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<td>2793</td>
<td>What is meaningful use, and how does it apply to the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?</td>
<td>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, 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 final rule Medicare and Medicaid EHR Incentive Program, CMS has defined stage one of meaningful use. To view the final rule, please visit: <a href="http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf">http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf</a> For more information about the Medicare and Medicaid EHR Incentive Program, please visit <a href="http://www.cms.gov/EHRIncentivePrograms">http://www.cms.gov/EHRIncentivePrograms</a> Keywords: FAQ10084 Archived 12/15/2015</td>
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<td>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?</td>
<td>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.</td>
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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:

1. 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 treat 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. However, information on 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 requirements for submitting CQM information. However, the report of CQMs, meaningful use measures, and performance results do not specify that this capability must be used to calculate for numerators and denominators. EPs, eligible hospitals, and CAHs can use a separate, uncertified system to calculate numerators and denominators and to generate reports for all CQMs for which they have met or exceeded performance targets. 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. Providers may access the online Meaningful Use Attestation Calculator tool found at 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 to submit the same attestation information to submit an amended attestation data. For additional information, please see FAQ#6097. Created on 3/13/2013 Updated on 5/14/2013

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 Form/Good Faith Effort form and follow the instructions on the form requesting 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. Providers may access the online Meaningful Use Attestation Calculator tool found at 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 the Medicare 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 to submit the same attestation information to submit an amended attestation data. For additional information, please see FAQ#6097. Created on 3/13/2013 Updated on 5/14/2013
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?

The Stage 3 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), any licensed health care provider or a medical staff person who is a credentialed medical assistant or is credentialed to and performs the duties equivalent to a credentialed medical assistant can enter orders in the medical record, per state, local and professional guidelines. The remaining meaningful use objectives do not specify any requirement for who must enter information. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10071 Date Updated: 05/12/2016

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 Medicare share, a patient cannot be counted in the numerator if they would count for purposes of calculating the Medicaid share. Thus, in this case, the inpatient bed day of a dually eligible patient could not be counted in the Medicare share numerator. (See 495.306(h)(4), stating that the numerator of the Medicare 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 For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10106

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: “(A) 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 For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10151

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://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Participation-Timeline.html” Updated on 2/27/2013

If a dual-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 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 Medicare EHR incentive payment by adopting, implementing, or upgrading certified EHR technologies. Dual-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 for the first year and this may cause significant delays in receiving a Medicare EHR incentive payment. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10267

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 Medicaid and Medicare 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 Medicare 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. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10592

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. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10665

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: &nbsp;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 earlier than the start of the reporting year and no later than the date of attestation in order for the patients to be counted in the numerator, unless a longer look-back period is specifically indicated for the objective or measure. For program years 2015 and subsequent years, the requirements have been defined in the final rule (80 FR 62792) for information specific to the Security Risk Assessment in 2015 and subsequent years, see FAQ #13649 https://questions.cms.gov/faq.php?qId=13649 5005” Created on 4/26/2013 Updated on 6/23/2014 Updated on 9/24/2015 Updated on 12/11/2015 Updated on 12/14/2015
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<td>2781</td>
<td>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?</td>
<td>The Medicare and Medicaid EHR Incentive Programs are based on individual EP performance and not by group practice. Each EP within a group practice will need to demonstrate the full requirements of meaningful use in order to qualify for the EHR incentive payments or avoid a payment adjustment. To view the final rule for the Medicare and Medicaid EHR incentive programs, please visit: <a href="http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf">http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf</a> For more information about the Medicare and Medicaid EHR Incentive Program, please visit <a href="http://www.cms.gov/EHRIncentivePrograms">http://www.cms.gov/EHRIncentivePrograms</a> FAQ10076 Updated 5/12/2016</td>
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A number of measures for Meaningful Use objectives for eligible hospitals and critical access hospitals (CAHs) include patients admitted to an inpatient department or the Observation Services department. When determining the denominator for these measures, all hospital departments should be included in the denominator of the 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 Emergency Department (ED) measures. Which ED method to use is determined by the hospital's definition of "eligible hospital" and whether the ED method or the "All ED Visits method" would result in a higher denominator.

For the Medicare and Medicaid EHR Incentive Programs, please visit http://www.cms.gov/EHRIncentivePrograms/5/12/2016

No, nursery days and discharge days are not included in inpatient bed-days or discharge counts in calculating hospital incentives. We exclude nursery days and discharge days because they are not considered acute inpatient services based on the level of care provided during a normal nursery stay. Page 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 days applicable to hospital Medicaid incentive calculations. To view the Stage 1 final rule for the Medicare and Medicaid EHR incentive programs, please visit http://edocket.access.gpo.gov/2015/pdf/2015-27107.pdf. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms/Keywords: FAQ10466

No. ED visits may include all ED visits (POS 21) but that is excluded from the denominator of meaningful use objectives. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms/Keywords: FAQ10466

No. ED visits may include all ED visits (POS 21) but that is excluded from the denominator of meaningful use objectives. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms/Keywords: FAQ10466

No, ED visits may include all ED visits (POS 21) but that is excluded from the denominator of meaningful use objectives. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms/Keywords: FAQ10466

Yes. ED visits may include ED visits (POS 21) or hospital emergency department (POS 23) discharges. However, except for hospital-based CAHs, patients discharges because they are not considered acute care inpatient services based on the level of care provided during a normal nursery stay. Page 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 days applicable to hospital Medicaid incentive calculations. To view the Stage 1 final rule for the Medicare and Medicaid EHR incentive programs, please visit http://edocket.access.gpo.gov/2015/pdf/2015-27107.pdf. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms/Keywords: FAQ10466

No. ED visits may include all ED visits (POS 21) but that is excluded from the denominator of meaningful use objectives. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms/Keywords: FAQ10466

No. ED visits may include all ED visits (POS 21) but that is excluded from the denominator of meaningful use objectives. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms/Keywords: FAQ10466

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No. ED visits may include all ED visits (POS 21) but that is excluded from the denominator of meaningful use objectives. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms/Keywords: FAQ10466
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 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,” 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]).

