



EHR Incentive Programs

A program of the Centers for Medicare & Medicaid Services

News Updates

[Read More about What's Next for the EHR Incentive Programs in New CMS Blog Post](#)

In a [blog post](#) released today, CMS Administrator Andy Slavitt and HHS Acting Assistant Secretary Karen DeSalvo are providing expanded insight into the future of Meaningful Use. [Visit The CMS Blog](#) to read the full post.

To stay up to date on information on the EHR Incentive Programs, visit the [CMS website](#).



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EHR Incentive Programs

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News Updates

Visit the CMS EHR Incentive Programs Website for More Information

Today, CMS launched important changes to the Medicare EHR Incentive Program hardship exception process that will reduce burden on clinicians, hospitals, and critical access hospitals (CAHs). These changes are a result of recent Medicare legislation – the Patient Access and Medicare Protection Act (PAMPA), Pub. L. No. 114-115 – and our ongoing efforts to improve the program.

CMS has posted new, streamlined hardship applications, reducing the amount of information that eligible professionals (EPs), eligible hospitals, and CAHs must submit to apply for an exception. The new applications and instructions for a hardship exception from the Medicare Electronic Health Records Incentive Program 2017 payment adjustment are [available here](#).

This new, streamlined application process is the result of PAMPA, which established that the Secretary may consider hardship exceptions for “categories” of EPs, eligible hospitals, and CAHs that were identified on CMS’ website as of December 15, 2015. Prior to this law, CMS was required to review all applications on a “case-by-case” basis.

Importantly, EPs, eligible hospitals, and CAHs that wish to use the streamlined application must submit their application according to the timeline established in PAMPA:

- Eligible Professionals: March 15, 2016
- Eligible Hospitals & CAHs: April 1, 2016

Please note: CAHs should use the form specific for the CAH hardship exceptions related to an EHR reporting period in 2015. CAHs that have already submitted a form for 2015 are not required to resubmit.

In addition, we have heard from stakeholders that they would like a more efficient approach for submitting applications from *groups of providers*. Following Congress' efforts in PAMPA, we have reviewed our administrative authorities and determined that *groups of providers* may apply for a hardship exception on a *single* application. Under the group application, multiple providers and provider types may apply together using a single submission. The hardship exception categories are the same as those applicable for the individual provider application.

Providers will have the option to submit an electronic file (in excel or csv formats) with all National Provider Identifiers (NPIs) or CMS Certification Numbers (CCNs) for providers within the group or use a multiple NPI or CCN form to submit their application. In addition, facilities which include both inpatient and outpatient settings may include both the individual NPIs for any eligible professionals and the CCN for the eligible hospitals and CAHs on the same single submission for their organization.

We look forward to further simplifying and continuing to improve the EHR Incentive Programs in collaboration with the provider community and Congress.



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Use the Submission Engine Validation Tool to Test QRDA I Release 2 and QRDA III Release 1 Files

The Submission Engine Validation Tool (SEVT) located on the [Physician and Other Health Care Professionals Quality Reporting Portal](#) was updated on December 17, 2015. The updates include changes to the Quality Reporting Document Architecture (QRDA) Category I, Release 2 and electronic health record (EHR) QRDA Category 3, Release 1 requirements for 2015 submission. If you have previously tested QRDA Category 3 files, CMS highly encourages that you retest your files prior to the submission period.

Resources available for QRDA Reporting for the 2015 Reporting Period:

- [CMS Implementation Guide for Quality Reporting Document Architecture Category I and Category III](#)
- [Addendum to 2015 CMS QRDA Implementation Guide for Eligible Professional and Hospital Quality Reporting](#)

This [PQRS SEVT User Guide](#) provides the information necessary to effectively use the SEVT to validate the format of the data files. The files are validated against the most current published data submission specifications.

To access the PQRS SEVT, you must have a CMS Enterprise Identity Management (EIDM) account. To request an EIDM account, please see the [EIDM Quick Reference Guide](#).

Want More Information about PQRS?

Make sure to visit the [CMS PQRS website](#) for the latest news and updates on PQRS. You can also contact the QualityNet Help Desk at 1-866-288-8912 or qnetsupport@hcqis.org. They are available Monday through Friday from 7:00 a.m. to 7:00 p.m. CST. To avoid security violations, please do not include personal identifying information such as Social Security Number or Tax Identification Number in email inquiries to the QualityNet Help Desk.



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News Updates

Submit 2015 Physician Quality Reporting System (PQRS) Data by February 29, 2016

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the 2015 data submission timeframe for the electronic health record (EHR) direct and EHR data submission vendor reporting mechanisms. This data must be submitted via the quality data reporting architecture (QRDA) I or III between now and **February 29, 2016 at 8:00 PM EST.**

An Enterprise Identity Management (EIDM) account with the “Submitter Role” is required for these data submission methods. Please see the [EIDM System Toolkit](#) for additional information.

For questions, please contact the QualityNet Help Desk at 1-866-288-8912 or via email at Qnetsupport@hcqis.org from 7:00 a.m. - 7:00 p.m. CST. Visit the [CMS PQRS](#) website for more information.



