GENERAL		
FAQ Number	**Question**	**Answer**
2793	What is meaningful use, and how does it apply to the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?	Under the Health Information Technology for Economic and Clinical Health (HITECH Act), which was enacted under the American Recovery and Reinvestment Act of 2009 (Recovery Act), incentive payments are available to eligible professionals (EPs), critical access hospitals, 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: 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: FAQ10084 Archived 12/15/2015

HARDSHIP EXCEPTIONS		
FAQ Number	**Question**	**Answer**
14113	On the new hardship application form for the 2017 payment adjustment, there is nothing which says documentation is required to be submitted with the application form. Does this mean that CMS will only require the selection of a hardship category and the completion of the provider's identifying information in order to approve a hardship exception; or will CMS be reviewing the application and documentation on a case-by-case basis for each provider?	CMS does not require an EP, eligible hospital, or CAH – or any group of providers – to submit documentation for the hardship category selected and CMS will not be reviewing documentation supporting the application on a case-by-case basis. CMS will review the application to record the category selected and use the identifying information to approve the hardship exception for each provider listed on the application. Providers should retain documentation of their circumstances for their own records, but no such documentation is required for review by CMS.

ATTESTATION		
FAQ Number	**Question**	**Answer**
3209	To what attestation statements must an eligible professional (EP), eligible hospital, or critical access hospital (CAH) agree in order to submit an attestation, successfully demonstrate meaningful use, and receive an incentive payment under the Medicare Electronic Health Record (EHR) Incentive Program?	Currently, the attestation process requires EPs, eligible hospitals, and CAHs to indicate that they agree with the following attestation statements: The information submitted for clinical quality measures (CQMs) was generated as output from an identified certified EHR technology. The information submitted is accurate to the knowledge and belief of the EP or the person submitting on behalf of the EP, eligible hospital, or CAH.The information submitted is accurate and complete for numerators, denominators, exclusions, and measures applicable to the EP, eligible hospital, or CAH. The information submitted includes information on all patients to whom the measure applies. For CQMs, a zero was reported in the denominator of a measure when an EP, eligible hospital or CAH did not care for any patients in the denominator population during the EHR Reporting Period. CMS considers information to be accurate and complete for CQMs insofar as it is identical to the output that was generated from certified EHR technology. Numerator, denominator, and exclusion information for CQMs must be reported directly from information generated by certified EHR technology. By agreeing to the above statements, the EP, eligible hospital, or CAH is attesting that the information for CQMs entered into the Registration and Attestation System is identical to the information generated from certified EHR technology. CMS does not require EPs, eligible hospitals, or CAHs to provide any additional information beyond what is generated from certified EHR technology in order to satisfy the requirement for submitting CQM information. Please note that quality performance results for CQMs are not being assessed at this time under the EHR Incentive Programs. Complete and accurate information for the remaining meaningful use core and menu set measures does not necessarily have to be entered directly from information generated by certified EHR technology. By definition, for each meaningful use objective with a percentage-based measure, certified EHR technology must include the capability to electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage for these measures. However, with the exception of CQMs, meaningful use measures do not specify that this capability must be used to calculate the numerators and denominators. EPs, eligible hospitals, and CAHs can use a separate, uncertified system to calculate numerators and denominators and to generate reports on all measures of the core and menu set meaningful use objectives except CQMs. In order to provide complete and accurate information for certain of these measures, they may also have to include information from paper-based patient records or from records maintained in uncertified EHR technology. By agreeing to the above statements, the EP, eligible hospital, or CAH is attesting to providing all of the information necessary from certified EHR technology, uncertified EHR technology, and/or paper-based records in order to render complete and accurate information for all meaningful use core and menu set measures except CQMs. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10589
8035	Can attestation information submitted for the Electronic Health Records (EHR) Incentive Programs be updated, changed, cancelled or withdrawn after successful submission in the EHR Registration and Attestation System?	Once a provider has submitted their attestation and has been either locked for payment or had an incentive payment issued, they will not have the ability to amend the information in the attestation system. It is the provider's responsibility to maintain records that demonstrate they have met meaningful use requirements and determine whether corrections to their attestation information would enable them to continue to demonstrate meaningful use. If the provider is not able to demonstrate meaningful use with the amended data, it is the provider's responsibility to complete the Medicare EHR Incentive Program Return Payment/Withdrawal Form and follow the instructions on the form explaining how to return their EHR incentive payment. Further instructions on the steps necessary to withdraw an attestation from the EHR Incentive Program can be found on the Medicare Incentive Payment Withdrawal Form. Medicare Incentive Payment Withdrawal Form: "https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Medicare_EHR_Incentive_Withdrawal_Final.pdf" Providers may access the online Meaningful Use Attestation Calculator tool found at to enter their amended data and test whether they would continue to demonstrate meaningful use. An EP or hospital wishing to change or withdraw their attestation from a Medicaid EHR Incentive Program should contact their state directly to make this request. Please note that the Centers for Medicare and Medicaid Services (CMS) do not require providers who relied on flawed software for their attestation information to submit amended attestation data. For additional information, please see FAQ#6097. Created on 3/13/2013 Updated on 5/14/2013

ELIGIBILITY AND PARTICIPATION		
FAQ Number	**Question**	**Answer**
2771	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
2829	If patients are dually eligible for Medicare and Medicaid, can they be counted twice by hospitals in their calculations for incentive payment if they are applying for both Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?	For purposes of calculating the Medicaid share, a patient cannot be counted in the numerator if they would count for purposes of calculating the Medicare share. Thus, in this respect the inpatient bed day of a dually eligible patient could not be counted in the Medicaid share numerator. (See 1903(t)(5)(C), stating that the numerator of the Medicaid share does not include individuals "described in section 1886(n)(2)(D)(I).") In other respects; however, the patient would count twice. For example, in both cases, the individual would count in the total discharges of the hospital. To view the Stage 1 final rule, please visit: a http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf" .pdf For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10106
2821	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 t 495.306(h)(4), which says: "(4) The clinic or group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way. "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: FAQ10101
2883	If an eligible professional (EP) is unable to meet the measure of a Meaningful Use objective because it is outside of the scope of his or her practice, will the EP be excluded from meeting the measure of that objective under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?	Some Meaningful Use objectives provide exclusions and others do not. Exclusions are available only when our regulations specifically provide for an exclusion. EPs may be excluded from meeting an objective if they meet the circumstances of the exclusion. If an EP is unable to meet a Meaningful Use objective for which no exclusion is available, then that EP would not be able to successfully demonstrate Meaningful Use and would not receive incentive payments under the Medicare and Medicaid EHR Incentive Programs. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10151
7737	If I participated in the Medicaid Electronic Health Records (EHR) Incentive Program last year, am I required to participate in the following year?	No. Medicaid providers are not required to participate in consecutive years of the EHR Incentive Program. Providers who skip years of participation will resume the progression of Meaningful Use (MU) where they left off. All providers are required to meet two years of Stage 1 in their first two years of MU and then proceed to Stage 2, regardless of not participating in consecutive years. (Note that there is an exception to that general rule for providers who demonstrated MU in 2011. These providers need not move to Stage 2 until 2014.) Note that eligible professionals who wish to maximize their incentive payments must qualify for an incentive payment for six years, but they can begin receiving payments no later than 2016, and may not receive payments after 2021. Also note that after 2016, eligible hospitals must have participated in the previous year in order to receive a payment. For more information on what your meaningful use and incentive payment timeline will be, please see the timeline widget at http://cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Participation-Timeline.html" Updated on 2/27/2013
2931	If a dually-eligible hospital initially registers only for the Medicaid EHR Incentive Program, but later decides that it wants to also register for the Medicare EHR Incentive Program, can it go back and change its registration from Medicaid only to both Medicare and Medicaid?	Hospitals that are eligible for EHR incentive payments under both Medicare and Medicaid should select "Both Medicare and Medicaid" during the registration process, even if they plan to apply only for a Medicaid EHR incentive payment by adopting, implementing, or upgrading certified EHR technology. Dually-eligible hospitals can then attest through CMS for their Medicare EHR incentive payment at a later date, if they so desire. It is important for a dually-eligible hospital to select "Both Medicare and Medicaid" from the start of registration in order to maintain this option. Hospitals that register only for the Medicaid program (or only the Medicare program) will not be able to manually change their registration (i.e., change to "Both Medicare and Medicaid" or from one program to the other) after a payment is initiated and this may cause significant delays in receiving a Medicare EHR incentive payment. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10267
3215	In order to meet the participation threshold of 50 percent of patient encounters in practice locations equipped with certified electronic health record (EHR) technology for the Medicare and Medicaid EHR Incentive Programs, how should patient encounters be calculated?	To be a meaningful EHR user, an EP must have 50 percent or more of their patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with certified EHR technology. For the purpose of calculating this 50 percent threshold, any encounter where a medical treatment is provided and/or evaluation and management services are provided should be considered a "patient encounter. "Please note that this is different from the requirements for establishing patient volume for the Medicaid EHR Incentive Program. You may wish to review those FAQs and other requirements related to Medicaid patient volume, since there is variation in what is considered to be a patient encounter. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10592
3309	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
8231	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 measure. The numerator for the following meaningful use measures should include only actions that take place within the EHR reporting period: Preventive Care (Patient Reminders) and Secure Electronic Messaging. For all other meaningful use measures, the actions may reasonably fall outside the EHR reporting period timeframe but must take place no 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 year 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?faqId=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

GROUP REPORTING		
FAQ Number	**Question**	**Answer**
2781	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?	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: 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" FAQ10076 Updated 5/12/2016

PLACE OF SERVICE		
FAQ Number	**Question**	**Answer**
2843	A number of measures for Meaningful Use objectives for eligible hospitals and critical access hospitals (CAHs) include patients admitted to the Emergency Department (ED). Which ED patients should be included in the denominators of these measures for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?	There are two methods for calculating ED admissions for the denominators for measures associated with Meaningful Use objectives. Eligible hospitals and CAHs must select one of the methods below for calculating ED admissions to be applied consistently to all denominators for the measures. That is, eligible hospitals and CAHs must choose either the "Observation Services method" or the "All ED Visits method" to be used with all measures. Providers cannot calculate the denominator of some measures using the "Observation Services method," while using the "All ED Visits method" for the denominator of other measures. Before attesting, eligible hospitals and CAHs will have to indicate which method they used in the calculation of denominators (77 FR 53984). Observation Services method. When using this method, the denominator should include the following visits to the ED: The patients who are admitted to the inpatient department (Place of Service (POS) 21) either directly or through the emergency department. The patients who are initially presented to the emergency department (POS 23) and receive observation services. Patients who receive observation services under both POS 22 and POS 23 should be included in the denominator. Details on observation services can be found in the Medicare Benefit Policy Manual, Chapter 6, Section 20.6. All ED Visits method. An alternate method for computing admissions to the ED is to include all ED visits (POS 23 only) in the denominator for all measures requiring inclusion of ED admissions. All actions taken in the inpatient or emergency departments (POS 21 and 23) of the hospital would count for purposes of determining meaningful use. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms 5/12/2016
2991	Are nursery days and nursery discharges (for newborns) included as acute-inpatient services in the calculation of hospital incentives for the Medicare and Medicaid EHR Incentive Programs?	No, nursery days and discharges are not included in inpatient bed-day or discharge counts in calculating hospital incentives. We exclude nursery days and discharges because they are not considered acute inpatient services based on the level of care provided during a normal nursery stay. Pages 44450 and 44453 of the Stage 1 final rule preamble explain that for the Medicare calculation, the statutory language clearly restricts discharges and inpatient bed-days to those from the acute care portion of a hospital. This is because of the definition of "eligible hospital" in section 1886(n)(6)(B) of the Social Security Act. Page 44497 of the Stage 1 final rule explains that statutory parameters placed on Medicaid incentive payments to hospitals are largely based on the methodology applied to Medicare incentive payments. Therefore, as Medicaid is held to the same parameters as Medicare, the same limitations on counting inpatient bed-days and total discharges apply to Medicaid hospital incentive calculations. To view the Stage 1 final rule for the Medicare and Medicaid EHR incentive programs, please visit: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf" .For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10361
3213	If an eligible hospital or critical access hospital (CAH) has a rehabilitation unit or a psychiatric unit that is part of the inpatient department and that bills under Place of Service (POS) code 21, but that is excluded from the inpatient prospective payment system (IPPS), should patients from these units be included in the denominator for the measures of meaningful use objectives for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?	No. CMS specified in the final rule that the statutory definition of "hospital" used in the EHR Incentive Program does not apply to hospitals and hospital units excluded from IPPS, such as rehabilitation or psychiatric units (75 FR 44448). Therefore, patients treated in these units should not be included in the denominators of measures. If patients are treated in either an inpatient rehabilitation or inpatient psychiatric unit but are also admitted to areas of the inpatient department that are part of the "subsection (d) hospital," then those patients and the actions taken for those patients outside of the inpatient rehabilitation or inpatient psychiatric units should be counted in the numerators and denominators for the meaningful use measures. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10591
3261	How should nursery day patients be counted in the denominators of meaningful use measures for eligible hospitals and critical access hospitals (CAHs) for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?	Nursery days are excluded from the calculation of hospital incentives because they are not considered inpatient-bed-days based on the level of care provided during a normal nursery stay. In addition, nursery day patients should not be included in the denominators of meaningful use measures. However, if the eligible hospital or critical access hospital's (CAH's) certified EHR technology cannot readily identify and exclude nursery day patients, those patients may be included in the calculations for the denominators of meaningful use measures. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10641
3077	If an eligible professional (EP) sees a patient in a setting that does not have certified electronic health record (EHR) technology but enters all of the patient's information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of meaningful use measures for the Medicare and Medicaid EHR Incentive Programs?	Starting in 2013, an EP must have access to Certified EHR Technology at a location in order to include patients seen in locations in the determination of whether they meet the threshold of 50% of patient encounters at locations equipped with Certified EHR Technology to be eligible for the EHR Incentive Program. However, if the EP meets this threshold and also includes information on patient encounters at locations where they do not have access to Certified EHR Technology, information about those encounters can be included when calculating the numerators and denominators for the meaningful use measures. For information about the patient encounters threshold, please visit FAQ 3215. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms 08/20/2013
2765	For eligible professionals (EPs) who see patients in both inpatient and outpatient settings (e.g., hospital and clinic), and where certified electronic health record (EHR) technology is available at each location, should these EPs base their denominators for meaningful use objectives on the number of unique patients in only the outpatient setting or on the total number of unique patients from both settings?	In this case, EPs should base both the numerators and denominators for meaningful use objectives on the number of unique patients in the outpatient setting, since this setting is where they are eligible to receive payments from the Medicare and Medicaid EHR Incentive Programs. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10068
3061	How is hospital-based status determined for eligible professionals in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?	A hospital-based eligible professional (EP) is defined as an EP who furnishes 90% or more of their covered professional services in either the inpatient (Place of Service 21) or emergency department (Place of Service 23) of a hospital. Covered professional services are physician fee schedule (PFS) services paid under Section 1848 of the Social Security Act. CMS uses PFS data from the Federal fiscal year immediately preceding the calendar year for which the EHR incentive payment is made (that is, the "payment year") to determine what percentage of covered professional services occurred in either the inpatient (Place of Service 21) or emergency department (Place of Service 23) of a hospital. The percentage determination is made based on total number of Medicare allowed services for which the EP was reimbursed, with each unit of a CPT billing code counting as a single service. States will use claims and/or encounter data (or equivalent data sources at the State's option) to make this determination for Medicaid. States may use data from either the prior fiscal or calendar year. EPs can learn whether or not they are considered hospital based for the Medicare EHR Incentive Program by registering now for the Medicare EHR Incentive Program. For the Medicaid EHR Incentive Program, EPs should contact their states for more information. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10464
3065	For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, should patient encounters in an ambulatory surgical center (Place of Service 24) be included in the denominator for calculating that at least 50 percent or more of an eligible professional's (EP's) patient encounters during the reporting period occurred at a practice/location or practices/locations equipped with certified EHR technology?	Yes. EPs who practice in multiple locations must have 50 percent or more of their patient encounters during the reporting period at a practice/location or practices/locations equipped with certified EHR technology. Every patient encounter in all Places of Service (POS) except a hospital inpatient department (POS 21) or a hospital emergency department (POS 23) should be included in the denominator of the calculation, which would include patient encounters in an ambulatory surgical center (POS 24). For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms"Keywords: FAQ10466
7811	If an eligible provider (EP) practices at an outpatient location, a location other than an inpatient (place of service 21) or emergency department (place of service 23), and that location is only equipped with Certified Electronic Health Records (EHR) Technology certified to the criteria applicable to an inpatient setting, must the EP include that location in their meaningful use calculations?	No, this location is not equipped with Certified EHR Technology with all the capabilities necessary for an EP to satisfy the meaningful use objectives and measures. Accordingly, this location (like all outpatient locations) would be in the denominator of the calculation to determine whether the EP's outpatient encounters meet the 50 percent threshold, but not in the numerator as the location is not equipped with Certified EHR Technology. Also the location would not be included in the calculations of the EP's meaningful use measures in either the denominator or the numerator. However, an EP can consider the location equipped with Certified EHR Technology if they have access to Certified EHR Technology certified to the criteria applicable to an ambulatory setting, which fills the gaps between inpatient and ambulatory. FAQ#3077 explains access to Certified EHR Technology, and ONC FAQ #6-12-025-2 outlines the gaps between inpatient and ambulatory Certified EHR Technology. If the EP chooses to equip the location with Certified EHR Technology with the applicable criteria, the EP must then include that location in all calculations including both the 50 percent threshold calculation and the meaningful use measures calculations. FAQ Created on 2/26/2013 Updated on 10/23/2013
3067	For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, does an eligible hospital have to count patients admitted to both the inpatient and emergency departments in the denominator of meaningful use measures, or can they count only emergency department patients?	For the hospital meaningful use objectives, the denominator is all unique patients admitted to an inpatient (POS 21) or emergency department (POS 23), which means all patients admitted to an inpatient department (POS 21) and all patients admitted to an emergency department (POS 23). If the eligible hospital elects to use the alternate method for calculating emergency department patients, as detailed in FAQ #10126 https://questions.cms.gov/faq.php?id=5005 faqId=2843" the denominator is all unique patients admitted to an inpatient department (POS 21) and all patients that initially present to the emergency department and are treated in the emergency department's observation unit or otherwise receive observation services, which includes patients who receive observation services under both POS 22 and POS 23. Patients admitted to the inpatient department must be included in the denominator of all applicable measures. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10468 Archived 12/15/2015