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

Keywords: FAQ10843

Updated 5/12/2016

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.

FAQ Created on 2/26/2013

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.

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

Keywords: FAQ10640

Updated 5/12/2013
I entered numerator and denominator information during my Medicare Electronic Health Incentive payments made to eligible professionals, eligible hospitals and critical access hospitals under the Medicare ... EHR Incentive Programs are not subject to audit under OMB Circular A-133. However, these payments are subject to audit by the Medicare program. For more information about the Medicare Electronic Health Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms. For more information about the Medicaid Electronic Health Incentive Program, please visit: http://www.medicaid.gov/medicaid-ehi-program/audits/AUDITS.html#FAQ8989.
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<td>2807</td>
<td>Where can I get answers to my privacy and security questions about electronic health records (EHRs)?</td>
<td>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 <a href="http://www.hhs.gov/ocr/">http://www.hhs.gov/ocr/</a>&quot; Keywords: FAQ10092</td>
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The Medicaid EHR Incentive Program is a non-hospital based eligible professional (EP) include their in-patient encounters for purposes of calculating patient volume 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 the 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 have selected the same 90-day period. For more information about the Medicaid and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms/keywords.html#FAQ10881

For the Medicaid 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 have received the actual incentive payment in early 2014, correct?

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)(3)(ii)(B). This statement also was made in the preamble, where we stated: “For purposes of administrative simplicity and timelessness, 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 44949. 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)(3)(ii) referring to “the 12-month period selected by the State.” Use of "of" 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” For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms/keywords.html#FAQ10104

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 is to be kept the same 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?

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 (495.10(c)). To view the Stage 1 final rule, please visit: “http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf” For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms/keywords.html#FAQ10109

Data sharing with neighboring States permitted for the Medicaid EHR Incentive Program. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/apps/files/medicaid-HIT-sites/ found here and updated monthly) to get more information on how patient volume is calculated in each State. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms/keywords.html#FAQ10110

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. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms/keywords.html#FAQ10110

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 patient * 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 (Unduplicated encounters in that same 90-day period) Note that the same equation applies to calculating a determination for each non-eligible individual, where “Medicaid” is substituted by “Needy Indigent.” In this calculation, “unduplicated” simply means that an eligible professional may not include the 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 counted by 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 (http://www.cms.gov/apps/files/medicaid-HIT-sites/ found here and updated monthly) to get more information on how patient volume is calculated in each State. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms/keywords.html#FAQ10476

For CMS #017 (or old FAQ #017), my tribal clinic is considered a Federally Qualified Health Center (FQHC) for the Medicaid EHR Incentive Program. So under the Medicaid EHR Incentive Program, what does it mean to have “unduplicated encounters”?

Under the Medicaid EHR Incentive Program, the requirement that eligible professionals and eligible hospitals choose at least one public health objective among four 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 state that States supersede the general definition?

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. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms/keywords.html#FAQ10532

Since your clinic receives IRS 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 Medicare EHR Incentive Program. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms/keywords.html#FAQ10878
3101 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. For more information about the Medicaid and Medicare EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

3102 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 maximum 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. For more information about the Medicaid and Medicare EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

3121 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 (SMHIP)? When are the SMHIPS 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 final rule, it would do so via its SMHIP. There is no due date for SMHIPS. States are implementing their Medicaid EHR Incentive Programs on a rolling basis. The SMHIPS are therefore expected to be iterative, as States implement their programs incrementally, especially in the early years. For more information about the Medicaid and Medicare EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

3123 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. For more information about the Medicaid and Medicare EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

5995 For the Medicaid EHR Incentive Program, how do we determine Medicaid patient volume for procedures that are billed globally, such as appendectomy (OB visits or any surgery)? Such procedures are billed to Medicaid at a global rate where one global rate might cover several visits.

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 providing providers (person rendering the service) or the billing provider?

In establishing an encounter for purposes of patient volume, please see the regulations at 459.100.e(2)(ii)(6) at 75 FR 44579. Furthermore, in estimating patient volume for any EP or hospital, we do not specify any requirements around billing, but rather the basis of 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 would need to adequately reflect the total universe of patients (both Medicaid and non-Medicaid) that 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/herself, if the State cannot 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: a http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

3015 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?

In this scenario, a State must show that the eligible professional is predominantly providing services under one model of care. CMS considers these two separate, but related issues. Meaningful use: Any eligible professional demonstrating meaningful use must have at least 50% of their patient encounters during the EHR reporting period at a practice/location or practice/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 can choose which 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 groupclinical proxy option), a professional may calculate across all practice sites, or just at the one site. For more information on applying the group/clinical proxy option, see FAQ10362 or here For more information about the Medicaid and Medicare EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

3017 Can tribal clinics be treated as Federally Qualified Health Centers (FQHCs) for the Medicaid Electronic Health Record (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 Health Care Improvement Act (Public Law 93-638), as amended, and constructed using sample data from a random file review that similarly breaks down any global payments into separate visits for Medicaid and non-Medicaid payments. To view the final rule, please visit: a http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf For more information about the Medicaid and Medicare EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

3099 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% or more 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. For more information about the Medicaid and Medicare EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

2485 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 1903(l)(3) defines an FQHC as an entity which, “(i) is receiving a grant under section 330 of the Public Health Service Act, or (ii) is receiving funding from such a grant under a contract with the recipient of such a grant and (iii) 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 facility 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 EHR 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. For more information about the Medicaid and Medicare EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.
If an eligible professional (EP) in the Medicaid EHR Incentive Program wants to leverage a clinic or group practice’s patient volume as a proxy for the individual EP, how should a clinic or group practice account for EPs practicing with them part-time and/or 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 EP 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 in the individual calculation or the group/practice as a whole. Furthermore, if the EP works in both clinics 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 EPs in Clinic A are 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 feasibility 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 using 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 EPs from using EPs’ individual patient volume, where the lower Medicaid patient volume EPs then use that 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 51% Medicaid encounters (51/100 encounters)” Medicaid 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 for a variety of reasons). For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentiveProgramsKW: Keywords: FA030528.