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News Updates

[An Alternate Method of Attestation is Available for Certain Medicaid Providers through the EHR Incentive Program Registration and Attestation System](#)

In the [final rule](#) for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, the Centers for Medicare & Medicaid Services (CMS) finalized the proposal to allow certain Medicaid eligible professionals (EPs) to use an alternate option of attesting through the EHR Incentive Program [Registration and Attestation System](#) for the purpose of avoiding the Medicare payment adjustment ([80 FR 62900 through 62901](#)).

To attest to the EHR Incentive Program requirements, Medicare EPs are required to use the Registration and Attestation System while Medicaid EPs are typically required to visit their state Medicaid agency's website.

Beginning in 2015, Medicaid EPs who have previously received an incentive payment under the Medicaid EHR Incentive Program, but will fail to meet the eligibility requirements for the program in subsequent years, will be allowed to attest using the EHR Incentive Program Registration and Attestation system for the purpose of avoiding the Medicare payment adjustment.

Note: There are no changes to the EHR Incentive Program Registration and Attestation System for the alternate attestation method.

For more information on who can participate in the Medicaid EHR Incentive Program and state milestones, visit the [Medicaid State Information](#) page on the [CMS website](#).



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News Updates

[Visit the CMS Website to Apply for a Hardship Exception in 2015](#)

CMS has launched important changes to the Medicare Electronic Health Record (EHR) Incentive Program hardship exception process that will reduce burdens on clinicians, hospitals, and critical access hospitals (CAHs). These changes are a result of recent Medicare legislation – the Patient Access and Medicare Protection Act (PAMPA), Pub. L. No. 114-115 – and the agency’s ongoing efforts to improve the program.

CMS has released an FAQ outlining the documentation requirements for submitting the new hardship application to avoid the 2017 payment adjustment.

FAQ #14113 - On the new hardship application form for the 2017 payment adjustment there is nothing which says documentation is required to be submitted with the application form. Does this mean that CMS will only require the selection of a hardship category and the completion of the provider’s identifying information in order to approve a hardship exception? Or will CMS be reviewing the application and documentation on a case-by-case basis for each provider?

CMS does not require an EP, eligible hospital, or CAH – or any group of providers – to submit documentation for the hardship category selected and CMS will not be reviewing documentation supporting the application on a case-by-case basis. CMS

will review the application to record the category selected and use the identifying information to approve the hardship exception for each provider listed on the application. Providers should retain documentation of their circumstances for their own records, but no such documentation is required for review by CMS.

CMS has also updated [FAQ #12845](#) to reflect these changes and to provide additional guidance specific to sub-category 2.2d of PAMPA – EHR Certification/Vendor Issues (CEHRT Issues). This category can be used for issues related to the 2015 rulemaking timeline and is included under the existing category for extreme and uncontrollable circumstances related to the implementation and use of certified EHR technology.

Providers who experienced an issue with their CEHRT related to the rule timing – and any other provider for whom the timing of the rule caused a significant hardship – should select sub-category 2.2d on the 2017 hardship exception application. No additional documentation is required for this selection.

For More Information

To review the hardship exception application and instructions, visit the [Payment Adjustments and Hardship Information](#) page on the CMS website.



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News Updates

RFI Comment Period Extended

CMS & ONC Release Request for Information: Certification Frequency and Requirements for the Reporting of Quality Measures under CMS Programs

The Centers for Medicare and Medicaid Services (CMS), in conjunction with the Office of the National Coordinator for Health Information Technology (ONC), published the *Request for Information: Certification Frequency and Requirements for the Reporting of Quality Measures under CMS Programs* on December 31, 2015. It can be found on the [Federal Register](#).

On February 1, 2016, a comment period extension notice was posted in the [Federal Register](#). Now, the RFI has a 45-day comment period. Comments are due February 16, 2016.

CMS and ONC are seeking public comment on several items related to the certification of health information technology (IT), including electronic health record (EHR) products used for reporting to the:

- EHR Incentive Programs; and

- Certain CMS quality reporting programs such as, but not limited to, the Hospital Inpatient Quality Reporting (IQR) Program, and the Physician Quality Reporting System (PQRS).

CMS and ONC request feedback on how often to require recertification, the number of CQMs a certified Health IT Module should be required to certify to and ways to improve testing of certified Health IT Module(s). The feedback will inform CMS and ONC of elements that may need to be considered for future rules relating to the reporting of quality measures under CMS programs. This request for information is part of the effort of CMS to streamline/reduce Eligible Professional (EP), eligible hospital, critical access hospital (CAH), and health IT developer burden around government requirements.

Please visit the RFI for instructions on how to submit comments. We want to hear from you and value all input received from our stakeholders.



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News Updates

[Learn More about Clinical Decision Support Interventions](#)

Clinical Decision Support (CDS) is a key functionality of health IT that contributes to improved quality of care and enhanced outcomes by avoiding errors and adverse events, improving efficiencies, reducing costs, and enhancing provider and patient satisfaction.

For the [Medicare and Medicaid Electronic Health Record \(EHR\) Incentive Programs in 2016](#), eligible professionals and eligible hospitals must meet the CDS objective by:

1. Implementing five CDS rules related to four or more clinical quality measures (CQMs) or related to a high-priority health condition for the EP, eligible hospital, or CAH's scope of practice or patient population.
2. Enabling and implementing functionality for drug-drug and drug-allergy interaction checks.

