

New ID#9676

Old ID# N/A

169) If an eligible provider fails to meet meaningful use (MU) during a participation year in the Medicare Electronic Health Records (EHR) Incentive Program, can he/she continue to participate and earn incentives?

An Eligible Professional (EP), Eligible Hospital or Critical Access Hospital (CAH) that participates in the Medicare EHR Incentive Program and does not meet MU for one participation year is highly encouraged to continue to attest and earn incentive payments for future participation years.

If a participating provider does not successfully attest for a given year, he/she will not be eligible to receive an incentive payment for that year. However, attesting and receiving an incentive payment for a future participation year is based on the provider's ability to meet MU during that year and not based on success or failure in previous years.

When a provider continues to participate and submit attestation information in subsequent years, the progression through the stages of MU will continue to follow

the CMS-established timeline of meeting the MU criteria of each stage for two program years, regardless of whether he/she demonstrates MU in each consecutive year.

For example, if an EP demonstrates the stage 1 criteria for the 1st payment year, but does not meet the stage 1 criteria in the 2nd payment year, the EP will receive an incentive payment for the 1st payment year but not receive the associated incentive payment for the 2nd year.

When the EP proceeds to attest for the 3rd payment year, he/she may be eligible to receive the associated incentive payment if MU is met. However, since the EP has completed the 1st and 2nd program years, the EP will be expected to demonstrate the stage 2 meaningful use criteria to receive payment in the 3rd year, even if he/she did not meet the stage 1 criteria in the 2nd year.

If a provider registers to participate in the EHR Incentive Program for the first year but chooses to withdraw their attestation, the provider may have the opportunity to start over and "repeat" their first year of participation in the Incentive Program if a CMS post payment or prepayment audit has not been initiated. If the provider withdraws their attestation during or after a CMS audit has been conducted, the provider forfeits the ability to reattest as a Year 1 participant and must attest as a Year 2 participant in the next year. Once the provider has withdrawn and the audit has been initiated, the progression along the EHR Incentive Program timeline has begun and the provider would need to meet MU along this schedule in order to earn the associated incentive payments.

Please see FAQ 7737 for information about the meaningful use progression in the Medicaid EHR Incentive Program.

For more information about the EHR Incentive Program timeline, please visit:
<http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Basics.html>

To use the interactive "My EHR Participation Timeline" tool, please visit:
<http://cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Participation-Timeline.html>

Date Updated: 11/19/2013

New ID# 9220 Old ID# N/A

170) When meeting the meaningful use measure for computerized provider order entry (CPOE) in the Electronic Health Records (EHR) Incentive Programs, does an individual need to have the job title of medical assistant in order to use the CPOE function of Certified EHR Technology (CEHRT) for the entry to count toward the measure, or can they have other titles as long as their job functions are those of medical assistants?

If a staff member of the eligible provider is appropriately credentialed and performs similar assistive services as a medical assistant but carries a more specific title due to either specialization of their duties or to the specialty of the medical professional they assist, he or she can use the CPOE function of CEHRT and have it count towards the measure. This determination must be made by the eligible provider based on individual workflow and the duties performed by the staff member in question. Whether a staff member carries the title of medical assistant or another job title, he or she must be credentialed to perform the medical assistant services by an organization other than the employing organization. Also, each provider must evaluate his or her own ordering workflow, including the use of CPOE, to ensure compliance with all applicable federal, state, and local law and professional guidelines.

Date Updated: 8/20/2013

New ID#9058 Old ID# N/A

171) While the denominator for measures used to calculate meaningful use in the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs is restricted to patients seen during the EHR reporting period, is the numerator also restricted to activity during the EHR reporting period or can actions for certain meaningful use measures be counted in the numerator if they took place after the EHR reporting period has ended?

The criteria for a numerator is not constrained to the EHR reporting period unless expressly stated in the numerator statement for a given meaningful use measure. The numerator for the following meaningful use measures should include only actions that take place within the EHR reporting period: Preventive Care (Patient Reminders) and Secure Electronic Messaging.

For all other meaningful use measures, the actions may reasonably fall outside the EHR reporting period timeframe but must take place no later than the date of attestation in order for the patients to be counted in the numerator.

Date Updated: 4/26/2013

New ID# 8231 Old ID# N/A

172) When combining meaningful use data from multiple locations equipped with Certified Electronic Health Records (EHR) Technology, is it required to have a full meaningful use report from each location or is it acceptable to only collect denominator information from one or more locations?

An eligible provider (EP) must have accurate denominators for the meaningful use measures. If an EP is unable to access data from a location to determine whether a patient or action in the denominator should be included in the numerator for a given measure, the EP should be aware that this could negatively impact their performance on the measure, and the EP might not meet the required threshold for the measure.

Date Updated: 2/26/2013

New ID# 7815 Old ID# N/A

Questions about Stage 1 Meaningful Use Measures & Objectives

173) Is a hospital participating in the Medicare and Medicaid EHR Incentive Programs required to report quality metrics on ALL patients? How will the measurement be defined with regards to numerator and denominator?

The technical specifications issued by CMS for the clinical quality measures under the Medicare and Medicaid EHR Incentive Programs specify what data should be included in the numerator and the denominator. Clinical quality measure reporting is inclusive of all applicable patients or actions during the Electronic Health Record reporting period, with no differentiation by payer.

Date Updated: 3/28/2011

New ID #3125 Old ID #10538

174) For the Stage 1 meaningful use objective of "capability to exchange key clinical information" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, does exchange of electronic information using physical media, such as USB, CD-ROM, or other formats, meet the measure of this objective?

No, the use of physical media such as a CD-ROM, a USB or hard drive, or other formats to exchange key clinical information would not utilize the certification capability of certified EHR technology to electronically transmit the information, and therefore would not meet the measure of this objective.

No, the use of physical media such as a CD-ROM, a USB or hard drive, or other formats to exchange key clinical information would not utilize the certification capability of certified EHR technology to electronically transmit the information, and therefore would not meet the measure of this objective.

For the purposes of the Stage 1 "capability to exchange key clinical information" measure, exchange is defined as electronic transmission and acceptance of key clinical information using the capabilities and standards of certified EHR technology (as specified at 45 CFR 170.304(i) for EPs and 45 CFR 170.306(f) for eligible hospitals and CAHs). We expect that this information would be exchanged in structured electronic format when available (e.g., drug or clinical lab data); however, where the information is available only in unstructured electronic formats (e.g., free text or scanned images), the exchange of unstructured information would satisfy this measure. For more information about electronic exchange of key clinical information, please refer to the following FAQ:

http://questions.cms.hhs.gov/app/answers/detail/a_id/10270/kw/10270.

Please note that this objective is distinct from objectives such as "provide a summary of care record for each transition of care," where electronic exchange of the summary of care record is not a requirement but an option. To satisfy the measure of the "provide a summary of care record for each transition of care" objective, a provider is permitted to send an electronic or paper copy of the summary care

record directly to the next provider or can provide it to the patient to deliver. In this case, the use of physical media such as a CD-ROM, a USB or hard drive, or other formats could satisfy the measure of this objective.

Effective 2013, this objective and measure are no longer required.

Date Updated: 8/23/2012

New ID #3255 Old ID #10638

175) For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, if the certified EHR technology possessed by an eligible professional (EP) generates zero denominators for all clinical quality measures (CQMs) in the additional set that it can calculate, is the EP responsible for determining whether they have zero denominators or data for any remaining CQMs in the additional set that their certified EHR technology is not capable of calculating?

This FAQ applies to providers who are reporting 2013 CQMs.

No, the EP is not responsible for determining the status of CQMs that their certified EHR technology is not capable of calculating. The certification criterion for ambulatory CQMs sets a minimum threshold in order for the certification criterion to be met. A 2011 edition EHR technology must be certified to the 6 core CQMs (3 core and 3 alternate core CQMs in Table 7 of the Stage 1 final rule) and at least 3 CQMs from the additional set (Table 6 of the Stage 1 final rule). In the Stage 1 final rule, we stated that it was our expectation that EPs would seek out certified EHR technologies that include and were certified for CQMs relevant to their scope of practice. Starting in 2014, EPs will have 2014 edition EHR technology which has different criteria. This FAQ applies only through the end of 2013.

To view the Stage 1 final rule for the Medicare and Medicaid EHR incentive programs, please visit: <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

To view the Stage 1 final rule for the Medicare and Medicaid EHR incentive programs, please visit: <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

Date Updated: 11/14/2014

New ID #3275 Old ID #10648

176) For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, how should an eligible professional (EP), eligible hospital, or critical access hospital (CAH) that sees patients in multiple practice locations equipped with certified EHR technology calculate numerators and denominators for the meaningful use objectives and measures?

EPs, eligible hospitals, and CAHs should look at the measure of each meaningful use objective to determine the appropriate calculation method for individual numerators and denominators. The calculation of the numerator and denominator for each measure is explained in the July 28, 2010 Stage 1 final rule (75 FR 44314).

For objectives that require a simple count of actions (e.g., number of permissible prescriptions written, for the objective of "Generate and transmit permissible prescriptions electronically (eRx)"; number of patient requests for an electronic copy of their health information, for the objective of "Provide patients with an electronic copy of their health information"; etc.), EPs, eligible hospitals, and CAHs can add the numerators and denominators calculated by each certified EHR system in order to arrive at an accurate total for the numerator and denominator of the measure.

For objectives that require an action to be taken on behalf of a percentage of "unique patients" (e.g., the objectives of "Record demographics", "Record vital signs", etc.), EPs, eligible hospitals, and CAHs may also add the numerators and denominators calculated by each certified EHR system in order to arrive at an accurate total for the numerator and denominator of the measure. Previously CMS had advised providers to reconcile information so that they only reported unique patients. However, because it is not possible for providers to increase their overall percentage of actions taken by adding numerators and denominators from multiple systems, we now permit simple addition for all meaningful use objectives. Please keep in mind that patients whose records are not maintained in certified EHR technology will need to be added to denominators whenever applicable in order to provide accurate numbers.

To report clinical quality measures, EPs who practice in multiple locations that are equipped with certified EHR technology should generate a report from each of those certified EHR systems and then add the numerators, denominators, and exclusions from each generated report in order to arrive at a number that reflects the total data output for patient encounters at those locations. To report clinical quality measures, eligible hospitals and CAHs that have multiple systems should generate a report from each of those certified EHR systems and then add the numerators, denominators, and exclusions from each generated report in order to arrive at a number that reflects the total data output for patient encounters in the relevant departments of the eligible hospital or CAH (e.g., inpatient or emergency department (POS 21 or 23)).

To view the Stage 1 final rule for the Medicare and Medicaid EHR incentive programs, please visit: <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

Date Updated: 4/11/2012

New ID #3609

Old ID #10843

177) For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, how should an eligible hospital or critical access hospital (CAH) with multiple certified EHR systems report their clinical quality measures?

To report clinical quality measures, eligible hospitals and CAHs that have multiple systems should generate a report from each of those certified EHR systems and then add the numerators, denominators, and exclusions from each generated report in order to arrive at a number that reflects the total data output for patient encounters in the relevant departments of the eligible hospital or CAH (e.g., inpatient or

emergency department (POS 21 or 23)).

Date Updated: 10/20/2011

New ID #3611

Old ID #10844

178) What are the requirements for dentists participating in the Medicaid EHR Incentive Program?

Dentists must meet the same eligibility requirements as other eligible professionals (EP) in order to qualify for payments under the Medicaid EHR Incentive Program. This also means that they must demonstrate all 15 of the core meaningful use objectives and five from the menu of their choosing. The core set includes reporting of six clinical quality measures (three core and three from the menu 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 as there is no blanket exclusion by type of EP.

Date Updated: 9/12/2012

New ID #3109

Old ID #10527

179) What information must an eligible professional provide in order to meet the Stage 1 measure of the meaningful use objective for “provide a clinical summary for patients for each office visit” under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

In our Stage 1 final rule, we defined "clinical summary" as: an after-visit summary that provides a patient with relevant and actionable information and instructions containing, but not limited to, the patient name, provider's office contact information, date and location of visit, an updated medication list, updated vitals, reason(s) for visit, procedures and other instructions based on clinical discussions that took place during the office visit, any updates to a problem list, immunizations or medications administered during visit, summary of topics covered/considered during visit, time and location of next appointment/testing if scheduled, or a recommended appointment time if not scheduled, list of other appointments and tests that the patient needs to schedule with contact information, recommended patient decision aids, laboratory and other diagnostic test orders, test/laboratory results (if received before 24 hours after visit), and symptoms.

The EP must include all of the above that can be populated into the clinical summary by certified EHR technology. If the EP's certified EHR technology cannot populate all of the above fields, then at a minimum the EP must provide in a clinical summary the data elements for which all EHR technology is certified for the purposes of this program (according to §170.304(h)):

- Problem List
- Diagnostic Test Results
- Medication List
- Medication Allergy List

This answer applies to clinical summaries generated by certified EHR technology for electronic or paper dissemination. Also, if one form of dissemination (paper or electronic) has a more limited set of fields than the other, this does not serve as a limit on the other form. For example, certified EHR technology may be capable of populating a clinical summary with a greater number of data elements when the clinical summary is provided to the patient electronically than when the clinical summary is printed on paper. When the clinical summary in this example is provided electronically, it should include all of the above elements that can be populated by the certified EHR technology. The clinical summary would not be limited by the data elements that are capable of being displayed on a paper printout.

Date Updated: 4/5/2011

New ID #3157

Old ID #10558

180) For the Stage 1 meaningful use objectives of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs that require a provider to test the transfer of data, such as "capability to exchange key clinical information" and testing submission of data to public health agencies, can the eligible professional (EP), eligible hospital or critical access hospital (CAH) conduct the test from a test environment or test domain of its certified EHR technology in order to satisfy the measures of these objectives?

Yes, it is acceptable to conduct a test of information exchange from a test environment or test domain of certified EHR technology in order to satisfy the measures of the objective for "capability to exchange key clinical information" or any of the public health objectives (e.g., immunization registry, syndromic surveillance, or reportable lab results). A provider can also use simulated data when conducting these tests—the use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy these objectives.

However, it is important to note that in order to meet the objective for "capability to exchange key clinical information," the provider must conduct the test with another provider of care with distinct certified EHR technology or other system capable of receiving the information. Simulated transfers of information or transfers of information through means that do not reach another provider of care (e.g., "dummy" websites that exist solely for providers to send information) are not acceptable to satisfy this objective.

Similarly, to meet any of the public health objectives, the provider's test must involve the actual submission of information to public health agencies, and follow up submission is required if the test is successful. Please note that some public health agencies will not allow providers to submit test information about fictional patients. Providers submitting information to public health agencies that do not allow test information must submit actual patient information as a test in order to satisfy the measures of these objectives.

Date Updated: 2/13/2012

New ID #3817

Old ID #10978

181) For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, if certified EHR technology possessed by an eligible professional (EP) includes the ability to calculate clinical quality measures (CQMs) from the additional set that are not indicated by the EHR developer or on the Certified Health Information Technology Product List (CHPL) as tested and certified by an ONC - Authorized Testing and Certification Body (ONC-ATCB), can the EP submit the results of those CQMs to CMS as part of their meaningful use attestation?

To view the Stage 1 final rule for the Medicare and Medicaid EHR incentive programs, please visit: <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

Through 2013, yes, the EP can submit results for CQMs in the additional set (Table 6 of the Stage 1 final rule) calculated by certified EHR technology, even if those CQMs were not individually tested and certified by an ONC-ATCB. We expect to revisit CQM requirements in more detail for later stages of meaningful use as well as the corresponding certification requirements. Starting in 2014, the EP must have 2014 edition Certified EHR Technology and will be required to only submit results generated by EHR technologies certified to the 2014 edition criteria.

To view the Stage 1 final rule for the Medicare and Medicaid EHR incentive programs, please visit: <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

Date Updated: 5/23/2011

New ID #3277 Old ID #10649

182) What information must an eligible professional provide in order to meet the Stage 1 measure of the meaningful use objective for "provide patients with an electronic copy of their health information" under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

In our Stage 1 final rule, we limited the information that must be provided electronically to that information that exists electronically in or accessible from the certified EHR technology and is maintained by or on behalf of the EP, eligible hospital or CAH.

We encourage all providers to meet patient's request for information with all of the information that the patient requests and meets the description above. However, if the provider's certified EHR technology cannot provide all of patient requested information within the 3 business day timeline, a minimum level of information is defined in the certification process. All EHR technology is certified for the purposes of this program (according to § 170.304(f)) to provide:

- Problem List
- Diagnostic Test Results
- Medication List
- Medication Allergy List

An EP, eligible hospital or CAH that provides these four elements within 3 business days of the patient request in the specified standards meets the measure associated

with this objective. Again, we encourage all providers to continue to work with patients to provide information patients may request above and beyond these four elements.

Date Updated: 7/20/2011

New ID #3305 Old ID #10663

183) For the Medicare and Medicaid EHR Incentive Programs, how does an eligible professional (EP) determine whether a patient has been "seen by the EP" in cases where the service rendered does not result in an actual interaction between the patient and the EP, but minimal consultative services such as just reading an EKG? Is a patient seen via telemedicine included in the denominator for measures that include patients "seen by the EP"?

All cases where the EP and the patient have an actual physical encounter with the patient in which they render any service to the patient should be included in the denominator as seen by the EP. Also a patient seen through telemedicine would still count as a patient "seen by the EP." However, in cases where the EP and the patient do not have an actual physical or telemedicine encounter, but the EP renders a minimal consultative service for the patient (like reading an EKG), the EP may choose whether to include the patient in the denominator as "seen by the EP" provided the choice is consistent for the entire EHR reporting period and for all relevant meaningful use measures. For example, a cardiologist may choose to exclude patients for whom they provide a one-time reading of an EKG sent to them from another provider, but include more involved consultative services as long as the policy is consistent for the entire EHR reporting period and for all meaningful use measures that include patients "seen by the EP." EPs who never have a physical or telemedicine interaction with patients must adopt a policy that classifies as least some of the services they render for patients as "seen by the EP" and this policy must be consistent for the entire EHR reporting period and across meaningful use measures that involve patients "seen by the EP" -- otherwise, these EPs would not be able to satisfy meaningful use, as they would have denominators of zero for some measures.

Date Updated: 6/6/2011

New ID #3307 Old ID #10664

184) For the Stage 1 "Incorporate clinical lab-test results" menu objective of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, how should a provider attest if the numerator displayed by their certified EHR technology is larger than the denominator?

For the Stage 1 "Incorporate clinical lab-test results" menu objective, a provider's certified EHR technology might return a numerator larger than the denominator if the EHR does not match lab orders to results on a one-for-one basis or if the EHR records a panel that returns multiple lab results as a single order within the system. However, the CMS EHR Incentive Programs Attestation System will not allow an eligible professional, eligible hospital, or critical access hospital (CAH) to input a numerator that is greater than the denominator. In the case where your certified EHR

technology reports a numerator larger than the denominator, you should input a numerator equal to your denominator in the Attestation System. However, notwithstanding the numerator and denominator values that are entered into the Attestation System, a provider must actually surpass the 40% threshold to meet the measure of this objective. You should maintain documentation regarding the numerator and denominator values generated by your certified EHR technology and, in the event of an audit, be prepared to demonstrate that you satisfied the percentage threshold for this measure.

Date Updated: 2/13/2012

New ID #3823 Old ID #10981

185) For Stage 1 meaningful use objectives of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs that require a provider to test the transfer of data, such as "capability to exchange key clinical information" and testing submission of data to public health agencies, if multiple eligible professionals (EPs) are using the same certified EHR technology across several physical locations, can a single test serve to meet the Stage 1 measures of these objectives?

The Stage 2 Final Rule (CMS-0044-F) changed the way shared Certified EHR Technologies are handled for testing, registration and onboarding of public health agencies for both Stage 1 and Stage 2. Previously, if multiple EPs are using the same certified EHR technology in different physical locations/settings (e.g., different practice locations), there must be a single test performed for each physical location/setting.

The intent of the public health objectives is to demonstrate that a provider has the full capability to use their certified EHR technology to successfully submit data to public health agencies in a live setting.

Under changes made in the Stage 2 Final Rule, providers within the same organization that use the same certified EHR technology and share a network for which their organization either has operational control of or license to use can conduct one test or one single effort to register and onboard that covers all providers in the organization. For example, if a large group practice of EPs with multiple physical locations uses the same EHR technology and those locations are connected using a network that the group has either operational control of or license to use, then a single test would cover all EPs in that group to meet this objective.

Please note that this provision only applies to meeting public health meaningful use objectives and does not supersede local, state and federal requirements stipulated by the public health registries themselves or other governing bodies such as local or state government.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit <http://www.cms.gov/EHRIncentivePrograms>.

Date Updated: 4/2/2014

New ID #3819

Old ID #10979

186) For the Medicare and Medicaid EHR Incentive Programs, when a patient is only seen by a member of the eligible professional's (EP's) clinical staff during the EHR reporting period and not by the EP themselves, do those patients count in the EP's denominator?