3609	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
7815	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
3259	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

AUDITS		
FAQ Number	**Question**	**Answer**
3677	Will EHR Incentive Payments be subject to audits under OMB Circular A-133?	Incentive payments made to eligible professionals, eligible hospitals and critical access hospitals under the Medicare and Medicaid EHR Incentive Programs are not subject to audit under OMB Circular A-133. However, these payments are subject to audit by the EHR Incentive Programs. Federal funding received by states following CMS approval of their Health Information Technology Planning Advance Planning Documents (HIT PAPDs) and Health Information Technology Implementation Advance Planning Documents (HIT IAPDs) for the planning and implementation of Medicaid EHR Incentive Programs is subject to audit under OMB Circular A-133. Federal funding that states receive to disburse as Medicaid EHR incentive payments is also subject to audit under OMB Circular A-133. Additional guidance on how OMB Circular A-133 applies to the Medicare and Medicaid EHR Incentive Programs is available in the A http://www.cms.gov/EHRIncentivePrograms/60_RegulationsNotices.asp#TopOfPage" section of the EHR Incentive Programs website A http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/OMB_Circular_-A-133_Guidance_EHR_Incentive_Programs.pdf. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10886
6097	I entered numerator and denominator information during my Medicare Electronic Health Record (EHR) Incentive Program attestation from my certified EHR technology, but subsequently discovered that the method of calculation included in the software was flawed. The software vendor has updated the reports. If CMS audits me, will I be held responsible for the difference between what I reported and what the updated software calculates?	CMS does not plan to conduct an audit to find providers who relied on flawed software for their attestation information. We realize that providers relied on the software they used for accuracy of reporting, and we believe that most providers who were improperly deemed meaningful users would have met the requirements of the EHR Incentive Programs using the updated certified EHR technology. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ2001
7711	Will the Centers for Medicare & Medicaid Services (CMS) conduct audits as part of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?	Any provider attesting to receive an EHR incentive payment for either the Medicare or Medicaid EHR Incentive Program potentially can be subject to an audit. Here's what you need to know to make sure you're prepared: Overview of the CMS EHR Incentive Programs Audits• All providers attesting to receive an EHR incentive payment for either the Medicare or Medicaid EHR Incentive Programs should retain ALL relevant supporting documentation (in either paper or electronic format) used in the completion of the Attestation Module responses. Documentation to support the attestation should be retained for six years post-attestation. Documentation to support payment calculations (such as cost report data) should continue to follow the current documentation retention processes.• CMS, and its contractors, will perform audits on Medicare and dually-eligible (Medicare and Medicaid) providers.• States, and their contractors, will perform audits on Medicaid providers.• CMS and states will also manage appeals processes. Preparing for an Audit• To ensure you are prepared for a potential audit, save the electronic or paper documentation that supports your attestation. Also save the documentation that supports the values you entered in the Attestation Module for Clinical Quality Measures (CQMs). Hospitals should also maintain documentation that supports their payment calculations.• Upon audit, the documentation will be used to validate that the provider accurately attested and submitted CQMs, as well as to verify that the incentive payment was accurate. Details of the Audits• There are numerous pre-payment edit checks built into the EHR Incentive Programs' systems to detect inaccuracies in eligibility, reporting, and payment. • Post-payment audits will also be completed during the course of the EHR Incentive Programs.• Medicare audit notification will come from Figliozzi and Company, or the EHR Meaningful Use Audit Team.• If, based on an audit, a provider is found to not be eligible for an EHR incentive payment, the payment will be recouped. • CMS has an appeals process for eligible professionals, eligible hospitals, and critical access hospitals that participate in the Medicare EHR Incentive Program.• States will implement appeals processes for the Medicaid EHR Incentive Program. For more information about these appeals, please contact your State Medicaid Agency. What information should an eligible professional, eligible hospital, or critical access hospital participating in the Medicare or Medicaid Electronic Health Record (EHR) Incentive Programs maintain in case of an audit? An audit may include a review of any of the documentation needed to support the information that was entered in the attestation. The level of the audit review may depend on a number of factors, and it is not possible to include an all-inclusive list of supporting documents. The primary documentation that will be requested in all reviews is the source document(s) that the provider used when completing the attestation. This document should provide a summary of the data that supports the information entered during attestation. Ideally, this would be a report from the certified EHR system, but other documentation may be used if a report is not available or the information entered differs from the report. This summary document will be the starting point of most reviews and should include, at minimum:• The numerators and denominators for the measures• The time period the report covers • Evidence to support that it was generated for that eligible professional, eligible hospital, or critical access hospital. Although the summary document is the primary review step, there could be additional and more detailed reviews of any of the measures, including review of medical records and patient records. The provider should be able to provide documentation to support each measure to which he or she attested, including any exclusions claimed by the provider. A few examples of additional support are as follows:• Drug-Drug/Drug-Allergy Interaction Checks and Clinical Decision Support – Proof that the functionality is available, enabled, and active in the system for the duration of the EHR reporting period.• Electronic Exchange of Clinical Information – Screenshots from the EHR system or other documentation that document a test exchange of key clinical information (successful or unsuccessful) with another provider of care. Alternately, a letter or email from the receiving provider confirming the exchange, including specific information such as the date of the exchange, name of providers, and whether the test was successful.• Protect Electronic Health Information – Proof that a security risk analysis of the certified EHR technology was performed prior to the end of the reporting period (e.g., report which documents the procedures performed during the analysis and the results). • Drug Formulary Checks – Proof that the functionality is available, enabled, and active in the system for the duration of the EHR reporting period.• Immunization Registries Data Submission, Reportable Lab Results to Public Health Agencies, and Syndromic Surveillance Data Submission– Screenshots from the EHR system or other documentation that document a test submission to the registry or public health agency (successful or unsuccessful). Alternately, a letter or email from registry or public health agency confirming the receipt (or failure of receipt) of the submitted data, including the date of the submission, name of parties involved, and whether the test was successful.• Exclusions – Documentation to support each exclusion to a measure claimed by the provider.For Medicare eligible professionals and for hospitals that are eligible for both Medicare and Medicaid EHR incentive payments - When a provider is selected for an audit, they will receive an initial request letter from the audit contractor. The request letter will be sent electronically by the audit contractor from a CMS email address and will include the audit contractor's contact information. The email address provided during registration for the EHR Incentive Program will be used for the initial request letter. The initial review process will be conducted at the audit contractor's location, using the information received as a result of the initial request letter. Additional information might be needed during or after this initial review process, and in some cases an on-site review at the provider's location could follow. A demonstration of the EHR system could be requested during the on-site review. A secure communication process has been established by the contractor, which will assist the provider to send any information that could be considered sensitive. Any questions pertaining to the information request should be directed to the audit contractor. States will have separate audit processes for their Medicaid EHR Incentive Program. For more information about these audit processes, please contact your State Medicaid Agency. Updated on 11/19/2013

PRIVACY AND SECURITY		
FAQ Number	**Question**	**Answer**
2807	Where can I get answers to my privacy and security questions about electronic health records (EHRs)?	The Office for Civil Rights (OCR) is responsible for enforcing the Privacy and Security rules related to the HITECH program. More information is available at OCR's website at http://www.hhs.gov/ocr/" Keywords: FAQ10092

MEDICAID		
FAQ Number	**Question**	**Answer**
3585	For the Medicaid EHR Incentive Program, can a non-hospital based eligible professional (EP) include their in-patient encounters for purposes of calculating Medicaid patient volume even if the patient is included in the eligible hospital's patient volume for the same 90-day period?	Yes, an EP who sees patients in an in-patient setting, and is not hospital based, can include the in-patient encounter in their Medicaid patient volume calculation. Both an eligible hospital and an EP can include an encounter from the same patient in their Medicaid patient volume calculations, respectively. This is because the services performed by the EP are distinct from those performed by the eligible hospital. Section 495.306 defines an encounter as a service rendered to an individual enrolled in a Medicaid program by either an EP or an eligible hospital. An EP who sees patients in an in-patient setting bills Medicaid for the services personally rendered by the EP, while at same time the hospital bills Medicaid for the services rendered by the hospital, such as the bed and medications. Given that these are two distinct sets of services for the same patient, both the eligible hospital and the EP can count them as an encounter for Medicaid patient volume if they happened to select the same 90-day period. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" keywords: FAQ10831
7537	The EHR Incentive Programs Stage 2 Rule describes changes to how a state considers CHIP patients in the Medicaid patient volume total when determining provider eligibility. Patients in which CHIP programs are now appropriate to be considered in the Medicaid patient volume total?	States that have offered CHIP as part of a Medicaid expansion under Title 19 or Title 21 can include those patients in their provider's Medicaid patient volume calculation as there is cost liability to the Medicaid program in either case (under the Stage 1 Rule, only CHIP programs created under a Medicaid expansion via Title 19 were eligible). Patients in standalone CHIP programs established under Title 21 are not to be considered part of the patient volume total (in Stage 1 or Stage 2). This change to the patient volume calculation is applicable to all eligible providers, regardless of the stage of the Medicaid EHR Incentive Program they are participating in. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms
2823	For the Medicaid Electronic Health Record (EHR) Incentive Program, if the EHR Reporting Period is calendar year (CY) 2013, then the payment year also refers to 2013 even though an eligible professional (EP) may receive the actual incentive payment in early 2014, correct?	The payment year is the year for which the payment is made (see 42 CFR 495.4 and the definition of "First, second, third, fourth, fifth, or sixth payment years."). So, the questioner is correct that if the EHR reporting period is in CY 2013, the payment year also refers to 2013. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10102
2825	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 1final rule explicitly stipulate that the 12-month period selected by the state for the Medicaid share data needs to be in the federal fiscal year (FY_ before the hospital's FY that serves as the first payment year. Am I correct in this interpretation? In other words, a state could use two different 12-month periods to calculate the discharge-related amount and the Medicaid share?	No, this is not correct. The regulation is clear that the discharge-related amount must be calculated using a 12-month period that ends in the Federal fiscal year before the hospital's fiscal year that serves as the first payment year. 42 CFR 495.310(g)(1)((I)(B). This statement also was made in the preamble, where we stated: "For purposes of administrative simplicity and timeliness, we require that States use data on the hospital discharges from the hospital fiscal year that ends during the Federal fiscal year prior to the fiscal year that serves as the first payment year" 75 FR 44498. In addition, the regulation indicates that the period that is used for the Medicaid share is the same period as that used for the discharge-related amount. See 42 CFR 495.310(g)(2)(I) referring to "the 12-month period selected by the State." Use of "the" in 495.310(g)(2) indicates that this is the same 12-month period that is used under 495.310(g)(1). In addition, we believe that using different periods for the Medicaid share versus the discharge-related amount would lead to inaccurate estimates, as data would be drawn from inconsistent periods. To view the Stage 1 final rule, please visit: "http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf" For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10104
2833	Is data sharing with neighboring States permitted regarding total Medicaid days for purposes of paying full incentives to hospitals or eligible professionals (EPs) with utilization in multiple states under the Medicaid Electronic Health Record (EHR) Incentive Program?	Yes. The CMS Stage 1 final rule clarifies the policy about calculating patient volume for Medicaid providers with clinical practices in more than one State, both in terms of what is "Medicaid patient volume" and about the cross-border issue. See 75 FR 44503, stating: "[W]e recommend that States consider the circumstances of border State providers when developing their policies and attestation methodologies. To afford States maximum flexibility to develop such policies, we will not be prescriptive about whether a State may allow a Medicaid EP to aggregate his/her patients across practice sites, if the State has a way to verify the patient volume attestation when necessary. States will propose their policies and attestation methodologies to CMS for approval in their State Medicaid HIT plans." However, as stated in the Stage 1 final rule, EPs and hospitals are permitted to receive payment from only one State in a payment year (495.310(e)).To view the Stage 1 final rule, please visit: href="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: FAQ10109
2835	Does a State have the option of solely using a state-submitted alternative methodology (pending CMS approval) for determining patient volume, or is the State additionally required to use one of the CMS specified methodologies (patient encounter or patient volume) for the Medicaid Electronic Health Record (EHR) Incentive Program?	Yes, the State can submit to us for approval only the alternative methodology that meets the requirements of 495.306(g). As we stated in the preamble to the Stage 1 final rule, we believe most States will not submit alternative methodologies until after the first year of the program, allowing for alternatives to recognize evolving State and provider experience with patient volume estimate methodologies. We recommend that States consider the methodologies that were put forward in the Stage1 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: FAQ10110
3079	If a State utilizes the option to include patient panels when looking at patient volume for the Medicaid EHR Incentive Program, what does it mean to have "unduplicated encounters"?	The requirements for this option to calculate patient volume are to account for eligible professionals treating patients in a care management role (often managed care or a medical home), as well as any additional encounters outside of a care management arrangement (often fee-for-service). When a State has leveraged this option, the calculation is: Total Medicaid patients* assigned to the provider in any representative continuous 90-day period in the preceding calendar year with at least one encounter in the calendar year preceding the start of the 90-day period] -PLUS- [Unduplicated Medicaid encounters* in that same 90-day period] DIVIDED BY-[Total patients assigned to the provider in the same 90-day with at least one encounter in the calendar year preceding the start of the 90-day period] -PLUS- [All unduplicated encounters in that same 90-day period] *Note that this same equation applies to making a determination for Needy Individual patient volume, where "Medicaid" is substituted by "Needy Individuals." In this calculation, "unduplicated" simply means that an eligible professional may not include the same encounters more than once. There may be multiple encounters with patients (even with patients included on the panel), but these may not be counted in more than one place in the equation. In addition, as noted in the preamble of the July 28, 2010 Federal Register (page 44488), the "unduplicated encounters" would only be encounters with non-panel Medicaid patients that occurred during the representative 90-day period. As the question notes, not all States will use this option in determining patient volume. Please talk to your State or visit their website (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 A href="http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10476
3119	Under the Medicaid EHR Incentive Program, will the requirement that eligible professionals and eligible hospitals choose at least one public health objective among the meaningful use measures still apply to those States that ask CMS for approval to change the definition of meaningful use? That is, if a State wants to require Immunization reporting, is the provider still required to choose another public health objective or does the new meaningful use definition in that State supersede the general definition?	If the State required any of the public health measures as core measures for the Medicaid EHR Incentive Program, then that would fulfill the eligible professional's (EP) requirement to select at least one public health measure. If the EP meets the exclusion criteria for any of the public health measures that a State has moved to the core set, with CMS approval, they would still have to select at least one public health measure from the menu set. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10532
3501	Per CMS #3017 (or old FAQ #10417), my tribal clinic is considered a Federally Qualified Health Center (FQHC) for the Medicaid EHR Incentive Program. So our eligible professionals (EPs) need to have 30% "needy individual" patient volume in order to qualify. I understand that needy individual encounters include encounters covered by Medicaid, the Children's Health Insurance Program (CHIP), a sliding fee scale or uncompensated care. My clinic receives Indian Health Services (IHS) funding which only partially offsets the cost of these encounters that are not covered by Medicaid or CHIP, but my clinic does not impose costs on these individuals and does not have a sliding fee scale, so how do I count them?	Since your clinic receives IHS funding, the encounters are not truly "uncompensated", but the encounters would be considered services furnished at no cost (even if your clinic does not have a sliding fee scale), and therefore can be counted towards needy individual patient volume for tribal clinic-based EPs applying for the Medicaid EHR Incentive Program. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10787