CMS Guidance for CDS Interventions

The CDS objective gives providers flexibility in the types of CDS interventions they employ, as well as the timing of the CDS.

Providers can customize the implementation of the CDS to their own needs for their clinical practice and patient population. The CDS should be implemented at a

“relevant point in patient care,” which refers to a relevant point in clinical workflows when the intervention can influence clinical decision-making before diagnostic or treatment action is taken in response to the intervention.

Additionally, providers are not limited to just “pop-up” alert CDS interventions. They can meet the objective by using [other methods of CDS](#), including, but not limited to:

- Computerized alerts and reminders for providers and patients
- Information displays or links
- Clinical guidelines
- Condition-specific order sets
- Focused patient data reports and summaries
- Documentation templates
- Diagnostic support
- Contextually relevant reference information

Note: These functionalities may be deployed on a variety of platforms (e.g., mobile, cloud-based, installed).

To Learn More

For more information on CDS, review the specification sheets for [eligible professionals](#) and [eligible hospitals](#).



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News Updates

New CMS Tipsheet Can Help You Determine Eligibility for Broadband Access Exclusions

Broadband access is required to meet certain objectives outlined in the Medicare and Medicaid EHR Incentive Programs [final rule](#). Therefore, The Centers for Medicare & Medicaid Services (CMS) has maintained exclusions for providers in areas with limited broadband availability as identified by the Federal Communications Commission (FCC):

- **Objective 8, Patient Electronic Access - EPs and eligible hospitals/CAHs**
 - **Measure 2 Only:** Any EP or eligible hospital/CAH who conducts 50 percent or more of his or her patient encounters in a county where 50 percent or more of its housing units do not have 4Mbps broadband availability on the first day of the EHR reporting period, according to the latest information available from the FCC.
- **Objective 9, Secure Messaging – EPs only**
 - Any EP who has no office visits during the EHR reporting period, or any EP who conducts 50 percent or more of his or her patient encounters in a county where 50 percent or more of its housing units do not have 4Mbps broadband availability on the first day of the

EHR reporting period, according to the latest information available from the FCC.

CMS recently released a [new tipsheet](#) to help providers determine their eligibility for the broadband access exclusions. The tipsheet provides a list of states and associated counties with less than 4 Mbps of broadband download speed, which is required to claim the exclusions.

For More Information

To learn more about the specific exclusion criteria, visit the [EHR Incentive Programs](#) page on the [CMS website](#).



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News Updates

CMS Extends the Attestation Deadline for the EHR Incentive Programs to March 11, 2016

The Centers for Medicare & Medicaid Services (CMS) extended the attestation deadline for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs to **Friday, March 11, 2016 at 11:59 p.m. ET**, from the original deadline of Monday, February 29.

Eligible professionals, eligible hospitals, and critical access hospitals (CAHs) participating in the Medicare EHR Incentive Program can attest through the CMS [Registration and Attestation System](#). Providers participating in the Medicaid EHR Incentive Program should refer to their respective [states](#) for attestation information and deadlines. Certain Medicaid eligible professionals may use the [Registration and Attestation System](#) as an alternate attestation method to avoid the Medicare payment adjustment ([80 FR 62900 through 62901](#)).

To attest to the EHR Incentive Programs in 2015:

- **Eligible Professionals** may select an EHR reporting period of any continuous 90 days from January 1, 2015 (the start of the 2015 calendar year) through December 31, 2015.
- **Eligible Hospitals/CAHs** may select an EHR reporting period of any continuous 90 days from October 1, 2014 (the start of the federal fiscal year) through December 31, 2015.

Attestation Resources

For assistance with attestation, please review the following CMS resources:

- [Preparing to Participate in the EHR Incentive Programs Fact Sheet](#)
- [Attestation Worksheet](#) and [User Guide](#) for Eligible Professionals
- [Attestation Worksheet](#) and [User Guide](#) for Eligible Hospitals and CAHs
- [Broadband Access Exclusions Tip Sheet](#)
- [Health Information Exchange Fact Sheet](#)
- [Public Health Reporting in 2015 for Eligible Professionals](#)
- [Public Health Reporting in 2015 for Eligible Hospitals/CAHs](#)

For More Information

Visit the [Registration and Attestation](#) and the [2015 Program Requirements](#) pages on the [CMS EHR Incentive Programs website](#).

For attestation questions, please contact the EHR Information Center Help Desk at (888) 734-6433/ TTY: (888) 734-6563. The hours of operation are Monday to Friday between 7:30 a.m. and 6:30 p.m. EST.



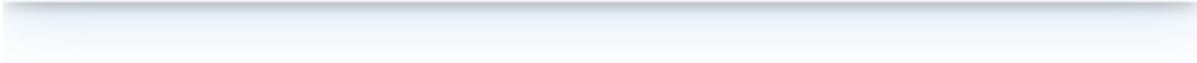
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News Updates

View Updated FAQs on the CMS Website

The Centers for Medicare & Medicaid Services (CMS) has recently updated two FAQs that provide information on: 1) hospital-based eligible professionals' eligibility to receive incentive payments from the Medicare and Medicaid EHR Incentive Programs, and 2) eligible hospitals' requirements for meeting the specialized registry objective. Please review the updated information below.

