CMS Meaningful Use EHR FAQ
Brought to you by ecfirst
A Meaningful Use Program for Physician Practices

STePS is an ecfirst Program Targeted at Jumpstarting Physician Practices & Eligible Professionals (EPs) to Address Meaningful Use Incentive Requirements for Electronic Health Records (EHR).

We at ecfirst refer to this consulting model as – “Meaningful STePS to Meaningful Use.” ecfirst resources may be applied to enable your practice, plan, prepare and implement needed capabilities for addressing meaningful use requirements. The ecfirst STePS Program is laser beam focused on getting your practice prepared to address meaningful use incentive requirements. For a flat fee, the ecfirst STePS Program includes the following:

- Private Webcast, customized as mutually determined, with a focus on HITECH Meaningful Use and its impact on your practice
- Preliminary analysis of your current capabilities for managing health records – paper and electronic
- Publication of a Summary Report of current status and capabilities as it directly relates to EHR including current systems, software and applicable applications
- Access to a highly specialized tool and resources to address Meaningful Use mandates for HIPAA and HITECH risk assessment (Meaningful Use Core Objective)

| Meaningful Use Core Objective | Implement systems to protect privacy and security of patient data | Conduct or review a security risk analysis and implement security updates as necessary, and correct identified security deficiencies. |
CMS Meaningful Use EHR FAQ

- Complete set of HIPAA Privacy, HIPAA Security policy templates to comply with mandates
- Updated HITECH Data Breach Notification policy and procedure template to comply with requirements
- Coordination with an EHR vendor as mutually determined to establish critical requirements for a solution for your practice

The ecfirst STePS Program is unique in several ways and includes the following characteristics:
- Delivered anywhere in the United States
- Deep Healthcare Information Technology (HIT) and compliance expertise
- Mix and match skills for assistance with EHR advisory and consulting services
- 2-page contract
- Get started with an immediate resource commitment

About ecfirst – Home of the STePS Meaningful Use Program

Industry leader delivering world-class services in Healthcare Information Technology (HIT) for over a decade

Recognized as an Inc. 500 Business in 1st Year of Eligibility

Minority Business Enterprise Certified

Unique, business-driven, compliance and security solutions; based on the proprietary BizShield™ methodology

ecfirst delivers world-class Healthcare Information Technology (HIT) solutions with expertise in HITECH, HIPAA mandates and global standards such as ISO 27000 and PCI DSS.

With over 1,600+ clients, ecfirst was recognized as an Inc. 500 business – America’s Top 500 Fastest Growing Privately Held Business in 2004 – our first year of eligibility. ecfirst assists organizations with their compliance initiatives for a secure information infrastructure that is compliant with regulations such as HITECH, HIPAA, ISO 27000, or federal and state legislations (such as California or Massachusetts).

Talk to ecfirst and you will find an organization that is passionate about the services we deliver and exceptionally devoted to its clients.

*We deliver value with intensity and are paranoid about our performance for your organization.*

For more information and to download the Meaningful Use STePS Quick Reference Card for Physician Practices please visit [http://www.ecfirst.com/](http://www.ecfirst.com/).

**Contact ecfirst**

Contact John Schelewitz for a customized STePS Meaningful Use Program proposal to address your specific requirements. John may be reached at [John.Schelewitz@ecfirst.com](mailto:John.Schelewitz@ecfirst.com) or at 1.480.663.3225.

The STePS Meaningful Use Program from ecfirst provides your organization with access to specialized healthcare information technology consultants and senior advisors with no short term or long term commitments. Get Started Today!
Q: My electronic health record (EHR) system is CCHIT certified. Does that mean it is certified for the Medicare and Medicaid EHR Incentive Programs?

A: No. All EHR systems and technology must be certified specifically for this program.

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

Through the temporary certification program, new certification bodies will be established to test and certify EHR technology. Upon the “opening” of the certifying bodies, vendors can submit their EHR products to be tested and certified. Hospitals and practices who have developed their own EHR systems or products can also seek to have their existing systems or products tested and certified. Complete EHRs may be certified as well as EHR modules that meet at least one of the certification criteria. Once a product is certified, the name of the product will be published on the ONC web site. EHRs will be certified and listed on the ONC web site in the fall 2010.

Q: 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?

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

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

A: 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:
1. The use of a certified EHR in a meaningful manner (e.g.: e-Prescribing);
2. The use of certified EHR technology for electronic exchange of health information to improve quality of health care;
3. 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.
Q: Do I need to have an electronic health record (EHR) system in order to register for the Medicare and Medicaid EHR Incentive Programs?