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 Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10523
3107	Are the criteria for needy patient volumes under the Medicaid EHR Incentive Program only applied to eligible professionals (EPs) practicing predominantly in Federally Qualified Health Centers (FQHCs) and/or Rural Health Clinics (RHCs), or can they also apply to hospital patient volumes?	Criteria for minimum patient volumes attributable to needy individuals apply only to EPs practicing predominantly in an FQHC or RHC. These criteria do not apply to hospital patient volumes. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10526
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 (SMHP)? When are the SMHPs due?	Yes, if a State wishes to request flexibility with the definition of meaningful use, to the extent permissible under the Medicare and Medicaid EHR Incentive Programs final rule, it would do so via its SMHP. There is no due date for SMHPs. States are implementing their Medicaid EHR Incentive Programs on a rolling basis. The SMHPs are therefore expected to be iterative, as States implement their programs incrementally, especially in the early years. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentiveProgram words: FAQ10533
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 Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10534
3373	How does CMS define pediatrician for purposes of the Medicaid EHR Incentive Program?	CMS does not define pediatrician for this program. Pediatricians have special eligibility and payment flexibilities offered under the program and it is up to States to define pediatrician, consistent with other areas of their Medicaid programs. You can find your State's contact information http://www.cms.gov/apps/files/statecontacts.pdf" here For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10715
5995	For the Medicaid EHR Incentive Program, how do we determine Medicaid patient volume for procedures that are billed globally, such as obstetrician (OB) visits or some surgeries? Such procedures are billed to Medicaid at a global rate where one global rate might cover several visits.	CMS leaves it up to the states how to operationalize the patient volume considerations of global payments with the following guidance: the numerator and denominator must be incorporated consistently. The total encounters can be kept global, or broken down into individual visits. If a global payment is broken down into separate visits in the numerator, then for purposes of the denominator, the state must break down any other global payments received from other payers. We recognize this could be administratively challenging and are open to reviewing strategies for doing this that may involve sampling (e.g., if the Medicaid global payment for OB averages 12 visits, we would expect to see the numerator expanded to 12 visits for Medicaid encounters, and a denominator constructed using sample data from a random file review that similarly breaks down any global payments into separate visits for Medicaid and non-Medicaid payers). Additionally, if the state's approach to global payments excludes providers from the Medicaid EHR Incentive Program who would otherwise be eligible, the state must create a mechanism to re-review their eligibility. Keywords: FAQ10957
2817	The billing provider on a claim is an eligible professional (EP) but the performing provider type is not an EP. If we use claims to validate patient volume or meaningful use for the Medicaid Electronic Health Record (EHR) Incentive Program, should we count performing providers (person rendering the service) or the billing provider?	In establishing an encounter for purposes of patient volume, please see the regulations at 495.306(e)(2)(I)-(ii) at 75 FR 44579. Furthermore, in estimating patient volume for any EP or hospital, we do not specify any requirements around billing, but rather we discuss patients. For example, if a physician's assistant (PA) provides services, but they are billed through the supervising physician, it seems reasonable that a State has the discretion to consider the patient as part of the patient volume for both professionals. However, this policy would need to be applied consistently. In this scenario, using services provided by the PA but billed under the physician in the physician's numerator (e.g., Medicaid encounters) also would increase the physician's denominator (all encounters), because the State would need to adequately reflect the total universe of patients (both Medicaid and non-Medicaid) who the PA saw, but for whom the physician billed. In terms of meaningful use, because each eligible professional must demonstrate meaningful use of certified EHR technology him ;or herself, if the State cannot not distinguish between the physician's claims and the PA's individual claims, then this would not be an adequate audit methodology. To view the final rule, please visit: 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" Keywords: FAQ10098
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?	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 practices/locations equipped with certified EHR technology capable of meeting all of the meaningful use objectives. Therefore, States should collect information on meaningful users' practice locations in order to validate this requirement in an audit. Patient volume: Eligible professionals may choose one (or more) clinical sites of practice in order to calculate their patient volume. This calculation does not need to be across all of an eligible professional's sites of practice. However, at least one of the locations where the eligible professional is adopting or meaningfully using certified EHR technology should be included in the patient volume. In other words, if an eligible professional practices in two locations, one with certified EHR technology and one without, the eligible professional should include the patient volume at least at the site that includes the certified EHR technology. When making an individual patient volume calculation (i.e., not using the group/clinic proxy option), a professional may calculate across all practice sites, or just at the one site. For more information on applying the group/clinic proxy option, see FAQ #10362 or here For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10416
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 Self-Determination and Education Assistance Act (Public Law 93-638, as amended) must be reimbursed as FQHCs in order to be considered FQHCs in the Medicaid EHR Incentive Program. CMS revised this policy and will allow any such tribal clinics, as well as urban clinics that are funded by urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act (Public Law 94-437, as amended) for the provision of primary health services http://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_pc_p3c19#3-19.2D to be considered as FQHCs for the Medicaid EHR Incentive Program, regardless of their reimbursement arrangements. For more information on how FQHCs are defined, please see href="https://questions.cms.gov/faq.php?id=5005 faqId=3017" For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10417
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% 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 Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10522
2845	How does CMS define Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) for the purposes of the Medicaid EHR Incentive Program?	The Social Security Act at section 1905(l)(2) defines an FQHC as an entity which, "(I) is receiving a grant under section 330 of the Public Health Service Act, or (ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant and (II) meets the requirements to receive a grant under section 330 of the Public Health Service Act, (iii) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, and is determined by the Secretary to meet the requirements for receiving such a grant including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity; or (iv) was treated by the Secretary, for purposes of Part B of title XVIII, as a comprehensive Federally-funded health center as of January 1, 1990, and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act for the provision of primary health services. RHCs are defined as clinics that are certified under section 1861(aa)(2) of the Social Security Act to provide care in underserved areas, and therefore, to receive cost-based Medicare and Medicaid reimbursements. In considering these definitions, it should be noted that programs meeting the FQHC requirements commonly include the following (but must be certified and meet all requirements stated above): Community Health Centers, Migrant Health Centers, Healthcare for the Homeless Programs, Public Housing Primary Care Programs, Federally Qualified Health Center Look-Alikes, and Tribal Health Centers. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10127

2993	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 applying for the incentive through a different location (e.g., where an EP is practicing both inside and outside the clinic/group practice, such as part-time in two clinics)?	EPs may use a clinic or group practice's patient volume as a proxy for their own under three conditions: (1) The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);(2) there is an auditable data source to support the clinic's patient volume determination; and (3) so long as the practice and EPs decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data). The clinic or practice must use the entire practice's patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice. In order to provide examples of this answer, please refer to Clinics A and B, and assume that these clinics are legally separate entities. If Clinic A uses the clinic's patient volume as a proxy for all EPs practicing in Clinic A, this would not preclude the part-time EP from using the patient volume associated with Clinic B and claiming the incentive for the work performed in Clinic B. In other words, such an EP would not be required to use the patient volume of Clinic A simply because Clinic A chose to invoke the option to use the proxy patient volume. However, such EP's Clinic A patient encounters are still counted in Clinic A's overall patient volume calculation. In addition, the EP could not use his or her patient encounters from clinic A in calculating his or her individual patient volume. The intent of the flexibility for the proxy volume (requiring all EPs in the group practice or clinic to use the same methodology for the payment year) was to ensure against EPs within the same clinic/group practice measuring patient volume from that same clinic/group practice in different ways. The intent of these conditions was to prevent high Medicaid volume EPs from applying using their individual patient volume, where the lower Medicaid patient volume EPs then use the clinic volume, which would of course be inflated for these lower-volume EPs.CLINIC A (with a fictional EP and provider type)" EP #1 (physician): individually had 40% Medicaid encounters (80/200 encounters)" EP# 2 (nurse practitioner): individually had 50% Medicaid encounters (50/100 encounters)" Practitioner at the clinic, but not an EP (registered nurse): individually had 75% Medicaid encounters (150/200)" Practitioner at the clinic, but not an EP (pharmacist): individually had 80% Medicaid encounters (80/100)" EP #3 (physician): individually had 10% Medicaid encounters (30/300)" EP #4 (dentist): individually had 5% Medicaid encounters (5/100)" EP #5 (dentist): individually had 10% Medicaid encounters (20/200) In this scenario, there are 1200 encounters in the selected 90-day period for Clinic A. There are 415 encounters attributable to Medicaid, which is 35% of the clinic's volume. This means that 5 of the 7 professionals would meet the Medicaid patient volume criteria under the rules for the EHR Incentive Program. (Two of the professionals are not eligible for the program on their own, but their clinical encounters at Clinic A should be included.) The purpose of these rules is to prevent duplication of encounters. For example, if the two highest volume Medicaid EPs in this clinic (EPs #1 and #2) were to apply on their own (they have enough Medicaid patients to do that), the clinic's 35% Medicaid patient volume is no longer an appropriate proxy for the low-volume providers (e.g., EPs #4 and #5).If EP #2 is practicing part-time at both Clinic A, and another clinic, Clinic B, and both Clinics are using the clinic-level proxy option, each such clinic would use the encounters associated with the respective clinics when developing a proxy value for the entire clinic. EP #2 could then apply for an incentive using data from one clinic or the other. Similarly, if EP #4 is practicing both at Clinic A, and has her own practice, EP # 4 could choose to use the proxy-level Clinic A patient volume data, or the patient volume associated with her individual practice. She could not, however, include the Clinic A patient encounters in determining her individual
3111	For the Medicaid EHR Incentive Program, how are the reporting periods for Medicaid patient volume and for demonstrating meaningful use affected if an eligible professional (EP) skips a year or takes longer than 12 months between attestations?	Regardless of when the previous incentive payment was made, the following reporting periods apply for the Medicaid EHR Incentive Program:- For patient volume, an eligible professional (EP) should use any continuous, representative 90-day period in the prior calendar year. For demonstrating they are a meaningful users of Electronic Health Records (EHRs), EPs should use the EHR reporting period associated with that payment year (for the first payment year that an EP is demonstrating meaningful use, the reporting period is a continuous 90-day period within the calendar year; for subsequent years the period is the full calendar year). For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10528
3115	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/EHRIncentivePrograms" Keywords: FAQ10530
3117	Under the Medicaid EHR Incentive Program, can a qualifying eligible professional (EP) who is an employee of a federally-owned Indian Health Services facility (other than a tribally-owned facility or Federally Qualified Health Center) assign his/her incentive payment to the federally-owned facility in the same way as other EPs?	Yes, EPs are permitted to reassign their incentive payments to their employer or to an entity with which they have a contractual arrangement allowing the employer or entity to bill and receive payment for the EP's covered professional services, including a federally-owned Indian Health Services facility. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10531
7535	The EHR Incentive Programs Stage 1 Rule stated that, in order for a Medicaid encounter to count towards the patient volume of an eligible provider, Medicaid had to either pay for all or part of the service, or pay all or part of the premium, deductible or coinsurance for that encounter. The Stage 2 Rule now states that the Medicaid encounter can be counted towards patient volume if the patient is enrolled in the state's Medicaid program (either through the state's fee-for-service programs or the state's Medicaid managed care programs) at the time of service without the requirement of Medicaid payment liability. How will this change affect patient volume calculations for Medicaid eligible providers?	Importantly, this change affecting the Medicaid patient volume calculation is applicable to all eligible providers, regardless of the stage of the Medicaid EHR Incentive Program they are participating in. Billable services provided by an eligible provider to a patient enrolled in Medicaid would count toward meeting the minimum Medicaid patient volume thresholds. Examples of Medicaid encounters under this expanded definition that could be newly eligible might include: behavioral health services, HIV/AIDS treatment, or other services that might not be billed to Medicaid/managed care for privacy reasons, but where the provider has a mechanism to verify eligibility. Also, services to a Medicaid-enrolled patient that might not have been reimbursed by Medicaid (or a Medicaid managed care organization) may now be included in the Medicaid patient volume calculation (e.g., oral health services, immunization, vaccination and women's health services, , telemedicine/telehealth, etc.). Providers who are not currently enrolled with their state Medicaid agency who might be newly eligible for the incentive payments due to these changes should note that they are not necessarily required to fully enroll with Medicaid in order to receive the payment. In some instances, it may now be appropriate to include services denied by Medicaid in calculating patient volume. It will be appropriate to review denial reasons. If Medicaid denied the service for timely filing or because another payer's payment exceeded the potential Medicaid payment, it would be appropriate to include that encounter in the calculation. If Medicaid denied payment for the service because the beneficiary has exceeded service limits established by the Medicaid program, it would be appropriate to include that encounter in the calculation. If Medicaid denied the service because the patient was ineligible for Medicaid at the time of service, it would not be appropriate to include that encounter in the calculation. Further guidance regarding this change will be distributed to the states as appropriate. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms
2625	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 Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ9810
3103	When calculating Medicaid patient volume or needy patient volume for the Medicaid EHR Incentive Program, are eligible professionals (EPs) required to use visits, or unique patients?	There are multiple definitions of encounter in terms of how it applies to the various requirements for patient volume. Generally stated, a patient encounter is any one day where an individual enrolled in a Medicaid program receives service. The requirements differ for EPs and hospitals. In general, the same concept applies to needy individuals. Please contact your State Medicaid agency for more information on which types of encounters qualify as Medicaid/needy individual patient volume. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10524
3315	When calculating inpatient bed days for the Medicaid Electronic Health Record (EHR) Incentive Program, can Critical Access Hospitals (CAHs) exclude swing bed days from the average length of stay if this is consistent with how they complete the Medicare and Medicaid cost reports?	Swing beds days that are used to furnish skilled nursing facility (SNF) or nursing facility-level care would not normally be considered part of the inpatient acute-care part of the hospital, whereas swing bed days that are used to furnish inpatient-level care are part of the acute-care part of the hospital. However, for CAHs participating in the Medicaid EHR Incentive program, when there is no way to distinguish between days used to furnish SNF-level care versus inpatient acute-level care, we will allow States to exclude these days, if it is consistent with how the CAH completes the Medicare and Medicaid cost report. As the Medicaid EHR Incentive Program requires eligible acute care hospitals to have an average length of stay of 25 days or fewer, exclusion of swing bed days may facilitate CAH participation in the Medicaid EHR Incentive Program. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10668
5993	In order to qualify for payment under the Medicaid EHR Incentive Program for having adopted, implemented, or upgraded to (AIU) certified EHR technology, an eligible professional (EP) working at an Indian Health Services (IHS) clinic may be asked to submit to their State Medicaid Agency an official letter containing information about the clinic's electronic health record from IHS (which is an Operating Division of the United States Department of Health and Human Services). The information in this letter identifies the EHR vendor, the ONC Certified Heath IT Product List (CHPL) number of the EHR, as well as other information regarding the EHR product version and licensure. Does this letter meet states' documentation requirements for AIU?	Yes. This is an official letter from the United States Department of Health and Human Services and the IHS clinic generating this letter uses a certified EHR system created for the IHS. The state does not need to collect additional documentation for AIU (pre-payment or post-payment, or in the event of an audit) in instances where one of these letters is provided. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10956