For the Medicaid EHR Incentive Program, how are EPs allowed to use proxy patient volume for demonstrating meaningful use in assessing if an eligible professional (EP) skips a year or takes longer than 12 months between attestations? Regardless of whether the previous incentive payment was made, the following reporting periods apply for the Medicaid EHR Incentive Program: For patient performance, an eligible professional (EP) must conduct a 90-day reporting period in the calendar year. For demonstrating meaningful users of Electronic Health Records (EHRs), EPs should use the 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 will be the full calendar year). For more information about the Medicaid and Medicare EHR Incentive Program, please visit http://www.cms.gov/EHRIncentiveProgramsKW: Keywords: FA020531.

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) correctly identifying them as eligible for the EHR Incentive Programs. 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. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentiveProgramsKW: Keywords: FA030530.

Under the Medicaid EHR Incentive Program, can a qualifying professional (EP) who is an employee of a federally-owned Indian Health Service 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 reallocate 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 Service facility. For more information about the Medicaid and Medicare EHR Incentive Program, please visit http://www.cms.gov/EHRIncentiveProgramsKW: Keywords: FA020510.

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. For more information about the Medicaid and Medicare EHR Incentive Program, please visit http://www.cms.gov/EHRIncentiveProgramsKW: Keywords: FA028110.

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.&nbsp; Generally stated, a patient encounter is any one day where an individual enrolled in a Medicaid program receives service.&nbsp; The requirements differ for EPs and hospitals.&nbsp; In general, the same concept applies to need.&nbsp; Please consult your State Medicaid agency for more information on which types of encounters qualify as Medicaid/needy individual patient volume. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentiveProgramsKW: Keywords: FA028054.

When calculating ineligible 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 report the Medicare and Medicaid cost reports? There are multiple definitions of encounter in terms of how it applies to the various requirements for patient volume.&nbsp; Generally stated, a patient encounter is any one day where an individual enrolled in a Medicaid program receives service.&nbsp; The requirements differ for EPs and hospitals.&nbsp; In general, the same concept applies to need.&nbsp; Please consult your State Medicaid agency for more information on which types of encounters qualify as Medicaid/needy individual patient volume. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentiveProgramsKW: Keywords: FA026686.

In order to qualify for payment under the Medicaid EHR Incentive Program for having adopted, implemented, or upgraded to (AU) certified EHR technology, an eligible professional (EP) working at an Indian Health Service (IHS) clinic may be asked to provide the 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 license.&nbsp; Does this letter meet states’ documentation requirements for AU? 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 AU (pre-payment or post-payment, or in the event of an audit) in instances where one of these letters is provided. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentiveProgramsKW: Keywords: FA029596.
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. “No, in all ways possible, the Medicaid hospital incentive calculation is similar to Medicare, based on the language.&nbsp; Medicare retrieves from the calculation any Medicaid cost report that offers additional flexibility in data sources, the data parameters for Medicaid are the same as Medicare.&nbsp; 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 Medicaid “would not be considered in the same manner”. In the final rule, we have proposed that Medicaid “would not be considered in the same manner”.

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 attribution” approach, as not all of the EPs in the group proxy may use the same 90-day period.

In the Stage 2 final rule, CMS adopted a final policy that allows states to designate 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) attribution (see 77 FR 54112, 42 CFR 495.306(b)&nbsp;). 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.&nbsp; For EPs who calculate patient volume at the group proxy or clinic level under 42 CFR 495.306(b), the states may select any continuous 90-day period in the 12 months preceding the EP's attribution.&nbsp; In such scenarios where it would be impossible to use the same representative, continuous 90-day period for EPs in the group proxy or clinic, we would allow different representatives, continuous 90-day periods to be used long as all of the providers of 42 CFR 495.306(b)&nbsp; are used.

What funding sources may States use to fund the non-federal share of HITECH incentive payments if they meet the eligibility criteria?

States may use Federal and non-Federal funds to fund the non-federal share of incentive payments. States may use Federal funds through HITECH Administrative payments or bonafide 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 funding plan in detail, including its funding sources, amount, and methodology. Federal funds are available for the non-federal share for all Medicaid expenditures. Consistent with that authority, which includes Social Security Act sections 500(b)(2), and 1903(a), 42 CFR Part 433, subpart B, the Secretary has “established” how she counts the number of inpatient bed days per statutory authority.

Under the Medicaid Electronic Health Record (EHR) Incentive Program, how long is the EHR reporting period for each participation year demonstrating meaningful use?