The EP can include or not include those patients in their denominator at their discretion as long as the decision applies universally to all patients for the entire EHR reporting period and the EP is consistent across meaningful use measures. In cases where a member of the EP's clinical staff is eligible for the Medicaid EHR incentive in their own right (NPs and certain physician assistants (PA)), patients seen by NPs or PAs under the EP's supervision can be counted by both the NP or PA and the supervising EP as long as the policy is consistent for the entire EHR reporting period.

Date Updated: 6/6/2011

New ID #3309

Old ID #10665

187) What lab tests should be included in the denominator of the Stage 1 measure for the "incorporate clinical lab-test results" objective under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

For the Stage 1 "incorporate clinical lab-test results" objective, the denominator consists of the number of lab tests ordered during the EHR reporting period by the eligible professional (or authorized providers of the eligible hospital or critical access hospital (CAH) for patients admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 and 23)) whose results are expressed in a positive or negative affirmation or as a number. Providers may limit the denominator to only those lab tests that were ordered during the EHR reporting period and for which results were received during the same EHR reporting period.

Date Updated: 5/17/2011

New ID #3263

Old ID #10642

188) How should patients in swing beds be counted in the denominators of meaningful use measures for eligible hospitals and critical access hospitals (CAHs) for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

A number of the meaningful use measures for eligible hospitals and CAHs require the denominator to be based on the number of unique patients admitted to the inpatient or emergency department during the EHR reporting period. Unique swing bed patients who receive inpatient care should be included in the denominators of meaningful use measures. However, if the eligible hospital or CAH's certified EHR technology cannot readily identify and include unique swing bed patients who have received inpatient care, those patients may be excluded from the calculations for the denominators of meaningful use measures.

Date Updated: 5/17/2011

New ID #3259

Old ID #10640

189) For the Medicare and Medicaid EHR Incentive Programs' clinical quality measures (CQMs) ED-1, ED-2, and Stroke-4, how should eligible hospitals and critical access hospitals (CAHs) define an Emergency Department patient since the UB-04 data set referred to in the HITSP specifications no longer provides this information?

The measure steward recommends that hospitals use the data element 'ED Patient', defined as any patient receiving care or services in the Emergency Department. This data element specification to be used for ED-1, ED-2, and Stroke-4 can be found at <http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228767363466> in Section 1 Data Dictionary/Alphabetical Data Dictionary (page 1-146).

Date Updated: 12/16/2011

New ID #3673 Old ID #10883

190) For the Medicare and Medicaid EHR Incentive Programs, who do I contact to suggest adding/deleting a code on a clinical quality measure (CQM) or to suggest other CQM improvements?

Please contact the measure steward (the entity responsible for maintaining and updating a clinical quality measure) if you have suggestions or comments for improving the measure, comments regarding the measure's scientific or medical soundness/applicability, or would like to add specific vocabulary taxonomies or codes to the measure that may be appropriate for the measure population. The measure steward for each CQM is identified in the electronic specifications and in CMS's July 28, 2010 Stage 1 final rule (see 75 FR 44398-44420, Tables 6, 7, and 10).

Date Updated: 12/16/2011

New ID #3675 Old ID #10884

191) If my certified electronic health record (EHR) technology is capable of submitting batch files to an immunization registry using the standards adopted by the Office of the National Coordinator of Health Information Technology (HL7 2.3.1 or 2.5.1, and CVX), is that sufficient to meet the Stage 1 Meaningful Use objective "submit electronic data to immunization registries" for the Medicare and Medicaid EHR Incentive Programs?

Submitting batch files to an immunization registry, provided that they are formatted according to the standards adopted by the Office of the National Coordinator of Health Information Technology, is sufficient to meet the Meaningful Use objective "submit electronic data to immunization registries."

Date Updated: 7/11/2011

New ID #3369 Old ID #10713

192) If my certified EHR technology only includes the capability to submit information to an immunization registry using the HL7 2.3.1 standard but the immunization registry only accepts information formatted in the HL7 2.5.1 or some other standard, will I qualify for an exclusion because the immunization registry does not have the capacity to receive the information electronically? What if the immunization registry

has a waiting list or is unable to test for other reasons but can accept information formatted in HL7 2.3.1, is that still a valid exclusion?

If the immunization registry does not accept information in the standard to which your EHR technology has been certified—that is, if your EHR is certified to the HL7 2.3.1 standard and the immunization registry only accepts HL7 2.5.1, or vice versa—and if the immunization registry is the only immunization registry to which you can submit such information, then you can claim an exclusion to this Meaningful Use objective because the immunization registry does not have the capacity to receive the information electronically. The capacity of the immunization registry is determined by the ability of the immunization registry to test with an individual EP or eligible hospital.

An immunization registry may have the capacity to accept immunization data from another EP or hospital, but if for any reason (e.g. waiting list, on-boarding process, other requirements, etc) the registry cannot test with a specific EP or hospital, that EP or hospital can exclude the objective. It is the responsibility of the EP or hospital to document the justification for their exclusion (including making clear that the immunization registry in question is the only one it can submit information to). If the immunization registry, due to State law or policy, would not accept immunization data from you (e.g., not a lifespan registry, etc), you can also claim the exclusion for this objective. Please note, this FAQ applies in principle to all of the Stage 1 public health meaningful use measures (syndromic surveillance and reportable lab conditions).

Date Updated: 7/11/2011

New ID #3371 Old ID #10714

193) How should nursery day patients be counted in the denominators of meaningful use measures for eligible hospitals and critical access hospitals (CAHs) for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

Nursery days are excluded from the calculation of hospital incentives because they are not considered inpatient-bed-days based on the level of care provided during a normal nursery stay. In addition, nursery day patients should not be included in the denominators of meaningful use measures. However, if the eligible hospital or critical access hospital's (CAH's) certified EHR technology cannot readily identify and exclude nursery day patients, those patients may be included in the calculations for the denominators of meaningful use measures.

Date Updated: 5/17/2011

New ID #3261 Old ID #10641

194) For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, how should an eligible professional (EP) who orders medications infrequently calculate the measure for the “computerized provider order entry (CPOE)” objective if the EP sees patients whose medications are maintained in the medication list by the EP but were not ordered or prescribed by the EP?

The CPOE measure is structured to minimize reporting burden. However, if all of the following conditions are met it can also create a unique situation that could prevent an EP from successfully demonstrating meaningful use. An EP who:

- 1) prescribes more than 100 medications during the EHR reporting period;
- 2) maintains medication lists that include medications that they did not order; and
- 3) orders medications for less than 30 percent of patients with a medication in their medication list during the EHR reporting period.

In these circumstances, an EP may be both unable to meet this measure and unable to qualify for the exclusion. In the unique situation where all three criteria listed above apply, an EPs may limit their denominator to only those patients for whom the EP has previously ordered medication, if they so choose. EPs who do not meet the three criteria listed above must still base their calculation on the number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period regardless of who ordered the medication or medications in the patient's medication list.

Date Updated: 5/17/2011

New ID #3257 Old ID #10639

195) If an eligible professional (EP) is unable to meet the measure of a Meaningful Use objective because it is outside of the scope of his or her practice, will the EP be excluded from meeting the measure of that objective under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

Some Meaningful Use objectives provide exclusions and others do not. Exclusions are available only when our regulations specifically provide for an exclusion. EPs may be excluded from meeting an objective if they meet the circumstances of the exclusion. If an EP is unable to meet a Meaningful Use objective for which no exclusion is available, then that EP would not be able to successfully demonstrate Meaningful Use and would not receive incentive payments under the Medicare and Medicaid EHR Incentive Programs.

Date Updated: 9/29/2010

New ID #2883 Old ID #10151

196) For the meaningful use objective "Capability to submit electronic syndromic surveillance data to public health agencies," what is the definition of "syndromic surveillance"?

Syndromic surveillance uses individual and population health indicators that are available before confirmed diagnoses or laboratory confirmation to identify outbreaks or health events and monitor the health status of a community. For additional information about syndromic surveillance data, please visit:

<http://www.cdc.gov/EHRmeaningfuluse/Syndromic.html>.

Date Updated: 10/20/2011

New ID #3615 Old ID #10846

197) For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, does an eligible hospital have to count patients admitted to both the

inpatient and emergency departments in the denominator of meaningful use measures, or can they count only emergency department patients?

For the hospital meaningful use objectives, the denominator is all unique patients admitted to an inpatient (POS 21) or emergency department (POS 23), which means all patients admitted to an inpatient department (POS 21) and all patients admitted to an emergency department (POS 23). If the eligible hospital elects to use the alternate method for calculating emergency department patients, as detailed in FAQ #10126 (http://questions.cms.hhs.gov/app/answers/detail/a_id/10126/kw/ed), the denominator is all unique patients admitted to an inpatient department (POS 21) and all patients that initially present to the emergency department and are treated in the emergency department's observation unit or otherwise receive observation services, which includes patients who receive observation services under both POS 22 and POS 23. Patients admitted to the inpatient department must be included in the denominator of all applicable measures.

Date Updated: 9/4/2012

New ID #3067 Old ID #10468

198) For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, should patient encounters in an ambulatory surgical center (Place of Service 24) be included in the denominator for calculating that at least 50 percent or more of an eligible professional's (EP's) patient encounters during the reporting period occurred at a practice/location or practices/locations equipped with certified EHR technology?

Yes. EPs who practice in multiple locations must have 50 percent or more of their patient encounters during the reporting period at a practice/location or practices/locations equipped with certified EHR technology. Every patient encounter in all Places of Service (POS) except a hospital inpatient department (POS 21) or a hospital emergency department (POS 23) should be included in the denominator of the calculation, which would include patient encounters in an ambulatory surgical center (POS 24).

Date Updated: 2/18/2011

New ID #3065 Old ID #10466

199) For the Stage 1 meaningful use objective of "capability to exchange key clinical information" in the Medicare and Medicaid EHR Incentive Programs, what forms of electronic transmission can be used to meet the measure of the objective?

For the purposes of the "capability to exchange key clinical information" measure, exchange is defined as electronic transmission and acceptance of key clinical information using the capabilities and standards of certified EHR technology (as specified at 45 CFR 170.304(i) for eligible professionals and 45 CFR 170.306(f) for eligible hospitals and critical access hospitals). There are many acceptable transmission methods for conducting a test of the electronic exchange of key clinical information with providers of care and patient authorized entities (see FAQ 10270 (http://questions.cms.hhs.gov/app/answers/detail/a_id/10270/))

To meet the measure of this objective a provider must:

- (1) Use certified EHR technology to generate a continuity of care document (CCD)/continuity of care record (CCR), and
- (2) Electronically transmit the CCD/CCR.

To complete step 2, an eligible professional, eligible hospital, or critical access hospital may use any means of electronic transmission according to any transport standard(s) (SMTP, FTP, REST, SOAP, etc.) regardless of whether it was included by an EHR technology developer as part of the certified EHR technology in the eligible professional's, eligible hospital's, or critical access hospital's possession.

Please note that the use of USB, CD-ROM, or other physical media or electronic fax would not meet the measure of this objective and has been addressed in another FAQ (see FAQ 10638 (http://questions.cms.hhs.gov/app/answers/detail/a_id/10638/)). If the test involves the transmission of actual patient information, all current privacy and security regulations must be met.

Date Updated: 6/21/2011

New ID #3359 **Old ID #10691**

200) If a provider feeds data from certified electronic health record (EHR) technology to a data warehouse, can the provider report on Meaningful Use objectives and clinical quality measures from the data warehouse?

To be a meaningful EHR user based on the Stage 1 criteria a provider must do three things:

1. Have complete certified EHR technology for all meaningful use objectives either through a complete EHR or a combination of modules; and
2. Meet 20 measures (19 for eligible hospitals and CAHs), including all of the core and five (5) menu-set measures associated with the objectives (unless excluded). Core measures include reporting clinical quality measures.
3. Use the capabilities and standards of certified EHR technology in meeting the measure of each objective.

If the conditions above are met and data is transferred from the certified EHR technology to a data warehouse, the provider can use information from the data warehouse to report on Meaningful Use objectives and clinical quality measures. However, in order to report calculated clinical quality measures, the data warehouse may need to be certified.

The Office of the National Coordinator of Health Information Technology has addressed the issue of certification of a data warehouse in the following Frequently Asked Question:

<http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3163&PageID=20775>.

For more information about certification, you can contact ONC directly at

onc.certification@hhs.gov.

Date Updated: 3/7/2011

New ID #2885 Old ID #10153

201) The meaningful use standards for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program require interoperability. Who will pay for ensuring connectivity between physician practices and hospitals? Will there be federal guidance, or will this be hashed out at a local/community level?

The Office of the National Coordinator for Health Information Technology (ONC) has awarded funds to 56 states, eligible territories, and qualified State Designated Entities (SDEs) under the Health Information Exchange Cooperative Agreement Program to help fund efforts to rapidly build capacity for exchanging health information across the health care system both within and between states. These exchanges will play a critical role in facilitating the exchange capacity of doctors and hospitals to help them meet interoperability requirements which will be part of meaningful use. More information on ONC's Health Information Exchange grantees is available at: <http://healthit.hhs.gov/>.

Date Updated: 2/17/2011

New ID #2795 Old ID #10085

202) In recording height as part of the Stage 1 core Meaningful Use objective "Recording vital signs" for eligible professionals (EPs), eligible hospitals, and Critical Access Hospitals (CAHs), how should providers account for patients who are too sick or otherwise cannot be measured safely?

In cases where taking an actual height measurement is inappropriate, self-reported or estimated height can be used.

Date Updated: 9/29/2010

New ID #2891 Old ID #10156

203) How should eligible professionals (EPs) select menu objectives for the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs?

EPs participating in Stage 1 of the EHR Incentive Programs are required to report on a total of 5 meaningful use objectives from the menu set of 9 objectives. When selecting five objectives from the menu set, EPs must choose at least one option from the public health menu set. If an EP is able to meet the measure of one of the public health menu objectives but can be excluded from the other, the EP should select and report on the public health menu objective they are able to meet.

If an EP can be excluded from both public health menu objectives, the EP may meet the menu requirement one of two ways:

1. Claim an exclusion from only one public health objective and report on four additional menu objectives from outside the public health menu set.
2. Report on five menu objectives from outside the public health menu set.

EPs participating in Stage 2 are required to report 3 meaningful use objectives from the menu set of 6.

We encourage EPs to select menu objectives that are relevant to their scope of practice, and claim an exclusion for a menu objective only in cases where there are no remaining menu objectives for which they qualify or if there are no remaining menu objectives that are relevant to their scope of practice. For example, we hope that EPs will report on 5 measures, if there are 5 measures that are relevant to their scope of practice and for which they can report data, even if they qualify for exclusions in the other objectives.

The registration and attestation system may prompt an EP to report on additional measures if they claim an exclusion. This is because starting in 2014 the exclusion criteria will no longer count as reporting a meaningful use objective from the menu set. An EP must meet the measure criteria for the objectives or report on all of the menu set objectives through a combination of meeting exclusion and meeting the measure.

However, some EPs who elect option 1 above may be asked to report on non-public health measures when they claim that exclusion in the attestation system. These providers should document this issue for their records and then claim the exclusion for the remaining measures in order to allow the system to accept their attestation.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit <http://www.cms.gov/EHRIncentivePrograms>.

Date Updated: 11/20/2014

New ID #2903 Old ID #10162

204) In order to meet the participation threshold of 50 percent of patient encounters in practice locations equipped with certified electronic health record (EHR) technology for the Medicare and Medicaid EHR Incentive Programs, how should patient encounters be calculated?

To be a meaningful EHR user, an EP must have 50 percent or more of their patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with certified EHR technology. For the purpose of calculating this 50 percent threshold, any encounter where a medical treatment is provided and/or evaluation and management services are provided should be considered a "patient encounter."

Please note that this is different from the requirements for establishing patient volume for the Medicaid EHR Incentive Program. You may wish to review those FAQs

and other requirements related to Medicaid patient volume, since there is variation in what is considered to be a patient encounter.

Date Updated: 4/22/2011

New ID #3215 Old ID #10592

205) For the meaningful use objective to “record and chart changes in vital signs” for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, can an eligible professional (EP) claim an exclusion if the EP regularly records only one or two of the required vital signs but not all three?

An exclusion for this objective is provided only for EPs who either see no patients 2 years or older, or who believe that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice. If an EP believes that one or two of these vital signs are relevant to their scope of practice, then they must record all three vital signs in order to meet the measure of this objective and successfully demonstrate meaningful use.

Starting in 2013, an EP will have the option to exclude just blood pressure and base their measure on height and weight. They will also have the option to exclude height and weight and base their measure on blood pressure. To be excluded from the measure entirely they will have to attest to the exclusion of believing that all three vital signs of height, weight and blood pressure have no relevance to their scope of practice.

Date Updated: 4/22/2011

New ID #3217 Old ID #10593

206) If an eligible hospital or critical access hospital (CAH) has a rehabilitation unit or a psychiatric unit that is part of the inpatient department and that bills under Place of Service (POS) code 21, but that is excluded from the inpatient prospective payment system (IPPS), should patients from these units be included in the denominator for the measures of meaningful use objectives for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

No. CMS specified in the Stage 1 final rule that the statutory definition of “hospital” used in the EHR Incentive Program does not apply to hospitals and hospital units excluded from IPPS, such as rehabilitation or psychiatric units (75 FR 44448). Therefore, patients treated in these units should not be included in the denominators of measures. If patients are treated in either an inpatient rehabilitation or inpatient psychiatric unit but are also admitted to areas of the inpatient department that are part of the “subsection (d) hospital,” then those patients and the actions taken for those patients outside of the inpatient rehabilitation or inpatient psychiatric units should be counted in the numerators and denominators for the meaningful use measures.

Date Updated: 4/22/2011

New ID #3213 Old ID #10591

207) For the meaningful use objective of "record demographics" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program, what documentation is required when recording the preliminary cause of death in the event of mortality?

Eligible hospitals and critical access hospitals (CAHs) must record in the patient's EHR the clinical impression and preliminary assessment of the cause of death. No further documentation is required. This measure does not require the cause of death to be updated if the case is referred to the Department of Health or coroner's office.

Date Updated: 10/18/2010

New ID #2909 Old ID #10165

208) If a patient visit spans several days and the patient is seen by multiple eligible professionals (EPs) during that time period, does each EP need to provide a separate clinical summary or can the provision of a single clinical summary at the end of the visit meet the meaningful use objective for "provide clinical summaries for patients after each office visit" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

When a patient visit lasts several days and/or the patient is seen by multiple EPs, a single clinical summary at the end of the visit can be used to meet the meaningful use objective for "provide clinical summaries for patients after each office visit."

Date Updated: 10/18/2010

New ID #2911 Old ID #10166

209) To meet the Stage 1 meaningful use objective "provide patients with an electronic copy of their health information" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, how should the numerator and denominator be calculated for patients who see multiple eligible professionals (EPs) in the same practice (e.g., in a multi-specialty group practice)?

If the request for an electronic copy of their health information is made by a patient to a specific EP, then the patient should be counted in the numerator and denominator for that specific EP. If the patient makes a request for an electronic copy of their health information that is not to a specific EP (e.g., by request to the practice's administrative staff), then the patient should be counted in the numerators and denominators for all EPs with whom the patient has had an office visit.

Date Updated: 6/3/2011

New ID #2935 Old ID #10269

210) To meet the Stage 1 meaningful use objective "capability to exchange key clinical information" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, can different providers of care (e.g., physicians, hospitals, etc.) share EHR technology and successfully meet this objective?

In order to meet this objective, clinical information must be sent between different legal entities with distinct certified EHR technology and not between organizations

that share a certified EHR technology or organizations that are part of the same legal entity, since no actual exchange of clinical information would take place in these latter instances. Distinct certified EHR technologies are those that can achieve certification and operate independently of other certified EHR technologies. It is possible for different legal entities to meet this objective by using separate instances of the same certified EHR technology (e.g. both entities using separate license of the same program), subject to the following limitations:

- A different legal entity is an entity that has its own separate legal existence. Indications that two entities are legally separate would include (1) they are each separately incorporated; (2) they have separate Boards of Directors; and (3) neither entity is owned or controlled by the other.
- In order to be distinct certified EHR technology, each instance of certified EHR technology must be able to be certified and operate independently from all others. Separate instances of certified EHR technology that must link to a common database in order to gain certification would not be considered distinct. However, instances of certified EHR technology that link to a common, uncertified system or component would be considered distinct. Instances of certified EHR technology can be from the same vendor and still be considered distinct.
- The exchange of key clinical information requires that the eligible professional, eligible hospital, or critical access hospital (CAH) must use the standards of certified EHR technology as specified by the Office of the National Coordinator for Health IT, not the capabilities of uncertified or other vendor-specific alternative methods for exchanging clinical information.

Date Updated: 12/14/2010

New ID #5985 Old ID #10270

211) For the meaningful use objective of "generate and transmit prescriptions electronically (eRx)" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program, how should the numerator and denominator be calculated? Should electronic prescriptions fulfilled by an internal pharmacy be included in the numerator?