7649	May a hospital include zero pay Medicaid eligible days in the Medicaid hospital EHR Incentive Program payment calculation?	No, zero pay Medicaid eligible days must be excluded from the Medicaid hospital incentive calculation. Section 1903(t)(5)(C) of the Act requires the Medicaid share to be calculated “in the same manner as the Medicare share. ” In all ways possible, the Medicaid hospital incentive calculation is similar to Medicare, based on this language. Medicare retrieves data for the calculation exclusively from the Medicare cost report. Although Medicaid offers additional flexibility in data sources, the data parameters for Medicaid are the same as Medicare. This is cited in the Stage 1 final rule where CMS said: “The statute requires us to calculate the Medicaid share ‘in the same manner’ as the Medicare share under section 1886(n)(2)(D) of the Act and such substitute service days would not be considered ‘in the same manner.’ Thus, we proposed that for purposes of the Medicaid formula, we would count only those days that would count as inpatient-bed-days for Medicare purposes under section 1886(n)(2)(D) of the Act.” In the CMS Stage 1 final rule, CMS also made clear: “[T]he EHR hospital incentive payment calculation requires the inclusion of only paid inpatient-bed-days.” 75 Fed. Reg. at 44500. Given this, a joint FAQ was published (FAQ # 3471) that mirrored cost report data sources for the calculation. Per the cost report instructions, all acute inpatient days must be paid. While CMS uses line 2 of worksheet S-3 part 1, which contains HMO data as well as other data used to calculate the Disproportionate Share Hospital (DSH) calculation (including zero pay days), Medicare is removing all of the DSH data from line 2 and using only the paid managed care days. Medicare does not include unpaid days as acute inpatient days, so following the same manner for Medicaid means using only paid days as well. Additionally, 1903(t)(5)(C) states that the Secretary establishes how the “inpatient bed-days” used in the Medicaid numerator are counted. The statute specifically says that the Medicaid share has as its numerator “the amount that is equal to the number of inpatient-bed-days (as established by the Secretary) which are attributable to individuals who are receiving medical assistance under this title.” By using only paid inpatient Medicaid days, the Secretary has “established” how she counts the number of inpatient bed days per statutory authority.
9822	For Eligible Professionals (EP) in the Medicaid Electronic Health Records (EHR) Incentive Program using the group proxy method of calculating patient volume, how should the EPs calculate patient volume using the “12 months preceding the EP’s attestation” approach, as not all of the EPs in the group practice may use the same 90-day period.	In the Stage 2 final rule, CMS adopted a final policy that allows states the option for their providers to calculate patient volume in any representative, continuous 90-day period in the 12 months preceding the eligible professional’s (EP) attestation (see 77 FR 54121, 42 CFR 495.306(b)). This option is in addition to the method of calculating patient volume in any representative, continuous 90-day period in the calendar year preceding the payment year for which the EP is attesting. For EPs who calculate patient volume at the group practice or clinic level under 42 CFR 495.306(h), although we expect the same 90-day period to be used for all EPs in the group practice or clinic, we understand this may not be feasible in scenarios where EPs attest on different dates. For example, for the 2013 payment year, if one EP in the group attested on April 1, 2013 and another EP in the group attested on February 1, 2014, there would not be a continuous 90-day period that occurred within the 12 months preceding the first EP’s attestation and also within the 12 months preceding the second EP’s attestation. In such scenarios where it would be impossible to use the same representative, continuous 90-day period for EPs in the group practice or clinic, we would allow different representative, continuous 90-day periods to be used, as long as all of the provisions of 42 CFR 495.306(h) are satisfied. For more information, please visit the Stage 2 Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.
2819	Do States need to verify the "installation" or "a signed contract" for adopt, implement, or upgrade (AIU) in the Medicaid EHR Incentive Program?	States should make clear to providers when they attest for AIU what documentation they must maintain, and for how long, in case of audit. If States determine that certain provider types are a high risk for potential fraud/abuse for AIU, then they can ask for some verification of adopting, implementation or upgrading but CMS encourages that this be done in a targeted manner, with the most electronic and simple means possible and not in such a way that would be burdensome to providers. For AIU, a provider does not have to have installed certified EHR technology. The definition of AIU in 42 CFR 495.302 allows the provider to demonstrate AIU through any of the following: (a) acquiring, purchasing or securing access to certified EHR technology capable of meeting meaningful use; (b) installing or commencing utilization of certified EHR technology capable of meeting meaningful use requirements; or (c) expanding the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the EHR certification criteria published by the Office of the National Coordinator of Health Information Technology (ONC). Thus, a signed contract indicating that the provider has adopted or upgraded would generally be sufficient. However, if a provider has been identified as high risk, states could further investigate the provider’s intention (or lack thereof) to AIU. While a signed contract indicating that the provider has adopted or upgraded might generally be sufficient to establish an intent to AIU, the state could still determine that other, contradictory evidence demonstrated that the provider in fact had no intent to AIU. In such cases, that contradictory evidence might outweigh the presence of a signed contract. For more information about the Medicare and Medicaid EHR Incentive Program, please visit "http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10100 Updated on 4/2/2014
2831	For calculation of a Medicaid hospital’s electronic health record (EHR) incentive payment, is the estimated growth rate for hospitals most recent three years based on growth in total days or growth in discharges?	The average annual growth rate should be for discharges (see 1903(t)(5)(B), referring to the annual rate of growth of the most recent 3 years for “discharge data.”) We agree that the sources are different. Hospitals would probably have to use MMIS or auditable hospital records to get accurate discharge data rate of growth. To view the Stage 1 ;final rule, please visit: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf" For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10108
2839	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 (AIU) certified EHR technology in their first year, the provider will not have to demonstrate meaningful use (MU) in order to receive payment. In the second year they will have to demonstrate MU for a 90 day period only. A provider that is already a meaningful user would have to demonstrate for a 90 day period the first year and subsequent years they would have to demonstrate it for the full year. The exception to this rule is for the year 2014. 24 CFR 495.4 establishes a one-time exception for providers attesting to meaningful use in 2014 during which the reporting period for Medicaid providers is any continuous 90-day period within the reporting year. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10112
3113	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 Medicaid Management Information System (MMIS) funding or Health Information Technology for Economic and Clinical Health (HITECH) funding. Governance only is relevant under the MMIS regulations, as it pertains to the matching rate determination. States should talk to CMS about their ideas in draft, informally, so that CMS can give a more State-specific response around appropriate funding, matching rates, etc. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10529
7809	What funding sources may States use to fund the 10% non-federal share of HITECH administrative expenditures?	States must fund the 10 percent non-federal share of the Health Information Technology (HITECH) Act administrative expenditures consistent with the law and regulations applicable to the non-federal share for all Medicaid expenditures. Consistent with that authority, which includes Social Security Act sections 1902(a)(2), 1903(a), 1903(w), and 42 CFR Part 433, subpart B, states may fund the non-federal share of Medicaid expenditures through legislative appropriations to the Medicaid agency, intergovernmental transfers (IGTs), certified public expenditures (CPEs), permissible health-care related taxes, and bona-fide donations. States must submit their proposed strategies for funding the non-federal share of HITECH administrative payments to CMS for review as part of the HIT plan approval process. CMS will review each individual State’s proposal to ensure that each proposed non-federal share funding source meets federal requirements. During this process, CMS can address specific questions about funding the non-federal share of Medicaid expenditures. CMS strongly urges States to work on their funding proposals with their CMS HIT Coordinators as early as possible before claiming for HITECH administrative expenditures, to ensure funding structures are appropriate. HITECH administrative expenditures, like other title XIX expenditures, are subject to audit, and federal funds may be at risk if funding sources are found not to be in compliance with federal requirements. Below are some statutory and regulatory citations pertaining to non-federal share financing requirements. Please note this is not an all-inclusive list of funding requirements. Use of Federal Funds Social Security Act §1903 42 CFR 433.51(c)•State Appropriations Social Security Act §1902(a)(2) 42 CFR 433.51•Intergovernmental Transfers Social Security Act §1903(w)(6)(A) 42 CFR 433.51•Certified Public Expenditures Social Security Act §1903(w)(6)(A)42 CFR 433.51 Healthcare-Related Taxes and Provider-Related Donations 42 CFR part 433, subpart B Created 2/7/2013
8902	Can a state capture electronic Clinical Quality Measures, or eCQMs, for the Medicaid EHR Incentive Program through a Health Information Exchange (HIE)	Yes, a state can capture clinical quality data for eCQMs using an HIE, and states should consider the health data landscape of their state when designing a system to collect eCQMs for the Medicaid EHR Incentive Program. Utilizing an HIE can allow the state to collect more sophisticated patient-level data, to encourage provider adoption, and to facilitate alignment between various programs, such as those authorized under the HITECH Act, Accountable Care Organizations, and Medical Homes. In order to use an HIE for quality data collection, a state would need to develop infrastructure to capture electronic clinical quality measures through the Quality Reporting Data Architecture (QRDA) format. In addition, eligible professionals and hospitals would either have to generate the QRDA files using the provider’s Certified EHR Technology and/or the HIE itself would have to be certified as an EHR module for eCQMs. The Office of the National Coordinator for Health Information Technology and CMS published a state-focused electronic clinical quality reporting toolkit to provide support for states developing the policy and IT infrastructure for electronic clinical quality measurement. Further, states can request Federal Financial Participation at the 90/10 HITECH rate to assist in building the infrastructure to submit eCQMs electronically for the Medicaid EHR Incentive program. For more information, please see the State Medicaid Directors Letter #11-004: http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/ Created on 7/24/2013
8037	Can eligible professionals (EPs) or eligible hospitals round their patient volume percentage when calculating patient volume in the Medicaid Electronic Health Records (EHR) incentive program?	To participate in the Medicaid EHR incentive program, EPs are required to demonstrate a patient volume of at least 30% Medicaid patients over a 90-day period in the prior calendar year or in the 12 months before attestation. The Centers for Medicare and Medicaid Services allow rounding 29.5% and higher to 30% for purposes of determining patient volume. Similarly, pediatric patient volume may be rounded from 19.5% and higher to 20%. Finally, acute care hospitals are required to demonstrate a patient volume of at least 10% Medicaid patients over a 90-day period in the prior fiscal year preceding the hospital's payment year or in the 12 months before attestation. Hospitals' patient volume may be rounded from 9.5% and higher to 10%. Created on 3/13/2013
2767	Are eligible professionals (EPs) who practice in State Mental Health and Long Term Care Facilities eligible for Medicaid electronic health record (EHR) incentive payments if they meet the eligibility criteria (e.g., patient volume, non-hospital based, certified EHR)?	The setting in which a physician, nurse practitioner, certified nurse-midwife, or dentist practices is not relevant in determining eligibility for the Medicaid EHR Incentive Program (except for purposes of determining whether an EP can qualify through "needy individual" patient volume). Setting is relevant for physician assistants (PA), as they are eligible only when they are practicing at a Federally Qualified Health Center (FQHC) that is led by a PA or a Rural Health Center (RHC) that is so led. All providers must meet all program requirements prior to receiving an incentive payment (e.g. adopt, implement or meaningfully use certified EHR technology, patient volume, etc.). For more information about the Medicare and Medicaid EHR Incentive Program, please visit "http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10069 Updated 5/12/2016

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/" FAQ #10717For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10771

OBJECTIVES AND MEASURES		
FAQ Number	**Question**	**Answer**
14401	For 2016, what alternate exclusions are available for the public health reporting objective?Is there an alternate exclusion available to accommodate the changes to how the measures are counted?	We do not intend to inadvertently penalize providers for changes to their systems or reporting made necessary by the provisions of the 2015 EHR Incentive Programs Final Rule. This includes alternate exclusions for providers for certain measures in 2016 which might require the acquisition of additional technologies they did not previously have or did not previously intend to include in their activities for meaningful use (80 FR 62945).For 2016, EPs scheduled to be in Stage 1 or Stage 2 must attest to at least 2 measures from the Public Health Reporting Objective Measures 1-3 and eligible hospitals or CAHs scheduled to be in Stage 1 or Stage 2 must attest to at least 3 public health measures from the Public Health Reporting Objective Measures 1-4. We will allow providers to claim an alternate exclusion for the Public Health Reporting measure(s) which might require the acquisition of additional technologies providers 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 2016 as follows: 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 • May claim an Alternate Exclusion for Measure 2 and Measure 3 (Syndromic Surveillance and Specialized Registry Reporting).• An Alternate Exclusion may only be claimed for up to two measures, then the provider must either attest to or meet the exclusion requirements for the remaining measure described in 495.22 (e)(10)(i)(C). 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 (Specialized Registry Reporting) • 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 measures described in 495.22 (e)(10)(ii)(C). Created 02/25/2016
2851	Who can enter medication orders in order to meet the measure for the computerized provider order entry (CPOE) meaningful use objective under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?	As mentioned in 80 FR 62798, a medical staff person who is a credentialed medical assistant or is credentialed to and performs the duties equivalent to a credentialed medical assistant may enter orders. We maintain our position that medical staff must have at least a certain level of medical training in order to execute the related CDS for a CPOE order entry. We defer to the provider to determine the proper credentialing, training, and duties of the medical staff entering the orders as long as they fit within the guidelines we have proscribed. We believe that interns who have completed their medical training and are working toward appropriate licensure would fit within this definition. We maintain our position that, in general, scribes are not included as medical staff that may enter orders for purposes of the CPOE objective. However, we note that this policy is not specific to a job title but to the appropriate medical training, knowledge, and experience. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10134 Date Updated: 05/12/2016
	For the meaningful use objective "Capability to submit electronic syndromic surveillance data to public health agencies," what is the definition of "syndromic surveillance"?	Syndromic surveillance uses individual and population health indicators that are available before confirmed diagnoses or laboratory confirmation to identify outbreaks or health events and monitor the health status of a community. For additional information about syndromic surveillance data, please visit: http://www.cdc.gov/EHRmeaningfuluse/Syndromic.html" For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: 10846
7623	In perioperative settings and emergent situations, medications and diagnostic studies are sometimes initiated by the provider without a formal order, or given by someone under direct supervision of the provider immediately following a verbal order and before any record of the order is created. How should those events be counted in the CPOE measure if they are subsequently recorded using the CPOE function of Certified EHR Technology by a licensed healthcare professional or certified medical assistant?	We agree that in some situations it may be impossible or inadvisable to wait to initiate an intervention until a record of the order has been created. For example, situations where an intervention is identified and immediately initiated by the provider, or initiated immediately after a verbal order by the ordering provider to a licensed healthcare professional under his/her direct supervision. Therefore in these situations, so long as the order is entered using CPOE by a licensed healthcare professional or certified medical assistant to create the first record of that order as it becomes part of the patient's medical record, these orders would count in the numerator of the CPOE measure. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms
11960	To meet public health objectives in the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs, when does the provider need to possess, own and/or install a Certified EHR Technology (CEHRT)?	Providers must own and have CEHRT installed by the first day of their EHR reporting period. There are certain core functions that must be fully functional on the first day and in use by the providers for their entire EHR reporting period. There is other functionality, including for the public health objectives, where the CEHRT may not be fully functional at the start of the provider's EHR reporting period and that is acceptable. Completing the implementation and making it fully functional would be part of the onboarding process with the public health agency. Created on 3/4/2015
11962	For Stage 2 of the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs, is it acceptable for providers to register their intent with the Public Health Agency (PHA) prior to the start of their EHR reporting period?	Yes, it is acceptable for providers to register with PHA prior to their EHR reporting period to begin communications and to help plan their resources for onboarding with the PHA. If registering their intent prior to the start of the EHR reporting period, the provider would not have to have Certified Electronic Health Record Technology (CEHRT) at that point, but must own and have CEHRT installed by the first day of their EHR reporting period. There are certain core functions that must be fully functional on the first day and in use by the providers for their entire EHR reporting period. There is other functionality, including for the public health objectives, where the CEHRT may not be fully functional at the start of the provider's EHR reporting period and that is acceptable. Completing the implementation and making it fully functional would be part of the onboarding process with the PHA. Created on 03/04/2015
11964	To meet public health objectives in the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs, must providers register their intent to submit data for Stage 2 of Meaningful Use during each year of participation to meet the measure?	No. Providers only need to register once, with the Public Health Agency (PHA) or other body to whom the provider will be submitting data, to indicate their intent to initiate ongoing submission of data to meet a public health objective. If in subsequent years of participation, providers have not progressed into testing and validation or ongoing submission (i.e. production) status, the documentation of the initial registration of intent may be used for attestation. PHAs may periodically ask providers to verify or update the information from the initial registration. PHAs use the information collected to manage communication and prioritization of their onboarding processes. Created 03/04/2015
11978	For the Stage 2 objectives of the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs that require submission of electronic data to Public Health Agencies (PHA), can a provider meet the objective even though they may not have successfully submitted data to the PHA for their entire EHR reporting period? Created 03/04/2015	Eligible professionals (EP) and hospitals may satisfy these objectives if they meet one of the four criteria for ongoing submission: 1. Ongoing submission was already achieved for an EHR reporting period in a prior year and continues throughout the current EHR reporting period. 2. Registration with the PHA or other body to whom the information is being submitted or intent to initiate ongoing submission was made by the deadline (within 60 days of the start of the EHR reporting period) and ongoing submission was achieved. 3.Registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is still engaged in testing and validation of ongoing electronic submission. 4. Registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is awaiting invitation to begin testing and validation. Providers that meet the last two of these criteria would not have achieved ongoing submission during their EHR reporting period. In addition, providers that meet the second criteria may not have ongoing submission for their entire EHR reporting period. In order to meet the objective, providers who have been invited by the PHA to begin the onboarding process must participate in that process. Providers who fail to participate in the onboarding process as demonstrated by failure to respond to the PHA written requests for action within 30 days on two separate occasions during their EHR reporting period would not meet the objective. Created 03/04/2015
11982	If an eligible professional (EP) or hospital meets an exclusion for a public health objective, does the EP or hospital need to have CEHRT that meets the certification criteria related to that public health objective?	If the EP or hospital qualifies for and attests to an exclusion for a public health measure, they would not need to have CEHRT that meets the certification criteria related to that public health objective. For example, if an EP does not give any immunizations during their EHR reporting period, they would not need to have CEHRT that meets the certification criteria related to the immunization reporting objective in order to attest to the exclusion. However, if the EP or hospital qualifies for an exclusion, but elects to try to meet objective, they would need to have and use CEHRT that meets the certification criteria for the objective. Created on 3/5/2015
11984	If an eligible professional (EP) in the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs is part of a group practice that has achieved ongoing submission to a public health agency (PHA), but the EP himself/herself did not administer any immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry during their EHR reporting period, can he/she attest to meeting the measure since they are part of the group practice that is submitting data to the registry?	If a provider does not administer immunizations, they should not attest to the measure; they must claim the exclusion. If a provider does administer immunizations, but did not have any for a particular EHR reporting period, they are not required to claim the exclusion as long as they have done any necessary registration and testing and are reporting when they do have the data to report. Created on 3/5/2015 Updated on 9/30/2015