Under the Medicaid Electronic Health Record (EHR) Incentive Program, if a provider adopts, implements or upgrades (AU) certified EHR technology in their practice site, it must have met meaningful use by the first day of the reporting period to be considered. The definition of AU in 42 CFR 495.302 allows the provider to demonstrate AU 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 through upgrade, 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 for 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 would need to file an attestation with CMS. This signed contract indicating that the provider has adopted or upgraded might generally be sufficient to establish an intent to Au, the state could still determine that other, contradictory evidence demonstrated that the provider in fact had no intent to AU. In such cases, that contradictory evidence might outweigh the presence of a signed contract. For more information about the Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10100 Updated on 4/2/2014

Can a State access enhanced matching funds for the Medicaid EHR Incentive Program to participate in the creation of a Health Information Exchange (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 Medicare Management Information System (MMIS) funding or Health Information Technology for Economic and Clinical Health (HITECH) funding. Governance is only relevant under the MMIS regulations, as it pertains to the match 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. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10112

Under the Medicaid Electronic Health Record (EHR) Incentive Program, for a provider to participate in the Medicaid EHR incentive programs, how should the hospital inpatient days be calculated for purposes of the Medicaid formula?

The setting in which a physician, nurse practitioner, certified nurse-midwife, or dentist practices is not relevant in determining eligibility for the Medicaid EHR incentive program. For more information about the Medicaid Electronic Health Record (EHR) Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10208 Updated on 5/17/2016.
| 3471 | 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 http://questions.cms.hhs.gov/app/answers/detail/a_id/10717/FAQ10717. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms. Keywords: FAQ10771 |
For 2016, what alternate exclusions are available for the public health reporting objective? There are alternate exclusions available to accommodate the changes to how the measures are calculated.

We do not intend to rashly 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 intend to include in their activities for meaningful use (80 FR 62946). 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 2 public health measures from the Public Health Reporting Objective Measures 1-4. We will allow providers to claim an alternate exclusion for the Public Health Reporting measure(s) which might require the acquisition of additional technologies provided they did not previously have or did not previously intend to include in their activities for meaningful use. We will allow Alternate Exclusions for the Public Health Reporting Objective in 2015 on a case by case basis. EPs scheduled to be in Stage 1 and Stage 2 must attest to at least 2 measures from the Public Health Reporting Objective Measures 1-3. We may allow an Alternate Exclusion for Measure 2 and Measure 3 (Symptomatic Surveillance and Syndromic Surveillance—Reporting). An Alternate Exclusion may only be claimed for up to two measures, the provider must either attest to or meet the exclusion requirements for the remaining measure described in 495.22(d)(1)(ii)(A). Eligible hospitals/CAHs scheduled to be in Stage 1 and Stage 2 must attest to at least 3 measures from the Public Health Reporting Objective Measures 1-4. May claim an Alternate Exclusion for Measure 3 (Symptomatic Registry Reporting) or an Alternate Exclusion may only be claimed for one measure, then the provider must either attest to or meet the exclusion requirements for the remaining measure described in 495.22(d)(1)(ii)(C).

We do not intend to rashly 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 62946). 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 2 public health measures from the Public Health Reporting Objective Measures 1-4. We will allow providers to claim an alternate exclusion for the Public Health Reporting measure(s) which might require the acquisition of additional technologies provided they did not previously have or did not previously intend to include in their activities for meaningful use. We will allow Alternate Exclusions for the Public Health Reporting Objective in 2015 on a case by case basis. EPs scheduled to be in Stage 1 and Stage 2 must attest to at least 2 measures from the Public Health Reporting Objective Measures 1-3. We may allow an Alternate Exclusion for Measure 2 and Measure 3 (Symptomatic Surveillance and Syndromic Surveillance—Reporting). An Alternate Exclusion may only be claimed for up to two measures, the provider must either attest to or meet the exclusion requirements for the remaining measure described in 495.22(d)(1)(ii)(A). Eligible hospitals/CAHs scheduled to be in Stage 1 and Stage 2 must attest to at least 3 measures from the Public Health Reporting Objective Measures 1-4. May claim an Alternate Exclusion for Measure 3 (Symptomatic Registry Reporting) or an Alternate Exclusion may only be claimed for one measure, then the provider must either attest to or meet the exclusion requirements for the remaining measure described in 495.22(d)(1)(ii)(C).
For the meaningful use objective of "generate and transmit prescriptions electronically (eRx)" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program, should electronic prescriptions fulfilled by an internal pharmacy be included in the numerator?

We define a permissible prescription as all drugs meeting the definition of prescription not listed as a controlled substance in Schedules I–V.

The measure for prescription fill data includes all drugs that meet the definition of prescription and are not controlled substances. The measure numerator includes electronic prescriptions filled by internal pharmacies. If the measure is being reported for Stage 1 providers, the measure numerator will be calculated using any prescription fill data reported by the provider in the last 90 days. Stage 2 providers have the option to report prescription fill data in EHR systems (as opposed to via other means such as referrals) or to use data from the National Claims Datafile (NCD) as prescription fill data. Stage 3 providers must only use prescription fill data from EHR systems.

For Objective 1: Protect Patient Health Information (ePHI), can the health record (EHR) also be used to meet the meaningful use objectives of patient engagement (POE) and public health objectives?

Yes, the Meaningful Use Program allows providers to use the EHR for a number of different purposes, including patient engagement and public health activities. The EHR system is a powerful tool for improving patient care, but its usefulness can be limited by the lack of data or information that is available within the system.

More information on the Meaningful Use Program can be found at the Centers for Medicare & Medicaid Services (CMS) website: http://www.cms.gov/EHRIncentivePrograms/
In order to satisfy the Meaningful Use objective for electronic health record (EHR) Incentive Programs, providers can use interim measures that permit information from the certified EHR into a computer-based record for sending to the pharmacy and include this transaction in the numerator for the measure of this objective. The threshold for a prescribing for an EHR reporting period in 2015 through 2017 is more than 50 percent for EPs and more than 10 percent for eligible hospitals and CAHs. If the EP generates an electronic prescription and transmits it electronically using the standards for electronic prescription and transmits it electronically, then the prescription need not have any alerts about possible interactions or other clinical decision support. This necessitates that CPOE occurs when the order first becomes part of the patient's medical record and before any action can be taken. 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, allow for clinical judgment before the medication is given, and is the first time the order becomes part of the patient's medical record.