The denominator for this objective consists of the number of prescriptions written for drugs requiring a prescription in order to be dispensed, other than controlled substances, during the EHR reporting period. The numerator consists of the number of prescriptions in the denominator generated and transmitted electronically using certified EHR technology. In order to meet the measure of this objective, 40 percent of all permissible prescriptions written by the EP must be generated and transmitted electronically according to the applicable certification criteria and associated standards adopted for certified EHR technology as specified by the Office of the National Coordinator for Health IT (ONC).

ONC has released an FAQ stating that "with respect to the capability a Complete EHR or EHR Module must demonstrate in order to be certified to the certification criterion adopted at 170.304(b), a Complete EHR or EHR Module must be capable of electronically transmitting prescriptions to external recipients according to NCPDP SCRIPT 8.1 or 10.6 in addition to the adopted vocabulary standard for medications (45 CFR 170.207(d))." Given such FAQ, prescriptions transmitted electronically within an organization (the same legal entity) would not need to use these NCPDP standards. However, an EP's EHR must meet all applicable certification criteria and be certified as having the capability of meeting the external transmission requirements of §170.304(b). In addition, the EHR that is used to transmit prescriptions within the organization would need to be Certified EHR Technology.

The EP would include in the numerator and denominator both types of electronic transmissions (those within and outside the organization) for the measure of this objective. We further clarify that for purposes of counting prescriptions "generated and transmitted electronically," we consider the generation and transmission of prescriptions to occur simultaneously if the prescriber and dispenser are the same person and/or are accessing the same record in an integrated EHR to creating an order in a system that is electronically transmitted to an internal pharmacy.

Date Updated: 12/17/2010

New ID #2939

Old ID #10284

212) Do controlled substances qualify as "permissible prescriptions" for meeting the electronic prescribing (eRx) meaningful use objective under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

The term "permissible prescriptions" refers to the restrictions that were established by the Department of Justice (DOJ) on electronic prescribing (eRx) for controlled substances in Schedule II-V. (The substances in Schedule II-V can be found at http://www.deadiversion.usdoj.gov/schedules/orangebook/e_cs_sched.pdf). Any prescription not subject to these restrictions would be a permissible prescription. Although DOJ recently published an Interim Final Rule that allows the electronic prescribing of these substances, we were unable to incorporate these recent guidelines into the Medicare and Medicaid EHR Incentive Programs. Therefore, the determination of whether a prescription is a "permissible prescription" for purposes of the eRx meaningful use objective should be made based on the guidelines for prescribing Schedule II-V controlled substances in effect on or before January 13, 2010, when the notice of proposed rulemaking was published in the Federal Register.

Date Updated: 2/17/2011

New ID #2763

Old ID #10067

213) For eligible professionals (EPs) who see patients in both inpatient and outpatient settings (e.g., hospital and clinic), and where certified electronic health record (EHR) technology is available at each location, should these EPs base their denominators for meaningful use objectives on the number of unique patients in only the outpatient setting or on the total number of unique patients from both settings?

In this case, EPs should base both the numerators and denominators for meaningful use objectives on the number of unique patients in the outpatient setting, since this setting is where they are eligible to receive payments from the Medicare and Medicaid EHR Incentive Programs.

Date Updated: 1/8/2013

New ID #2765 Old ID #10068

214) If a patient is dually eligible for both Medicare and Medicaid, can they be counted twice by hospitals in their calculations if they are applying for electronic health record (EHR) incentive payments through both the Medicare and Medicaid EHR Incentive Programs?

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.

To view the Stage 1 final rule for the Medicare and Medicaid EHR incentive programs, please visit: <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

Date Updated: 2/17/2011

New ID #2769 Old ID #10070

215) If my practice does not typically collect information on any of the core, alternate core, and additional clinical quality measures (CQMs) listed in the Final Rule on the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, do I need to report on CQMs for which I do not have any data?

This FAQ applies to providers who are reporting 2013 CQMs.

Eligible professionals (EP) are not excluded from reporting CQMs, but zero is an acceptable value for the CQM denominator. If there were no patients who met the denominator population for a CQM, then the EP would report a zero for the denominator and a zero for the numerator. For the core measures, if the EP reports a zero for the core measure denominator, then the EP must report results for up to three alternate core measures (potentially reporting on all 6 core/alternate core measures). For the menu-set measures, we expect the EP to report on measures which do not have a denominator of zero. If none of the measures in the menu set applies to the EP, then the EP must report on three of such measures, reporting a denominator of zero, and then attest that the remainder of the menu-set measures has a value of zero in the denominator. As we stated in the final rule (75 FR 44409-10): "The expectation is that the EHR will automatically report on each core clinical quality measure, and when one or more of the core measures has a denominator of

zero then the alternate core measure(s) will be reported. If all six of the clinical quality measures in Table 7 have zeroes for the denominators (this would imply that the EPs patient population is not addressed by these measures), then the EP is still required to report on three additional clinical measures of their choosing from Table 6 in this final rule. In regard to the three additional clinical quality measures, if the EP reports zero values, then for the remaining clinical quality measures in Table 6 (other than the core and alternate core measures) the EP will have to attest that all of the other clinical quality measures calculated by the certified EHR technology have a value of zero in the denominator, if the EP is to be exempt from reporting any of the additional clinical quality measures (other than the core and alternate core measures) in Table 6."

To view the final rule, please visit: <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

Date Updated: 11/14/2014

New ID #2773 Old ID #10072

216) Can eligible professionals (EPs) use clinical quality measures (CQMs) from the alternate core set to meet the requirement of reporting three additional measures for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

This FAQ applies to providers who are reporting 2013 CQMs.

No, if EPs report data on all three CQMs from the core set, they would not report on any from the alternate core set. The three additional CQMs must come from Table 6 of the final rule (75 FR 44398-44408), excluding those CQMs included in either the core set or the alternate core set.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit <http://www.cms.gov/EHRIncentivePrograms>.

Date Updated: 11/14/2014

New ID #2779 Old ID #10075

217) In a group practice, will each provider need to demonstrate meaningful use in order to get Medicare and Medicaid electronic health record (EHR) incentive payments or can meaningful use be calculated or averaged at the group level?

Yes. Medicare and Medicaid incentive payments are made on a per EP basis, not by practice. Each EP will need to demonstrate the full requirements of meaningful use in order to qualify for the EHR incentive payments. We made this clear in the preamble to the Stage 1 final rule when we declined to adopt alternative means for demonstrating meaningful use on a group-practice level (75 FR 44437).

To view the Stage 1 final rule for the Medicare and Medicaid EHR incentive programs, please visit: <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

Date Updated: 2/17/2011

New ID #2781 Old ID #10076

218) Can the drug-drug and drug-allergy interaction alerts of my electronic health record (EHR) also be used to meet the Stage 1 meaningful use objective for implementing one clinical decision support rule for the Medicare and Medicaid EHR Incentive Programs?

No. The drug-drug and drug-allergy checks and the implementation of one clinical decision support rule are separate core meaningful use objectives. EPs and eligible hospitals must implement one clinical decision support rule in addition to drug-drug and drug-allergy interaction checks. We would not have listed these core requirements as separate measures, nor required that EPs and hospitals meet all core objectives and measures listed in the regulation, had we intended for them to be met simultaneously.

Date Updated: 2/17/2011

New ID #2783 Old ID #10077

219) What do the numerators and denominators mean in measures that are required to demonstrate meaningful use for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program?

There are 15 measures for EPs and 14 measures for eligible hospitals that require the collection of data to calculate a percentage, which will be the basis for determining if the Meaningful Use objective was met according to a minimum threshold for that objective.

Objectives requiring a numerator and denominator to generate this calculation are divided into two groups: one where the denominator is based on patients seen or admitted during the EHR reporting period, regardless of whether their records are maintained using certified EHR technology; and a second group where the objective is not relevant to all patients either due to limitations (e.g., recording tobacco use for all patients 13 and older) or because the action related to the objective is not relevant (e.g., transmitting prescriptions electronically). For these objectives, the denominator is based on actions related to patients whose records are maintained using certified EHR technology. This grouping is designed to reduce the burden on providers. Table 3 in the Medicare and Medicaid EHR Incentive programs Stage 1 final rule (FR 75 44376 - 44380) lists measures sorted by the method of measure calculation. To view the Stage 1 final rule, please visit:

<http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

Date Updated: 2/17/2011

New ID #2813 Old ID #10095

220) 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 enter 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.

Date Updated: 10/18/2010

New ID #2851 Old ID #10134

221) 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.

Date Updated: 7/20/2011

New ID #2855 Old ID #10136

222) In order to satisfy the Meaningful Use objective for electronic prescribing (eRx) 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.

Date Updated: 9/27/2010

New ID #2857 Old ID #10137

223) If one of the measures for the core set of clinical quality measures (CQMs) for eligible professionals (EP) 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?

This FAQ applies to providers who are reporting 2013 CQMs.

An eligible professional (EP) is not excluded from reporting core clinical quality measures (CQMs). However, zero is an acceptable value to report for the denominator of a CQM if there is no patient population within the EHR to whom that CQM 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.

To view the final rule for the Medicare and Medicaid EHR incentive programs, please visit: <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

Date Updated: 11/14/2014

New ID #2865

Old ID #10142

224) If 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?

This FAQ applies to providers who are reporting 2013 CQMs.

In the event that none of the 44 clinical quality measures (CQMs) 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 CQMs. If all of the remaining 44 CQMs 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 CQMs 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 CQMs, then for the remaining menu-set CQMs, 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 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.

To view the final rule for the Medicare and Medicaid EHR incentive programs, please visit: <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

Date Updated: 11/14/2014

New ID #2869 Old ID #10144

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

This FAQ applies to providers who are reporting 2013 CQMs.

If the denominator value for all three of the core CQMs is zero, an EP must report a zero denominator for all such core measures, and then must also report on all 3 alternate core CQMs. If the denominator values for all three of the alternate core CQMs are also '0,' an EP still needs to report on 3 additional CQMs. Zero is an acceptable denominator provided that this value was produced by certified EHR technology. Please see question number 10144 for a discussion of zero denominators reporting in the menu set.

Date Updated: 11/14/2014

New ID #2871 Old ID #10145

226) To meet the Stage 1 Meaningful Use objective "maintain an up-to-date problem list of current and active diagnoses" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, are eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) required to use ICD-9 or SNOMED-CT®?

The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs do not specify the use of ICD-9 and SNOMED-CT® to meet the measure for the Meaningful Use objective "maintain an up-to-date problem list of current and active diagnoses." However, the Office of the National Coordinator for Health Information Technology (ONC) has adopted ICD-9 and SNOMED-CT® as a standard for the entry of structured data in certified EHR technology. Therefore, EPs, eligible hospitals, and CAHs will need to maintain an up-to-date problem list of current and active diagnoses using ICD-9 and SNOMED-CT® in order to meet the measure for this objective.

Date Updated: 9/29/2010

New ID #2881 Old ID #10150

227) To meet the meaningful use objective "use computerized provider order entry (CPOE)" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, should eligible professionals (EPs) include hospital-based observation patients (billed under POS 22) whose records are maintained using the hospital's certified EHR system in the numerator and denominator calculation for this measure?

If the patient has records that are maintained in both the hospital's certified EHR system and the EP's certified EHR system, the EP should include those patients seen in

locations billed under POS 22 in the numerator and denominator calculation for this measure. If the patient's records are maintained only in a hospital certified EHR system, the EP does not need to include those patients in the numerator and denominator calculation to meet the measure of the "use computerized provider order entry (CPOE)" objective.

Date Updated: 2/18/2011

New ID #3057 Old ID #10462

228) If data is captured using certified electronic health record (EHR) technology, can an eligible professional or eligible hospital use a different system to generate reports used to demonstrate meaningful use for the Medicare and Medicaid EHR Incentive Programs?

By definition, certified EHR technology must include the capability to electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage for all percentage-based meaningful use measures (specified in the certification criterion adopted at 45 CFR 170.302(n)). However, the meaningful use measures do not specify that this capability must be used to calculate the numerators and denominators. Eligible professionals and eligible hospitals may use a separate, non-certified system to calculate numerators and denominators and to generate reports on the measures of the core and menu set meaningful use objectives.

Eligible professionals and eligible hospitals will then enter this information in CMS' web-based Medicare and Medicaid EHR Incentive Program Registration and Attestation System. Eligible professionals and eligible hospitals will fill in numerators and denominators for meaningful use objectives, indicate if they qualify for exclusions to specific objectives, report on clinical quality measures, and legally attest that they have successfully demonstrated meaningful use.

Please note that eligible professionals and eligible hospitals cannot use a non-certified system to calculate the numerators, denominators, and exclusion information for clinical quality measures. Numerator, denominator, and exclusion information for clinical quality measures must be reported directly from certified EHR technology. For additional clarification about this, please refer to the following FAQ from the Office of the National Coordinator of Health Information Technology: http://healthit.hhs.gov/portal/server.pt/community/onc_regulations_faqs/3163/faq_13/20775.

Date Updated: 10/7/2011

New ID #3063 Old ID #10465

229) For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, is an eligible professional or eligible hospital limited to demonstrating meaningful use in the exact way that EHR technology was tested and certified? For example, if a Complete EHR has been tested and certified using a specific workflow, is an eligible professional or eligible hospital required to use that specific workflow when it demonstrates meaningful use? Similarly, if the EHR technology was tested

and certified with certain clinical decision support rules, are those the only clinical decision support rules an eligible health care provider is permitted to use when demonstrating meaningful use?

In most cases, an eligible professional or eligible hospital is not limited to demonstrating meaningful use to the exact way in which the Complete EHR or EHR Module was tested and certified. As long as an eligible professional or eligible hospital uses the certified Complete EHR or certified EHR Module's capabilities and, where applicable, the associated standard(s) and implementation specifications that correlate with the respective meaningful use objective and measure, they can successfully demonstrate meaningful use even if their exact method differs from the way in which the Complete EHR or EHR Module was tested and certified.

It is important to remember the purpose of certification. Certification is intended to provide assurance that a Complete EHR or EHR Module will properly perform a capability or capabilities according to the adopted certification criterion or criteria to which it was tested and certified (and according to the applicable adopted standard(s) and implementation specifications, if any). The Temporary Certification Program and Permanent Certification Program Final Rules (75 FR 36188 and 76 FR 1301, respectively), published by the Office of the National Coordinator for Health IT (ONC), acknowledged that eligible professionals and eligible hospitals could, where appropriate, modify their certified Complete EHR or certified EHR Module to meet local health care delivery needs and to take full advantage of the capabilities that the certified Complete EHR or certified EHR Module includes.

These rules also cautioned that modifications made to a Complete EHR or EHR Module post-certification have the potential to adversely affect the technology's capabilities such that it no longer performs as it did when it was tested and certified, which could ultimately compromise an eligible professional or eligible hospital's ability to successfully demonstrate meaningful use.

In instances where a certification criterion expresses a capability which could potentially be added to or enhanced by an eligible professional or eligible hospital, the way in which EHR technology was tested and certified generally would not limit a provider's ability to modify the EHR technology in an effort to maximize the utility of that capability. Examples of this could include adding clinical decision support rules, adjusting or adding drug-drug notifications, or generating patient lists or patient reminders based on additional data elements beyond those that were initially required for certification. Modifications that adversely affect the EHR technology's capability to perform in accordance with the relevant certification criterion could, however, ultimately compromise an eligible professional or eligible hospital's ability to successfully demonstrate meaningful use.

In instances where the EHR technology was tested and certified using a sample workflow and/or generic forms/templates, an eligible professional or eligible hospital generally is not limited to using that sample workflow and/or those generic

forms/templates. In this context, the “workflow” would constitute the specific steps, methods, processes, or tasks an eligible professional or eligible hospital would follow when using one or more capabilities of the certified Complete EHR or certified EHR Module to meet meaningful use objectives and associated measures. An eligible health care provider could use a different workflow and/or substitute different forms/templates for those that are included in the certified Complete EHR or certified EHR Module. Again, care should be taken to ensure that such actions do not adversely affect the Complete EHR's or EHR Module's performance of the capabilities for which it was tested and certified, which could ultimately compromise an eligible professional or eligible hospital's ability to successfully demonstrate meaningful use.

Date Updated: 3/7/2011

New ID #3073

Old ID #10473

230) Why does the result of the clinical quality measure for CMS140v2 not accurately reflect an accurate performance rate upon calculation according to the measure logic in the specification?

An error has been found in the logic for CMS140v2, Breast Cancer Hormonal Therapy for Stage IC-IIIc Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer (NQF 0387). This version of the measure was posted on CMS's website on June 29, 2013, after an annual update of the 2014 eligible professional (EP) clinical quality measures (CQMs).

The error relates to the relative timing of the diagnosis of breast cancer and the diagnosis of ER or PR positive breast cancer. In clinical practice, a diagnosis of breast cancer should precede the more specific diagnosis of ER or PR positive breast cancer. The logic in CMS140v2 reverses this order. The expected impact of this error is that very few but most likely no patients will meet the denominator criteria.

Regulatory requirements limit CMS's ability to provide or post a correction at this time. We are strongly urging Electronic Health Records (EHR) vendors seeking certification for the EHR Incentive Program to use the prior version of this measure, CMS140v1, published in December 2012. Eligible professionals are also strongly urged to use CMS140v1 for reporting for the EHR Incentive Program in 2014. Eligible professionals will receive credit for the EHR Incentive Program for reporting either version of the measure through attestation.

In addition to the EHR Incentive Program, this measure may also be reported through the Physician Quality Reporting System (PQRS) Program. The error described above applies only to the EHR version of the measure in the PQRS program. PQRS Program requirements do not permit measures with denominators equal to zero to be submitted for credit for the program. PQRS Program requirements also require using the most current version of the measure for reporting.

As with electronic reporting for the EHR Incentive Program, CMS finalized in the CY2014 Physician Fee Schedule final rule that only CMS140v1 would be accepted for electronic reporting in PQRS.

<http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2013-Fact-Sheets-Items/2013-11-27.html>.

For more information about eCQM specifications, please visit the eCQM Library:

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html

Date Updated: 2/06/2014

New ID# 9678 Old ID# N/A

231) When maintaining an up-to-date problem list as part of achieving meaningful use in the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs, can both SNOMED CT as well as non-SNOMED CT (for example ICD-9 or ICD-10) elements be included to meet the measure?

Prior to 2014, the Medicare and Medicaid EHR Incentive Programs permitted either SNOMED CT or ICD-9 to be used when a patient's problems were recorded by 2011 Edition Certified EHR Technology (CEHRT) as structured data. However, when an eligible professional (EP), eligible hospital, or critical access hospital (CAH) begins its 2014 EHR reporting period (for Stage 1 or Stage 2) it will need to use 2014 Edition CEHRT which only permits recording patient problems in SNOMED-CT®.

Therefore, beginning with the 2014 EHR reporting period, EPs, eligible hospitals, and CAHs will need to use the capabilities and standards included in 2014 Edition CEHRT to maintain the problem list using SNOMED-CT® as structured data. This policy also applies to other Stage 1 and Stage 2 objectives and measures in which problems data is required, such as creating a Consolidated Clinical Document Architecture (CCDA) formatted summary record for the purposes of meeting the Stage 2 "transitions of care" measure #2 (10% electronic transmissions).

If the provider uses other code sets to identify/select problems for the problem list as part of a user interface (which is permitted), such codes will need to be mapped to the corresponding SNOMED-CT® codes when recorded in the CEHRT. For example, if the CEHRT is certified and uses both ICD and SNOMED-CT® codes, the ICD codes need to be "cross-walked" to the appropriate SNOMED-CT® codes to be included in the problem list to meet this measure.

Date Updated: 11/21/2013

New ID# 9274 Old ID# N/A

232) Am I permitted to count a patient in the numerator of the "record demographics" objective and measure if the preferred language I record for the patient is outside of the minimum required by the standard for Certified Electronic Health Records (EHR) Technology?

Yes, similar to the collection of race and ethnicity demographic data, we appreciate that providers may need to collect more precise information about preferred language to manage their patient population. If a patient's preferred language is not included in the standard required for EHR technology certification, you may count that patient in the numerator of the measure as long as the preferred language is recorded as structured data, as required by the measure. Eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) that seek to record other preferred languages (beyond those minimally required for EHR technology certification) are encouraged to consult their EHR technology developer to ensure that an attestation report will properly account for those patients.

Please see [ONC FAQ 11-13-043-1](#), which clarifies the use of additional language codes beyond the preferred language standard requirements for EHR technology certification.

<http://www.healthit.gov/policy-researchers-implementers/43-question-11-13-043>

Date Updated: 11/6/2013

New ID# 9208 Old ID# N/A

233) Can an eligible professional (EP) or hospital charge patients a fee to have access to the Certified Electronic Health Records (EHR) Technology solution that is used to meet the meaningful use objective of providing patients the ability to view online, download and transmit their health information?