[FAQ #2639](#) - 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 percent or more of his/her services in either the inpatient or emergency department of a hospital. Hospital-based EPs do not qualify for Medicare or Medicaid EHR incentive payments.

If you are a new EP and need to determine your hospital-based status, contact the EHR information center at (888)734-6433 and choose option 4 in the interactive voice response system (IVR). You will need your National Provider Identifier (NPI) and the last 5 digits of your Tax Identification Number (TIN). If you are an existing EP, review and resubmit your registration on the [Registration & Attestation website](#) to determine your hospital based status.

[FAQ #14117](#) - What steps do eligible hospitals need to take to meet the specialized registry objective? Is it different from EPs?

For an eligible hospital, the process is the same as for an EP. However, we note that eligible hospitals do not need to explore every specialty society with which their hospital-based specialists may be affiliated. The hospital may simply check with the jurisdiction and any such organization with which it is an affiliate, if no such organization exists, and if their jurisdiction has no registry, they may simply exclude from the measure.

For More Information

Visit the [CMS website](#) to review the full list of frequently asked questions.



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News Updates

CMS Plans to Correct Attestation System to Allow EPs to Claim an Exclusion for Measure 1 of the Patient Electronic Access Objective

The [Centers for Medicare & Medicaid Services \(CMS\)](#) will shut down the [Medicare & Medicaid EHR Incentive Program Registration and Attestation System](#) on Sunday, **February 21, 2016, between 6:00 a.m. and 10:00 a.m. EST**, to correct an error that is preventing eligible professionals (EPs) from claiming an exclusion for Measure 1 of the [Patient Electronic Access Objective](#) (referred to as 8A in the attestation system).

- *Patient Electronic Access, Measure 1 Exclusion: Any EP who neither orders nor creates any of the information listed for inclusion as part of the measures except for 'Patient Name' and 'Provider's name and office contact information.'*

EPs whose attestation was rejected as a result of not meeting objective 8 may modify and resubmit their attestation information after February 21, 2016. EPs who have successfully attested to the EHR Incentive Programs' 2015 requirements do not need to take any action.

Batch attestation users who have not yet submitted their files will also need to wait to submit their data until after February 21. To successfully upload a batch attestation with this exclusion, please ensure the batch files include a 'Y/N' indicator for each provider record on the file. Users who have already submitted a batch attestation file for the 2015 program year do not need to resubmit.

For More Information

Visit the [CMS website](#) or contact the EHR Information Center Help Desk at (888) 734-6433/ TTY: (888) 734-6563. The hours of operation are Monday through Friday between 7:30 a.m. and 6:30 p.m. EST.



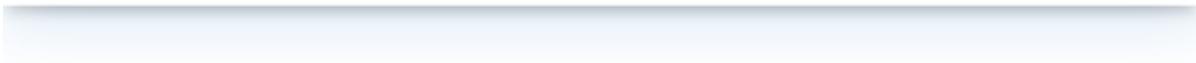
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News Updates

Provide Valuable Feedback for the Future of the MIPS Program

Are you a health care provider or hospital administrator who is attending the [HIMSS Annual Conference](#)? The [Centers for Medicare & Medicaid Services \(CMS\)](#) is eager to learn from you about your thoughts on the future of the [Merit-Based Incentive Payment System \(MIPS\)](#) program. Please join CMS program leaders for one of three Design Lean Planning Sessions (more details provided below) during this year's HIMSS Annual Conference in Las Vegas (February 29-March 4). These sessions will create an opportunity for providers and practice administrators, managers, and data analysts to contribute valuable feedback and help inform the future design of the MIPS program.

Event Purpose

Use of Human Centered Design and Lean theories (Design Lean) in the MIPS operational development process will help streamline multiple programs within the MIPS program. This process allows CMS to proactively engage stakeholders and users; collect feedback before the system is designed; and potentially prevent future challenges.

CMS will host three one-hour Design Lean Planning Sessions during this year's conference. Space is very limited; please email CMSeHealthTeam@ketchum.com with

the session of your choice, as well as your Name, Title, Role (e.g, provider, etc.), and Organization to register.

When:

- Tuesday, March 1: 2:30-3:30pm PST
- Wednesday, March 2: 2:30-3:30pm PST
- Thursday, March 3: 11:30am-12:30pm PST

Where: CMS Meeting Room, Venetian Level 4, Zeno 4603 ([floorplan](#))

For More Information

To learn more about MIPS, visit the [CMS website](#). For questions about the MIPS Design Lean at HIMSS16, please email: CMSeHealthTeam@ketchum.com.



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News Updates

Please See Updated Phone Instructions for Eligible Professionals in FAQ #2639

The Centers for Medicare & Medicaid Services (CMS) has recently updated two FAQs that provide information on: 1) hospital-based eligible professionals' eligibility to receive incentive payments from the Medicare and Medicaid EHR Incentive Programs, and 2) eligible hospitals' requirements for meeting the specialized registry objective. Please review the updated information below.