For EHR reporting periods in 2015 through 2017, providers are not required to report that a specific security update has been implemented or that a specific security deficiency has been corrected by the time the definition of security updates and deficiencies correction is driven by the provider's risk management process. The scope of that security risk analysis must include data generated or maintained by the provider's EHR. As long as the provider meets the requirements for producing more than 45 CFR 164.308(a)(1), including the requirement to "Implement security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level" as required with 45 CFR 164.304(a), then the provider's risk management process drives the timeframe for the implementation of security updates and correction of security deficiencies, not the date a provider chooses to submit the meaningful use attestation. Providers are not entitled to becoming a specific security update has been implemented or a specific security deficiency by the definition of security updates and deficiencies correction is driven by the provider's risk management process. This objective and measure do not impose security requirements beyond those within the HIPAA Security Rule.
Are Computerized Provider Order Entry (CPOE) and Clinical Decision Support (CDS) required objectives under the Medicare and Medicaid EHR Incentive Programs?

In the 2017 OPPS rule, we finalized the elimination of the CPOE and CDS objectives and associated measures for eligible hospitals and Critical Access Hospitals (CAHs). The elimination of the CPOE and CDS objectives and associated measures also applies to dual-eligible hospitals that are attesting to CMS for both the Medicare and Medicaid EHR Incentive Programs. However, the CPOE and CDS objectives and measures are still required for the Medicaid EHR Incentive Program to successfully attest to meaningful use.

Please also note we did not include CPOE and CDS objectives and associated measures as part of the advancing care information performance category, thus, they are not required for reporting by MIPS eligible clinicians.
Can an eligible professional (EP) use EHR technology certified for an inpatient setting to meet a meaningful use objective and measure in an ambulatory setting?

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, no EHR technology can receive certification to one transport standard and be able to transport information according to all other transport standards. EHR technology presented for certification must be able to transport information under the )Transport and Exchange of Data (section 170.314(a)(3)) of the EMTP only if it can also electronically receive and transmit information according to the other transport standards. In other words, if EHR technology was presented for certification and could only perform the specific “create a CCDA” capability (as specified in section 170.314(a)(3)(i) of the EMTP), then it would need to be certified to an additional transport standard (e.g., for Secure Health Transport) and 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 worth it for each patient. For more information about the Medicare and Medicaid EHR Incentive Programs, please visit http://www.cms.gov/States/IncentivePrograms.

The CEHRT is an ID number assigned to an EHR technology by ONC, as described in detail at http://www.healthit.gov/mvc/cehrt. This number is used for identifying a particular EHR technology to the public and to ONC. CEHRTs are assigned only to those EHR technologies that are certified to meet the requirements of the meaningful use objectives. That is, only those EHR technologies that have successfully completed the CEHRT certification process can be assigned a CEHRT. CEHRTs are not assigned to EHR technologies that still need to complete the CEHRT certification process. CEHRTs are assigned on a per-EHR technology basis, so EHR technologies that have completed the CEHRT certification process can have multiple CEHRTs, provided each CEHRT corresponds to a different CEHRT application. The CEHRT is used by ONC to manage the CEHRT certification process and as an identification mechanism for EHR technologies that are certified to meet the meaningful use objectives. It is not an EHR technology identifier or a version number.

In order to meet the clinical 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. Providing 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 Secure Health Transport specification. EHR technology presented for certification must be able to electronically receive and transmit information according to the other transport standards. The Applicability Statement for Secure Health Transport specification and the XDR and XDM for Secure Health Transport specification. EHR technology presented for certification must be able to electronically receive and transmit information according to the other transport standards. In other words, if EHR technology was presented for certification and could only perform the specific “create a CCDA” capability (as specified in section 170.314(a)(3)(i) of the EMTP), then it would need to be certified to an additional transport standard (e.g., for Secure Health Transport) and 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 worth it for each patient. For more information about the Medicare and Medicaid EHR Incentive Programs, please visit http://www.cms.gov/States/IncentivePrograms.

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If a provider utilizes a health information organization that participates with the Health Level Seven (HL7) 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 certifies 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 10054). Created on 7/26/2013

What if your product is decertified?

If your product is decertified, you can still use that product to attest if your EHR reporting period ended before the decertification occurred. If your EHR reporting period ended after the decertification occurred, you can apply for a hardship exception. If the decertification occurs after the hardship exception period has already closed for the payment adjustment year which would be applicable for your reporting period, please contact the EHR Incentive Program via email at EHRinquiries@cms.hhs.gov to apply for a hardship exception. If the decertification occurs after the hardship exception period has already closed for the payment adjustment year which would be applicable for your reporting period, please contact CMS Hardship exception at EHRinquiries@cms.hhs.gov to apply for a hardship exception under the Extreme and/or Uncontrollable Circumstances category per CMS discretion to allow such an application. Also, if you are a first-time participant at a group practice which is switching products and the product is decertified after the hardship deadline, contact CMS at mailto:EHRinquiries@cms.hhs.gov for more information. Created on 9/23/2015

Can a submission to a specialized registry be counted towards a measure?

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 certifies 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 10054). Created on 7/26/2013

Does integration of the PDMP (Prescription Drug Monitoring Program) into an EHR count as a specialized registry?

If the PDMP within a jurisdiction has declared itself a specialized registry ready to accept data, then the integration with a PDMP can count towards a specialized registry. The EHR must be CEHRT, but there are no standards for the exchange of data. Created on 11/4/2013

Let's talk about ENCentralization of the PDMP (Prescription Drug Monitoring Program) into an EHR count towards a specialized registry?