We do not believe it would be appropriate for the EP or hospital to charge the patient a fee to access the Certified EHR Technology solution regardless of whether the solution is in the form of a provider-specific portal, an online personal health record, community portal or some other solution. This is consistent with the position taken in the Stage 1 final rule (75 FR 44358) and reiterated in the Stage 2 final rule (77 FR 53999) with regard to the meaningful use objective to provide patients with clinical summaries of office visits. Access to the Certified EHR Technology solution would be provided to satisfy the requirements of the “view online, download and transmit” objective, rather than in response to a request from a patient. We note that the charging of fees for health information provided in response to a patient's request is governed by the HIPAA Privacy Rule.

To view the Stage 1 final rule for the Medicare and Medicaid EHR incentive programs, please visit: <http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/pdf/2010-17207.pdf>.

To view the Stage 2 final rule for the Medicare and Medicaid EHR incentive programs, please visit: <http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf>

Date Updated: 10/23/2013

New ID# 9112 Old ID# N/A

234) The specifications for Denominator 2 for measure CMS64v2 do not produce an accurate calculation according to the measure's intent. When will a correction to this clinical quality measure (CQM) be published?

The Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs Stage 2 final rule (77 FR 54056) states that updates to the CQM specifications may be published annually approximately 6 months prior to the beginning of the calendar year (CY) for which the data would be collected (e.g., for the EHR reporting periods in CY 2014, approximately 6 months in advance of the beginning of CY 2014). A correction for this measure will be included in the next annual update, to be published in CY 2014.

Within the logic for Denominator 2, there is a missing "OR" operator in the Risk Assessment Logic between count ≥ 3 and count = 2. This omission may result in cases incorrectly excluded from the denominator. This missing "OR" operator in Denominator 2 creates a situation where 3+ risk factors AND a High Density Lipoprotein (HDL) laboratory result of >60 mg/dL will cause the patient to not fall into Denominator 2, which is an error.

The issue would only impact cases when a patient's Framingham Risk Score is not recorded in the EHR.

The exact impact on the performance calculation for Denominator 2 is unknown. Since the CQM asks for either the data to calculate risk or a pre-calculated Framingham Risk Score, the result will not be miscalculated in denominator 2 if there is a Framingham score already in the EHR system.

It is highly recommended that eligible professionals (EPs) implementing this CQM record a Framingham Risk Score as outlined in the U.S. Department of Health & Human Services' Third Report of the National Cholesterol Education Program (NCEP) (2002, p. III-4 – III-5) to ensure accurate performance calculation:

<http://www.nhlbi.nih.gov/guidelines/cholesterol/atp3full.pdf>

Date Updated: 8/22/2013

New ID# 9062 Old ID# N/A

235) If an Eligible Professional (EP) or hospital attesting to meaningful use (MU) in the Electronic Health Records (EHR) Incentive Program submits a successful test to the immunization registry in year 1 of Stage 1 and engages with the immunization registry in year 2, but does not achieve ongoing submission of data to the immunization registry during their reporting period in year 1 or year 2, should they attest to the measure or the exclusion?

The Stage 1 MU measure requires the EP or hospital to perform at least one test of certified EHR technology's capacity to submit electronic data to immunization registries, and follow-up submission if that test is successful. An EP or hospital that can demonstrate engagement with the immunization registry during year 2 would attest to meeting the measure even if that engagement was not in the form of another

test. This engagement could be communication with the immunization registry showing that another test is not beneficial, work towards follow-up submission or an update showing that additional action by the provider towards follow-up submission is not beneficial for year 2. It is not acceptable to use the test from year 1 to meet the measure for year 2. The provider needs to show evidence of action taken during year 2 that demonstrates both that another test is not beneficial in moving towards follow-up submission and that follow-up submission is not possible in year 2. This principle applies to all of the public health objectives.

Date Updated: 7/29/2013

New ID# 8910 Old ID# N/A

236) Can a public health agency use a Health Information Exchange (HIE) to interface with providers who are submitting public health data to meet the public health objectives of meaningful use (such as submitting information to an immunization registry, reporting lab results to a public health agency or reporting syndromic surveillance information)?

There are a variety of methods for the exchange of public health information, and CMS does not limit or define the receiving capabilities of public health entities. Among other requirements as specified in the regulations, a provider must submit data for the public health objectives of meaningful use as follows:

- The information required by a public health meaningful use objective must originate from the provider's Certified Electronic Health Records Technology (CEHRT); and
- The information sent from the provider's Certified EHR Technology must be formatted according to the standards and implementation specifications associated with the public health meaningful use objective.

If a provider intends to use an intermediary as an extension of their CEHRT to satisfy a meaningful use requirement and not simply to transport the data, the intermediary would need to be certified as an EHR Module for that purpose. When obtaining a CMS certification number from the Certified HIT Products List (CHPL), a provider would need to include the intermediary's certification number during their attestation.

Date Updated: 7/24/2013

New ID# 8904 Old ID# N/A

237) When can a hospital use the case number threshold exemption for the clinical quality measure (CQM) requirement of meaningful use?

The case number threshold exemption for hospital CQM reporting helps reduce the burden placed on hospitals that very seldom have cases that would be counted in the denominator of certain CQMs. Eligible hospitals and critical access hospitals (CAHs) with a low number of inpatient discharges per electronic health records (EHR) reporting period as defined by a CQM's denominator population, could be exempted from reporting on that CQM.

The CQM case number threshold exemption for eligible hospitals and CAHs is available beginning in FY2013 for all stages of meaningful use (MU). The hospital must submit the aggregate population and sample size counts for Medicare and non-Medicare discharges for the EHR reporting period for the CQM(s) for which the hospital seeks an exemption.

To meet the threshold for exemption from reporting a CQM, the following criteria must be met for the corresponding EHR reporting periods:

- 1st year of demonstrating MU
 - 90-day EHR reporting period
 - 5 or fewer discharges during the EHR reporting period
- 2nd year or beyond of demonstrating MU
 - Full year EHR reporting period
 - 20 or fewer discharges during the EHR reporting period
 - In FY 2014, three-month quarter EHR reporting period with 5 or fewer discharges during the EHR reporting period
 - Discharges are defined by the CQM's denominator population
 - Applies on a CQM by CQM basis

When invoking the case number threshold exemption in FY 2013:

- All 15 of the CQMs from Stage 1 final rule are required.
- The number of CQMs required to report is reduced by the number of CQMs for which the hospital does not meet the case number threshold of discharges.

When invoking the case number threshold exemption in FY 2014:

- 16 CQMs covering at least 3 domains from a list of 29 CQMs are required.
- The same process as in FY 2013 is employed, but in order to be exempted from reporting fewer than 16 CQMs, the hospital would need to qualify for the case number threshold exemption for more than 13 of the 29 CQMs.
- If the CQMs for which the hospital can meet the case number threshold of discharges do not cover at least 3 domains, the hospital would be exempt from the requirement to cover the remaining domains.

To view the rules that include this policy for the Medicare and Medicaid EHR Incentive programs, please visit:

- Stage 2 Final Rule (77 FR 54080): <http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf>
- Interim Final Rule (77 FR 72988 – 72989): <http://www.gpo.gov/fdsys/pkg/FR-2012-12-07/pdf/2012-29607.pdf>

Date Updated: 7/1/2013

New ID# 8400 Old ID# N/A

238) In calculating the meaningful use objectives requiring patient action, if a patient sends a message or accesses his/her health information made available by their eligible professional (EP), can the other EPs in the practice get credit for the patient's action in meeting the objectives?

Yes. This transitive effect applies to the Secure Messaging and the 2nd measure of the Patient Access (View, Download and Transmit) core objectives.

If a patient sends a secure message about a clinical or health related subject to the group practice of their EP, that patient can be counted in the numerator of the Secure Messaging measure for any of the EPs at the group practice who use the same certified electronic health records technology (CEHRT) that saw and patient during their EHR reporting period.

Similarly, if a patient views, downloads or transmits to a third party the health information that was made available online by their EP, that patient can be counted in the numerator of the 2nd Patient Access measure for any of the EPs in that group practice who use the same CEHRT and saw that patient during their EHR reporting period.

For more information on accurately calculating the numerator for measures, please visit FAQ 8231: <https://questions.cms.gov/faq.php?faqlid=8231>

Date Updated: 4/2/2014

New ID# 9686 Old ID# N/A

239) I am an eligible professional. What should I do if my patients don't have broadband access?

Some meaningful use objectives require broadband access. The infrastructure required for the Secure Electronic Messaging objective is similar to the infrastructure required for the Patient Electronic Access objective's successful usage of an online patient portal, as required in the second measure.

Therefore, CMS finalized an exclusion for those two requirements:

An eligible professional that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 3Mbps broadband availability, according to the latest information available from the FCC, on the first day of the EHR reporting period may exclude the second measure of the Patient Electronic Access objective and the Secure Electronic Messaging objective.

The FCC's National Broadband Map allows eligible professionals to search, analyze, and map broadband availability in their area: <http://www.broadbandmap.gov/>.

Date Updated: 8/18/2014

New ID# 10454 Old ID# N/A

240) In the inpatient setting, when providing patient data to satisfy the Summary of Care and View Online, Download, and Transmit objectives, does a hospital have to provide two different documents for patients and providers?

Eligible hospitals may create one consolidated document for the download requirement of the View Online, Download, and Transmit objective and the Summary of Care objective, as long as it:

- Has the required fields in it for both objectives
- Meets the standards for structured data for both objectives.

Date Updated: 8/18/2014

New ID# 10456 Old ID# N/A

241) How can a provider meet the “Protect Electronic Health Information” core objective in the Electronic Health Records (EHR) Incentive Programs?

To meet the “Protect Electronic Health Information” core objective for Stage 1, eligible professionals (EP), eligible hospitals or critical access hospitals (CAH) must conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.

In Stage 2, in addition to meeting the same security risk analysis requirements as Stage 1, EPs and hospitals will also need to address the encryption and security of data stored in the certified EHR technology (CEHRT).

These steps may be completed outside or the EHR reporting period timeframe but must take place no earlier than the start of the EHR reporting year and no later than the provider attestation date. For example, a EP who is reporting Meaningful Use for a 90-day EHR reporting period may complete the appropriate security risk analysis requirements outside of this 90-day period as long as it is completed no earlier than January 1st of the EHR reporting year and no later than the date the provider submits their attestation for that EHR reporting period.

This meaningful use objective complements but does not impose new or expanded requirements on the HIPAA Security Rule. In accordance with the requirements under (45 CFR 164.308(a)(1)(ii)), providers are required to conduct an accurate and thorough analysis of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information (ePHI). Once the risk analysis is completed, providers must take any additional “reasonable and appropriate” steps to reduce identified risks to reasonable and appropriate levels.

Please note that a security risk analysis or review needs to be conducted during each EHR reporting year for Stage 1 and Stage 2 of meaningful use to ensure the privacy and security of their patients' protected health information.

For more information about completing a security risk analysis, please see the following resources:

Security Risk Assessment Tip Sheet:

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/SecurityRiskAssessment_FactSheet_Updated20131122.pdf.

Health Information Privacy and Security: A 10 Step Plan:

<http://www.healthit.gov/providers-professionals/ehr-privacy-security/10-step-plan>.

Date Updated: 11/5/2014

New ID# 10754 Old ID# N/A

VIII. Questions about Stage 2 Meaningful Use and 2014 Clinical Quality Measures

General Questions about Stage 2

242) For the Medicare and Medicaid EHR Incentive Programs, what changes were made to Stage 1 objectives and policies in the August 23, 2012 Final Rule?

The August 23, 2012, final rule includes some changes to the Stage 1 meaningful use objectives, measures, and exclusions for eligible professionals, eligible hospitals, and critical access hospitals. Some of these changes will take effect as early as October 1, 2012, for eligible hospitals and critical access hospitals, or January 1, 2013, for eligible professionals. Other Stage 1 changes will not take effect until the 2014 fiscal or calendar year, and will be optional in 2013.

Please see the full FAQ online to see a chart of the changes to specific objectives, measures and policies: <https://questions.cms.gov/faq.php?id=5005&faqId=7527>.

Date Updated: 8/23/2012

New ID #7527 Old ID #N/A

243) What is Stage 2 for the Medicare and Medicaid EHR Incentive Programs?

In August 2012, CMS published a final rule that specifies the Stage 2 meaningful use criteria that eligible professionals, eligible hospitals, and critical access hospitals must meet to continue to participate in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs and avoid payment adjustments.

Stage 2 retains the core and menu structure for meaningful use objectives. Although some Stage 1 objectives were either combined or eliminated, most of the Stage 1 objectives are now core objectives under the Stage 2 criteria. For many of these Stage 2 objectives, the threshold that providers must meet for the objective has been raised.

New objectives are also introduced for Stage 2, and most of these are introduced as menu objectives. As with the previous stage, many of the Stage 2 objectives have exclusions that allow providers to achieve meaningful use without having to meet objectives outside of their normal scope of clinical practice.

To demonstrate meaningful use under Stage 2 criteria—

- Eligible professionals must meet 17 core objectives and 3 menu objectives they select from a list of 6, for a total of 20 core objectives (the same number of objectives that had to be met in Stage 1).
- Eligible hospitals and critical access hospitals must meet 16 core objectives and 3 menu objectives they select from a list of 6, for a total of 19 core objectives (the same number of objectives that had to be met in Stage 1).

Please note, providers who were early demonstrators of meaningful use in 2011 will meet three consecutive years of meaningful use under the Stage 1 criteria before advancing to the Stage 2 criteria in 2014. All other providers would meet two years of meaningful use under the Stage 1 criteria before advancing to the Stage 2 criteria in their third year, regardless of the year in which you begin participation.

The Stage 2 final rule also includes some changes to the Stage 1 meaningful use objectives, measures, and exclusions. Some of the changes to Stage 1 will take effect as early as October 1, 2012, for eligible hospitals and critical access hospitals, or January 1, 2013, for eligible professionals. Other changes to Stage 1 will not be required until FY 2014 (for hospitals) or CY 2014 (for EPs), but will be optional in FY 2013 (for hospitals) or CY 2013 (for EPs).

Date Updated: 8/23/2012

New ID #7529

Old ID #N/A

244) If multiple eligible professionals contribute information to a shared portal or to a patient's online personal health record (PHR), how is it counted for meaningful use when the patient accesses the information on the portal or PHR?

This answer is relevant to the following meaningful use measure:

For Eligible Professionals:

“More than 5 percent of all unique patients seen by the eligible professional during the EHR reporting period (or their authorized representatives) view, download or transmit to a third party their health information.”

For Eligible Hospitals and Critical Access Hospitals:

“More than 5 percent of all unique patients (or their authorized representatives) who are discharged from the inpatient or emergency department (Place of Service 21 or 23) of an eligible hospital or CAH view, download or transmit to a third party their information during the EHR reporting period.”

If an eligible professional sees a patient during the EHR reporting period, the eligible professional may count the patient in the numerator for this measure if the patient (or an authorized representative) views online, downloads, or transmits to a third party any of the health information from the shared portal or online PHR. The same would apply for an eligible hospital or CAH if a patient is discharged during the EHR reporting period. The respective eligible professional, eligible hospital, or CAH must have contributed at least some of the information identified in the Stage 2 final rule to the shared portal or online PHR for the patient. However, the respective provider need not have contributed the particular information that was viewed, downloaded, or transmitted by the patient.

Although availability varies by state and geographic location, some Health Information Exchanges (HIEs) provide shared portal or PHR services. If a provider uses an HIE for these services to make information available to patients, in order to meet

meaningful use requirements the provider must use an HIE that is certified as an EHR Module for that purpose. The HIE must be able to verify whether a particular provider actually contributed some of the information identified in the Stage 2 final rule to the shared portal or PHR for a particular patient. If a provider elects to use the HIE for these shared portal or PHR services, the provider must include the HIE's certification number as part of their attestation.

Date Updated: 7/24/2013

New ID #7735 Old ID #N/A

245) When meeting the meaningful use measure for computerized provider order entry (CPOE) in the Electronic Health Records (EHR) Incentive Programs, does an individual need to have the job title of medical assistant in order to use the CPOE function of Certified EHR Technology (CEHRT) for the entry to count toward the measure, or can they have other titles as long as their job functions are those of medical assistants?

If a staff member of the eligible provider is appropriately credentialed and performs similar assistive services as a medical assistant but carries a more specific title due to either specialization of their duties or to the specialty of the medical professional they assist, he or she can use the CPOE function of CEHRT and have it count towards the measure. This determination must be made by the eligible provider based on individual workflow and the duties performed by the staff member in question. Whether a staff member carries the title of medical assistant or another job title, he or she must be credentialed to perform the medical assistant services by an organization other than the employing organization. Also, each provider must evaluate his or her own ordering workflow, including the use of CPOE, to ensure compliance with all applicable federal, state, and local law and professional guidelines.

Date Updated: 8/20/2013

New ID#9058 Old ID# N/A

246) While the denominator for measures used to calculate meaningful use in the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs is restricted to patients seen during the EHR reporting period, is the numerator also restricted to activity during the EHR reporting period or can actions for certain meaningful use measures be counted in the numerator if they took place after the EHR reporting period has ended?

The criteria for a numerator is not constrained to the EHR reporting period unless expressly stated in the numerator statement for a given meaningful use measure. The numerator for the following meaningful use measures should include only actions that take place within the EHR reporting period: Preventive Care (Patient Reminders) and Secure Electronic Messaging.

For all other meaningful use measures, the actions may reasonably fall outside the EHR reporting period timeframe but must take place no later than the date of attestation in order for the patients to be counted in the numerator.

Date Updated: 4/26/2013

New ID# 8231 Old ID# N/A

247) When combining meaningful use data from multiple locations equipped with Certified Electronic Health Records (EHR) Technology, is it required to have a full meaningful use report from each location or is it acceptable to only collect denominator information from one or more locations?

An eligible provider (EP) must have accurate denominators for the meaningful use measures. If an EP is unable to access data from a location to determine whether a patient or action in the denominator should be included in the numerator for a given measure, the EP should be aware that this could negatively impact their performance on the measure, and the EP might not meet the required threshold for the measure.

Date Updated: 2/26/2013

New ID# 7815 Old ID# N/A

Questions about Stage 2 Meaningful Use Measures & Objectives

248) For meaningful use Stage 2's transitions of care and referrals objective, in what ways can I meet the second measure that requires more than 10% of the summary care records I provide for transitions of care and referrals to be electronically transmitted?

An EP, eligible hospital, or CAH could use 3 distinct approaches (which could also be used in combination) to meet this measure. The first two rely solely on the use of CEHRT, while the third is slightly different.

For the first two approaches, this measure can only be met if the EP, eligible hospital, or CAH uses the capabilities and standards included as part of its Certified EHR Technology (CEHRT) to electronically transmit summary care records for transitions of care and referrals (specifically those capabilities certified to the certification criterion adopted by ONC at 45 CFR 170.314(b)(2) "transitions of care – create and transmit transition of care/referral summaries," which specifies standards for data content and transport).

For the third approach, the EP, eligible hospital, or CAH must use its CEHRT to create a summary care record for transitions of care and referrals, but instead of using a transport standard specified in ONC's certification criterion at 45 CFR 170.314(b)(2) (included as part of its CEHRT) to electronically transmit the summary care record, the EP, eligible hospital, or CAH may use a NwHIN Exchange participant to facilitate the electronic transmission to the recipient. The NwHIN Exchange is now known as "eHealth Exchange" and a list of participants can be found here.

The following are more detailed explanations of each permitted approach. We also emphasize that regardless of the way an EP, eligible hospital, or CAH chooses to transmit the summary of care record, such a transmission will only count in the numerator if it is received by the provider to whom the sending provider is referring or transferring the patient.

1. Use of the transport standard capability required for certification. As required by ONC to meet the CEHRT definition, every EP, eligible hospital, and CAH, must have EHR technology that is capable of electronically transmitting a summary care record for transitions of care and referrals according to the primary Direct Project specification (the Applicability Statement for Secure Health Transport). Thus, EPs, eligible hospitals, or CAHs that electronically transmit summary care records using their CEHRT's "Direct" capability (natively or combined with an intermediary) would be able to count all such electronic transmissions in their numerator.
2. Use of the SOAP-based optional transport standard capability permitted for certification. As part of certification, ONC permits EHR technology developers to voluntarily seek certification for their EHR technology's capability to perform SOAP-based electronic transmissions. EHR technology developers who take this approach would enable their customers to also use this approach to meet the measure. Thus, EPs, eligible hospitals, or CAHs that electronically transmit summary care records using their CEHRT's "SOAP-based" capability (natively or combined with an intermediary) would be able to count all of those transmissions in their numerator.
3. Use of CEHRT to create a summary care record in accordance with the required standard (i.e., Consolidated CDA as specified in 45 CFR 170.314(b)(2)), and the electronic transmission is accomplished through the use of an eHealth Exchange participant who enables the electronic transmission of the summary care record to its intended recipient. Thus, EPs, eligible hospitals, or CAHs who create standardized summary care records using their CEHRT and then use an eHealth Exchange participant to electronically transmit the summary care record would be able to count all of those transmissions in their numerator.