2939	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 II–V http://www.deadiversion.usdoj.gov/schedules/index.html". Although the Drug Enforcement Administration's (DEA) interim final rule on electronic prescriptions for controlled substances (75 FR 16236) removed the Federal prohibition to electronic prescribing of controlled substances, some challenges remain including more restrictive state law and widespread availability of products both for providers and pharmacies that include the functionalities required by the DEA's regulations. We continue to exclude over the counter (OTC) medicines from the definition of a prescription (77 FR 53989). We continue to allow providers the option to include or exclude controlled substances in the denominator where such medications can be electronically prescribed. These prescriptions may be included in the definition of ''permissible prescriptions'' at the providers discretion where allowable by law (80 FR 62801). The denominator for this objective is "Number of permissible prescriptions written during the EHR reporting period for drugs requiring a prescription in order to be dispensed" for EPs" and "''Number of permissible new, changed, or refill prescriptions written for drugs requiring a prescription in order to be dispensed for patients discharged during the EHR reporting period'' for eligible hospitals and CAHs. The revised definition of permissible prescriptions allows providers the option of including or excluding prescriptions for controlled substances where the electronic prescription of controlled substances is permissible under state and federal law. Prescriptions from internal pharmacies and drugs dispensed on site may be excluded from the denominator. The numerator for this objective is a query of a drug formulary for EPs, eligible hospitals and CAHs. The provider may still count a patient in the numerator where no formulary exists to conduct a query and limit their effort to query a formulary to simply using the function available to them in their CEHRT with no further action required.The provider would include in the numerator and denominator both types of electronic transmissions (those within and outside the organization) for the measure of this objective. We further clarify that for purposes of counting prescriptions "generated and transmitted electronically," we consider the generation and transmission of prescriptions to occur simultaneously if the prescriber and dispenser are the same person and/or are accessing the same record in an integrated EHR to creating an order in a system that is electronically transmitted to an internal pharmacy. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10284 Updated 5/12/2016
3057	To meet the meaningful use objective "use computerized provider order entry (CPOE)" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, should eligible professionals (EPs) include hospital-based observation patients (billed under POS 22) whose records are maintained using the hospital's certified EHR system in the numerator and denominator calculation for this measure?	If the patient has records that are maintained in both the hospital's certified EHR system and the EP's certified EHR system, the EP should include those patients seen in locations billed under POS 22 in the numerator and denominator calculation for this measure. If the patient's records are maintained only in a hospital certified EHR system, the EP does not need to include those patients in the numerator and denominator calculation to meet the measure of the "use computerized provider order entry (CPOE)" objective. For more information about the Medicare and Medicaid EHR Incentive Program, please visit "https://questions.cms.gov/localadmin/%20http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10462
8904	Can a public health agency use a Health Information Exchange (HIE) to interface with providers who are submitting public health data to meet the public health objectives of meaningful use (such as submitting information to an immunization registry, reporting lab results to a public health agency or reporting syndromic surveillance information)?	There are a variety of methods for the exchange of public health information, and CMS does not limit or define the receiving capabilities of public health entities. Among other requirements as specified in the regulations, a provider must submit data for the public health objectives of meaningful use as follows• The information required by a public health meaningful use objective must originate from the provider's Certified Electronic Health Records Technology (CEHRT); and• The information sent from the provider's Certified EHR Technology must be formatted according to the standards and implementation specifications associated with the public health meaningful use objective.If a provider intends to use an intermediary as an extension of their CEHRT to satisfy a meaningful use requirement and not simply to transport the data, the intermediary would need to be certified as an EHR Module for that purpose; When obtaining a CMS certification number from the Certified HIT Products List (CHPL), a provider would need to include the intermediary's certification number during their attestation.Created on 7/24/2013
9058	When meeting the meaningful use measure for computerized provider order entry (CPOE) in the Electronic Health Records (EHR) Incentive Programs, does an individual need to have the job title of medical assistant in order to use the CPOE function of Certified EHR Technology (CEHRT) for the entry to count toward the measure, or can they have other titles as long as their job functions are those of medical assistants?	If a staff member of the eligible provider is appropriately credentialed and performs similar assistive services as a medical assistant but carries a more specific title due to either specialization of their duties or to the specialty of the medical professional they assist, he or she can use the CPOE function of CEHRT and have it count towards the measure This determination must be made by the eligible provider based on individual workflow and the duties performed by the staff member in question. Whether a staff member carries the title of medical assistant or another job title, he or she must be credentialed to perform the medical assistant services by an organization other than the employing organization. Also, each provider must evaluate his or her own ordering workflow, including the use of CPOE, to ensure compliance with all applicable federal, state, and local law and professional guidelines. Created: 08/20/2013
10660	For Measure 1 of the Stage 3 Health Information Exchange objective for the Electronic Health Records (EHR) Incentive Programs, may an eligible professional (EP), eligible hospital or critical access hospital (CAH) count a transition of care or referral in its numerator for the measure if they electronically create and send a summary of care document using their CEHRT to a third party organization that plays a role in determining the next provider of care and ultimately delivers the summary of care document?	Please note that beginning in Stage 3, the initiating provider must send a C–CDA document that the receiving provider would be capable of electronically incorporating as a C–CDA on the receiving end. In other words, if a provider sends a C–CDA and the receiving provider converts the C–CDA into a pdf or a fax or some other format, the sending provider may still count the transition or referral in the numerator. If the sending provider converts the file to a format the receiving provider could not electronically receive and incorporate as a C–CDA, the initiating provider may not count the transition in their numerator.
10754	How can a provider meet the "Protect Electronic Health Information" core objective in the Electronic Health Records (EHR) Incentive Programs?	To meet the "Protect Electronic Health Information" core objective for Stage 1, eligible professionals (EP), eligible hospitals or critical access hospitals (CAH) must conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process. In Stage 2, in addition to meeting the same security risk analysis requirements as Stage 1, EPs and hospitals will also need to address the encryption and security of data stored in the certified EHR technology (CEHRT). These steps may be completed outside or the EHR reporting period timeframe but must take place no earlier than the start of the EHR reporting year and no later than the provider attestation date. For example, a EP who is reporting Meaningful Use for a 90-day EHR reporting period may complete the appropriate security risk analysis requirements outside of this 90-day period as long as it is completed no earlier than January 1st of the EHR reporting year and no later than the date the provider submits their attestation for that EHR reporting period. This meaningful use objective complements but does not impose new or expanded requirements on the HIPAA Security Rule. In accordance with the requirements under (45 CFR 164.308(a)(1)(ii)), providers are required to conduct an accurate and thorough analysis of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information (ePHI). Once the risk analysis is completed, providers must take any additional "reasonable and appropriate" steps to reduce identified risks to reasonable and appropriate levels. Please note that a security risk analysis or review needs to be conducted during each EHR reporting year for Stage 1 and Stage 2 of meaningful use to ensure the privacy and security of their patients' protected health information. For more information about completing a security risk analysis, please see the following resources: Security Risk Assessment Tip Sheet: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/SecurityRiskAssessment_FactSheet_Updated20131122.pdf">https://www.cms.gov/Regulations-and- Health Information Privacy and Security: A 10 Step Plan: a http://www.healthit.gov/providers-professionals/ehr-privacy-security/Created 10/6/2014 Updated 11/5/2014 Archived 12/15/15
13649	For Objective 1: Protect Patient Health Information (ePHI), can the security risk analysis or review take place outside the EHR reporting period?	Yes, it is acceptable for the security risk analysis to be conducted outside the EHR reporting period; however, the analysis must be conducted for the certified EHR technology used during the EHR reporting period and the analysis or review must be conducted on an annual basis. In other words, the provider must conduct a unique analysis or review applicable for the EHR reporting period and the scope of the analysis or review must include the full EHR reporting period. The analysis or review for the EHR reporting period must be conducted prior to the date of attestation. Created 12/11/2015
3605	Where can I find a list of public health agencies and immunization registries to submit my data as required by the public health objectives for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?	For information and/or instructions on where to submit your public health-related data, please contact your local or state public health agencies and immunization registries. For more information on specialized registry, see FAQ #13657 and #14117 For more information about the Medicare and Medicaid EHR Incentive Program, please visit "http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10841 Updated 5/12/2016
3257	For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, how should an eligible professional (EP) who orders medications infrequently calculate the measure for the "computerized provider order entry (CPOE)" objective if the EP sees patients whose medications are maintained in the medication list by the EP but were not ordered or prescribed by the EP?	Stage 1 providers may have this issue if they choose the alternate specification. yes;"However, these providers may simply use the total number of orders for the denominator. If they prescribe fewer than 100 medications, they may qualify for the exclusion. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10639 Updated 5/12/2016
2763	Do controlled substances qualify as "permissible prescriptions" for meeting the electronic prescribing (eRx) meaningful use objective under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?	The inclusion of controlled substances in the permissible prescriptions for the purposes of the eRx meaningful use objective is an option for providers, but not be required. As discussed in the Stage 3 Final Rule, many states have varying policies regarding controlled substances and may address different schedules, dosages, or types of prescriptions differently. Given these developments with states easing some of the prior restrictions on electronically prescribing controlled substances, we believe it is no longer necessary to categorically exclude controlled substances from the term "permissible prescriptions" (80 FR 62801). yes;"Therefore, for the purposes of this objective, that prescriptions for controlled substances may be included in the definition of permissible prescriptions where the electronic prescription of a specific medication or schedule of medications is permissible under state and federal law." For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10067 Updated 5/12/2016
2783	Can the drug-drug and drug-allergy interaction alerts of my electronic health record (EHR) also be used to meet the meaningful use objective for implementing one clinical decision support rule for the Medicare and Medicaid EHR Incentive Programs?	No. The drug-drug and drug-allergy checks and the implementation of clinical decision support interventions are separate measures. EPs and eligible hospitals must implement five clinical decision support interventions in addition to CDS drug-drug and drug-allergy interaction.For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10077 Updated 5/12/2016

2857	In order to satisfy the Meaningful Use objective for electronic prescribing (eRx) in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, can providers use intermediary networks that convert information from the certified EHR into a computer-based fax for sending to the pharmacy and include this transaction in the numerator for the measure of this objective?	The threshold for e-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 of certified EHR technology to either a pharmacy or an intermediary network, and this results in the prescription being filled without the need for the provider to communicate the prescription in an alternative manner, then the prescription would be included in the numerator. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Updated 6/29/16
3369	If my certified electronic health record (EHR) technology is capable of submitting batch files to an immunization registry using the standards adopted by the Office of the National Coordinator of Health Information Technology, is that sufficient to meet the Meaningful Use objective "submit electronic data to immunization registries" for the Medicare and Medicaid EHR Incentive Programs?	Submitting batch files to an immunization registry, provided that they are formatted according to the standards adopted by the Office of the National Coordinator of Health Information Technology, is sufficient to meet the Public Health Reporting objective measure 1, Immunization Registry reporting. However, if a provider within the group does not administer immunizations, they should not attest to meeting the measure; they must instead claim the exclusion. If a provider within the group does administer immunizations, but did not;have any for a particular EHR reporting period, they are not required to claim the exclusion as long as they have done any necessary registration and testing and are reporting when they do have the data to report. (See FAQ #11984) For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Updated 1/7/2016
7693	Does the inclusion of certified Medical Assistant in the list of professionals who can enter orders into the EHR using CPOE and have them count in the numerator?	Any licensed healthcare professional can enter orders into the medical record for purposes of including the order in the numerator for the measure of the CPOE objective if they can enter the order per state, local, and professional guidelines. The order must be entered by someone who could exercise clinical judgment in the case that the entry generates any alerts about possible interactions or other clinical decision support aides. This necessitates that CPOE occurs when the order first becomes part of the patient's medical record and before any action can be taken on the order. Each provider will have to evaluate on a case-by-case basis whether a given situation is entered according to state, local, and professional guidelines, allows for clinical judgment before the medication is given, and is the first time the order becomes part of the patient's medical record.
7705	Both the Stage 1 and Stage 2 objective and measure for protecting electronic health information created or maintained by Certified EHR Technology privacy and security contain the phrase “implement security updates as necessary and correct identified security deficiencies as part of the provider’s risk management process.” Does this mean that all security deficiencies must be fully corrected prior to attestation?	Providers are not required to attest that a specific security update has been implemented or a specific security deficiency has been corrected by the attestation date as the timing of security updates and deficiency corrections is driven by the provider’s risk management process. The scope of that security risk analysis must include data created or maintained by the provider’s CEHRT. As long as the provider meets the requirements under 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 to comply with [45 CFR]§164.306(a),” then the provider’s risk management process drives the timeline 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 attesting to having made a specific security update has been implemented or a specific security deficiency by the attestation date as the timing of security updates and deficiency corrections 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. yes;"
12825	In calculating the meaningful use objectives requiring patient action, if a patient sends a message or accesses his/her health information made available by their eligible professional (EP), can the other EPs in the practice get credit for the patient’s action in meeting the objectives?	Yes.This transitive effect applies to the Secure Electronic Messaging objective, the 2nd measure of the Patient Electronic Access (View, Download and Transmit) objective, and the Patient Specific Education objective. If a patient sends a secure message about a clinical or health related subject to the group practice of their EP, that patient can be counted in the numerator of the Secure Electronic ;Messaging measure for any of the EPs at the group practice who use the same certified electronic health records technology (CEHRT) that saw and patient during their EHR reporting period. Similarly, if a patient views, downloads or transmits to a third party the health information that was made available online by their EP, that patient can be counted in the numerator of the 2nd Patient Electronic Access measure for any of the EPs in that group practice who use the same CEHRT and saw that patient during their EHR reporting period. If patient-specific education resources are provided electronically, it may be counted in the numerator for any provider within the group sharing the CEHRT who has contributed information to the patient's record if that provider has the patient in their denominator for the EHR reporting period. For more information on accurately calculating the numerator for measures, please visit FAQ 8231: https://questions.cms.gov/faq.php?faqId=8231 Created 10/2/2015 Updated 11/9/2015
9204	If an eligible hospital (EH) or critical access hospital (CAH) does not have any reportable lab results during the EHR reporting period (for example, the EH or CAH outsources all lab testing to a commercial lab or does not perform any lab tests for conditions that are reportable in their jurisdiction) can they be excluded from the requirement in the Electronic Health Records (EHR) Incentive programs to submit reportable lab results to a public health agency? yes;	The EH or CAH should indicate the following exclusion when attesting yes; Does not perform or order laboratory tests that are reportable in their jurisdiction during the EHR reporting period (80 FR 62824). Updated 5/12/2016
9824	Can a hospital count a patient toward the measures of the “Patient Electronic Access” objective in the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs if the patient accessed his/her information before they were discharged?	The second measure of Objective 8: Patient Electronic Access for eligible hospitals and CAHs states, "For EHR reporting period in 2016, at least 1 patient who is discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH (or patient authorized representative) views, downloads or transmits to a third party his or her health information during the EHR reporting period."In 2017, the threshold increases to more than 5% of unique patients.The denominator for measure 2 includes the number of unique patients discharged from the inpatient or emergency department (POS 21 or 23) of the eligible hospital or CAH during the EHR reporting period (80 FR 62816). Patients may choose to access their information prior to leaving the hospital, where guidance and support in using the online patient portal is still available to them. To this end, the hospital may include patients found in the denominator who access their information on or before the hospital discharge date in the numerator. Patients may also access their information after the hospital discharge date, but must take place no later than the date of attestation in order to be counted in the numerator. The calculation may include actions taken before, during, or after the EHR reporting period if the period is less than one full year; however, consistent with FAQ 8231, these actions must be taken no earlier than the start of the same year as the EHR reporting period and no later than the date of attestation (80 FR 62814). For more information about actions taken outside of the EHR reporting period and numerator calculations, please see FAQ 8231. https://questions.cms.gov/faq.php?faqId=8231"Updated 5/12/2016
14117	What steps do eligible hospitals and Critical Access Hospitals need to take to meet the specialized registry objective? Is it different from EPs?	For an eligible hospital or Critical Access Hospitals (CAHs), the process is the same as for an EP. The eligible hospital or CAH should check their State* and any such organization or specialty society with which they are affiliated to determine if that entity maintains a specialized registry and for which they have made a public declaration of readiness to receive data for meaningful use no later than the first day of the provider’s EHR reporting period. However, we note that eligible hospitals or CAHs do not need to explore every specialty society with which their hospital-based specialists may be affiliated. The hospital may simply check with their State* and any such organization with which it is affiliated, and if no registries exist, they may simply exclude from the measure. For further information please see FAQ "FAQ #13657" href="http://questions.cms.gov/faq.php?faqId=13657 For eligible hospitals and CAHs: The provider may meet the specialized registry measure up to 3 times. This can be done through reporting to: Three registries maintained by a public health agency Three registries maintained by one or more specialized societies One or two registries maintained by a public health agency and two or one maintained by a specialty society Two registries maintained by a public health agency and one exclusion Two registries maintained by a specialty society and one exclusion One registry maintained by a public health agency and one registry maintained by a specialty society and one exclusions* One registry maintained by a public health agency and two exclusions* One registry maintained by a specialty society and two exclusions* *In these cases, the exclusion which overlaps a category of registries would be based on there being no additional option for reporting beyond those already selected by the eligible hospital or CAH. In 2015, providers may also simply claim an alternate exclusion for a measure as defined in FAQ https://questions.cms.gov/faq.php?faqId=12985 *If you report to an entity other than a State as your reporting jurisdiction (such as a county) you may elect to check with them.
14393	Can a provider register their intent after the first 60 days of the reporting period in order to meet the measures if a registry becomes available after that date?	If a registry declares readiness at any point in the calendar year after the initial 60 days, a provider may still register their intent to report with that registry to meet the measure under Active Engagement Option 1. However, a provider who could report to that registry may still exclude for that calendar year if they had already planned to exclude based on the registry not being ready to allow for registrations of intent within the first 60 days of the reporting period.Created 02/25/2016
1959	Will the National Provider Identifier (NPI) be used as the standard identifier for E-Prescribing transactions?	The NPI will eventually be the standard identifier for e-prescribing under Part D. It already is a standard identifier that will have to be used in standard transactions after the NPI compliance date, as required under HIPAA. This means that covered entities (including Medicare, Medicaid, private insurers, clearinghouses, and other covered entities) must accept and use NPIs for covered HIPAA transactions by May 23, 2007, and May 23, 2008 for small health plans. On April 7th 2007 CMS published a second final rule that adopted additional standards for e-prescribing under Part D. In that final rule CMS adopted the individual level NPI for all e-prescribing transactions under Part D.