If the PDMP within a jurisdiction has declared itself a specialized registry ready to accept data, then the integration with a PDMP can count towards a specialized registry. The EHR must be CEHRT, but there are no standards for the exchange of data. Created on 11/4/2013

Let's talk about ENCentralization of the PDMP (Prescription Drug Monitoring Program) into an EHR count towards a specialized registry?

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 (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](http://www.healthit.hhs.gov/chpl). This is a list of complete EHRs and EHR modules that have been certified for the purposes of this program. A provider may use a single product or a combination of products and/or modules to meet the requirements. For more information, please visit the Office of the National Coordinator’s website at [http://healthit.hhs.gov/](http://healthit.hhs.gov/). For more information, please visit the Office of the National Coordinator’s website at [http://healthit.hhs.gov/](http://healthit.hhs.gov/).

The Medicare and Medicaid EHR Incentive Programs require interoperability, is there guidance regarding who will pay for ensuring connectivity between physician practices and hospitals?

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 programs is available at [http://healthit.hhs.gov/](http://healthit.hhs.gov/).


Certiﬁcation of a PDMP (Prescription Drug Monitoring Program) into an EHR count towards a specialized registry?

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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 rule preamble discusses what it means for a PA to have lead role in an FQHC or RHC at page 44483. 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. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentiveProgramsKeywords: FAQ10128.

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. However, eligible professionals who qualify for an EHR incentive payment may reassign that incentive payment with respect to more than 4 consecutive payment years. The incentive payment made to a qualifying CAH equals: 

Allowable cost amount

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 (to its FQHC or RHC). The Medicare contractor will then calculate the allowable amount. The interim incentive payment is then subject to recalculation 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. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentiveProgramsKeywords: FAQ10718.

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. 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. 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 is essentially the same as a virtual purchase agreement, as defined in 42 CFR 413.130(b)(18) of the regulations and the Medicare Provider Reimbursement Manual (PMR). A capital lease is treated as though the CAH (lessor) 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 is 42 CFR 413.134(b)(11) 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 such virtual purchase asset (see CMS Pub. 15-1, section 110 B.1.b.) may continue to be included on the cost report.

Clinics are not directly eligible for the Medicaid EHR Incentive Program 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. For more information about the Medicare and Medicaid EHR Incentive Program, please visit a http://www.cms.gov/EHRIncentiveProgramsKeywords: FAQ10129.

Clinics are not directly eligible for the Medicaid EHR Incentive Program 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. For more information about the Medicare and Medicaid EHR Incentive Program, please visit a http://www.cms.gov/EHRIncentiveProgramsKeywords: FAQ10129.
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). For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10716

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). For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10719

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 or 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. For more information about the Medicaid and Medicare EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10520

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.A 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. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10163
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). There are 16 CQMs that are shared by the two programs, and hospitals must report all 16 CQMs, unless they are not available in the certified EHR technology. The measure steward recommends that hospitals use the data element 'ED Patient', defined as any patient receiving care or services in the Emergency Department, to report the ED-1, ED-2, and Stroke-4 clinical quality measures. Hospitals will need to check with their state Medicaid programs to determine all necessary requirements to participate in the Medicaid 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 Certified EHR Technology and will be required to only submit results generated by EHR technologies certified to the 2014 edition criteria. To view the FAQs for the Medicare and Medicaid EHR Incentive Programs, please visit http://www.cms.gov/EHRIncentivePrograms/Keywords: FAQ10883.

For the Medicare and Medicaid EHR Incentive Programs, what data should be included in the numerator and the denominator? Clinical quality measure reporting is inclusive of all applicable patients or services, but providers must 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. Army&El&We will continue to collaborate with our partners in the Office of the National Coordinator for Health Information Technology (ONC) and with stakeholders to make further headways in system interoperability, standards for EHR data, as well as certification of vendor products. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms/Keywords: FAQ10839.

For the Medicare and Medicaid 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 number of patient encounters in the relevant eligible hospital or CAH (e.g., inpatient or emergency department). For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms/Keywords: FAQ10884.

For the Medicare and Medicaid EHR Incentive Programs, what data should be included in the numerator and the denominator? Clinical quality measure reporting is inclusive of all applicable patients or services, but providers must 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. Army&El&We will continue to collaborate with our partners in the Office of the National Coordinator for Health Information Technology (ONC) and with stakeholders to make further headways in system interoperability, standards for EHR data, as well as certification of vendor products. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms/Keywords: FAQ10839.

For the Medicare and Medicaid EHR Incentive Programs, can I report a CQM with a zero result in the denominator when the certified EHR technology generated a zero denominator value? 

If a zero denominator was generated by the certified EHR technology, then a zero numerator result must be reported. If a zero denominator is calculated similar to the Hospital Inpatient Quality Reporting (IQR) Program, we recommend that hospitals report a zero numerator for clinical quality measures that have been calculated based on that denominator. However, the measure steward recommends that hospitals use the data element 'ED Patient', defined as any patient receiving care or services in the Emergency Department, to report the ED-1, ED-2, and Stroke-4 clinical quality measures. The measure steward recommends that hospitals use the data element 'ED Patient', defined as any patient receiving care or services in the Emergency Department, to report the ED-1, ED-2, and Stroke-4 clinical quality measures. Hospitals will need to check with their state Medicaid programs to determine all necessary requirements to participate in the Medicaid 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 Certified EHR Technology and will be required to only submit results generated by EHR technologies certified to the 2014 edition criteria. To view the FAQs for the Medicare and Medicaid EHR Incentive Programs, please visit http://www.cms.gov/EHRIncentivePrograms/Keywords: FAQ10883.