We note that for this third approach, the regulation also permits an EP, eligible hospital, or CAH to count in their numerator instances where a summary care record for transitions of care or referrals was received via electronic exchange facilitated in a manner consistent with the governance mechanism ONC establishes for the nationwide health information network. ONC has not yet established a governance mechanism for the nationwide health information network. Until ONC establishes such a governance mechanism, this specific option will not be available.

Date Updated: 11/5/2012

New ID #7697

Old ID #N/A

249) To meet the third measure of the objective of providing "a summary of care record for each transition of care or referral" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, must the electronic exchange with a recipient using technology designed by a different EHR developer occur for each provider or can there be one exchange per location? What if the provider chooses instead to exchange information with the CMS test EHR?

The Stage 2 Final Rule (CMS-0044-F) changed the way shared Certified EHR Technologies are handled for the Stage 2 measure option for summary of care records at transitions of care and referrals. Previously, if multiple EPs are using the same certified EHR technology in different physical locations/settings (e.g., different practice locations), there must be a single test performed for each physical location/setting.

The intent of the objective is to demonstrate that a provider has the full capability to use their certified EHR technology to successfully transmit a summary of care document to a different EHR vendor in a live setting.

Under changes made in the Stage 2 Final Rule providers that use the same EHR technology and share a network for which their organization either has operational control of or license to use can conduct one test for the successful electronic exchange of a summary of care document with either a different EHR technology or the CMS designated test EHR that covers all providers in the organization. For example, if a large group of EPs with multiple physical locations use the same EHR technology and those locations are connected using a network that the group has either operational control of or license to use, then a single test would cover all EPs in that group.

For more information, please visit the EHR Incentive Programs Stage 2 Final Rule: <http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf>.

Date Updated: 4/2/2014

New ID #7729 Old ID #N/A

250) When maintaining an up-to-date problem list as part of achieving meaningful use in the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs, can both SNOMED CT as well as non-SNOMED CT (for example ICD-9 or ICD-10) elements be included to meet the measure?

Prior to 2014, the Medicare and Medicaid EHR Incentive Programs permitted either SNOMED CT or ICD-9 to be used when a patient's problems were recorded by 2011 Edition Certified EHR Technology (CEHRT) as structured data. However, when an eligible professional (EP), eligible hospital, or critical access hospital (CAH) begins its 2014 EHR reporting period (for Stage 1 or Stage 2) it will need to use 2014 Edition CEHRT which only permits recording patient problems in SNOMED-CT®.

Therefore, beginning with the 2014 EHR reporting period, EPs, eligible hospitals, and CAHs will need to use the capabilities and standards included in 2014 Edition CEHRT to maintain the problem list using SNOMED-CT® as structured data. This policy also applies to other Stage 1 and Stage 2 objectives and measures in which problems data is required, such as creating a Consolidated Clinical Document Architecture (CCDA) formatted summary record for the purposes of meeting the Stage 2 "transitions of care" measure #2 (10% electronic transmissions).

If the provider uses other code sets to identify/select problems for the problem list as part of a user interface (which is permitted), such codes will need to be mapped to the corresponding SNOMED-CT® codes when recorded in the CEHRT. For example, if the CEHRT is certified and uses both ICD and SNOMED-CT® codes, the ICD codes need to be “cross-walked” to the appropriate SNOMED-CT® codes to be included in the problem list to meet this measure.

Date Updated: 11/21/2013

New ID# 9274 Old ID# N/A

251) If a hospital operates in a jurisdiction where a public health agency (PHA) has the ability to accept certain reportable laboratory results electronically and in the required standards, but the hospital does not generate those particular reportable laboratory results, how must the hospital attest to the core measure for Electronic Reportable Laboratory Results?

If laboratory results generated by a hospital do not align with those that are defined as reportable by the PHAs with jurisdiction over the hospital, either because the laboratory results are not reportable or because the PHA does not support electronic submission of those particular results or both, the hospital can attest to the exclusion to this measure.

The reasoning is based on exclusion one in Stage 2 of this objective. An eligible hospital or critical access hospital (CAH) operating in a jurisdiction for which no public health agency is capable of receiving electronic reportable laboratory results in the specific standards required for Certified Electronic Health Records (EHR) Technology at the start of the EHR reporting period may be excluded from this objective.

For example, a hospital can claim an exclusion for this objective if:

- The hospital conducts tests X, Y and Z and those are not reportable or not accepted electronically by any public health agencies.
- There are PHAs that accept tests A, B and C, but the hospital is incapable of conducting these tests.

This answer assumes the hospital is not otherwise required by law to report the lab results that are considered reportable by the PHA.

Date Updated: 11/6/2013

New ID# 9206 Old ID# N/A

252) Am I permitted to count a patient in the numerator of the “record demographics” objective and measure if the preferred language I record for the patient is outside of the minimum required by the standard for Certified Electronic Health Records (EHR) Technology?

Yes, similar to the collection of race and ethnicity demographic data, we appreciate that providers may need to collect more precise information about

preferred language to manage their patient population. If a patient's preferred language is not included in the standard required for EHR technology certification, you may count that patient in the numerator of the measure as long as the preferred language is recorded as structured data, as required by the measure. Eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) that seek to record other preferred languages (beyond those minimally required for EHR technology certification) are encouraged to consult their EHR technology developer to ensure that an attestation report will properly account for those patients.

Please see [ONC FAQ 11-13-043-1](#), which clarifies the use of additional language codes beyond the preferred language standard requirements for EHR technology certification.

<http://www.healthit.gov/policy-researchers-implementers/43-question-11-13-043>

Date Updated: 11/6/2013

New ID# 9208 Old ID# N/A

253) Can an eligible professional (EP) or hospital charge patients a fee to have access to the Certified Electronic Health Records (EHR) Technology solution that is used to meet the meaningful use objective of providing patients the ability to view online, download and transmit their health information?

We do not believe it would be appropriate for the EP or hospital to charge the patient a fee to access the Certified EHR Technology solution regardless of whether the solution is in the form of a provider-specific portal, an online personal health record, community portal or some other solution. This is consistent with the position taken in the Stage 1 final rule (75 FR 44358) and reiterated in the Stage 2 final rule (77 FR 53999) with regard to the meaningful use objective to provide patients with clinical summaries of office visits. Access to the Certified EHR Technology solution would be provided to satisfy the requirements of the “view online, download and transmit” objective, rather than in response to a request from a patient. We note that the charging of fees for health information provided in response to a patient's request is governed by the HIPAA Privacy Rule.

To view the Stage 1 final rule for the Medicare and Medicaid EHR incentive programs, please visit: <http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/pdf/2010-17207.pdf>

To view the Stage 2 final rule for the Medicare and Medicaid EHR incentive programs, please visit: <http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf>

Date Updated: 10/23/2013

New ID# 9112 Old ID# N/A

254) When meeting the meaningful use measure for “secure messaging” in the Electronic Health Records (EHR) Incentive Programs, which requires that more than 5

percent of unique patients send a secure message using the electronic messaging function of Certified EHR Technology (CEHRT), is it required that the patient only use an interface that is certified or can any secure message received into the eligible professional's CEHRT count for this measure?

As part of this objective, the eligible professional (EP) must make available to patients a secure messaging option certified to the 2014 edition certification criteria. However, this option is not the only way that a patient can send a secure message to an EP. Any secure message that is received using the electronic messaging function of the EP's CEHRT counts toward the measure regardless of whether the interface the patient used to create the message was specific to the EP's CEHRT.

Date Updated: 10/23/2013

New ID#9114

Old ID# N/A

255) For the meaningful use Stage 2's transitions of care and referrals objective, in what ways can the second measure be met that requires more than 10% of the summary care records provided for transitions of care and referrals to be electronically transmitted in the Electronic Health Records (EHR) Incentive programs?

An EP, eligible hospital, or critical access hospital (CAH) could use three approaches) to meet this measure.

For the first two approaches, this measure can only be met if the EP, eligible hospital, or CAH uses the capabilities and standards included as part of its Certified EHR Technology (CEHRT) to electronically transmit summary care records for transitions of care and referrals (specifically those capabilities certified to the certification criterion adopted by the Office of the National Coordinator (ONC) at 45 CFR 170.314(b)(2) "transitions of care – create and transmit transition of care/referral summaries," which specifies standards for data content and transport).

For the third approach, the EP, eligible hospital, or CAH must use its CEHRT to create a summary care record for transitions of care and referrals. However, instead of using a transport standard specified in ONC's certification criterion at 45 CFR 170.314(b)(2) (included as part of its CEHRT) to electronically transmit the summary care record, the EP, eligible hospital, or CAH may use a Nationwide Health Information Network (NwHIN) Exchange participant to facilitate the electronic transmission to the recipient. The NwHIN Exchange is now known as "eHealth Exchange" and a list of participants can be found at <http://www.healthwayinc.org/index.php/exchange/participants>.

The following are more detailed explanations of each permitted approach. We also emphasize that regardless of the way an EP, eligible hospital, or CAH chooses to transmit the summary of care record, such a transmission will only count in the numerator if it is received by the provider to whom the sending provider is referring or transferring the patient.

1. Use of the transport standard capability required for certification – the primary Direct Project specification (the Applicability Statement for Secure Health Transport) hereafter referred to as simply “Direct”. This specification is required by ONC to meet the CEHRT definition and every EP, eligible hospital, and CAH, must have EHR technology that is capable of electronically transmitting a summary care record for transitions of care and referrals according to it. To count electronically transmitted summary care records in their numerator, EPs, eligible hospitals, or CAHs:

- Must use their CEHRT's “Direct” capability (whether provided as an integrated part of their EHR technology or combined with another service provider). If an EHR technology developer uses another service provider (for example, an Health Information Exchange organization (HIE) or Health Information Service Provider (HISP)) to achieve certification for Direct, an EP, eligible hospital, CAH can only count in their numerator electronically transmitted summary care records using that certified configuration. In other words, if an EP, eligible hospital, or CAH, sought to use a different service provider that was not certified with their EHR for Direct, that service provider would not be part of their CEHRT and, thus, any Direct transmissions using that service provider would not count toward the numerator.
- May use, if their CEHRT includes it, the “Direct + XDR/XDM for Direct Messaging” transport capability which enables EHR technology to include additional metadata and communicate with SOAP-based systems.

2. Use of the SOAP-based optional transport standard capability permitted for certification. As part of certification, ONC permits EHR technology developers to voluntarily seek certification for their EHR technology's capability to perform SOAP-based electronic transmissions. EHR technology developers who take this approach would enable their customers to also use this approach to meet the measure. To count electronically transmitted summary care records in their numerator, EPs, eligible hospitals, or CAHs:

- May use their CEHRT's “SOAP-based” capability (again if their EHR technology has been certified for it). The SOAP-based standard ONC adopted for certification is a baseline on top of which an EHR technology developer may add more advanced exchange capabilities (i.e., query). An EP, eligible hospital or CAH using an EHR technology certified to that SOAP baseline may count electronic transmissions in the numerator that utilize more advanced exchange capabilities even if those capabilities were not included when the EHR technology was certified.

3. Use of CEHRT to create a summary care record in accordance with the required standard (i.e., Consolidated CDA as specified in 45 CFR 170.314(b)(2)), and the electronic transmission is accomplished through the use of an eHealth Exchange participant who enables the electronic transmission of the summary care record to its intended recipient. Thus, EPs, eligible hospitals, or CAHs who create standardized summary care records using their CEHRT and then use an eHealth Exchange

participant to electronically transmit the summary care record would be able to count all of those transmissions in their numerator. EPs, eligible hospitals, and CAHs, do NOT themselves need to become an eHealth Exchange participant in order to use this option. Rather, it is sufficient and acceptable to use the exchange services of a third party organization, like a health information exchange entity, that is an eHealth Exchange participant.

For this third approach, the regulation also permits an EP, eligible hospital, or CAH to count in their numerator instances where a summary care record for transitions of care or referrals was received via electronic exchange facilitated in a manner consistent with the governance mechanism ONC establishes for the nationwide health information network. ONC has not yet established a governance mechanism for the nationwide health information network. Until ONC establishes such a governance mechanism, this specific option will not be available.

Date Updated: 8/23/2013

New ID# 9064 Old ID# N/A

256) The specifications for Denominator 2 for measure CMS64v2 do not produce an accurate calculation according to the measure's intent. When will a correction to this clinical quality measure (CQM) be published?

The Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs Stage 2 final rule (77 FR 54056) states that updates to the CQM specifications may be published annually approximately 6 months prior to the beginning of the calendar year (CY) for which the data would be collected (e.g., for the EHR reporting periods in CY 2014, approximately 6 months in advance of the beginning of CY 2014). A correction for this measure will be included in the next annual update, to be published in CY 2014.

Within the logic for Denominator 2, there is a missing "OR" operator in the Risk Assessment Logic between count ≥ 3 and count = 2. This omission may result in cases incorrectly excluded from the denominator. This missing "OR" operator in Denominator 2 creates a situation where 3+ risk factors AND a High Density Lipoprotein (HDL) laboratory result of >60 mg/dL will cause the patient to not fall into Denominator 2, which is an error.

The issue would only impact cases when a patient's Framingham Risk Score is not recorded in the EHR.

The exact impact on the performance calculation for Denominator 2 is unknown. Since the CQM asks for either the data to calculate risk or a pre-calculated Framingham Risk Score, the result will not be miscalculated in denominator 2 if there is a Framingham score already in the EHR system.

It is highly recommended that eligible professionals (EPs) implementing this CQM record a Framingham Risk Score as outlined in the U.S. Department of Health & Human Services' Third Report of the National Cholesterol Education Program

(NCEP) (2002, p. III-4 – III-5) to ensure accurate performance calculation:
<http://www.nhlbi.nih.gov/guidelines/cholesterol/atp3full.pdf>

Date Updated: 8/22/2013

New ID# 9062 Old ID# N/A

257) Can a public health agency use a Health Information Exchange (HIE) to interface with providers who are submitting public health data to meet the public health objectives of meaningful use (such as submitting information to an immunization registry, reporting lab results to a public health agency or reporting syndromic surveillance information)?

There are a variety of methods for the exchange of public health information, and CMS does not limit or define the receiving capabilities of public health entities. Among other requirements as specified in the regulations, a provider must submit data for the public health objectives of meaningful use as follows:

- The information required by a public health meaningful use objective must originate from the provider's Certified Electronic Health Records Technology (CEHRT); and
- The information sent from the provider's Certified EHR Technology must be formatted according to the standards and implementation specifications associated with the public health meaningful use objective.

If a provider intends to use an intermediary as an extension of their CEHRT to satisfy a meaningful use requirement and not simply to transport the data, the intermediary would need to be certified as an EHR Module for that purpose. When obtaining a CMS certification number from the Certified HIT Products List (CHPL), a provider would need to include the intermediary's certification number during their attestation.

Date Updated: 7/24/2013

New ID# 8904 Old ID# N/A

258) If a provider utilizes a health information organization that participates with the eHealth Exchange but is not connected to public health entities in the provider's state, does the provider still need to connect to those entities for purposes of participating in the Medicare and Medicaid EHR Incentive Program?

Yes, to meet the requirements for meaningful use, the provider must connect to the appropriate public health entities in his or her state, even if the provider has connected to an eHealth Exchange participant for other reasons. This can be accomplished by expanding the eHealth Exchange participant connections to include public health agencies, or through direct connections from the provider to the public health agency, or through a different third-party interface.

The information required by a public health meaningful use objective must originate from the provider's Certified Electronic Health Records Technology (CEHRT), and the information sent from that technology must be formatted according to the

standards and implementation specifications associated with the public health meaningful use objective. If a provider wishes to use an health information exchange (HIE) or other intermediary to connect to a public health agency and perform a function to meet the meaningful use requirement, the provider must use an HIE or intermediary that is certified as an EHR Module for that purpose.

CMS recognizes the variety of methods in which the exchange of public health information could take place, and therefore does not seek to limit or define the receiving capabilities of public health entities (see FAQ 3461).

Date Updated: 7/24/2013

New ID# 8906 Old ID# N/A

259) When can a hospital use the case number threshold exemption for the clinical quality measure (CQM) requirement of meaningful use?

The case number threshold exemption for hospital CQM reporting helps reduce the burden placed on hospitals that very seldom have cases that would be counted in the denominator of certain CQMs. Eligible hospitals and critical access hospitals (CAHs) with a low number of inpatient discharges per electronic health records (EHR) reporting period as defined by a CQM's denominator population, could be exempted from reporting on that CQM.

The CQM case number threshold exemption for eligible hospitals and CAHs is available beginning in FY2013 for all stages of meaningful use (MU). The hospital must submit the aggregate population and sample size counts for Medicare and non-Medicare discharges for the EHR reporting period for the CQM(s) for which the hospital seeks an exemption.

To meet the threshold for exemption from reporting a CQM, the following criteria must be met for the corresponding EHR reporting periods:

- 1st year of demonstrating MU
 - 90-day EHR reporting period
 - 5 or fewer discharges during the EHR reporting period
- 2nd year or beyond of demonstrating MU
 - Full year EHR reporting period
 - 20 or fewer discharges during the EHR reporting period
 - In FY 2014, three-month quarter EHR reporting period with 5 or fewer discharges during the EHR reporting period
 - Discharges are defined by the CQM's denominator population
 - Applies on a CQM by CQM basis

When invoking the case number threshold exemption in FY 2013:

- All 15 of the CQMs from Stage 1 final rule are required.
- The number of CQMs required to report is reduced by the number of CQMs for which the hospital does not meet the case number threshold of discharges.

When invoking the case number threshold exemption in FY 2014:

- 16 CQMs covering at least 3 domains from a list of 29 CQMs are required.
- The same process as in FY 2013 is employed, but in order to be exempted from reporting fewer than 16 CQMs, the hospital would need to qualify for the case number threshold exemption for more than 13 of the 29 CQMs.
- If the CQMs for which the hospital can meet the case number threshold of discharges do not cover at least 3 domains, the hospital would be exempt from the requirement to cover the remaining domains.

To view the rules that include this policy for the Medicare and Medicaid EHR Incentive programs, please visit:

- Stage 2 Final Rule (77 FR 54080): <http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf>
- Interim Final Rule (77 FR 72988 – 72989): <http://www.gpo.gov/fdsys/pkg/FR-2012-12-07/pdf/2012-29607.pdf>

Date Updated: 7/1/2013

New ID# 8400

Old ID# N/A

260) When providing the clinical summary as part of an office visit to meet the measure “Clinical summaries provided to patients or patient-authorized representatives within 1 business day for more than 50 percent of office visits” (§ 495.6(j)(11)(ii)), can a provider determine whether to include information that was not changed or addressed during the visit?

Yes. Most of the elements listed in the regulation have text associated with them that are meant to provide additional context such as “for or of the office visit,” “current,” “pending,” “during the visit,” “if applicable to the visit,” “recent” and “future.” Some elements listed do not have these qualifiers because we believed the context was implicit.

Those elements are: clinical instructions, laboratory test results, referrals to other providers, demographic information, smoking status and care plan field(s), including goals and instructions. All of these elements only have to be included if changed due to the visit in question.

For example, the laboratory test results included in a clinical summary only need to be those ordered or reviewed during the visit and do not need to be laboratory test results from prior visits or other providers. Similarly, referrals are referrals made as a result of the visit and care plans are those pertaining to the visit. Smoking status and demographics are those updated at the visit.

A provider is free to include any information that was not updated at the visit just as they are free to include any information not listed in the regulation. In order for an

EHR to be certified, it must include the ability for the provider to customize the data included in the clinical summary.

Date Updated: 5/9/2013

New ID# 8237 Old ID# N/A

261) When creating a clinical summary as part of an office visit to meet the measure “Clinical summaries provided to patients or patient-authorized representatives within 1 business day for more than 50 percent of office visits” (§ 495.6(j)(11)(ii)), do all of the information elements specified by CMS for a clinical summary need to be individually listed?

No. The Stage 2 final rule did not include any requirements on the design of the clinical summary. For example, the information about future appointments, provider referrals, scheduled tests, and clinical instructions could be included in a section of the summary called "Next steps." If all of these information elements were empty, then "next steps" could just be "none" and all the information elements that feed this section would be covered.

If the summary is provided on letterhead that includes the office location and the provider name, that information does not have to be repeated in the text of the summary.

This design flexibility extends to all information elements of the clinical summary. Rather than listing procedures, tests, and immunizations separately, these could be collapsed under one heading and if no information feeds into that heading then "none" in that heading would cover all of those information elements. If some information does appear under that heading there does not need to be an accompanying indication that the other information elements are not applicable to that visit.

Date Updated: 5/9/2013

New ID# 8239 Old ID# N/A

262) Can a hospital count a patient toward the measures of the “Patient Electronic Access” objective in the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs if the patient accessed his/her information before they were discharged?