12821	If multiple eligible professionals or eligible hospitals contribute information to a shared portal or to a patient's online personal health record (PHR), how is it counted for meaningful use when the patient accesses the information on the portal or PHR?	This answer is relevant to the following meaningful use objectives: Patient Specific Education and Patient Electronic Access measure 2.If an eligible professional sees a patient during the EHR reporting period, the eligible professional may count the patient in the numerator for this measure if the patient (or an authorized representative) views online, downloads, or transmits to a third party any of the health information from the shared portal or online PHR. The same would apply for an eligible hospital or CAH if a patient is discharged during the EHR reporting period. If patient-specific education resources are provided electronically, it may be counted in the numerator for any provider within the group sharing the CEHRT who has contributed information to the patient's record if that provider has the patient in their denominator for the EHR reporting period. The respective eligible professional, eligible hospital, or CAH must have contributed at least some of the information identified in the Medicare and Medicaid Programs; Electronic Health Record Incentive Program ;Stage;3 and Modifications to Meaningful Use in 2015 Through 2017 final rule (80 FR 62807 through 62809);to the shared portal or online PHR for the patient.& However, the respective provider need not have contributed the particular information that was viewed, downloaded, or transmitted by the patient. Although availability varies by state and geographic location, some Health Information Exchanges (HIEs) provide shared portal or PHR services. If a provider uses an HIE for these services to make information available to patients, in order to meet meaningful use requirements the provider must use an HIE that is certified as an EHR Module for that purpose. The HIE must be able to verify whether a particular provider actually contributed some of the information identified in the Medicare and Medicaid Programs; Electronic Health Record Incentive Program -;Stage;3 and Modifications to Meaningful Use in 2015 Through 2017;final rule to the shared portal or PHR for a particular patient. If a provider elects to use the HIE for these shared portal or PHR services, the provider must include the HIE’s certification number as part of their attestation.Created 10/2/2015 Updated 11/9/2015

22349	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.

CEHRT		
FAQ Number	**Question**	**Answer**
6421	Can an eligible professional (EP) use EHR technology certified for an inpatient setting to meet a meaningful use objective and measure?	Yes. For objectives and measures where the capabilities and standards of EHR technology designed and certified for an inpatient setting are equivalent to or require more information than EHR technology designed and certified for an ambulatory setting, an EP can use the EHR technology designed and certified for an inpatient setting to meet an objective and measure. There are some EP objectives, however, that have no corollary on the inpatient side. As a result, an EP must possess Certified EHR Technology designed for an ambulatory setting for such objectives. Please reference ONC FAQ 12-10-021-1 and 9-10-017-2 and CMS FAQ 10162 for discussions on what it means to possess Certified EHR Technology, ONC FAQ 6-12-025-1 for a list of affected capabilities and standards, and how that relates to the exclusion and deferral options of meaningful use. To view the ONC FAQs, please visit: http://healthit.hhs.gov/portal/server.pt/community/onc_regulations_faqs/ For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms
2809	What is the purpose of certified electronic health record (EHR) technology?	Certification of EHR technology will provide assurance to purchasers and other users that an EHR system or product offers the necessary technological capability, functionality, and security to help them satisfy the meaningful use objectives for the Medicare and Medicaid EHR Incentive Programs. Providers and patients must also be confident that the electronic health information technology (IT) products and systems they use are secure, can maintain data confidentially, and can work with other systems to share information. Confidence in health IT systems is an important part of advancing health IT system adoption and realizing the benefits of improved patient care. For more information, please visit the Office of the National Coordinator's website at http://healthit.hhs.gov/certification" For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10093
14397	What should a provider do in 2016 if they did not previously intend to report to a public health reporting measure that was previously a menu measure in Stage 2 and they do not have the necessary software in CEHRT or the interface the registry requires available in their health IT systems? What if the software is potentially available but there is a significant cost to connect to the interface?	In the 2015 EHR Incentive Programs Final Rule, we stated that we did not intend for providers to be inadvertently penalized for changes to their systems or reporting made necessary by the provisions of that regulation. This included alternate exclusions for providers for certain measures in 2016 which might require the acquisition of additional technologies they did not previously have for measures they did not previously intend to include in their activities for meaningful use (80 FR 62945).Therefore, in order that providers are not held accountable to obtain and implement new or additional systems, we will allow providers to claim an alternate exclusion from certain public health reporting measures in 2016 if they did not previously intend to report to the Stage 2 menu measure. LIST OF MEASURES FOR EPs WHICH WOULD ALLOW AN ALTERNATE EXCLUSION LIST OF MEASURES FOR EHs WHICH WOULD ALLOW AN ALTERNATE EXCLUSION:EN-US; Public Health Reporting measure 3 - specialized registry) Created 02/25/2016
2937	To meet the meaningful use objective "capability to exchange key clinical information" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, can different providers of care (e.g., physicians, hospitals, etc.) share EHR technology and successfully meet this objective?	In order to meet this objective, clinical information must be sent between different legal entities with distinct certified EHR technology and not between organizations that share a certified EHR technology or organizations that are part of the same legal entity, since no actual exchange of clinical information would take place in these latter instances. Distinct certified EHR technologies are those that can achieve certification and operate independently of other certified EHR technologies. It is possible for different legal entities to meet this objective by using separate instances of the same certified EHR technology (e.g. both entities using separate license of the same program), subject to the following limitations: A different legal entity is an entity that has its own separate legal existence. 160; Indications that two entities are legally separate would include (1) they are each separately incorporated; (2) they have separate Boards of Directors; and (3) neither entity is owned or controlled by the other. In order to be distinct certified EHR technology, each instance of certified EHR technology must be able to be certified and operate independently from all others. Separate instances of certified EHR technology that must link to a common database in order to gain certification would not be considered distinct. However, instances of certified EHR technology that link to a common, uncertified system or component would be considered distinct. Instances of certified EHR technology can be from the same vendor and still be considered distinct. The exchange of key clinical information requires that the eligible professional, eligible hospital, or critical access hospital (CAH) must use the standards of certified EHR technology as specified by the Office of the National Coordinator for Health IT, not the capabilities of uncertified or other vendor-specific alternative methods for exchanging clinical information. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms
7699	What certification approaches would satisfy the 2014 Edition transitions of care certification criteria adopted at 45 CFR 170.314(b)(1) and (b)(2) as well as permit an eligible provider to have EHR technology that meets the Certified EHR Technology (CEHRT) definition? Please emphasize how the adopted transport standards fit in.	In general, EHR technology developers can take the three approaches outlined in the table below to meet the transitions of care certification criteria and their included transport standard(s). EHR technology certified according to any one of these three approaches could then be used by eligible providers to meet the CEHRT definition. As additional context, it is important to keep in mind the "scope of a certification criterion" in the 2014 Edition EHR certification criteria (see 77 FR 54168). In the final rule, we describe that in order for a certification criterion to be met, all specific capabilities expressed under the second regulation text paragraph (e.g., everything under 170.314(b)(1)) would need to be demonstrated for certification. In other words, if EHR technology was presented for certification and could only perform the specific "create a CCDA" capability expressed in 170.314(b)(2)(I), that EHR technology would not meet this certification criterion. With respect to transport standards, both certification criteria at 170.314(b)(1) and (b)(2) follow the same framework. At a minimum, EHR technology presented for certification must be able to electronically receive and transmit (in the respective certification criteria) transitions of care/referral summaries according to the Applicability Statement for Secure Health Transport. EHR technology developers are also able to seek certification to two optional transport standards: The Applicability Statement for Secure Health Transport specification and the XDR and XDM for Direct Messaging specification; and •The Simple Object Access Protocol (SOAP)-Based Secure Transport Requirements Traceability Matrix (RTM) version 1.0 standard and the XDR and XDM for Direct Messaging specification. The EHR technology presented for certification can perform all of the specific capabilities expressed by the certification criterion, including the required capabilities for content and transport standard (and any optional transport standards) (e.g., for 170.314(b)(1), receipt according to transport standards, display of CCD/C32, CCR, and CCDA, and incorporation of CCDA sections). The EHR technology presented for certification could either be from an EHR technology developer that likely includes other clinical capabilities or from an EHR technology developer (e.g., HIE/HISP) that focuses on transition of care/transmission related capabilities. The EHR technology presented for certification can perform most of the capabilities expressed by the certification criterion (e.g., CCDA creation for 170.314(b)(2)), but also relies on a health information exchange (HIE) organization, health information service provider (HISP), or other 3 party's technology to perform the required transport standard capability (and any optional transport standards). Under this approach and to meet the certification criterion: The EHR technology must be presented for certification together with the technology supplied by the other entity to perform the transport capability (this other technology would be treated as "relied upon" software under ONC's certification rules (see FAQ 16)). The certification issued would represent the unique pairing of the EHR technology and the other entity's transport technology. Finally, we note that these certification approaches could also be pursued in combination so long as the full scope of the certification criterion is met. For example, in order for an EHR technology developer to get its EHR technology certified to meet the required transport standard capability it could pursue the second approach and also seek certification for its EHR technology's native capability to perform to the second optional transport requirement (i.e., the SOAP-based RTM + XDR/XDM), which would enable its customers to have additional transport capabilities as part of their CEHRT.
2907	To meet the meaningful use objective "use certified EHR technology to identify patient-specific resources and provide those resources to the patient" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, does the certified EHR have to generate the education resources or can the	In the patient-specific education resources objective, education resources or materials do not have to be stored within or generated by the certified EHR. However, the provider should utilize certified EHR technology in a manner where the technology suggests patient-specific educational resources based on the information stored in the certified EHR technology. The provider can make a final decision on whether the education resource is useful and relevant to a specific patient. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" FAQ10164
3063	If data is captured using certified electronic health record (EHR) technology, can an eligible professional or eligible hospital use a different system to generate reports used to demonstrate meaningful use for the Medicare and Medicaid EHR Incentive Programs?	By definition, certified EHR technology must include the capability to electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage for all percentage-based meaningful use measures (specified in the certification criterion adopted at 45 CFR 170.302(n)). However, the meaningful use measures do not specify that this capability must be used to calculate the numerators and denominators. Eligible professionals and eligible hospitals may use a separate, non-certified system to calculate numerators and denominators and to generate reports on the measures. Eligible professionals and eligible hospitals will then enter this information in CMS' web-based Medicare and Medicaid EHR Incentive Program Registration and Attestation System. Eligible professionals and eligible hospitals will fill in numerators and denominators for meaningful use objectives, indicate if they qualify for exclusions to specific objectives, report on clinical quality measures, and legally attest that they have successfully demonstrated meaningful use. For additional clarification about this, please refer to the following FAQ from the Office of the National Coordinator of Health Information Technology: http://healthit.hhs.gov/portal/server.pt/community/onc_regulations_faqs/3163/faq_13/20775" For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10465 Updated 5/12/2016
2893	Must providers have their electronic health record (EHR) technology certified prior to beginning the EHR reporting period in order to demonstrate Meaningful Use under the Medicare and Medicaid EHR Incentive Programs?	No. An EP or hospital may begin the EHR reporting period for demonstrating Meaningful Use before their EHR technology is certified. Certification need only be obtained prior to the end of the EHR reporting period. However, Meaningful Use must be completed using the capabilities and standards outlined in the ONC Standards and Certification Regulation for certified EHR technology. Any changes to the EHR technology after the beginning of the EHR reporting period that are made in order to get the EHR technology certified would be evidence that the provider was not using the capabilities and standards necessary to accomplish Meaningful Use because those capabilities and standards would not have been available, and thus, any such change (no matter how minimal) would disqualify the provider from being a meaningful EHR user. If providers begin the EHR reporting period prior to certification of their EHR technology, they are taking the risk that their EHR technology will not require any changes for certification. Any changes made to gain certification must be done prior to the beginning of the EHR reporting period during which Meaningful Use will be demonstrated. This does not apply to changes made to EHR technology that were not necessary for certification. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10157
12653	Can providers that have switched Certified Electronic Health Record (EHR) Technology vendors apply for a hardship exception to avoid the Medicare payment adjustment?	Yes, if a provider switches EHR vendors during the Program Year and is unable to demonstrate meaningful use, the provider may apply for an Extreme and/or Uncontrollable Circumstances hardship exception and if approved may be exempt from the payment adjustment. For example, if an Eligible Professional (EP), eligible hospital, or CAH switches EHR vendors in 2015 and is unable to demonstrate meaningful use in 2015, the EP, eligible hospital, or CAH can apply for an EHR Vendor Issue hardship, before the July 1, 2016 submission deadline, and be exempt from the payment adjustment in 2017. Created on 09/23/15 Updated on 12/21/15
3073	For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, is an eligible professional or eligible hospital limited to demonstrating meaningful use in the exact way that EHR technology was tested and certified? For example, if a Complete EHR has been tested and certified using a specific workflow, is an eligible professional or eligible hospital required to use that specific workflow when it demonstrates meaningful use? Similarly, if the EHR technology was tested and certified with certain clinical decision support rules, are those the only clinical decision support rules an eligible health care provider is permitted to use when demonstrating meaningful use?	In most cases, an eligible professional or eligible hospital is not limited to demonstrating meaningful use to the exact way in which the Complete EHR or EHR Module was tested and certified. As long as an eligible professional or eligible hospital uses the certified Complete EHR or certified EHR Module's capabilities and, where applicable, the associated standard(s) and implementation specifications that correlate with the respective meaningful use objective and measure, they can successfully demonstrate meaningful use even if their exact method differs from the way in which the Complete EHR or EHR Module was tested and certified. It is important to remember the purpose of certification. Certification is intended to provide assurance that a Complete EHR or EHR Module will properly perform a capability or capabilities according to the adopted certification criterion or criteria to which it was tested and certified (and according to the applicable adopted standard(s) and implementation specifications, if any). The Temporary Certification Program and Permanent Certification Program Final Rules (75 FR 36188 and 76 FR 1301, respectively), published by the Office of the National Coordinator for Health IT (ONC), acknowledged that eligible professionals and eligible hospitals could, where appropriate, modify their certified Complete EHR or certified EHR Module to meet local health care delivery needs and to take full advantage of the capabilities that the certified Complete EHR or certified EHR Module includes. These rules also cautioned that modifications made to a Complete EHR or EHR Module post-certification have the potential to adversely affect the technology's capabilities such that it no longer performs as it did when it was tested and certified, which could ultimately compromise an eligible professional or eligible hospital's ability to successfully demonstrate meaningful use. In instances where a certification criterion expresses a capability which could potentially be added to or enhanced by an eligible professional or eligible hospital, the way in which EHR technology was tested and certified generally would not limit a provider's ability to modify the EHR technology in an effort to maximize the utility of that capability. Examples of this could include adding clinical decision support rules, adjusting or adding drug-drug notifications, or generating patient lists or patient reminders based on additional data elements beyond those that were initially required for certification. Modifications that adversely affect the EHR technology's capability to perform in accordance with the relevant certification criterion could, however, ultimately compromise an eligible professional or eligible hospital's ability to successfully demonstrate meaningful use. In instances where the EHR technology was tested and certified using a sample workflow and/or generic forms/templates, an eligible professional or eligible hospital generally is not limited to using that sample workflow and/or those generic forms/templates. In this context, the "workflow" would constitute the specific steps, methods, processes, or tasks an eligible professional or eligible hospital would follow when using one or more capabilities of the certified Complete EHR or certified EHR Module to meet meaningful use objectives and associated measures. An eligible health care provider could use a different workflow and/or substitute different forms/templates for those that are included in the certified Compete EHR or certified EHR Module. Again, care should be taken to ensure that such actions do not adversely affect the Complete EHR's or EHR Module's performance of the capabilities for which it was tested and certified, which could ultimately compromise an eligible professional or eligible hospital's ability to successfully demonstrate meaningful use. For more information about the Medicare and Medicaid EHR Incentive Program, please visit a http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10473