Note: FAQ #2639 includes new instructions for EPs—that are highlighted in bold text below—who would like to contact the EHR information center about their hospital-based status.

[FAQ #2639](#) - 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 percent or more of his/her services in either the inpatient or emergency department of a hospital. Hospital-based EPs do not qualify for Medicare or Medicaid EHR incentive payments.

If you are a new EP and need to determine your hospital-based status, contact the EHR information center at (888) 734-6433. **Choose option 1 for the EHR Incentive**

Programs, then choose option 4 in the interactive voice response system (IVR). You will need your National Provider Identifier (NPI) and the last 5 digits of your Tax Identification Number (TIN). If you are an existing EP, review and resubmit your registration on the [Registration & Attestation website](#) to determine your hospital-based status.

[FAQ #14117](#) - What steps do eligible hospitals need to take to meet the specialized registry objective? Is it different from EPs?

For an eligible hospital, the process is the same as for an EP. However, we note that eligible hospitals do not need to explore every specialty society with which their hospital-based specialists may be affiliated. The hospital may simply check with the jurisdiction and any such organization with which it is an affiliate, if no such organization exists, and if their jurisdiction has no registry, they may simply exclude from the measure.

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News Updates

Visit the CMS Website for Additional Guidance on Submitting a Hardship Exception Application for the 2015 EHR Reporting Period

The [Centers for Medicare & Medicaid Services \(CMS\)](#) has released a new frequently asked question (FAQ) that indicates providers who submit a hardship exception application may still attest to the [Medicare Electronic Health Record \(EHR\) Incentive Program](#) for the 2015 EHR Reporting Period.

[FAQ #14357](#) - If I submit a hardship exception application by the March 15, 2016 deadline, does that mean that I cannot attest for the 2015 EHR reporting period and possibly receive an incentive payment?

No. Submission of a hardship exception application does not prevent providers from attesting and receiving an incentive payment if meaningful use requirements are met.

Attestation for the 2015 EHR reporting period is currently open. We urge providers to try to attest by the March 11, 2016 attestation deadline. If they attest successfully, they will avoid the payment adjustment in 2017 and may also be eligible to receive an EHR incentive payment.

However, if providers cannot attest for a 2015 reporting period— or if they believe their attestation may be unsuccessful—then they may apply for a hardship exception to avoid the payment adjustment in 2017. The application will not prevent providers from earning an incentive if their attestation is successful. The deadline to submit a hardship exception application is **March 15, 2016 for eligible professionals** and **April 1, 2016 for eligible hospitals**.

For More Information

Please visit the [Payment Adjustments and Hardship Information](#) page on the CMS website.



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News Updates

Join CMS Education Sessions at HIMSS16 in Las Vegas

CMS is participating in the 2016 Healthcare Information and Management Systems Society (HIMSS) Annual Conference & Exhibition in Las Vegas from February 29-March 4, 2016.

Are you attending [HIMSS16](#) next week? Attend CMS education sessions, visit the CMS **Booth #10309**, and talk to CMS experts during office hours! Please join CMS at the following sessions:

Tuesday, March 1

- **CMS EHR Incentive Programs in 2015 through 2017 Overview**, 10:00 AM-11:00 AM PT (Session 26, Palazzo B)
- **CMS Listening Session: EHR Incentive Programs in 2018 & Beyond**, 1:00 PM-2:00 PM PT (Session 56, Palazzo B)
- **A Special Session with ONC and CMS**, 5:30 PM-6:30 PM PT (Rock of Ages Theatre)

Wednesday, March 2

- **CMS Listening Session: Merit-Based Incentive Payment System (MIPS)**, 8:30 AM-9:30 AM PT (Session 101, Palazzo B)
- **CMS Electronic Clinical Quality Measurement (eCQM) Development and Reporting**, 11:30 AM-12:30 PM PT (Session 131, Palazzo B)

Thursday, March 3

- **CMS Person and Family Engagement: Incentivizing Advances that Matter to Consumers**, 1:00 PM-2:00 PM PT (Session 234, Palazzo B)

CMS Office Hours

Experts from CMS will be available at specific times throughout the conference to discuss programs and address questions at CMS Booth #10309. More details about the office hours coming soon!

Join the Twitter Conversation at HIMSS16

CMS is tweeting about sessions at HIMSS16! Follow the [@CMSSGov](#) Twitter handle and join the conversation using #HIMSS16.



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Join CMS at Booth #10309 for Office Hours Sessions at HIMSS16 in Las Vegas

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Are you going to [HIMSS16](#) next week? Attend CMS office hours at the **CMS Booth #10309!** You will have the opportunity to talk with CMS experts about the Medicare & Medicaid Electronic Health Record (EHR) Incentive Programs, Merit-Based Incentive Payment System (MIPS), Quality Measure Development and Reporting, and more.