The 2nd measure of the “Patient Electronic Access” core objective for hospitals and critical access hospitals (CAH) requires that more than 5 percent of the unique patients who are discharged during the EHR reporting period access an online patient portal to view, download or transmit to a third party their information about their hospital admission. The intent is to encourage patients to use online access to their health information for the active management of their care.

The denominator for this measure includes all unique patients whose discharge date from the hospital or CAH falls within the EHR reporting period selected.

Patients may choose to access their information prior to leaving the hospital, where guidance and support in using the online patient portal is still available to them. To this end, the hospital may include patients found in the denominator who access their information on or before the hospital discharge date in the numerator.

For patients who access their information after the hospital discharge date, the access must take place no later than the date of attestation in order for those patients to be counted in the numerator.

For more information about actions taken outside of the EHR reporting period and numerator calculations, please see FAQ 8231.

<https://questions.cms.gov/faq.php?faqId=8231>

Date Updated: 4/2/2014

New ID# 9824 Old ID# N/A

263) When demonstrating Stage 2 meaningful use in the Electronic Health Records (EHR) Incentive programs, would an eligible professional (EP) be required to report on the "Electronic Notes" objective even if he or she did not see patients during their reporting period?

The intent of the Stage 2 Electronic Notes menu objective is to encourage documentation that assists in communicating individual patient circumstances and coordination with previous documentation of patient observations, treatments and/or results in the electronic health record.

The measure requires that electronic progress notes be created for 30 percent of an EP's unique patients who have at least one office visit during the EHR reporting period.

An EP can claim an exclusion from reporting this objective if he or she demonstrates that they had no office visits during the EHR reporting period for which they are attesting.

Date Updated: 4/2/2014

New ID# 9826 Old ID# N/A

264) When reporting on the Summary of Care objective in the Electronic Health Records (EHR) Incentive Program, which transitions would count toward the numerator of the measures?

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. To count toward the Summary of Care objective, the transition or referral must take place between providers with different billing identities such as a different National Provider Identifier (NPI) or hospital CMS Certification Number (CCN).

For Measure 1 of the Summary of Care objective, include the transitions of care in which a summary of care document was provided to the recipient of the transition or referral by any means.

For Measure 2 of the Summary of Care objective, include the transitions of care in which a summary of care document was transmitted electronically to the recipient using a CEHRT, or via exchange facilitated by an organization that is an eHealth Exchange participant, or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network.

If the receiving provider already has access to the CEHRT of the initiating provider of the transition or referral, simply accessing the patient's health information does not count toward meeting this objective. However, if the initiating provider also sends a summary of care document, this transition can be included in the denominator and the numerator as long as it is counted consistently across the organization and across both measures.

For Measure 3 of the Summary of Care objective, a single summary of care document sent to a provider using a different EHR and EHR Vendor or a test with the CMS and ONC Randomizer test system would meet the measure.

Date Updated: 4/2/2014

New ID# 9690 Old ID# N/A

265) For Measure 2 of the Stage 2 Summary of Care objective for the Electronic Health Records (EHR) Incentive Programs, may an eligible professional (EP), eligible hospital or critical access hospital (CAH) count a transition of care or referral in its numerator for the measure if they electronically create and send a summary of care document using their CEHRT to a third party organization that plays a role in determining the next provider of care and ultimately delivers the summary of care document?

Yes. An EP, eligible hospital or CAH may count transmissions in this measure's numerator when a third party organization is involved so long as:

- The summary of care document is created using certified EHR technology (CEHRT);
- The summary of care document electronically transmitted by the EP, eligible hospital or CAH to the third party organization is done so using EITHER:
 - (a) their CEHRT's transport standard capability; or
 - (b) an exchange facilitated by an organization that is an eHealth Exchange participant.
- The third party organization can confirm for the sending provider that the summary of care document was ultimately received by the next provider of care.

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. Nor are there any 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).

For more information about the Summary of Care objective, please see FAQ 9690.

Date Updated: 11/14/2014

New ID# 10660 Old ID# N/A

266) How can a provider meet the “Protect Electronic Health Information” core objective in the Electronic Health Records (EHR) Incentive Programs?

To meet the “Protect Electronic Health Information” core objective for Stage 1, eligible professionals (EP), eligible hospitals or critical access hospitals (CAH) must conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.

In Stage 2, in addition to meeting the same security risk analysis requirements as Stage 1, EPs and hospitals will also need to address the encryption and security of data stored in the certified EHR technology (CEHRT).

These steps may be completed outside or the EHR reporting period timeframe but must take place no earlier than the start of the EHR reporting year and no later than the provider attestation date. For example, a EP who is reporting Meaningful Use for a 90-day EHR reporting period may complete the appropriate security risk analysis requirements outside of this 90-day period as long as it is completed no earlier than January 1st of the EHR reporting year and no later than the date the provider submits their attestation for that EHR reporting period.

This meaningful use objective complements but does not impose new or expanded requirements on the HIPAA Security Rule. In accordance with the requirements under (45 CFR 164.308(a)(1)(ii)), providers are required to conduct an accurate and thorough analysis of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information (ePHI). Once the risk analysis is completed, providers must take any additional “reasonable and appropriate” steps to reduce identified risks to reasonable and appropriate levels.

Please note that a security risk analysis or review needs to be conducted during each EHR reporting year for Stage 1 and Stage 2 of meaningful use to ensure the privacy and security of their patients' protected health information.

For more information about completing a security risk analysis, please see the following resources:

Security Risk Assessment Tip Sheet:

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/SecurityRiskAssessment_FactSheet_Updated20131122.pdf.

Health Information Privacy and Security: A 10 Step Plan:

<http://www.healthit.gov/providers-professionals/ehr-privacy-security/10-step-plan>.

Date Updated: 11/5/2014

New ID# 10754 Old ID# N/A

267) For the certification criteria that providers must have in place to meet the Clinical Decision Support (CDS) objective, what type of interventions must the EHR technology trigger to meet the criteria? For this and for the Eligible Provider and Eligible Hospital Core Measures related to the Objective “use clinical decision support to improve performance on high-priority health conditions,” are “pop-up” alerts the only type of intervention that a provider can use to meet the CDS objective?

The intention of the CDS intervention certification requirement is to ensure certified EHR technology helps providers make timely and informed decisions. The certification requirement that CDS interventions be ‘triggered’ means that a CDS intervention – which may come in many forms other than “pop-ups” – be based on relevant, timely patient and care process information and that it may appear in ‘real time’ when it is most relevant to improve care provision.

CDS is not simply an alert, notification, or explicit care suggestion. Providers can meet the objective by using other kinds of CDS, including, but not limited to clinical guidelines; condition-specific order sets; focused patient data reports and summaries; documentation templates; diagnostic support; and contextually relevant reference information. In addition, CDS interventions are not only for doctors or nurses, but also for support staff, patients, and other caregivers, and may be delivered outside of the examination room or treatment setting.

Date Updated: 7/21/2014

New ID# 10228 Old ID# N/A

268) I am an eligible professional. What should I do if my patients don’t have broadband access?

Some meaningful use objectives require broadband access. The infrastructure required for the Secure Electronic Messaging objective is similar to the infrastructure required for the Patient Electronic Access objective’s successful usage of an online patient portal, as required in the second measure.

Therefore, CMS finalized an exclusion for those two requirements:

An eligible professional that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 3Mbps broadband availability, according to the latest information available

from the FCC, on the first day of the EHR reporting period may exclude the second measure of the Patient Electronic Access objective and the Secure Electronic Messaging objective.

The FCC's National Broadband Map allows eligible professionals to search, analyze, and map broadband availability in their area: <http://www.broadbandmap.gov/>.

Date Updated: 8/18/2014

New ID# 10454 Old ID# N/A

269) In the inpatient setting, when providing patient data to satisfy the Summary of Care and View Online, Download, and Transmit objectives, does a hospital have to provide two different documents for patients and providers?

Eligible hospitals may create one consolidated document for the download requirement of the View Online, Download, and Transmit objective and the Summary of Care objective, as long as it:

- Has the required fields in it for both objectives
- Meets the standards for structured data for both objectives.

Date Updated: 8/18/2014

New ID# 10456 Old ID# N/A

270) When reporting on the Summary of Care objective in the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program, how can eligible professionals and eligible hospitals meet measure 3 if they are unable to complete a test with the CMS designated test EHR (Randomizer)?

CMS is aware of difficulties eligible professionals, eligible hospitals, and critical access hospitals (CAHs) are having in use of the CMS Designated Test EHRs (NIST EHR-Randomizer Application) to meet measure 3 of the Stage 2 Summary of Care objective. At this time the two CMS Designated Test EHRs can only exchange/match with an eligible professional or eligible hospital that is Direct Trust (DT) Accredited. There is not a non-DT Accredited Test EHR for providers to use to successfully complete the test.

The following actions are currently in place to meet the Summary of Care objective for measure 3:

1. Exchange a summary of care with a provider or third party who has different CEHRT as the sending provider as part of the 10% threshold for measure #2. A successful exchange in measure #2 allows the provider to meet the criteria for measure #3 without the need to conduct a test with the Randomizer as outlined in measure #3, or
2. Conduct at least one successful test with the CMS designated test EHR (if the provider is Direct Trust Accredited).

If providers do not exchange summary of care documents with recipients using a different CEHRT in common practice, and cannot use the CMS Designated Test EHR for the reasons outlined above, they may retain documentation on their circumstances and attest "Yes" to meeting measure #3 if they have and are using a certified EHR which meets the standards required to send a CCDA (§ 170.202).

This exchange may be conducted outside of the EHR reporting period timeframe, but must take place no earlier than the start of the year and no later than the end of the EHR reporting year or the attestation date, whichever occurs first.

For example, an eligible professional or eligible hospital that is reporting meaningful use for a 90-day EHR reporting period may conduct this exchange outside of this 90-day period as long as it is completed no earlier than the first day of the EHR reporting year and no later than the last day of the EHR reporting year.

For more information on the NIST EHR-Randomizer Application, please visit:

<https://ehr-randomizer.nist.gov/ehr-randomizer-app/#/home>

Date Updated: 1/22/2015

New ID #11666 **Old ID #N/A**

Questions about changes to the Medicare EHR Incentive Program from Stage 2

271) What are the payment adjustments for eligible professionals who are not participating in the Medicare EHR Incentive Program? Are there any hardship exceptions?

As part of the American Recovery and Reinvestment Act of 2009 (ARRA), Congress mandated payment adjustments to be applied to Medicare eligible professionals (EPs) who are not meaningful users of Certified Electronic Health Record (EHR) Technology under the Medicare EHR Incentive Programs. These payment adjustments will be applied beginning on January 1, 2015, for Medicare EPs. Medicaid EPs who can only participate in the Medicaid EHR Incentive Program and do not bill Medicare are not subject to these payment adjustments.

EPs who can participate in either the Medicare or Medicaid EHR Incentive Programs will be subject to the payment adjustments unless they are meaningful users under one of the EHR Incentive Programs in the time periods specified below.

Medicare EPs who are not meaningful users will be subject to a payment adjustment beginning on January 1, 2015.

For additional information on payment adjustments and hardship exceptions for EPs, please review the Payment Adjustments and Hardship Exceptions Tip Sheet which will be available on our website.

Date Updated: 8/23/2012

New ID #7531 **Old ID #N/A**

272) What are the payment adjustments for eligible hospitals and critical access hospitals that are not participating in the Medicare EHR Incentive Program? Are there any hardship exceptions?

As part of the American Recovery and Reinvestment Act of 2009 (ARRA), Congress mandated payment adjustments to be applied to Medicare eligible hospitals, and critical access hospitals (CAHs) that are not meaningful users of Certified Electronic Health Record (EHR) Technology under the Medicare EHR Incentive Programs. These payment adjustments will be applied beginning on October 1, 2014, for Medicare eligible hospitals. Payment adjustments for CAHs will be applied beginning with the fiscal year 2015 cost reporting period. Medicaid eligible hospitals that can only participate in the Medicaid EHR Incentive Program and do not bill Medicare are not subject to these payment adjustments.

Eligible hospitals and CAHs that can participate in either the Medicare or Medicaid EHR Incentive Programs will be subject to the payment adjustments unless they are meaningful users under one of the EHR Incentive Programs in the time periods specified below.

Medicare Subsection (d) eligible hospitals that are not meaningful users will be subject to a payment adjustment beginning on October 1, 2014. Critical Access Hospitals (CAHs) that are not meaningful users will be subject to a payment adjustment for fiscal year 2015.

For additional information on payment adjustments and hardship exceptions for eligible hospitals and CAHs, please review the Payment Adjustments and Hardship Exceptions Tip Sheet for Eligible Hospitals and CAHs which will be available on our website.

Date Updated: 8/23/2012

New ID #7533 Old ID #N/A

Questions about changes to the Medicaid EHR Incentive Program from Stage 2

273) The EHR Incentive Programs Stage 1 Rule stated that, in order for a Medicaid encounter to count towards the patient volume of an eligible provider, Medicaid had to either pay for all or part of the service, or pay all or part of the premium, deductible or coinsurance for that encounter. The Stage 2 Rule now states that the Medicaid encounter can be counted towards patient volume if the patient is enrolled in the state's Medicaid program (either through the state's fee-for-service programs or the state's Medicaid managed care programs) at the time of service without the requirement of Medicaid payment liability. How will this change affect patient volume calculations for Medicaid eligible providers?

Importantly, this change affecting the Medicaid patient volume calculation is applicable to all eligible providers, regardless of the stage of the Medicaid EHR Incentive Program they are participating in. Billable services provided by an eligible

provider to a patient enrolled in Medicaid would count toward meeting the minimum Medicaid patient volume thresholds. Examples of Medicaid encounters under this expanded definition that could be newly eligible might include: behavioral health services, HIV/AIDS treatment, or other services that might not be billed to Medicaid/managed care for privacy reasons, but where the provider has a mechanism to verify eligibility. Also, services to a Medicaid-enrolled patient that might not have been reimbursed by Medicaid (or a Medicaid managed care organization) may now be included in the Medicaid patient volume calculation (e.g., oral health services, immunization, vaccination and women's health services, , telemedicine/telehealth, etc.)

Providers who are not currently enrolled with their state Medicaid agency who might be newly eligible for the incentive payments due to these changes should note that they are not necessarily required to fully enroll with Medicaid in order to receive the payment.

In some instances, it may now be appropriate to include services denied by Medicaid in calculating patient volume. It will be appropriate to review denial reasons. If Medicaid denied the service for timely filing or because another payer's payment exceeded the potential Medicaid payment, it would be appropriate to include that encounter in the calculation. If Medicaid denied payment for the service because the beneficiary has exceeded service limits established by the Medicaid program, it would be appropriate to include that encounter in the calculation. If Medicaid denied the service because the patient was ineligible for Medicaid at the time of service, it would not be appropriate to include that encounter in the calculation.

Further guidance regarding this change will be distributed to the states as appropriate.

Date Updated: 8/23/2012

New ID #7535 Old ID #N/A

274) The EHR Incentive Programs Stage 2 Rule describes changes to how a state considers CHIP patients in the Medicaid patient volume total when determining provider eligibility. Patients in which CHIP programs are now appropriate to be considered in the Medicaid patient volume total?

States that have offered CHIP as part of a Medicaid expansion under Title 19 or Title 21 can include those patients in their provider's Medicaid patient volume calculation as there is cost liability to the Medicaid program in either case (under the Stage 1 Rule, only CHIP programs created under a Medicaid expansion via Title 19 were eligible). Patients in standalone CHIP programs established under Title 21 are not to be considered part of the patient volume total (in Stage 1 or Stage 2). This change to the patient volume calculation is applicable to all eligible providers, regardless of the stage of the Medicaid EHR Incentive Program they are participating in.

Date Updated: 8/23/2012
New ID #7537 Old ID #N/A

275) Are there any changes in the EHR Incentive Programs Stage 2 Rule to the base year for the Medicaid hospital incentive payment calculation?

Yes. Previously Medicaid eligible hospitals calculated the base year using a 12 month period ending in the Federal fiscal year before the hospital's fiscal year that serves as the first payment year. In an effort to encourage timely participation in the program, §495.310(g)(1)(i)(B) of the Stage 2 Rule was amended to allow hospitals to use the most recent continuous 12 month period for which data are available prior to the payment year. This change went into effect upon publication of the Stage 2 Rule. Only hospitals that begin participation in the program after the publication date of the Stage 2 Rule (i.e., program years 2013 and later) will be affected by this change. Hospitals that began participation in the program prior to the Stage 2 Rule will not have to adjust previous calculations.

Date Updated: 8/23/2012
New ID #7539 Old ID #N/A

IX. Questions about Attestation

276) For the Medicaid EHR Incentive Program, how are the reporting periods for Medicaid patient volume and for demonstrating meaningful use affected if an eligible professional (EP) skips a year or takes longer than 12 months between attestations?

Regardless of when the previous incentive payment was made, the following reporting periods apply for the Medicaid EHR Incentive Program:

- For patient volume, an eligible professional (EP) should use any continuous, representative 90-day period in the prior calendar year.
- For demonstrating they are meaningful users of Electronic Health Records (EHRs),

EPs 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).

Date Updated: 3/28/2011
New ID #3111 Old ID #10528

277) Can eligible professionals (EPs) allow another person to register or attest for them?

Yes. Users registering or attesting on behalf of an EP must have an Identity and Access Management System (I&A) web user account (User ID/Password) and be associated to the EP's NPI. If you are working on behalf of an EP(s) and do not have an I&A web user account, please visit

<https://nppes.cms.hhs.gov/NPPES/IASecurityCheck.do> to create one.

Date Updated: 4/22/2011
New ID #3169 Old ID #10565

278) How will I attest for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

Medicare eligible professionals and eligible hospitals will have to demonstrate meaningful use through CMS' web-based Medicare and Medicaid EHR Incentive Program Registration and Attestation System. In the Registration and Attestation System, providers will fill in numerators and denominators for the meaningful use objectives and clinical quality measures, indicate if they qualify for exclusions to specific objectives, and legally attest that they have successfully demonstrated meaningful use. Once providers have completed a successful online submission through the Attestation System, they will qualify for a Medicare EHR incentive payment. Starting no longer than 2014, there will also be a batch file upload option.

For the Medicaid EHR Incentive Program, providers will follow a similar process using their State's Attestation System. Check here to see states' scheduled launch dates for their Medicaid EHR Incentive Programs:

<http://www.cms.gov/apps/files/medicaid-HIT-sites/>.

Date Updated: 5/4/2012
New ID #3059 Old ID #10463

279) How can I change my attestation information after I have attested and/or received an incentive payment under the Medicare Electronic Health Record (EHR) Incentive Program?

If you discover that the information you entered during your Medicare attestation was not complete and accurate for some reason, please contact our EHR Information Center Help Desk and ask about the process for amending your attestation data. You can contact the EHR Information Center at 1-888-734-6433 (primary number) or 1-888-734-6563 (TTY number), 7:30 a.m. – 6:30 p.m. (Central Time) Monday through Friday, except federal holidays.

Providers who have questions about changing their completed Medicaid attestation should contact their State Medicaid Agency for assistance.

Date Updated: 2/13/2012
New ID #3825 Old ID #10982

280) Does the person who completes the registration for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs need to be the same person who completes the attestation?

No. For Medicare providers, CMS has determined that if there are multiple users approved to work on behalf of an eligible professional (EP), any of those authorized users can update the EP's registration or attestation. In addition, the EP could login

and update the information him or herself. For Medicaid, each State determines if they are allowing authorized third parties to attest on behalf of EPs.

Date Updated: 10/20/2011

New ID #3613 Old ID #10845

281) I entered numerator and denominator information during my Medicare Electronic Health Record (EHR) Incentive Program attestation from my certified EHR technology, but subsequently discovered that the method of calculation included in the software was flawed. The software vendor has updated the reports. If CMS audits me, will I be held responsible for the difference between what I reported and what the updated software calculates?

CMS does not plan to conduct an audit to find providers who relied on flawed software for their attestation information. We realize that providers relied on the software they used for accuracy of reporting, and we believe that most providers who were improperly deemed meaningful users would have met the requirements of the EHR Incentive Programs using the updated certified EHR technology.

Date Updated: 4/11/2012

New ID #6097 Old ID #22001

282) To what attestation statements must an eligible professional (EP), eligible hospital, or critical access hospital (CAH) agree in order to submit an attestation, successfully demonstrate meaningful use, and receive an incentive payment under the Medicare Electronic Health Record (EHR) Incentive Program?

Currently, the attestation process requires EPs, eligible hospitals, and CAHs to indicate that they agree with the following attestation statements:

- The information submitted for clinical quality measures (CQMs) was generated as output from an identified certified EHR technology.
- The information submitted is accurate to the knowledge and belief of the EP or the person submitting on behalf of the EP, eligible hospital, or CAH.
- The information submitted is accurate and complete for numerators, denominators, exclusions, and measures applicable to the EP, eligible hospital, or CAH.
- The information submitted includes information on all patients to whom the measure applies.
- For CQMs, a zero was reported in the denominator of a measure when an EP, eligible hospital or CAH did not care for any patients in the denominator population during the EHR Reporting Period.