8906	If a provider utilizes a health information organization that participates with the eHealth Exchange but is not connected to public health entities in the provider's state, does the provider still need to connect to those entities for purposes of participating in the Medicare and Medicaid EHR Incentive Program?	Yes, to meet the requirements for meaningful use, the provider must connect to the appropriate public health entities in his or her state, even if the provider has connected to an eHealth Exchange participant for other reasons. This can be accomplished by expanding the eHealth Exchange participant connections to include public health agencies, or through direct connections from the provider to the public health agency, or through a different third-party interface. The information required by a public health meaningful use objective must originate from the provider's Certified Electronic Health Records Technology (CEHRT), and the information sent from that technology must be formatted according to the standards and implementation specifications associated with the public health meaningful use objective. If a provider wishes to use an health information exchange (HIE) or other intermediary to connect to a public health agency and perform a function to meet the meaningful use requirement, the provider must use an HIE or intermediary that is certified as an EHR Module for that purpose.CMS recognizes the variety of methods in which the exchange of public health information could take place, and therefore does not seek to limit or define the receiving capabilities of public health entities (see FAQ 3461). Created on 7/24/2013
12657	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 CMS Hardship Coordinator at "mailto:EHRinquiries@cms.hhs.gov">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" Created on 09/23/15
13413	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 11/9/2015
2811	Do I need a single product for all functions or can I use a variety of certified systems?	The Medicare and Medicaid EHR Incentive Programs require the use of certified EHR technology, as established by a new set of standards and certification criteria. Existing EHR technology needs to be certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB) to meet these new criteria in order to qualify for the incentive payments. The Certified Health IT Product List (CHPL) is available at http://www.healthit.hhs.gov/CHPL. This is a list of complete EHRs and EHR modules that have been certified for the purposed of this program. A provider may use a single product or a combination of products and/or models to meet the requirements. For more information, please visit the Office of the National Coordinator's website at http://healthit.hhs.gov/certification. For more information, please visit the Office of the National Coordinator's website at http://healthit.hhs.gov/certification" For more information about the Medicare and Medicaid EHR Incentive Program, please visit "http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10094 Updated 5/12/2016
2795	The meaningful use standards for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program 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 grantees is available at: http://healthit.hhs.gov/" For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10085 Archived 12/15/15
8227	For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, how should an eligible professional (EP), eligible hospital, or critical access hospital (CAH) attest if the certified EHR vendor being used is switched to another certified EHR vendor in	If an EP, eligible hospital or CAH switches from one certified EHR vendor to another during the program year, the data collected for the selected menu objectives and quality measures should be combined from both of the EHR systems for attestation. yes;"The count of unique patients does not need to be reconciled when combining from the two EHR systems. Created on 4/22/2013 Updated 5/12/2016
13653	What can count as a specialized registry?	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. Until such time as a centralized repository is available to search for registries, 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, FTP, 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 provider 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 for PQRS or the EHR Incentive Programs. 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. Created 12/11/2015 Updated 02/25/2016
13657	What steps does a provider have to take to determine if there is a specialized registry available for them, or if they should instead claim an exclusion?	The eligible professional (EP) is not required to make an exhaustive search of all potential registries. Instead, they must do a few steps to meet due diligence in determining if there is a registry available for them, or if they meet the exclusion criteria. An EP should check with their State* to determine if there is an available specialized registry maintained by a public health agency. An EP should check with any specialty society with which they are affiliated to determine if the society maintains a specialized registry and for which they have made a public declaration of readiness to receive data for meaningful use no later than the first day of the provider's EHR reporting period. If the EP determines no registries are available, they may exclude from the measure. The provider may meet the specialized registry measure up to 2 times. This can be done through reporting to: Two registries maintained by one or more specialty societies One registry maintained by a public health agency and one maintained by a specialty society One registry maintained by a public health agency and one exclusion One registry maintained by a specialty society and one exclusion PLEASE NOTE: In 2015, providers may also simply claim an alternate exclusion for a measure as defined in FAQ href="https://questions.cms.gov/faq.php?faqId=12985 5005" *If you report to an entity other than a State as your reporting jurisdiction (such as a county) you may elect to check with them. Created 12/11/2015 Updated 02/25/2016

INCENTIVE PAYMENTS		
FAQ Number	**Question**	**Answer**
2847	We are a tribal clinic with one full-time physician, one part-time pediatrician, one part-time physicians assistant (PA). Are we going to receive electronic health record (EHR) incentive payments directly from Medicaid?	Clinics are not directly eligible for the Medicaid EHR Incentive Program payments, however if the practitioners at your clinic meet the eligibility criteria and successfully adopt, implement, upgrade or meaningfully use certified EHR technology, they may choose to reassign their incentive payments to your clinic. Your clinic would need to have a taxpayer identification number (TIN) that is already established with the State Medicaid agency. A PA is eligible only if your FQHC or RHC is led by a PA. Our Stage 1 final rule preamble discusses what it means for a PA to have lead role in an FQHC or RHC at page 44483.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/EHRIncentivePrograms Keywords: FAQ10128
3089	Are physicians who are employed directly by a tribally-operated facility and who meet all other eligibility requirements eligible for payments under the Medicaid EHR Incentive Program?	Physicians are one of the categories of eligible professionals under the Medicaid EHR Incentive Program. If they meet the other program eligibility requirements (they can demonstrate 30% Medicaid patient volume, they've adopted, implemented, upgraded or meaningfully used certified EHR technology, they are not hospital-based, etc.) then the fact that they are employed by a tribally-operated facility is irrelevant. For more information about the Medicare and Medicaid EHR Incentive Program, please visit A http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10517
3379	[EHR Incentive Programs] How are Medicare EHR Incentive Payments Calculated for Critical Access Hospitals (CAHs)?	CAHs are currently paid based on reasonable cost principles; therefore, their EHR incentive payments are calculated differently from the incentive payments to subsection (d) hospitals. A CAH must meet the definition of a meaningful EHR user to qualify to be paid the incentive payment for a payment year. A payment year means a Federal fiscal year beginning after FY 2010 and before FY 2016. In no case are incentive payments made with respect to cost reporting periods that begin during a payment year before FY 2011 or after FY 2015, and in no case may a CAH receive an incentive payment with respect to more than 4 consecutive payment years. The incentive payment made to a qualifying CAH equals: [Allowable cost amount] * [Medicare Share].The allowable cost amount equals the costs of depreciable assets purchased, such as computers and associated software, necessary to administer certified EHR technology. The incentive payment permits a qualifying CAH to expense the allowable cost amount in a single payment year rather than depreciating the costs over the useful life of the purchased asset. The allowable cost amount for a cost reporting period that begins in a payment year includes the reasonable cost incurred for the purchase of certified EHR technology in that payment year plus the undepreciated costs for assets purchased, prior to the CAH becoming qualified, that are also being used to administer certified EHR technology in that payment year. The Medicare Share is a fraction based on Medicare fee-for-service and managed care inpatient days, divided by total inpatient days, modified by charges for charity care: (1) The number of inpatient-bed-days which are attributable to individuals with respect to whom payment may be made under Part A, including individuals enrolled in section 1876 Medicare cost plans; and (2) The number of inpatient-bed-days which are attributable to individuals who are enrolled with a Medicare Advantage organization Denominator = Total number of acute care inpatient-bed-days; * ((Total amount of the eligible hospital's charges - charges attributable to charity care)/Total amount of the eligible hospital's charges)) For CAHs, 20 percentage points are added to the Medicare Share calculation (not to exceed 100 percent). In order for the CAH to receive its interim incentive payment, upon attestation, it must submit supporting documentation for its incurred costs of purchasing certified EHR technology to its Medicare contractor (Fiscal Intermediary/Medicare Administrative Contractor). The Medicare contractor will then calculate the allowable amount. The interim incentive payment is then subject to reconciliation to determine the final incentive payment amount. The final payment amount constitutes payment in full for the reasonable costs incurred for the purchase of certified EHR technology in the single payment year. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentiveProgramsKeywords: FAQ10718
3387	Can a Critical Access Hospital (CAH) include costs to lease/rent certified EHR technology in the Medicare EHR incentive payment?	Under the statute and the regulations, the CAHs EHR incentive payment shall only include reasonable costs for the purchase of certified EHR technology to which purchase depreciation (excluding interest) would apply. There are two types of lease agreements that a CAH may enter into to administer their EHR system… an operating lease or a capital lease. OPERATING LEASE An operating lease is merely a lease that involves an asset that is purchased, owned, and depreciated by the lessor and the lessee (the CAH) signs the lease agreement with the lessor to use the asset by paying a lease/rental fee for the term of the lease. The asset is returned to the lessor at the end of the lease without further obligation. Generally, the CAH can claim the entire lease/rental payment under an operating lease as an operating expense, unrelated to depreciation expenses. With an operating lease, the CAH does not purchase, own, or depreciate the asset, and the lease/rental expense does not meet the intent of the statute and regulations. Therefore, operating lease/rental expenses are not included in the CAH incentive payment. The CAH may, however, continue to include the operating lease expenses on its cost report, subject to reasonable cost principles. CAPITAL LEASE A capital lease agreement is essentially the same as a virtual purchase agreement, as defined in 42 CFR 413.130(b)(8) of the regulations and the Medicare Provider Reimbursement Manual (PRM), (CMS Pub. 15-1) section 110.B.1.b. A capital lease is treated as though the CAH (lessee) purchased the asset and the capital-related costs may not exceed the amount that the lessee would have included in capital-related costs if it had legal title to the asset (the cost of ownership). The cost of ownership includes straight-line depreciation, insurance and interest for computing the limitation. To be a capital lease, the agreement must satisfy at least one of the four conditions established by the Federal Accounting Standards Board (FASB). Similar to the FASB conditions, under CMS Pub. 15-1, section 110.B.1.b., a lease that meets any one of the following four conditions establishes a virtual purchase (otherwise the lease is considered an operating lease). The lease transfers title of the facilities or equipment to the lessee during the lease term, The lease contains a bargain purchase option, The lease term is 75 percent or more of the useful life of the facilities or equipment. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment, or The present value of the minimum lease payments (that is, payments to be made during the lease term, including bargain purchase option, guaranteed residual value, or penalties for failure to renew) equal 90 percent or more of the fair market value of the leased property. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment. The present value is computed using the lessee's incremental borrowing rate, unless the interest rate implicit in the lease is known and is less than the lessee's incremental borrowing rate, in which case, the interest rate implicit in the lease is used. Based on these criteria, a capital lease or virtual purchase meets the intent of the statute and regulation to qualify the leased asset as a purchased asset. Therefore, the CAHs' incentive payment may include the "cost" of such leased asset which must be based on the fair market value of the asset (see 42 CFR 413.134(b)(2)) at the date the lease was initiated. Other costs of ownership such as interest and insurance related to the virtual purchase lease shall not be included in the asset's cost for the purpose of the EHR incentive payment. However, the portion of the rental expense which relates to the interest and insurance portion of the cost of ownership of such virtual purchase asset (see CMS Pub. 15-1, section 110.B.1.b.) may continue to be included on
2849	What provisions are there for tribal clinics to receive payments from the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program, rather than the physicians themselves - especially when it is a family medicine practice? I heard there were certain percentage of patients that had to be either Medicare or Medicaid and that a physician had to decide which they were going to apply for. What if their practice includes both types of patients?	Clinics are not eligible for EHR incentive payments. However, eligible professionals who qualify for an EHR incentive payment may reassign that payment to the taxpayer identification number (TIN) of their employer, if they so choose. You are correct that eligible professionals must choose either the Medicare or the Medicaid EHR Incentive Program, and may not simultaneously receive payments from both programs if they qualify for both. They may make a one-time switch after having received an incentive payment, but the switch must occur before 2015. For more information about the Medicare and Medicaid EHR Incentive Program, please visit a http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10129
2769	If a patient is dually eligible for both Medicare and Medicaid, can they be counted twice by hospitals in their calculations if they are applying for electronic health record (EHR) incentive payments through both the Medicare and Medicaid EHR Incentive Programs?	For purposes of calculating the Medicaid share, a patient cannot be counted in the numerator if they would count for purposes of calculating the Medicare share. Thus, in this respect the inpatient bed day of a dually eligible patient could not be counted in the Medicaid share numerator. (See 1903(t)(5)(C), stating that the numerator of the Medicaid share does not include individuals "described in section 1886(n)(2)(D)(I)."") In other respects; however, the patient would count twice. For example, in both cases, the individual would count in the total discharges of the hospital. To view the 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 a http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ 10070

3375	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
3381	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 a http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10719
3095	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 Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10520
2905	What is the definition of "reasonable cost" for critical access hospitals (CAHs) under the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs?	The reasonable costs for which a CAH may receive an EHR incentive payment are the reasonable acquisition costs for the purchase of certified EHR technology to which purchase depreciation (excluding interest) would otherwise apply. Section 495.106(a) of the regulations states that reasonable costs incurred for the purchase of certified EHR technology for a qualifying CAH means the reasonable acquisition costs incurred for the purchase of depreciable assets as described in part 413 subpart G of the regulations, such as computers and associated hardware and software, necessary to administer certified EHR technology as defined in section 495.4 excluding any depreciation and interest expenses associated with the acquisition. This EHR incentive payment provision allows a qualifying CAH to expense the acquisition costs of a qualifying asset in a single payment year instead of depreciating the acquisition costs over the useful life of the asset. If a qualifying CAH incurs non-depreciable expenses related to implementing/maintaining its EHR system, those expenses cannot be included in the EHR incentive payment. However, those expenses may be an allowable cost for Medicare payment purposes, under the current reasonable cost payment methodology for CAHs, in the cost reporting period in which such expenses are incurred. For example, if a qualifying CAH rents its EHR technology assets, instead of purchasing the assets, the rent expense cannot be included in the EHR incentive payment. However, the rent expense may be an allowable cost for Medicare payment purposes, under the current reasonable cost payment methodology for CAHs, in the cost reporting period in which such expense is incurred. Qualifying CAHs should contact their Medicare contractor to answer questions on reasonable costs that will be included in the calculation of the EHR incentive payment. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10163