Please join CMS for the following office hours sessions:

Tuesday, March 1

- **MIPS** – 11:30 AM-12:30 PM PT
- **Quality Measurement Development and Reporting** – 12:30 PM-1:30 PM PT
- **EHR Incentive Programs** – 2:30 PM-3:30 PM PT

Wednesday, March 2

- **MIPS** – 10:00 AM-11:00 AM PT
- **EHR Incentive Programs** – 11:00 AM-12:00 PM PT

- **Quality Measurement Development and Reporting** – 2:00 PM-3:00 PM PT

Thursday, March 3

- **MIPS** – 9:30 AM-10:30 AM PT
- **EHR Incentive Programs** – 11:00 AM-12:00 PM PT
- **Quality Measurement Development and Reporting** – 1:00 PM-2:00 PM PT

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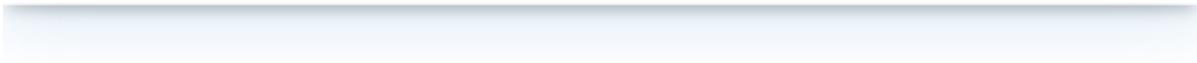
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News Updates

New and Updated FAQs Provide Guidance on Public Health Reporting Requirements for the EHR Incentive Programs

The Centers for Medicare & Medicaid Services (CMS) has published frequently asked questions (FAQs) about the public health reporting objective for the [Medicare and Medicaid Electronic Health Record \(EHR\) Incentive Programs](#). These include three new FAQs about when providers can register their intent to report to a registry, what a provider should do in 2016 if they did not previously intend to report to a public health reporting measure, and the alternate exclusions available for public health reporting in 2016. Review these FAQs below to learn more.

[FAQ #14393 \(New\): Can a provider register their intent after the first 60 days of the reporting period in order to meet the measures if a registry becomes available after that date?](#)

If a registry declares readiness at any point in the calendar year after the initial 60 days, a provider may still register their intent to report with that registry to meet the measure under Active Engagement Option 1. However, a provider who could report to that registry may still exclude for that calendar year if they had already planned to exclude based on the

registry not being ready to allow for registrations of intent within the first 60 days of the reporting period.

[FAQ #14397](#) (New): What should a provider do in 2016 if they did not previously intend to report to a public health reporting measure that was previously a menu measure in Stage 2 and they do not have the necessary software in CEHRT or the interface the registry requires available in their health IT systems? What if the software is potentially available but there is a significant cost to connect to the interface?

In the 2015 EHR Incentive Programs Final Rule, we stated that we did not intend for providers to be inadvertently penalized for changes to their systems or reporting made necessary by the provisions of that regulation. This included alternate exclusions for providers for certain measures in 2016, which might require the acquisition of additional technologies they did not previously have for measures they did not previously intend to include in their activities for meaningful use (80 FR 62945). Therefore, in order that providers are not held accountable to obtain and implement new or additional systems, we will allow providers to claim an alternate exclusion from certain public health reporting measures in 2016 if they did not previously intend to report to the Stage 2 menu measure...[read the full FAQ](#).

[FAQ #14401](#) (New): For 2016, what alternate exclusions are available for the public health reporting objective? Is there an alternate exclusion available to accommodate the changes to how the measures are counted?

We do not intend to inadvertently penalize providers for changes to their systems or reporting made necessary by the provisions of the 2015 EHR Incentive Programs Final Rule. This includes alternate exclusions for providers for certain measures in 2016, which might require the acquisition of additional technologies they did not previously have or did not previously intend to include in their activities for meaningful use (80 FR 62945). For 2016, EPs scheduled to be in Stage 1 or Stage 2 must attest to at least 2 measures from the Public Health Reporting Objective Measures 1-3 and eligible hospitals or CAHs scheduled to be in Stage 1 or Stage 2 must attest to at least 3 public health measures from the Public Health Reporting Objective Measures 1-4...[read the full FAQ](#).

[FAQ #13657](#) (Updated): What steps does a provider have to take to determine if there is a specialized registry available for them, or if they should instead claim an exclusion? [Read the full FAQ](#).

[FAQ #14117](#) (Updated): What steps do eligible hospitals and Critical Access Hospitals need to take to meet the specialized registry objective? Is it different from EPs? [Read the full FAQ.](#)

[FAQ #13653](#) (Updated): What can count as a specialized registry? [Read the full FAQ.](#)

For More Information

- [CMS EHR Incentive Program Website](#)
- [Eligible Professionals: Public Health Reporting in 2015](#)
- [Eligible Hospitals /CAHs: Public Health Reporting in 2015](#)
- [CMS EHR Incentive Program FAQs](#)



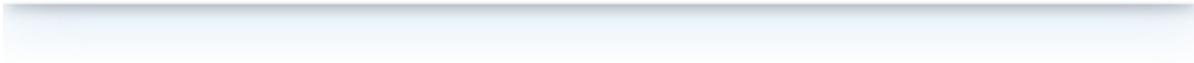
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News Updates

Hear from HHS Secretary Burwell and Dell CEO Michael Dell at Monday's Opening Keynote Address

CMS will participate in the 2016 Healthcare Information and Management Systems Society (HIMSS) Annual Conference & Exhibition in Las Vegas from February 29-March 4, 2016.

Are you attending [HIMSS16](#)? Attend Monday's opening [keynote address](#) by HHS Secretary Sylvia Mathews Burwell and Dell CEO Michael Dell at 5:00 p.m. PT in the Palazzo Ballroom at The Venetian.