For the Medicare and Medicaid EHR Incentive Programs, can I report a CQM with a zero result in the denominator when the certified EHR technology generated a zero denominator value? 

If a zero denominator was generated by the certified EHR technology, then a zero numerator result must be reported. If a zero denominator is calculated similar to the Hospital Inpatient Quality Reporting (IQR) Program, we recommend that hospitals report a zero numerator for clinical quality measures that have been calculated based on that denominator. However, the measure steward recommends that hospitals use the data element 'ED Patient', defined as any patient receiving care or services in the Emergency Department, to report the ED-1, ED-2, and Stroke-4 clinical quality measures. Hospitals will need to check with their state Medicaid programs to determine all necessary requirements to participate in the Medicaid 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 Certified EHR Technology and will be required to only submit results generated by EHR technologies certified to the 2014 edition criteria. To view the FAQs for the Medicare and Medicaid EHR Incentive Programs, please visit http://www.cms.gov/EHRIncentivePrograms/Keywords: FAQ10883.

For the Medicare and Medicaid EHR Incentive Programs, can I report a CQM with a zero result in the denominator when the certified EHR technology generated a zero denominator value? 

If a zero denominator was generated by the certified EHR technology, then a zero numerator result must be reported. If a zero denominator is calculated similar to the Hospital Inpatient Quality Reporting (IQR) Program, we recommend that hospitals report a zero numerator for clinical quality measures that have been calculated based on that denominator. However, the measure steward recommends that hospitals use the data element 'ED Patient', defined as any patient receiving care or services in the Emergency Department, to report the ED-1, ED-2, and Stroke-4 clinical quality measures. Hospitals will need to check with their state Medicaid programs to determine all necessary requirements to participate in the Medicaid 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 Certified EHR Technology and will be required to only submit results generated by EHR technologies certified to the 2014 edition criteria. To view the FAQs for the Medicare and Medicaid EHR Incentive Programs, please visit http://www.cms.gov/EHRIncentivePrograms/Keywords: FAQ10883.

For the Medicare and Medicaid EHR Incentive Programs, can I report a CQM with a zero result in the denominator when the certified EHR technology generated a zero denominator value? 

If a zero denominator was generated by the certified EHR technology, then a zero numerator result must be reported. If a zero denominator is calculated similar to the Hospital Inpatient Quality Reporting (IQR) Program, we recommend that hospitals report a zero numerator for clinical quality measures that have been calculated based on that denominator. However, the measure steward recommends that hospitals use the data element 'ED Patient', defined as any patient receiving care or services in the Emergency Department, to report the ED-1, ED-2, and Stroke-4 clinical quality measures. Hospitals will need to check with their state Medicaid programs to determine all necessary requirements to participate in the Medicaid 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 Certified EHR Technology and will be required to only submit results generated by EHR technologies certified to the 2014 edition criteria. To view the FAQs for the Medicare and Medicaid EHR Incentive Programs, please visit http://www.cms.gov/EHRIncentivePrograms/Keywords: FAQ10883.
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 it certified 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 CQM 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 8890 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. Created on 7/26/2013 Updated on 8/22/2013

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 tested 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 8898 and 8890 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. Updated on 8/22/2013

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 CQM 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 ≥10 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. 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. Added on 2/6/2014