CMS considers information to be accurate and complete for CQMs insofar as it is identical to the output that was generated from certified EHR technology.

Numerator, denominator, and exclusion information for CQMs must be reported directly from information generated by certified EHR technology. By agreeing to the above statements, the EP, eligible hospital, or CAH is attesting that the information for CQMs entered into the Registration and Attestation System is identical to the information generated from certified EHR technology.

CMS does not require EPs, eligible hospitals, or CAHs to provide any additional information beyond what is generated from certified EHR technology in order to satisfy the requirement for submitting CQM information.

Please note that quality performance results for CQMs are not being assessed at this time under the EHR Incentive Programs. Complete and accurate information for the remaining meaningful use core and menu set measures does not necessarily have to be entered directly from information generated by certified EHR technology. By definition, for each meaningful use objective with a percentage-based measure, certified EHR technology must include the capability to electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage for these measures. However, with the exception of CQMs, meaningful use measures do not specify that this capability must be used to calculate the numerators and denominators. EPs, eligible hospitals, and CAHs can use a separate, uncertified system to calculate numerators and denominators and to generate reports on all measures of the core and menu set meaningful use objectives except CQMs.

In order to provide complete and accurate information for certain of these measures, they may also have to include information from paper-based patient records or from records maintained in uncertified EHR technology. By agreeing to the above statements, the EP, eligible hospital, or CAH is attesting to providing all of the information necessary from certified EHR technology, uncertified EHR technology, and/or paper-based records in order to render complete and accurate information for all meaningful use core and menu set measures except CQMs.

Date Updated: 6/21/2012

New ID #3209 Old ID #10589

283) What is the deadline for eligible professionals to submit attestations for 2013?

EPs participate in the EHR Incentive Programs on the calendar year, which is January 1 to December 31. The attestation deadline is two months following the end of the 2013 reporting period. In order to receive an EHR incentive payment for an EHR reporting period in 2013, Medicare EPs) need to submit their attestation by 11:59 p.m. EST on February 28, 2014. Medicare EPs will not receive an incentive payment if they submit their attestation after the deadline.

EPs participating in the Medicaid EHR Incentive Program need to refer to their state deadlines for attestation.

EPs must attest to demonstrating meaningful use every year to receive an incentive and avoid a payment adjustment.

Date Updated: 11/20/2013

New ID# 9268 Old ID# N/A

284) What is the deadline for eligible hospitals and critical access hospitals to submit attestations for 2013?

Eligible hospitals participate in the EHR Incentive Programs on the fiscal year, which is October 1 to September 30. The attestation deadline is two months following the end of the 2013 reporting period. In order to receive an EHR incentive payment for and EHR reporting period in 2013, Medicare eligible hospitals and CAHs need to submit their attestation by 11:59 p.m. EST on November 30, 2013. Medicare eligible hospitals and CAHs will not receive an incentive payment if they submit their attestation after the deadline.

Hospitals participating in the Medicaid EHR Incentive Program need to refer to their state deadlines for attestation.

Hospitals must attest to demonstrating meaningful use every year to receive an incentive and avoid a payment adjustment.

Date Updated: 11/20/2013

New ID# 9270 Old ID# N/A

285) When meeting the meaningful use measure for “secure messaging” in the Electronic Health Records (EHR) Incentive Programs, which requires that more than 5 percent of unique patients send a secure message using the electronic messaging function of Certified EHR Technology (CEHRT), is it required that the patient only use an interface that is certified or can any secure message received into the eligible professional’s CEHRT count for this measure?

As part of this objective, the eligible professional (EP) must make available to patients a secure messaging option certified to the 2014 edition certification criteria. However, this option is not the only way that a patient can send a secure message to an EP. Any secure message that is received using the electronic messaging function of the EP’s CEHRT counts toward the measure regardless of whether the interface the patient used to create the message was specific to the EP’s CEHRT.

Date Updated: 10/23/2013

New ID#9114 Old ID# N/A

286) How does a provider attest to a meaningful use objective (e.g., the “transitions of care,” “view/download patient data,” and public health objectives) where the provider electronically transmits data using technical capabilities provided by a health information exchange (HIE)?

Several meaningful use objectives require eligible professionals, eligible hospitals, and Critical Access Hospitals (CAH) to conduct electronic transmissions. In general, eligible professionals, eligible hospitals, and CAHs may use an HIE’s services or technology to meet a particular meaningful use objective if the HIE technology used by the eligible professional, eligible hospital, or CAH has been certified to support that objective. If an eligible professional, eligible hospital, or CAH uses an HIE

to satisfy a particular meaningful use objective, the provider will need to include the HIE technology's certification number, as a certified Electronic Health Records (EHR) Module, in their attestation.

A provider can determine whether the HIE technology they intend to use has been certified to support meaningful use objectives by using the Certified Health Information Technology (HIT) Products List (CHPL), available at <http://www.healthit.gov/CHPL>. This is a list of all EHR technology issued a "Complete EHR" or "EHR Module" certification for the purposes of the EHR Incentive Program.

Date Updated: 8/20/2013

New ID# 8908 Old ID# N/A

287) For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, how should an eligible professional (EP), eligible hospital, or critical access hospital (CAH) attest if the certified EHR vendor uses 2011 edition Certified EHR Technology for the first part of 2013 and 2014 edition Certified EHR Technology for the remainder of 2013?

If an EP, eligible hospital or CAH switches from 2011 edition Certified EHR Technology to 2014 Edition Certified EHR Technology during the program year, the data collected for the selected menu objectives and quality measures should be combined from both of the EHR systems for attestation. The count of unique patients does not need to be reconciled when combining from the two EHR systems.

If the menu objectives and/or clinical quality measures used are also being changed when switching certified editions, the menu objectives and/or quality measures collected from the EHR system that was used for the majority of the EHR reporting period should be reported.

Date Updated: 8/20/2013

New ID# 9060 Old ID# N/A

288) Can attestation information submitted for the Electronic Health Records (EHR) Incentive Programs be updated, changed, cancelled or withdrawn after successful submission in the EHR Registration and Attestation System?

Once a provider has submitted their attestation and has been either locked for payment or had an incentive payment issued, they will not have the ability to amend the information in the attestation system. It is the provider's responsibility to maintain records that demonstrate they have met meaningful use requirements and determine whether corrections to their attestation information would enable them to continue to demonstrate meaningful use.

If the provider is not able to demonstrate meaningful use with the amended data, it is the provider's responsibility to complete the Medicare EHR Incentive Program Return Payment/Withdrawal Form and follow the instructions on the form explaining how to return their EHR incentive payment. Further instructions on the steps

necessary to withdraw an attestation from the EHR Incentive Program can be found on the Medicare Incentive Payment Withdrawal Form.

Medicare Incentive Payment Withdrawal Form:

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Medicare_EHR_Incentive_Withdrawal_Final.pdf.

Providers may access the online Meaningful Use Attestation Calculator tool found at www.cms.gov/apps/ehr to enter their amended data and test whether they would continue to demonstrate meaningful use.

An EP or hospital wishing to change or withdraw their attestation from a Medicaid EHR Incentive Program should contact their state directly to make this request.

Please note that the Centers for Medicare and Medicaid Services (CMS) do not require providers who relied on flawed software for their attestation information to submit amended attestation data. For additional information, please see FAQ#6097.

Date Updated: 5/14/2013

New ID# 8035 Old ID# N/A

289) For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, how should an eligible professional (EP), eligible hospital, or critical access hospital (CAH) attest if the certified EHR vendor being used is switched to another certified EHR vendor in the middle of the program year?

If an EP, eligible hospital or CAH switches from one certified EHR vendor to another during the program year, the data collected for the selected menu objectives and quality measures should be combined from both of the EHR systems for attestation. The count of unique patients does not need to be reconciled when combining from the two EHR systems.

If the menu objectives and/or clinical quality measures used are also being changed when switching vendors, the menu objectives and/or quality measures collected from the EHR system that was used for the majority of the program year should be reported.

Date Updated: 4/22/2013

New ID# 8227 Old ID# N/A

290) For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, how should an eligible professional (EP), eligible hospital, or critical access hospital (CAH) that sees patients in multiple practice locations attest when locations choose to implement different menu objectives and/or different clinical quality measures?

The attestation system only allows the selection of 5 menu objectives. If an EP practices in multiple locations that choose to implement the same menu objectives, the EP should combine the data for menu objectives for attestation. For menu objectives that are not shared across multiple locations, the EP should attest to the menu objectives implemented at the location where they have the greatest number of their patient encounters.

The attestation system only allows the selection of 6 additional clinical quality measures. If an EP practices in multiple locations that choose to implement the same quality measures, the EP should combine the data for quality measures for attestation. For clinical quality measures that are not shared across multiple locations, the EP should attest to the clinical quality measures implemented at the location where they have the greatest number of their patient encounters. For information on how to calculate the objectives and clinical quality measures that are the same at multiple locations please refer to FAQ #3609.

Date Updated: 1/22/2013

New ID# 7779 Old ID# N/A

291) For Eligible Professionals (EP) in the Medicaid Electronic Health Records (EHR) Incentive Program using the group proxy method of calculating patient volume, how should the EPs calculate patient volume using the “12 months preceding the EP’s attestation” approach, as not all of the EPs in the group practice may use the same 90-day period.

In the Stage 2 final rule, CMS adopted a final policy that allows states the option for their providers to calculate patient volume in any representative, continuous 90-day period in the 12 months preceding the eligible professional's (EP) attestation (see 77 FR 54121, 42 CFR 495.306(b)). This option is in addition to the method of calculating patient volume in any representative, continuous 90-day period in the calendar year preceding the payment year for which the EP is attesting. For EPs who calculate patient volume at the group practice or clinic level under 42 CFR 495.306(h), although we expect the same 90-day period to be used for all EPs in the group practice or clinic, we understand this may not be feasible in scenarios where EPs attest on different dates. For example, for the 2013 payment year, if one EP in the group attested on April 1, 2013 and another EP in the group attested on February 1, 2014, there would not be a continuous 90-day period that occurred within the 12 months preceding the first EP's attestation and also within the 12 months preceding the second EP's attestation. In such scenarios where it would be impossible to use the same representative, continuous 90-day period for EPs in the group practice or clinic, we would allow different representative, continuous 90-day periods to be used, as long as all of the provisions of 42 CFR 495.306(h) are satisfied.

For more information, please visit the Stage 2 Final Rule:

<http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf>

Date Updated: 4/2/2014

New ID# 9822 Old ID# N/A

X. Questions about Payments

Payment Amounts

292) How much are the Medicare and Medicaid Electronic Health Record (EHR) incentive payments to eligible professionals (EPs)?

Under the Medicare EHR Incentive Program, EPs who demonstrate meaningful use of certified EHR technology can receive up to a total of \$44,000 over 5 consecutive years. Additional incentives are available for Medicare EPs who practice in a Health Provider Shortage Area (HPSA) and meet the maximum allowed charge threshold. Under the Medicaid EHR Incentive Program, EPs can receive up to a total \$63,750 over the 6 years that they choose to participate in program. EPs may switch once between programs after a payment has been made and only before 2015.

Date Updated: 2/17/2011

New ID #2803 Old ID #10089

293) What is the maximum electronic health record (EHR) incentive an eligible professional (EP) can earn under Medicare?

EPs who successfully demonstrate meaningful use certified EHR technology as early as 2011 or 2012 may be eligible for up to \$43,720 or \$43,480, respectively, in Medicare EHR incentive payments spread out over five years.

This total reflects the payment reductions mandated by sequestration, required by the Budget Control Act of 2011. Under sequestration, a 2% mandatory reduction is applied to any Medicare EHR incentive payment for a reporting period that ends on or after April 1, 2013.

EPs who predominantly furnish services in a Health Professional Shortage Area (HPSA) are eligible for a 10 percent increase in the maximum incentive amount. Also note that this reduction does not apply to Medicaid EHR incentive payments, which are exempt from the mandatory reductions.

Please visit FAQ 8173 for more information on the effect of sequestration on Medicare EHR incentive payments.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit <http://www.cms.gov/EHRIncentivePrograms>.

Date Updated: 11/12/2013

New ID #2627 Old ID #9811

294) Do recipients of Medicare or Medicaid electronic health record (EHR) incentive payments need to file reports under Section 1512 of the American Recovery and Reinvestment Act of 2009 (Recovery Act)? Section 1512 of the Recovery Act outlines reporting requirements for use of funds.

No. The Medicare and Medicaid EHR incentive payments made to providers are not subject to Recovery Act 1512 reporting because they are not made available from appropriations made under the Act; however, the Health Information Technology for Clinical and Economic Health (HITECH) Act does require that information about eligible professionals (EPs), eligible hospitals and CAHs participating in the Medicare fee-for-service (FFS) or Medicare Advantage (MA) EHR incentive programs be posted on our website.

Date Updated: 2/17/2011

New ID #2775 Old ID #10073

Payment Timing

295) After successfully demonstrating meaningful use for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program, will incentive payments be paid as a lump sum or in multiple installments?

Eligible professionals (EPs) participating in the Medicare EHR Incentive Program will receive a single lump sum payment for each year they successfully demonstrate meaningful use of certified EHR technology no later than the end of the calendar year following the year in which the EP was eligible for the bonus payment. Eligible hospitals and critical access hospitals (CAHs) participating in the Medicare EHR Incentive Program will first receive an initial payment. The final payment will be determined at the time of settling the hospital cost report. Payments to Medicare providers will be made to the taxpayer identification number (TIN) selected at the time of registration, through the same channels their claims payments are made. However, for EPs practicing in a health professional shortage area (HPSA), the additional incentive payment will be paid separately to the same TIN as the incentive payment.

Medicaid incentives will be paid by the States. EPs, eligible hospitals, and CAHs participating in the Medicaid EHR Incentive Program should check with their State.

Date Updated: 1/17/2013

New ID #2901 Old ID #10161

296) How and when will incentive payments for the Medicare Electronic Health Record (EHR) Incentive Programs be made?

For eligible professionals (EPs), incentive payments for the Medicare EHR Incentive Program will be made approximately eight to twelve weeks after an EP successfully attests that they have demonstrated meaningful use of certified EHR technology. However, EPs will not receive incentive payments within that timeframe if they have not yet met the threshold for allowed charges for covered professional services furnished by the EP during the year. Payments will be held until the EP meets the threshold in allowed charges for the calendar year (\$24,000 in the EP's first year) in order to maximize the amount of the EHR incentive payment they receive.

Medicare EHR incentive payments are based on 75% of the estimated allowed charges for covered professional services furnished by the EP during the entire calendar year. If the EP has not met the threshold in allowed charges by the end of calendar year, CMS expects to issue an incentive payment for the EP in March of the following year (allowing two months after the end of the calendar year for all pending claims to be processed).

Payments to Medicare EPs will be made to the taxpayer identification number (TIN) selected at the time of registration, through the same channels their claims payments are made. The form of payment (electronic funds transfer or check) will be the same as claims payments.

Bonus payments for EPs who practice predominantly in a geographic Health Professional Shortage Area (HPSA) will be made as separate lump-sum payments no later than the end of the calendar year following the year in which the EP was eligible for the bonus payment.

Medicare EHR incentive payments to eligible hospitals and critical access hospitals (CAHs) will also be made approximately four to eight weeks after the eligible hospital or CAH successfully attests to having demonstrated meaningful use of certified EHR technology. Eligible hospitals and CAHs will receive an initial payment and a final payment. Final payment will be determined at the time of settling the hospital cost report. CAHs will be paid after they submit their reasonable cost data to their Medicare Administrative Contractor (MAC).

Please note that the Medicaid incentives will be paid by the States, but the timing will vary according to State. Please contact your State Medicaid Agency for more details about payment.

Date Updated: 2/26/2013

New ID #2899 Old ID #10160

297) When will a Critical Access Hospital (CAH) receive its Medicare EHR incentive payment?

Upon submission of a successful attestation, the CAH will be eligible for an EHR incentive payment. In order for the incentive payment to be calculated, the CAH must submit documentation to its Medicare contractor (Fiscal Intermediary/Medicare Administrative Contractor) to support the costs incurred for certified EHR technology. Once the Medicare contractor calculates the allowable amount and Medicare Share the CAH should expect its interim incentive payment within 4 to 6 weeks.

The CAH will receive an interim incentive payment that will later be reconciled on the Medicare cost report. The interim payment will be calculated using the Medicare Share based on the data reported on the hospital's latest submitted 12-month cost report.

The interim payment will be included on the CAH's cost report that begins during the payment year, and will be reconciled to the actual amounts at final settlement of the cost report.

Example – If a hospital has a December 31 fiscal year end, and attests as a meaningful user on August 1, 2011:

- The latest filed cost report when the CAH attests will most likely be the fiscal year end December 31, 2010 cost report. The data on that cost report will be used to calculate the Medicare Share for the initial payment.
- The cost reporting period that begins during the HITECH payment year (which is the federal fiscal year) is the fiscal year ending December 31, 2011 cost reporting period (since the begin date of January 1, 2011 falls within the fiscal year 2011 HITECH year). The interim payment will be reconciled at final settlement of the cost report for this period.

The new Medicare hospital cost report, Form CMS 2552-10, will contain worksheets to accommodate the EHR incentive payments.

Note – the EHR incentive payments will be made by a single payment contractor, and not by the hospitals' Medicare contractor (Fiscal Intermediary/Medicare Administrative Contractor).

Date Updated: 7/11/2011

New ID #3381 Old ID #10719

298) I am an eligible professional (EP) who has successfully attested for the Medicare Electronic Health Record (EHR) Incentive Program, so why haven't I received my incentive payment yet?

For EPs, incentive payments for the Medicare EHR Incentive Program will be made approximately eight to ten weeks after an EP successfully attests that they have demonstrated meaningful use of certified EHR technology. However, EPs will not receive incentive payments within that timeframe if they have not yet met the threshold for allowed charges for covered professional services furnished by the EP during the year.

The Medicare EHR incentive payments to EPs are based on 75% of the estimated allowed charges for covered professional services furnished by the EP during the entire payment year. Therefore, to receive the maximum incentive payment of \$18,000 for the first year of participation in 2011 or 2012, the EP must accumulate \$24,000 in allowed charges. If the EP has not met the \$24,000 threshold in allowed charges at the time of attestation, CMS will hold the incentive payment until the EP meets the \$24,000 threshold in order to maximize the amount of the EHR incentive payment the EP receives. If the EP still has not met the \$24,000 threshold in allowed charges by the end of calendar year, CMS expects to issue an incentive payment for the EP in March 2012 (allowing 60 days after the end of the 2011 calendar year for all pending claims to be processed).

Payments to Medicare EPs will be made to the taxpayer identification number (TIN) selected at the time of registration, through the same channels their claims payments are made. The form of payment (electronic funds transfer or check) will be the same as claims payments.

Bonus payments for EPs who practice predominantly in a geographic Health Professional Shortage Area (HPSA) will be made as separate lump-sum payments no later than the end of the calendar year following the year in which the EP was eligible for the bonus payment.

Date Updated: 9/22/2014

New ID #3361 Old ID #10692

299) After successfully demonstrating meaningful use for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program, will incentive payments be paid as a lump sum or in multiple installments?

Eligible professionals (EPs) participating in the Medicare EHR Incentive Program will receive a single lump sum payment for each year they successfully demonstrate meaningful use of certified EHR technology. Eligible hospitals and critical access hospitals (CAHs) participating in the Medicare EHR Incentive Program will first receive an initial payment. The final payment will be determined at the time of settling the hospital cost report. Payments to Medicare providers will be made to the taxpayer identification number (TIN) selected at the time of registration, through the same channels their claims payments are made. However, for EPs practicing in a health professional shortage area (HPSA), the additional incentive payment will be paid separately to the same TIN as the incentive payment.

Medicaid incentives will be paid by the States. EPs, eligible hospitals, and CAHs participating in the Medicaid EHR Incentive Program should check with their State.

Date Updated: 4/11/2011

New ID #2901 Old ID #10161

300) I am an eligible professional (EP) who has successfully attested for the Medicare Electronic Health Record (EHR) Incentive Program, so why haven't I received my incentive payment yet?

For EPs, incentive payments for the Medicare EHR Incentive Program will be made approximately eight to ten weeks after an EP successfully attests that they have demonstrated meaningful use of certified EHR technology. However, EPs will not receive incentive payments within that timeframe if they have not yet met the threshold for allowed charges for covered professional services furnished by the EP during the year.

The Medicare EHR incentive payments to EPs are based on 75% of the estimated allowed charges for covered professional services furnished by the EP during the entire payment year. Therefore, to receive the maximum incentive payment of

\$18,000 for the first year of participation in 2011 or 2012, the EP must accumulate \$24,000 in allowed charges. If the EP has not met the \$24,000 threshold in allowed charges at the time of attestation, CMS will hold the incentive payment until the EP meets the \$24,000 threshold in order to maximize the amount of the EHR incentive payment the EP receives. If the EP still has not met the \$24,000 threshold in allowed charges by the end of calendar year, CMS expects to issue an incentive payment for the EP in March 2012 (allowing 60 days after the end of the 2011 calendar year for all pending claims to be processed).