HHS Secretary Burwell will provide her perspective on how our nation's healthcare system has transformed over the last seven years while previewing the future of healthcare delivery and the shift to value-based patient care. Her presentation will also highlight the critical role that health IT and health information exchange play in this continuing evolution; and address the importance, benefits, and successes that the Affordable Care Act has brought since it became a law in March 2010.

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News Updates

The Medicare EHR Incentive Program Hardship Application Deadline for All Providers is Now July 1, 2016

Today, CMS is extending the application deadline for the Medicare EHR Incentive Program hardship exception process that reduces burden on clinicians, hospitals, and critical access hospitals (CAHs). The new deadline for Eligible Professionals, Eligible Hospitals and Critical Access Hospitals is July 1, 2016. CMS is extending the deadline so providers have sufficient time to submit their applications to avoid adjustments to their Medicare payments in 2017.

In January, CMS posted new, streamlined hardship exception application forms that reduce the amount of information that eligible professionals (EPs), eligible hospitals, and CAHs must submit to apply for an exception. The new applications and instructions for providers seeking a hardship exception are [available here](#).



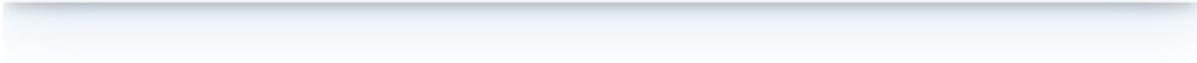
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Are you attending [HIMSS16](#)? Attend CMS educational sessions, visit CMS at **Booth #10309**, and talk with CMS experts! Please join CMS at the following sessions and office hours:

Monday, February 29

- **Opening Keynote: HHS Secretary Sylvia Mathews Burwell and Dell CEO Michael Dell**, 5:00 p.m. PT-7:00 p.m. PT (Palazzo Ballroom at The Venetian)

Tuesday, March 1

- **CMS EHR Incentive Programs in 2015 through 2017 Overview**, 10:00 a.m.-11:00 a.m. PT (Session 26, Palazzo B)
- **Office Hours: MIPS**, 11:30 a.m. -12:30 p.m. PT (Booth #10309)
- **Office Hours: Quality Measurement Development and Reporting**, 12:30 p.m.-1:30 p.m. PT (Booth #10309)

- **CMS Listening Session: EHR Incentive Programs in 2018 & Beyond**, 1:00 p.m.-2:00 p.m. PT (Session 56, Palazzo B)
- **Office Hours: EHR Incentive Programs**, 2:30 p.m.-3:30 p.m. PT (Booth #10309)
- **A Special Session with ONC and CMS**, 5:30 p.m.-6:30 p.m. PT (Rock of Ages Theatre)

Wednesday, March 2

- **CMS Listening Session: Merit-Based Incentive Payment System (MIPS)**, 8:30 a.m.-9:30 a.m. PT (Session 101, Palazzo B)
- **Office Hours: MIPS**, 10:00 a.m.-11:00 a.m. PT (Booth #10309)
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Are you attending [HIMSS16](#)? Please join CMS tomorrow at the following sessions:

CMS Listening Session: Merit-Based Incentive Payment System (MIPS)

8:30 a.m.-9:30 a.m. PT (Session 101, Palazzo B)

CMS will host a listening session on the new Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) legislation. CMS subject matter experts will explain important changes related to how Medicare will pay health care providers who care for Medicare beneficiaries under MACRA, and outline the transition to the Merit-Based Incentive Payment System (MIPS) program under the new law. Presenters will discuss how the new payment model structure aligns with the Secretary's Delivery System Reform Goals and the agency's overall quality strategy goals. A segment of the session will be dedicated to attendee engagement and feedback regarding MACRA and/or MIPS.

CMS Electronic Clinical Quality Measurement (eCQM) Development and Reporting

11:30 a.m.-12:30 p.m. PT (Session 131, Palazzo B)

CMS will present on the current state and the future of eCQM development. Experts will address challenges and explore new initiatives from CMS and its partners to improve the process of developing eCQMs in the future.

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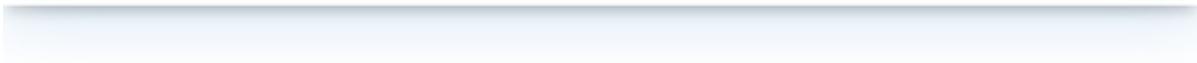
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CMS Person and Family Engagement: Incentivizing Advances that Matter to Consumers

1:00 p.m.-2:00 p.m. PT (Session 234, Palazzo B)

The Centers for Medicare & Medicaid Services (CMS) will host a panel discussion to explore how patient engagement aligns with HHS Secretary Burwell's Delivery System Reform goals and the goals of the agency's overall quality strategy. Panelists will include agency, provider, and patient representatives who will explore practical applications to incentivize patient engagement in health IT.