CLINICAL QUALITY MEASURES (CQMS)		
FAQ Number	**Question**	**Answer**
3601	Does a provider have to record all clinical data in their certified EHR technology in order to accurately report complete clinical quality measure data for the Medicare and Medicaid EHR Incentive Programs?	We recognize that providers are continuing to implement new workflow processes to accurately capture clinical data in their certified EHR technology, but many providers are not able to capture all data at this time. Although we encourage providers to capture complete clinical data in order to provide the best care possible for their patients, for the purpose of reporting clinical quality measure data, CMS does not require providers to record all clinical data in their certified EHR technology at this time. CMS recognizes that this may yield numerator, denominator, and exclusion values for clinical quality measures in the certified EHR technology that are not identical to the values generated from other methods (such as record extraction). However, at this time CMS requires providers to report the clinical quality measure data exactly as it is generated as output from the certified EHR technology in order to successfully demonstrate meaningful use. We will continue to collaborate with our partners in the Office of the National Coordinator for Health Information Technology and with industry stakeholders to make further headways in system interoperability, standards for EHR data, as well as certification of vendor products. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10839
3673	For the Medicare and Medicaid EHR Incentive Programs' clinical quality measures (CQMs) ED-1, ED-2, and Stroke-4, how should eligible hospitals and critical access hospitals (CAHs) define an Emergency Department patient since the UB-04 data set referred to in the HITSP specifications no longer provides this information?	The measure steward recommends that hospitals use the data element 'ED Patient', defined as any patient receiving care or services in the Emergency Department.This data element specification to be used for ED-1, ED-2, and Stroke-4 can be found at in Section 1 Data Dictionary/Alphabetical Data Dictionary (page 1-146). For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10883
3675	For the Medicare and Medicaid EHR Incentive Programs, who do I contact to suggest adding/deleting a code on a clinical quality measure (CQM) or to suggest other CQM improvements?	Please contact the measure steward (the entity responsible for maintaining and updating a clinical quality measure) if you have suggestions or comments for improving the measure, comments regarding the measure's scientific or medical soundness/applicability, or would like to add specific vocabulary taxonomies or codes to the measure that may be appropriate for the measure population. The measure steward for each CQM is identified in the electronic specifications and in CMS's July 28, 2010 final rule (see 75 FR 44398-44420, Tables 6, 7, and 10). For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10884
3277	For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, if certified EHR technology possessed by an eligible professional (EP) includes the ability to calculate clinical quality measures (CQMs) from the additional set that are not indicated by the EHR developer or on the Certified Health Information Technology Product List (CHPL) as tested and certified by an ONC - Authorized Testing and Certification Body (ONC-ATCB), can the EP submit the results of those CQMs to CMS as part of their meaningful use attestation?	Through 2013, yes, the EP can submit results for CQMs in the additional set (Table 6 of the Stage 1 final rule) calculated by certified EHR technology, even if those CQMs were not individually tested and certified by an ONC-ATCB. We expect to revisit CQM requirements in more detail for later stages of meaningful use as well as the corresponding certification requirements. Starting in 2014, the EP must have 2014 edition Certified EHR Technology and will be required to only submit results generated by EHR technologies certified to the 2014 edition criteria. To view the Stage 1 final rule for the Medicare and Medicaid EHR incentive programs, please visit: http://edocket.access.gpo.gov/2010/pdf/2010-17207. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10649
3611	For the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, how should an eligible hospital or critical access hospital (CAH) with multiple certified EHR systems report their clinical quality measures?	To report clinical quality measures, eligible hospitals and CAHs that have multiple systems should generate a report from each of those certified EHR systems and then add the numerators, denominators, and exclusions from each generated report in order to arrive at a number that reflects the total data output for patient encounters in the relevant departments of the eligible hospital or CAH (e.g., inpatient or emergency department (POS 21 or 23)).For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10844
9276	Can a hospital receive credit for any of the Inpatient Quality Reporting (IQR) Program requirements by electronically submitting the Clinical Quality Measures (CQMs) for the EHR Incentive Program?	Yes, a hospital will be able to receive credit for the EHR Incentive Program and IQR by electronically submitting the CQMs (also referred to as eCQMs) for the EHR Incentive Program, using the IQR system (Qualitynet.org). There are 16 CQMs that are shared by the two programs, and these shared measures are organized into four measure sets, stroke (seven measures), venous thromboembolism (six measures), emergency department (two measures) and perinatal care (one measure). Hospitals choosing to report the specified measure sets electronically to meet the CQM requirements for the Medicare EHR Incentive Program and the IQR Program, may report one quarter of data (either January – March 2014, April – June 2014, or July – September 2014). If a provider reports measures electronically, they are not required to report the same measures by via chart abstraction or attestation. Please note that both the IQR Program and the EHR Incentive Program have additional requirements which must be reported IQR Program For the IQR Program, a hospital must continue to submit all 14 of the remaining IQR measure sets each quarter if it wishes to fulfill the requirements for the IQR program. The 14 measure sets include data for the following: Clinical, HCAHPS, Aggregate Population and Sample size counts, HAI, Claims, and Structural Measures. Hospitals participating in the IQR program must also sign a notice of participation, provide a security administrator and complete the Data Accuracy and Completeness Acknowledgement (DACA). For more information regarding IQR requirements and a checklist for providers, please go to the Inpatient Quality Reporting Program Tab How to participate on http://www.qualitynet.org/"www.QualityNet.org EHR Incentive Program Electronic submission of the 16 eCQMs will meet the CQM requirement for the Medicare EHR Incentive Program. Hospitals also need to attest to the core and menu objectives for meaningful use through the Medicare EHR Incentive Program Registration and Attestation System. Critical Access Hospitals and Eligible Hospitals will need to check with their state Medicaid programs to determine all necessary requirements to participate in the Medicaid EHR Incentive Program. For more information on program details, please visit the CMS EHR Incentive Programs page. http://www.cms.gov/ehrincentiveprograms"Created on 11/22/2013 Updated on 11/27/2013
12356	For the Medicare EHR Incentive Program, can I report a CQM with a zero result in the numerator and/or denominator?	While we strongly encourage providers to report CQMs which are relevant to their patient population, zero is an acceptable result provided that this value was produced by certified EHR technology.Created on 06/29/15
9062	The specifications for Denominator 2 for measure CMS64v3 do not produce an accurate calculation according to the measure's intent. When will a correction to this clinical quality measure (CQM) be published?	The Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs; Stage 2 final rule (77 FR 54056) states that updates to the CQM specifications may be published annually approximately 6 months prior to the beginning of the calendar year (CY) for which the data would be collected (e.g., for the EHR reporting periods in CY 2014, approximately 6 months in advance of the beginning of CY 2014). A correction for this measure will be included in the next annual update, to be published in CY 2014. Within the logic for Denominator 2, there is a missing "OR" operator in the Risk Assessment Logic between count = 3 and count = 2. This omission may result in cases incorrectly excluded from the denominator. This missing "OR" operator in Denominator 2 creates a situation where 3+ risk factors AND a High Density Lipoprotein (HDL) laboratory result of 60 mg/dL will cause the patient to not fall into Denominator 2, which is an error. The issue would only impact cases when a patient's Framingham Risk Score is not recorded in the EHR. The exact impact on the performance calculation for Denominator 2 is unknown. Since the CQM asks for either the data to calculate risk or a pre-calculated Framingham Risk Score, the result will not be miscalculated in denominator 2 if there is a Framingham score already in the EHR system. It; is highly recommended that eligible professionals (EPs) implementing this CQM record a Framingham Risk Score as outlined in the U.S. Department of Health Human Services' Third Report of the National Cholesterol Education; Program (NCEP) (2002, p. III-4 – III-5) to ensure accurate performance calculation: http://www.nhlbi.nih.gov/guidelines/cholesterol/atp3full. Created on 8/22/2013 Updated on 8/29/2013
2873	For eligible hospitals and critical access hospitals (CAHs) under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, will the clinical quality measure results be calculated similar to the Hospital Inpatient Quality Reporting (IQR) Program (Formerly known as Reporting Hospital Quality Data for Annual Payment Update program)?	No. For all clinical quality measures reported for the Medicare and Medicaid EHR Incentive Programs, the certified EHR must report the numerator, denominator, and exclusion results. Providers will report their aggregate results for clinical quality measures during attestation to CMS or the States. For more information about the Medicare and Medicaid EHR Incentive Program, please visit: http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10146 Archived 12/15/15
3125	Is a hospital participating in the Medicare and Medicaid EHR Incentive Programs required to report quality metrics on ALL patients?	The technical specifications issued by CMS for the clinical quality measures under the Medicare and Medicaid EHR Incentive Programs specify what data should be included in the numerator and the denominator. Clinical quality measure reporting is inclusive of all applicable patients or actions during the Electronic Health Record reporting period, with no differentiation by payer. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10538
8400	When can a hospital use the case number threshold exemption for the clinical quality measure (CQM) requirement of meaningful use?	The case number threshold exemption for hospital CQM reporting helps reduce the burden placed on hospitals that very seldom have cases that would be counted in the denominator of certain CQMs. Eligible hospitals and critical access hospitals (CAHs) with a low number of inpatient discharges per electronic health records (EHR) reporting period as defined by a CQM's denominator population, could be exempted from reporting on that CQM. The CQM case number threshold exemption for eligible hospitals and CAHs is available beginning in FY2013 for all stages of meaningful use (MU). The hospital must submit the aggregate population and sample size counts for Medicare and non-Medicare discharges for the EHR reporting period for the CQM(s) for which the hospital seeks an exemption.To meet the threshold for exemption from reporting a CQM, the following criteria must be met for the corresponding EHR reporting periods:•;1st year of demonstrating MU 90-day EHR reporting period; 5 or fewer discharges during the EHR reporting period• 2nd year or beyond of demonstrating MU;Full year EHR reporting period ;20 or fewer discharges during the EHR reporting period; In FY 2014, three-month quarter EHR reporting period with 5 or fewer discharges during the EHR reporting period;Discharges are defined by the CQM's denominator population;Applies on a CQM by CQM basis When invoking the case number threshold exemption in FY 2013:•;All 15 of the CQMs from Stage 1 final rule are required.• The number of CQMs required to report is reduced by the number of CQMs for which the hospital does not meet the case number threshold of discharges. When invoking the case number threshold exemption in FY 2014:• 16 CQMs covering at least 3 domains from a list of 29 CQMs are required.•The same process as in FY 2013 is employed, but in order to be exempted from reporting fewer than 16 CQMs, the hospital would need to qualify for the case number threshold exemption for more than 13 of the 29 CQMs.•;If the CQMs for which the hospital can meet the case number threshold of discharges do not cover at least 3 domains, the hospital would be exempt from the requirement to cover the remaining domains.To view the rules that include this policy for the Medicare and Medicaid EHR Incentive programs, please visit:•;Stage 2 Final Rule (77 FR 54080): http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf"•Interim Final Rule (77 FR 72988 – 72989): http://www.gpo.gov/fdsys/pkg/FR-2012-12-07/pdf/2012-29607.pdf" Created on 7/1/2013

8896	When new versions of clinical quality measure (CQM) specifications are released by the Centers for Medicare and Medicaid Services (CMS), do developers of Electronic Health Records (EHR) technology need to seek retesting/recertification of their certified complete EHR or certified EHR module in order to keep its certification valid?	No. The minimum version required for 2014 Edition certification is the version of CQM specifications released by CMS in December 2012. EHR technology that has been issued a certification based on the December 2012 version will remain certified even when CMS releases new versions of CQM specifications. We strongly encourage EHR technology developers to update to the newest CQMs specifications as they become available since those updates include new codes, logic corrections and clarifications. We also recommend EHR technology developers consider that other CMS programs (beyond the EHR Incentive Programs) and other private sector programs generally update CQMs on an annual basis. As a result, an EHR technology developer's customers continued ability to successfully participate and report in those other programs could be impacted if the CQM data generated by the EHR technology is based on older specification versions (and no longer accepted by the other programs).Please see FAQ 8898 and 8900 for additional information pertaining to the relationship between EHR certification and the CQM specification updates. For more information on the 2014 CQM specifications, please visit: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html" For more information on ONC Health Information Technology (HIT) Certification, please visit: http://www.healthit.gov/policy-researchers-implementers/about-certification Created on 7/16/2013 Updated on 8/22/2013
8900	If Electronic Health Records (EHR) technology is not yet certified to the clinical quality measure (CQM) criteria (45 CFR 170.314(c)(1) through (3)), can the EHR technology be tested and certified to only the newest available version of the CQM specifications or must it be tested and certified to the December 2012 specifications (first or as well)?	Yes, EHR technology may be presented for testing and certification to only newest CQM specifications.We strongly encourage EHR technology developers to test and certify to the newest CQMs specifications as they become available since those updates include new codes, logic corrections and clarifications. In addition, other CMS programs (beyond the EHR Incentive Programs) and other private sector programs generally update CQMs on an annual basis. Updating EHR technology to the newest CQM version specifications enables providers to participate and report in those other programs for which they are eligible as well. Please see FAQ 8896 and 8898 for additional information pertaining to the relationship between EHR certification and the CQM specification updates. For more information on the 2014 CQM specifications, please visit: "http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html" For more information on ONC Health Information Technology (HIT) Certification, please visit: http://www.healthit.gov/policy-researchers-implementers/about-certification" Created 7/16/2013 Updated on 8/22/2013
9676	For some of the eligible professional (EP) clinical quality measures (CQMs), there are look back periods or look forward periods for which data was not available. How are these CQMs calculated for the reporting period?	CQMs that include look back periods or look forward periods may require data outside of the reporting period of a CMS quality reporting program. Look Back Period – Example CQM: An example of a CQM that includes a look back period is CMS130 (NQF 0034) Colorectal Cancer Screening. The CQM assesses performance on the percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer. If the screening occurred within the reporting period and through the EP's practice, it should be captured in the calculated performance rate. However, if the screening took place before the reporting period and/or occurred outside of the EP's practice, it is possible that the screening would be omitted from the calculated performance rate. Look Forward Period – Example CQM: An example of a CQM that includes a look forward period is CMS159 (NQF 0710) Depression Remission at Twelve Months. The CQM assesses performance on adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score >9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5 (includes newly diagnosed and existing patients with depression or dysthymia). If the assessment for remission at twelve months occurs within the reporting period and through the EP's practice, it should be captured in the calculated performance rate. However, if the assessment takes place after the reporting period and/or occurred outside of the EP's practice, it is possible that the occurrence of the remission would be omitted from the calculated performance rate. General Guidelines: We recommend that the information needed from the look back periods be requested from the patient as part of the encounter and recorded in the Electronic Health Records (EHR) technology, for example, as part of the patient's history. For EHR vendors, we recommend that EHRs include the capability of capturing the type of information needed for the look back periods as part of the encounter (e.g., in the history section of an encounter note) and then extract data from this entry for purposes of reporting CQMs with look back periods.There is no practical way to capture information for look forward periods that go into the next reporting period. In most cases, this should affect the performance rates of all EPs similarly. For CQM data reporting to CMS that may be used for a pay for performance program, the collective EP performance rates should be reflected in the benchmark for each respective CQM that contains a look forward period. Since EPs who are subject to the value-based payment modifier would be assessed, in part, based on the performance rate of the CQMs they report through the Physician Quality Reporting System (PQRS), those EPs may review the CQMs available and try to report on CQMs that are not affected by look back or look forward periods to help mitigate the issues described above for programs that have the option to select CQMs. Added on 2/6/2014
10786	Can SCIP INF-9 (CMS178v4 / NQF0453) still be used to meet the reporting requirements of the EHR Incentive Program (Meaningful Use) for Eligible Hospitals and the Hospital Inpatient Quality Reporting Program?	CMS suggests eligible hospitals participating in the Medicare & Medicaid EHR Incentive Programs and/or choosing the voluntary electronic reporting option under the Hospital Inpatient Quality Reporting (IQR) Program not select SCIP INF-9 (CMS 178v4/NQF 0453) as one of their electronic clinical quality measures (eCQMs) and choose another eCQM for Meaningful Use reporting and/or Hospital IQR reporting in 2015. A critical error identified in the measure (CMS 178v4/NQF 0453) renders a zero denominator. The denominator error noted in the SCIP INF-9 (CMS 178v4/NQF 0453) was identified after the 2014 Annual Update posting. If the measure is used for reporting, a zero in the denominator will count as a successful submission for that CQM for both the Medicare EHR Incentive Program and the Hospital IQR Program. Eligible hospitals and CAHs reporting CQMs using certified EHR technology are required to report on a minimum of 16 CQMs across 3 National Quality Strategy Domains. If an eligible hospital or CAH reports on a CQM generating a zero denominator, it will count toward the required 16 CQMS for the Medicare EHR Incentive Program and the Hospital IQR Program. For additional clarification on reporting zero denominators, please see the page 50323 of the FY 2015 IPPS Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2014-08-22/pdf/2014-18545.Created 10/9/2014

PAYMENT ADJUSTMENTS		
FAQ Number	**Question**	**Answer**
2709	Are Medicaid eligible professionals (EPs) and eligible hospitals subject to payment adjustments or penalties if they do not adopt electronic health record (EHR) technology or fail to demonstrate meaningful use?	There are no payment adjustments or penalties for Medicaid providers who fail to demonstrate meaningful use. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ9958
7531	What are the payment adjustments for eligible professionals who are not participating in the Medicare EHR Incentive Program? Are there any hardship exceptions?	As part of the American Recovery and Reinvestment Act of 2009 (ARRA), Congress mandated payment adjustments to be applied to Medicare eligible professionals (EPs) who are not meaningful users of Certified Electronic Health Record (EHR) Technology under the Medicare EHR Incentive Programs. These payment adjustments will be applied beginning on January 1, 2015, for Medicare EPs. Medicaid EPs who can only participate in the Medicaid EHR Incentive Program and do not bill Medicare are not subject to these payment adjustments.EPs who can participate in either the Medicare or Medicaid EHR Incentive Programs will be subject to the payment adjustments unless they are meaningful users under one of the EHR Incentive Programs in the time periods specified below. Medicare EPs who are not meaningful users will be subject to a payment adjustment beginning on January 1, 2015. For additional information on payment adjustments and hardship exceptions for EPs, please review the Payment Adjustments and Hardship Exceptions Tip Sheet which will be available on our website. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms
7533	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?	As part of the American Recovery and Reinvestment Act of 2009 (ARRA), Congress mandated payment adjustments to be applied to Medicare eligible hospitals, and critical access hospitals (CAHs) that are not meaningful users of Certified Electronic Health Record (EHR) Technology under the Medicare EHR Incentive Programs. These payment adjustments will be applied beginning on October 1, 2014, for Medicare eligible hospitals. Payment adjustments for CAHs will be applied beginning with the fiscal year 2015 cost reporting period. Medicaid eligible hospitals that can only participate in the Medicaid EHR Incentive Program and do not bill Medicare are not subject to these payment adjustments. Eligible hospitals and CAHs that can participate in either the Medicare or Medicaid EHR Incentive Programs will be subject to the payment adjustments unless they are meaningful users under one of the EHR Incentive Programs in the time periods specified below. Medicare Subsection (d) eligible hospitals that are not meaningful users will be subject to a payment adjustment beginning on October 1, 2014. Critical Access Hospitals (CAHs) that are not meaningful users will be subject to a payment adjustment for fiscal year 2015. For additional information on payment adjustments and hardship exceptions for eligible hospitals and CAHs, please review the Payment Adjustments and Hardship Exceptions Tip Sheet for Eligible Hospitals and CAHs which will be available on our website. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms
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"

ADVANCING CARE INFORMATION		
FAQ Number	**Question**	**Answer**
22533	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)?	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.
22537	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?	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 Circumstance category hardship exception, before the submission deadline.
22529	Will CMS require the submission of supporting documentation along with the Quality Payment Program hardship exception application?	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.
22525	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?	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.
22517	What can count as a specialized registry?	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.
22521	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?	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' 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 records 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.

22513	For the Protect Patient Health Information (ePHI) objective, can the security risk analysis or review take place outside the MIPS performance period.	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.
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?	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.
1215	What if my certified electronic health record technology (CEHRT) is decertified?	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.