Payments to Medicare EPs will be made to the taxpayer identification number (TIN) selected at the time of registration, through the same channels their claims payments are made. The form of payment (electronic funds transfer or check) will be the same as claims payments.

Bonus payments for EPs who practice predominantly in a geographic Health Professional Shortage Area (HPSA) will be made as separate lump-sum payments no later than the end of the calendar year following the year in which the EP was eligible for the bonus payment.

Date Updated: 9/22/2014

New ID #3361

Old ID #10692

EHR Incentive Payment and Other CMS Program Payments

301) Can eligible professionals (EPs) receive electronic health record (EHR) incentive payments from both the Medicare and Medicaid programs?

Not for the same year. If an EP meets the requirements of both programs, they must choose to receive an EHR incentive payment under either the Medicare program or the Medicaid program. After a payment has been made, the EP may only switch programs once before 2015.

Date Updated: 7/30/2010

New ID #2621

Old ID #9808

302) If I am receiving payments under the CMS Electronic Prescribing (eRx) Incentive Program, can I also receive Medicare and Medicaid Electronic Health Record (EHR) incentive payments?

No, if an eligible professional (EP) earns an incentive under the Medicare EHR Incentive Program, he or she cannot receive an incentive payment under the eRx Incentive Program in the same program year, and vice versa. However, if an EP earns an incentive under the Medicaid EHR Incentive Program, he or she can receive an incentive payment under the eRx Incentive Program in the same program year.

Date Updated: 3/7/2011

New ID #2801

Old ID #10088

303) If an eligible professional (EP) does not accept assignment for Medicare Part B, is the EP eligible for an incentive payment under the Medicare Electronic Health Records (EHR) Incentive Program?

An EP that is not a Medicare participating physician or supplier, but still submits claims to Medicare for Part B physician fee schedule services on behalf of Medicare patients to whom they furnish services would be eligible for Medicare EHR incentive payments. When the EP successfully registers and demonstrates meaningful use of certified EHR technology, the calculation of the EP's incentive payment will reflect claims for all services reimbursed under the Part B physician fee schedule regardless of whether the EP accepted assignment on those claims or not.

Date Updated: 5/17/2011

New ID #2913 Old ID #10167

Payment Adjustments and Hardship Exceptions

304) If I am participating in the Medicaid Electronic Health Record (EHR) Incentive Program but also provide care to Medicare patients, am I subject to the Medicare payment adjustments?

Yes. While there are no payment adjustments under the Medicaid EHR Incentive Program, those Medicaid EPs who are also paid under Medicare could be subject to payment adjustments if they are not meaningful EHR users for an applicable reporting period. Adopting, implementing and upgrading EHR technology is not considered meaningful use for these purposes.

We encourage you to familiarize yourself with the details of the Medicare payment adjustment by reviewing the Stage 1 and 2 final rules, regulations at 42 C.F.R. Part 495, and other guidance at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html.

Date Updated: 1/2/2013

New ID #7727 Old ID #N/A

Other Payment Questions

305) What if my electronic health record (EHR) system costs much more than the incentive the government will pay? May I request additional funds?

The Medicare and Medicaid EHR Incentive Programs provide incentives for the meaningful use of certified EHR technology. Under the Medicaid program, there is also an incentive for the adoption, implementation, or upgrade of certified EHR technology in the first year of participation. The incentives are not a reimbursement of costs, and maximum payments have been set.

Date Updated: 7/30/2010

New ID #2629 Old ID #9812

306) How will the public know who has received EHR incentive payments under Medicare and Medicaid EHR Incentive Program?

As required by the American Recovery and Reinvestment Act of 2009, CMS will post the names, business addresses, and business phone numbers of all Medicare eligible professionals, eligible hospitals and critical access hospitals (CAHs) that receive EHR incentive payments. There is no such requirement for CMS to publish information on eligible professionals and eligible hospitals receiving Medicaid EHR incentive payments, though individual States may opt to do so.

To view a list of eligible professionals, eligible hospitals, and CAHs that have received Medicare EHR Incentive Payments, please http://www.cms.gov/EHRIncentivePrograms/56_DataAndReports.asp. We expect to update this list on a quarterly basis.

Date Updated: 11/14/2011

New ID #2635 Old ID #9815

307) What is the earliest date the payment adjustments will start to be imposed on Medicare eligible professionals (EPs) and eligible hospitals that do not demonstrate meaningful use of certified electronic health record (EHR) technology?

Medicare payment adjustments will begin in 2015 for EPs and eligible hospitals that do not demonstrate meaningful use of certified EHR technology. There are no payment adjustments associated with the Medicaid provisions under Section 4201 of the American Recovery and Reinvestment Act of 2009.

Date Updated: 7/30/2010

New ID #2631 Old ID #9813

308) How are Medicare EHR Incentive Payments Calculated for Critical Access Hospitals (CAHs)?

CAHs are currently paid based on reasonable cost principles; therefore, their EHR incentive payments are calculated differently from the incentive payments to subsection (d) hospitals. A CAH must meet the definition of a meaningful EHR user to qualify to be paid the incentive payment for a payment year. A payment year means a Federal fiscal year beginning after FY 2010 and before FY 2016. In no case are incentive payments made with respect to cost reporting periods that begin during a payment year before FY 2011 or after FY 2015, and in no case may a CAH receive an incentive payment with respect to more than 4 consecutive payment years. The incentive payment made to a qualifying CAH equals:

[Allowable cost amount] * [Medicare Share].

The allowable cost amount equals the costs of depreciable assets purchased, such as computers and associated software, necessary to administer certified EHR technology. The incentive payment permits a qualifying CAH to expense the allowable cost amount in a single payment year rather than depreciating the costs

over the useful life of the purchased asset. The allowable cost amount for a cost reporting period that begins in a payment year includes the reasonable cost incurred for the purchase of certified EHR technology in that payment year plus the undepreciated costs for assets purchased, prior to the CAH becoming qualified, that are also being used to administer certified EHR technology in that payment year.

The Medicare Share is a fraction based on Medicare fee-for-service and managed care inpatient days, divided by total inpatient days, modified by charges for charity care:

- Numerator = (1) The number of inpatient-bed-days which are attributable to individuals with respect to whom payment may be made under Part A, including individuals enrolled in section 1876 Medicare cost plans; and (2) The number of inpatient-bed-days which are attributable to individuals who are enrolled with a Medicare Advantage organization
- Denominator = Total number of acute care inpatient-bed-days; * ((Total amount of the eligible hospital's charges – charges attributable to charity care)/Total amount of the eligible hospital's charges))

For CAHs, 20 percentage points are added to the Medicare Share calculation (not to exceed 100 percent).

In order for the CAH to receive its interim incentive payment, upon attestation, it must submit supporting documentation for its incurred costs of purchasing certified EHR technology to its Medicare contractor (Fiscal Intermediary/Medicare Administrative Contractor). The Medicare contractor will then calculate the allowable amount. The interim incentive payment is then subject to reconciliation to determine the final incentive payment amount. The final payment amount constitutes payment in full for the reasonable costs incurred for the purchase of certified EHR technology in the single payment year.

Date Updated: 7/11/2011

New ID #3379 Old ID #10718

309) Who is Figliozi and Company?

Figliozi and Company will be performing the meaningful use audits for CMS. If you are selected for an audit you will receive a letter from them with the CMS logo on the letterhead. Meaningful use audit questions can be directed to Peter Figliozi at (516) 745-6400 x302 or by email at pfigliozi@figliozi.com. Figliozi and Company's website is <http://www.figliozi.com/>.

Figliozi and Company will be performing the following audits to:

- Eligible Professionals
- Medicare
- Medicare Advantage (MA)

Last Updated: January, 2015

Eligible Hospitals

-Medicare only

-Dual Eligible (including MA hospitals)

Date Updated: 7/17/2012

New ID #7361

Old ID #N/A

310) For the Medicare and Medicaid EHR Incentive Programs, how will non-standard (or irregular) cost reporting periods be taken into account in determining the appropriate cost reporting periods to employ during the Medicare and Medicaid EHR Hospital Calculations?

This question was addressed in our Federal Register preamble (75 FR 44452) and in our rules requiring the use of a 12-month period for the discharge-related amount and the Medicaid share under Medicaid (495.310(g)). As stated there, non-standard cost reporting periods are typically employed to accommodate the circumstances of hospitals in several distinct situations, such as newly constructed hospitals, changes of ownership, and reorganization of a single multi-campus hospital into multiple separate providers. In these cases, one non-standard cost reporting period may be employed before the hospital resumes (or begins) cost reporting on a 12-month cycle. Non-standard cost reporting periods are not likely to be truly representative of a hospital's experience, even if methods were to be adopted for extrapolating data over a normal 12-month cost reporting period. In addition, these abbreviated or extended periods often capture the experience of a hospital during a period of transition (for example, change of ownership), which often renders the data highly unrepresentative.

Hospitals cannot use irregular or non-standard cost reporting periods when calculating the hospital incentive payment. Hospitals that have irregular or non-standard cost reporting periods will have to use the most recent consecutive 12 month cost reporting period available.

For the Medicare EHR Hospital Calculation:

For purposes of determining preliminary incentive payments, we will employ discharge and other relevant data from a hospital's most recently submitted 12-month cost report once the hospital has qualified as a meaningful user.

For purposes of determining final incentive payments, we will employ the first 12-month cost reporting period that begins after the start of the payment year, in order to settle payments on the basis of the hospital discharge and other data from that cost reporting period.

For the Medicaid EHR Hospital Calculation:

For purposes of extrapolating data from the cost report for the Medicaid EHR Hospital Calculation, the States should require a hospital's most recently submitted 12-month cost report. If a hospital has an irregular or non-standard reporting period, the State should require the hospital's next most recent 12-month cost report.

Since the State can use other auditable data sources beyond the Medicare cost report to calculate Medicaid aggregate EHR hospital incentive amounts, as well as determining Medicaid incentive payments to hospitals, the State has an opportunity to require other data sources if the hospitals still want to include the data from the irregular or non-standard cost reporting year, but the period used must be a period of 12 months.

Date Updated: 12/16/2011

New ID #3671 Old ID #10882

311) Are there any special incentives for rural providers in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

Under the Medicare EHR Incentive Program, the maximum allowed charge threshold for the annual incentive payment limit for each payment year will be increased by 10 percent for eligible professionals (EPs) who predominantly furnish services in a rural or urban geographic Health Professional Shortage Area (HPSA). Critical access hospitals (CAHs) can receive an incentive payment amount equal to the product of its reasonable costs incurred for the purchase of certified EHR technology and the Medicare share percentage. Under the Medicaid EHR Incentive Program, there are no additional incentives for rural providers, beyond the incentives already available.

Date Updated: 2/17/2011

New ID #2805 Old ID #10090

312) Who is the CMS EHR Meaningful Use Audit Team?

The CMS EHR Meaningful Use Audit Team performs meaningful use audits as part of the Medicare and Medicaid EHR Incentive Programs. If selected for a one of these audits, the eligible professional (EP), eligible hospital (EH) or critical access hospital (CAH) will receive a letter with the CMS logo on the letterhead providing instructions on providing supporting documentation and other required information.

Questions can be directed to: MedicareEHRaudit@cms.hhs.gov.

Please visit FAQ 7711 for more information about audits conducted in the EHR Incentive Programs.

Date Updated: 11/20/2013

New ID# 9272 Old ID# N/A

313) If a provider who is participating in the Electronic Health Records (EHR) Incentive Program either retires or opts out of Medicare or Medicaid, can he/she still receive an incentive payment?

In the Medicare EHR Incentive Program, eligibility to receive an incentive payment is tied to being an active provider in the Medicare program. If a provider retires or opts out of the Medicare program, it may affect their ability to receive an incentive payment

- If a provider retires or opts out of Medicare after successfully attesting to Meaningful Use (MU), the provider will be paid an incentive payment.
- If a provider retires or opts out of Medicare before successfully attesting, but has approved a third party proxy user to attest on his/her behalf in the Medicare system of record known as National Plan & Provider Enumeration System (NPPES), that proxy user can enter MU data and attest for the provider. If the attestation is successful, the provider will be paid an incentive payment.
- If a provider retires or opts out of Medicare before successfully attesting and has not approved a third party proxy user to attest on his/her behalf, the provider is no longer considered a participant of the Medicare EHR incentive program and will not receive an incentive payment.

In the Medicaid EHR Incentive Program, a provider must be a Medicaid provider either at the time they Adopt, Implement or Upgrade (AIU) Certified EHR Technology or during the EHR reporting period for MU. A provider who subsequently retires or opts out of a state's Medicaid program is still entitled to the incentive payment. Note that the rules for how a provider gets paid may vary by state. A state may be unable to process a payment to a provider who is not enrolled in its Medicaid Management Information System (MMIS) and therefore may require that a provider be enrolled in order to receive an incentive payment.

For more information, Medicaid providers should contact their state directly.

Date Updated: 7/9/2013

New ID#8406

Old ID# N/A

314) Will incentive payments earned in the Medicare and Medicaid Electronic Health Records (EHR) Incentive programs be affected by sequestration?

Incentive payments made through the Medicare EHR Incentive Program are subject to the mandatory reductions in federal spending known as sequestration, required by the Budget Control Act of 2011. The American Taxpayer Relief Act of 2012 postponed sequestration for 2 months. As required by law, President Obama issued a sequestration order on March 1, 2013. Under these mandatory reductions, Medicare EHR incentive payments made to eligible professionals and eligible hospitals will be reduced by 2%. This 2% reduction will be applied to any Medicare EHR incentive payment for a reporting period that ends on or after April 1, 2013. If the final day of the reporting period occurs before April 1, 2013, those incentive payments will not be subject to the reduction.

Please note that this reduction does not apply to Medicaid EHR incentive payments, which are exempt from the mandatory reductions.

Date Updated: 4/18/2013

New ID# 8173

Old ID# N/A

315) Can an appeal be filed if the Medicare eligible professional (EP) or eligible hospital disputes the amount of the incentive payment received after successfully demonstrating meaningful use under the Electronic Health Records (EHR) Incentive Program?

The Health Information Technology (HITECH) Act, which authorized the EHR Incentive Program, specifies that providers do not have a right to administrative or judicial review of their EHR incentive payment. As a result, the Centers for Medicare and Medicaid Services do not process appeals for provider's who dispute the amount of their EHR incentive payment.

After an EP successfully attests, a monthly report determines whether the allowable claims threshold for the program participation year has been met. After the close of the incentive payment year, incentive payments are made based on 75% of Medicare allowed charges for covered professional services furnished during the payment year that have been successfully submitted by the EP. After a hospital or critical access hospital successfully attests, an initial incentive payment is issued based on the latest available cost report which is then reconciled when the cost report is finalized.

For further details about incentive payments, withholds and payment adjustments, please contact the EHR Information Center at 1-888-734-6433 (primary number) or 1-888-734-6563 (TTY number), 7:30 a.m. – 6:30 p.m. (Central Time) Monday through Friday, except federal holidays.

Date Updated: 1/23/2013

New ID# 7801 Old ID# N/A

XI. Information for States

316) If a State proposes a new definition for meaningful use under its Medicaid EHR Incentive Program, will it need to include the new definition of meaningful use in its State Medicaid Health Information Technology Plan (SMHP)? When are the SMHPs due?

Yes, if a State wishes to request flexibility with the definition of meaningful use, to the extent permissible under the Medicare and Medicaid EHR Incentive Programs Stage 1 final rule, it would do so via its SMHP.

There is no due date for SMHPs. 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.

Date Updated: 3/28/2011

New ID #3121 Old ID #10533

317) If a State has a team of staff members who will be administering the Medicaid EHR Incentive Program from 2011-2021 (answering provider questions, engaging in reporting and analysis, assisting providers with eligibility and verifying provider eligibility, appeals, etc.), would there be 90% Federal Financial Participation for this team on an ongoing basis once approval is received from CMS on State Medicaid Health Information Technology Plan and the Health Information Technology Implementation Advance Planning Document?

Yes. However, if state staff members are not working full-time on the Medicaid EHR Incentive Program, their salaries need to be cost-allocated appropriately.

Date Updated: 3/28/2011

New ID #3123 Old ID #10534

318) Is there an assumption or expectation from CMS that States identify local Regional Extension Centers (RECs) as adoption entities for the Medicaid EHR Incentive Program?

States are not required to identify RECs as EHR adoption entities. Under the Medicaid EHR Incentive Program, it is entirely up to States to determine who they wish to designate as a permissible adoption entity, if any, in accordance with CMS regulations at 495.310(k) and 495.332(c)(9). It is entirely voluntary for an eligible professional to choose to reassign his/her incentive payments to a State-designated adoption entity.

Date Updated: 3/28/2011

New ID #3097 Old ID #10521

319) Assuming that the request excludes activities funded by the Office of the National Coordinator for Health Information Technology (ONC) or other technical assistance

efforts, and that the expenditures are subject to a cost allocation formula across all payers, can a State access enhanced matching funds for the Medicaid EHR Incentive Program to participate in the creation of a HIE that is not directly administered by the State Medicaid Agency?

The enhanced match rate depends upon whether the Health Information Exchange solution is using Medicaid Management Information System (MMIS) funding or Health Information Technology for Economic and Clinical Health (HITECH) funding. Governance only is relevant under the MMIS regulations, as it pertains to the matching rate determination. States should talk to CMS about their ideas in draft, informally, so that CMS can give a more State-specific response around appropriate funding, matching rates, etc.

Date Updated: 3/28/2011

New ID #3113 Old ID #10529

320) Can a state capture electronic Clinical Quality Measures, or eCQMs, for the Medicaid EHR Incentive Program through a Health Information Exchange (HIE)?

Yes, a state can capture clinical quality data for eCQMs using an HIE, and states should consider the health data landscape of their state when designing a system to collect eCQMs for the Medicaid EHR Incentive Program. Utilizing an HIE can allow the state to collect more sophisticated patient-level data, to encourage provider adoption, and to facilitate alignment between various programs, such as those authorized under the HITECH Act, Accountable Care Organizations, and Medical Homes. In order to use an HIE for quality data collection, a state would need to develop infrastructure to capture electronic clinical quality measures through the Quality Reporting Data Architecture (QRDA) format. In addition, eligible professionals and hospitals would either have to generate the QRDA files using the provider's Certified EHR Technology and/or the HIE itself would have to be certified as an EHR module for eCQMs. The Office of the National Coordinator for Health Information Technology and CMS published a state-focused electronic clinical quality reporting toolkit to provide support for states developing the policy and IT infrastructure for electronic clinical quality measurement. Further, states can request Federal Financial Participation at the 90/10 HITECH rate to assist in building the infrastructure to submit eCQMs electronically for the Medicaid EHR Incentive program.

For more information, please see the State Medicaid Directors Letter #11-004:

<http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD11004.pdf>

Date Updated: 7/24/2013

New ID# 8902 Old ID# N/A

321) What funding sources may States use to fund the 10% non-federal share of HITECH administrative expenditures?

States must fund the 10 percent non-federal share of the Health Information Technology (HITECH) Act administrative expenditures consistent with the law and regulations applicable to the non-federal share for all Medicaid expenditures. Consistent with that authority, which includes Social Security Act sections 1902(a)(2), 1903(a), 1903(w), and 42 CFR Part 433, subpart B, states may fund the non-federal share of Medicaid expenditures through legislative appropriations to the Medicaid agency, intergovernmental transfers (IGTs), certified public expenditures (CPEs), permissible health-care related taxes, and bona-fide donations.

States must submit their proposed strategies for funding the non-federal share of HITECH administrative payments to CMS for review as part of the HIT plan approval process. CMS will review each individual State's proposal to ensure that each proposed non-federal share funding source meets federal requirements. During this process, CMS can address specific questions about funding the non-federal share of Medicaid expenditures.

CMS strongly urges States to work on their funding proposals with their CMS HIT Coordinators as early as possible before claiming for HITECH administrative expenditures, to ensure funding structures are appropriate. HITECH administrative expenditures, like other title XIX expenditures, are subject to audit, and federal funds may be at risk if funding sources are found not to be in compliance with federal requirements.

Below are some statutory and regulatory citations pertaining to non-federal share financing requirements. Please note this is not an all-inclusive list of funding requirements.

- Use of Federal Funds
 - Social Security Act §1903
 - 42 CFR 433.51(c)
- State Appropriations
 - Social Security Act §1902(a)(2)
 - 42 CFR 433.51
- Intergovernmental Transfers
 - Social Security Act §1903(w)(6)(A)
 - 42 CFR 433.51
- Certified Public Expenditures
 - Social Security Act §1903(w)(6)(A)
 - 42 CFR 433.51
- Healthcare-Related Taxes and Provider-Related Donations
 - 42 CFR part 433, subpart B

Date Updated: 2/7/2013

New ID# 7809

Old ID# N/A