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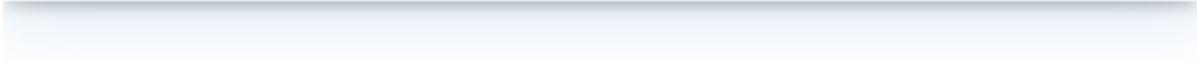
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News Updates

Providers Must Attest to 2015 Program Requirements by March 11, 2016

Eligible professionals, eligible hospitals, and critical access hospitals (CAHs) participating in the Medicare Electronic Health Record (EHR) Incentive Program must attest using the [Medicare & Medicaid EHR Incentive Program Registration and Attestation System](#) by **Friday, March 11, 2016 at 11:59 p.m. ET.**

Medicaid EHR Incentive Program participants should refer to their respective [states](#) for attestation information and deadlines. Certain Medicaid eligible professionals may use the [Registration and Attestation System](#) as an alternate attestation method to avoid the Medicare payment adjustment ([80 FR 62900 through 62901](#)).

To attest to the EHR Incentive Programs in 2015:

- **Eligible Professionals** may select an EHR reporting period of any continuous 90 days from the start of the 2015 calendar year (January 1, 2015) through December 31, 2015.
- **Eligible Hospitals/CAHs** may select an EHR reporting period of any continuous 90 days from October 1, 2014 (the start of the federal fiscal year) through December 31, 2015.

Attestation Resources

For assistance with attestation, please review the following CMS resources:

- [Preparing to Participate in the EHR Incentive Programs Fact Sheet](#)
- [Attestation Worksheet](#) and [User Guide](#) for Eligible Professionals
- [Attestation Worksheet](#) and [User Guide](#) for Eligible Hospitals and CAHs

For More Information

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News Updates

CMS Deadlines Approaching for the 2015 Physician Quality Reporting System (PQRS) Data Submission

The Centers for Medicare & Medicaid Services (CMS) would like to remind you that the 2015 PQRS data submission deadlines are as follows:

- **EHR Direct or Data Submission Vendor (QRDA I or III) - 3/11/16**
- **Qualified Clinical Data Registries (QCDRs) (QRDA III) - 3/11/16**
- **Group Practice Reporting Option (GPRO) Web Interface - 3/11/16**
- **Qualified Registries (Registry XML) - 3/31/16**
- **QCDRs (QCDR XML) - 3/31/16**

For each deadline listed above, the submission ends at **8:00 p.m. Eastern Time (ET)**. CMS encourages organizations to submit data well **in advance of 8:00 p.m. ET** to ensure it is fully submitted before the submission period closes.

An Enterprise Identity Management (EIDM) account with the “Submitter Role” is required for these PQRS data submission methods. For additional information, please review the [EIDM System Toolkit](#).

Eligible professionals who do not satisfactorily report quality measure data to meet the 2015 PQRS requirements will be subject to a negative PQRS payment adjustment on all Medicare Part B Physician Fee Schedule (PFS) services rendered in 2017.

For questions, please contact the QualityNet Help Desk at 1-866-288-8912 from 7:00 a.m. to 7:00 p.m. Central Time or via e-mail at Qnetsupport@hcqis.org. Complete information about PQRS is available on the [CMS PQRS website](#).



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News Updates

Providers Must Attest to 2015 EHR Incentive Program Requirements by March 11, 2016 at 11:59 PM EST

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Medicaid EHR Incentive Program participants should refer to their respective [states](#) for attestation information and deadlines. Certain Medicaid eligible professionals may use the [Registration and Attestation System](#) as an alternate attestation method to avoid the Medicare payment adjustment ([80 FR 62900 through 62901](#)).

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News Updates

Providers Must Attest to 2015 EHR Incentive Program Requirements by 11:59 PM EST Tonight

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News Updates

Review New Information for Guidance on Submitting Quality Reporting Document Architecture Files in the 2016 Reporting Period

The Centers for Medicare & Medicaid Services (CMS) has published the [2016 CMS Quality Reporting Document Architecture \(QRDA\) Implementation Guide \(IG\) for Eligible Professional \(EP\) Programs and Hospital Quality Reporting \(HQR\) Appendix \(Version 1.0, February 26, 2016\)](#). This is the Appendix to the 2016 CMS QRDA IG that was published on July 8, 2015.

The 2016 CMS QRDA IG provides implementation guidance for the 2016 reporting period for submitting QRDA Category I (QRDA-I) and/or QRDA Category III (QRDA-III) files to the CMS EP and HQR programs.

This Appendix lists important updates and clarifications to the [2016 CMS QRDA IG](#), which include:

- Technical corrections to some of the templates of the 2016 CMS QRDA IG.
- Clarifications and additional guidance for QRDA-I file submission to HQR.
- Clarifications on elements used for eligible hospital eCQM calculations when specifications are not clear.

- Clarifications and additional guidance for specific validations to the Physician Quality Reporting System (PQRS) programs.
- Patient Data Section entry templates constraints for PQRS.
- A complete list of the Universally Unique Identifiers (UUIDs) referenced by the [eCQM Specifications for EP Update June 2015](#) (total 64 eCQMs), which include the Version Specific Measure Identifier for each EP eCQM and the population identifiers for all population criteria within each of the eCQMs. It also includes the identifiers for reporting strata, if applicable.

Please refer to the change log within each schematron file for CMS program specific changes.

For More Information

You can find the 2016 CMS QRDA IG Appendix and Schematrons on the CMS [eCQM Library](#) and the [eCQI Resource Center](#).

CMS will notify stakeholders when test tools are available for the latest versions of the schematrons and when test files can be accepted by CMS systems for the 2016 reporting period.



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