/10776

Can SCPINF-9 (CMS130v4 / 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 the voluntary electronic reporting option under the Hospital Inpatient Quality Reporting (IQR) Program not select SCP-INF-9 (CMS130v4 / NQF0453) 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 (CMS130v4 / NQF0453) renders a zero denominator. The denominator error noted in the SCP-INF-9 (CMS130v4 / NQF0453) 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 zero denominators, please see the page 90225 of the FY 2013 IPPS Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2014-08-22/pdf/2014-18545.pdf. Created 10/9/2014
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<td>2709</td>
<td>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?</td>
<td>There are no payment adjustments or penalties for Medicaid providers who fail to demonstrate meaningful use. For more information about the Medicare and Medicaid EHR Incentive Program, please visit <a href="http://www.cms.gov/EHRIncentivePrograms">http://www.cms.gov/EHRIncentivePrograms</a> Keywords: FAQ9958</td>
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<td>7531</td>
<td>What are the payment adjustments for eligible professionals who are not participating in the Medicare EHR Incentive Program? Are there any hardship exceptions?</td>
<td>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. For more information about the Medicare and Medicaid EHR Incentive Program, please visit <a href="http://www.cms.gov/EHRIncentivePrograms">http://www.cms.gov/EHRIncentivePrograms</a></td>
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<td>7533</td>
<td>What are the payment adjustments for eligible hospitals and critical access hospitals that are not participating in the Medicare EHR Incentive Program and are there any hardship exceptions?</td>
<td>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 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. For more information about the Medicare and Medicaid EHR Incentive Program, please visit <a href="http://www.cms.gov/EHRIncentivePrograms">http://www.cms.gov/EHRIncentivePrograms</a></td>
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| 7727       | 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"
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<td>22521</td>
<td>If a practice has multiple office locations under the same Tax Identification Number (TIN), and one office is within a broadband availability area but the other office for the practice is not, would that practice still qualify for the hardship exception for insufficient Internet Connectivity (same TIN)?</td>
<td>No, the office with broadband availability would not qualify for the hardship exception and, if a practice has an office site with sufficient internet access, the group must report for those clinicians for whom they have data.</td>
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<td>22522</td>
<td>Can Merit-based Incentive Payment System (MIPS) eligible clinicians that have switched certified electronic health record technology (CEHRT) vendors apply for a hardship exception and have their advancing care information performance category weight reallocated to the quality performance category?</td>
<td>Yes, if a MIPS-eligible clinician switches CEHRT vendors during the performance period and is unable to report for the advancing care information performance category, the clinician may apply for an Extreme and Uncontrollable Circumstances hardship exception. For example, if a MIPS-eligible clinician switches CEHRT vendors in 2017 and is unable to submit measures for the advancing care information performance category for the 2017 performance period, the MIPS-eligible clinician can apply for an Extreme and Uncontrollable Circumstances category hardship exception, before the submission deadline.</td>
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<td>22523</td>
<td>Will CMS require the submission of supporting documentation along with the Quality Payment Program hardship exception application?</td>
<td>CMS does not require a Merit-based Incentive Payment System (MIPS) eligible clinician or group to submit documentation with the hardship exception application. CMS will review the application to record the category selected and use the identifying information for each clinician and group listed on the application. MIPS eligible clinicians and groups should retain documentation of their circumstances supporting their application for their own records in the event CMS requests data validation or audit.</td>
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<td>22524</td>
<td>If I submit a Quality Payment Program hardship exception application, does that mean that I cannot report on the advancing Care Information performance category for 2017 performance period?</td>
<td>No. You may still report on the advancing care information performance category, however if you choose to report, your data will be scored and your hardship exception will be dismissed.</td>
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<td>22525</td>
<td>If I submit a Quality Payment Program hardship exception application, does that mean that I cannot report on the advancing Care Information performance category for 2017 performance period?</td>
<td>A submission to a specialized registry may count if the receiving entity meets the following requirements: The receiving entity must declare that they are ready to accept data as a specialized registry and be using the data to improve population health outcomes. Most public health agencies and clinical data registries are declaring readiness via a public online posting. Registries should make this information publically available for potential registrants. The receiving entity must also be able to receive electronic data generated from CEHRT. The electronic file can be sent to the receiving entity through any appropriately secure mechanism including, but not limited to, a secure upload function on a web portal or Direct. Manual data entry into a web portal would not qualify for submission to a specialized registry. The receiving entity should have a registration of intent process, a process to take the MIPS eligible clinician through test and validation and a process to move into production. The receiving entity should be able to provide appropriate documentation for the sending provider or their current status in Active Engagement. For qualified clinical data registries, reporting to a QCDR may count for the public health specialized registry measure as long as the submission to the registry is not only for the purposes of meeting CQM requirements of the quality performance category of MIPS in other words, the submission may count if the registry is also using the data for a public health purpose. Many QCDRs use the data for a public health purpose beyond CQM reporting to CMS. A submission to such a registry would meet the requirement for the measure if the submission data is derived from CEHRT and transmitted electronically.</td>
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<td>22526</td>
<td>For the Merit-based Incentive Payment System (MIPS), to calculate the advancing care information measures and the advancing care information transition measures for View, Download, and Transmit, Secure Messaging and Patient-Specific Education requiring patient action, can other MIPS eligible clinicians in the group or as part of the care team get credit for the action in meeting the measure?</td>
<td>The transitive effect applies to the View, Download and Transmit measures, Secure Messaging measures and to the Patient-Specific Education measures. If a MIPS eligible clinician initiates or responds to a patient’s secure message about a clinical or health related subject to on behalf of the group or care team, that patient can be counted in the numerator of the Secure Messaging measure for any of the MIPS eligible clinicians in the group or part of the care team who use the same certified electronic health record technology (CEHRT), and who saw the patient during their performance period. Similarly, if a patient views, downloads, or transmits to a third party the health information that was made available online by their MIPS eligible clinician, that patient can be counted in the numerator for any of the MIPS eligible clinicians in that group or care team who use the same CEHRT and saw that patient during their performance period. If patient-specific education resources are provided electronically, it may be counted in the numerator for any MIPS eligible clinician within the group or part of the care team sharing the CEHRT who has contributed information to the patient’s record if that MIPS eligible clinician has the patient in their denominator for the performance period. We clarify that: if it is not possible to determine who provided the health information, or multiple MIPS eligible clinicians in the group (or part of the care team) saw the patient during their performance period or multiple MIPS eligible clinicians contributed information to the patient’s record and those MIPS eligible clinicians have the patient in their denominator for the performance period then the patient can be counted in the numerator of the applicable measure(s) for those MIPS eligible clinicians. We note that this could include all MIPS eligible clinicians who share the same CEHRT and saw the patient during the performance period.</td>
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<td>22513 For the Protect Patient Health Information (ePHI) objective, can the security risk analysis or review take place outside the MIPS performance period?</td>
<td>Yes, it is acceptable for the security risk analysis to be conducted outside the MIPS performance period; however, the analysis must be conducted for the certified EHR technology used during the MIPS performance period and the analysis or review must be conducted on an annual basis and within the calendar year of the performance period. In other words, the MIPS eligible clinician or group must conduct a unique analysis or review applicable for the MIPS performance period and the scope of the analysis or review must include the full MIPS performance period.</td>
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<td>22557 For the purposes of reporting to the advancing care information performance category, does an eligible clinician (EC) or group practice need to include data from certified electronic health records technology (CEHRT) certified to the criteria for an inpatient setting?</td>
<td>No, if the CEHRT is not equipped with all the capabilities necessary for an EC to satisfy the advancing care information measures, or is part of a CEHRT specific to an inpatient setting, the EC does not need to include data from that CEHRT in their calculations.</td>
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<td>1215 What if my certified electronic health record technology (CEHRT) is decertified?</td>
<td>If your CEHRT is decertified, you can still use that CEHRT to submit your advancing care information performance category measures if your performance period ended before the decertification occurred. If your performance period ended after the decertification occurred, you can apply for a hardship exception.</td>
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