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

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

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

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

Through the temporary certification program, new certification bodies will be established to test and certify EHR technology. Upon the "opening" of the certifying bodies, vendors can submit their EHR products to be tested and certified. Hospitals and practices who have developed their own EHR systems or products can also seek to have their existing systems or products tested and certified. Complete EHRs may be certified as well as EHR modules that meet at least one of the certification criteria. Once a product is certified, the name of the product will be published on the ONC web site. It is expected that the first EHRs will be certified and listed on the ONC web site in fall 2010.

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

A: EPs are not excluded from reporting clinical quality measures, but zero is an acceptable value for the CQM denominator. If there were no patients who met the denominator population for a CQM, then the EP would report a zero for the denominator and a zero for the numerator. For the core measures, if the EP reports a zero for the core measure denominator, then the EP must report results for up to three alternate core measures (potentially reporting on all 6 core/alternate core measures). For the menu-set measures, we expect the EP to report on measures which do not have a denominator of zero.

If none of the measures in the menu set applies to the EP, then the EP must report on three of such measures, reporting a denominator of zero, and then attest that the remainder of the menu-set measures have a value of zero in the denominator. As stated in the final rule (75 FR 44409-10): "The expectation is that the EHR will automatically report on each core clinical quality measure, and when one or more of the core measures has a denominator of zero then the alternate core measure(s) will be reported. If all six of the clinical quality measures in Table 7
have zeros for the denominators (this would imply that the EPs patient population is not addressed by these measures), then the EP is still required to report on three additional clinical measures of their choosing from Table 6 in this final rule. In regard to the three additional clinical quality measures, if the EP reports zero values, then for the remaining clinical quality measures in Table 6 (other than the core and alternate core measures) the EP will have to attest that all of the other clinical quality measures calculated by the certified EHR technology have a value of zero in the denominator, if the EP is to be exempt from reporting any of the additional clinical quality measures (other than the core and alternate core measures) in Table 6."

Q: 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)?

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

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

A: For a Medicare EP's first payment year, the EHR reporting period is a continuous 90-day period within a calendar year, so an EP must satisfy the meaningful use requirements for 90 consecutive days within their first year of participating in the program to qualify for an EHR incentive payment. In subsequent years, the EHR reporting period for EPs will be the entire calendar year. With regard to the Medicaid EHR Incentive program, EPs must have adopted, implemented, upgraded, or meaningfully used certified EHR technology during the first calendar year. If the Medicaid EP adopts, implements or upgrades in the first year of payment, and demonstrates meaningful use in the second year of payment, then the EHR reporting period in the second year is a continuous 90-day period within the calendar year; subsequent to that, the EHR reporting period is then the entire calendar year.

Q: When can I register and where do I register for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

A: Hospitals and eligible professionals (EPs) are expected to be able to register for the program in January 2011. The registration process will be the same for the Medicare and Medicaid programs. You will be able to find registration and other program information at http://www.cms.gov/EHRIncentivePrograms when it becomes available.
Q: With regard to the Medicaid Electronic Health Record (EHR) Incentive Program, I am interested in finding out how we should determine the cost of an EHR system to a provider in order for them to demonstrate their 15% of the net average allowable costs for an EHR. Can you provide a few scenarios?

A: 1) It is a group practice, owned by the clinicians. The cost of purchasing and implementing an EHR system was $300,000 and there are 30 clinicians.
   a) Each eligible clinician reports $300,000; or
   b) Each eligible clinician reports $10,000 ($300,000/30 clinicians = $10,000) as their contribution. This is the correct approach.

2) It is a group practice, privately owned. The cost of purchasing and implementing an EHR system was $300,000 and there are 30 employee clinicians.
   a) Each eligible clinician reports $300,000; or
   b) Each eligible clinician reports $10,000 ($300,000/30 clinicians = $10,000) as their contribution. This is the correct approach.

3) The cost of purchasing and implementing an EHR system was $300,000 and there are 30 employee clinicians at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC). These costs were paid for through a Federal grant.
   a) Each eligible clinician reports that the system cost $300,000; or
   b) Each eligible clinician reports the sum of the costs that s/he personally incurred to connect to the system, internet access, or any hardware, or software, or training expenses; or
   c) If all of the EHR software, licensing, training, hardware, internet and related software costs were paid by the FQHC with Federal funds, the eligible clinicians would report $0 as their contribution; or
   d) Each eligible clinician reports $10,000 ($300,000/30 eligible clinicians = $10,000) as their contribution. This is the correct approach.

Q: What is the difference between the Electronic Health Records (EHR) Demonstration and the Medicare and Medicaid EHR Incentive Programs?

A: The EHR Demonstration is a five-year demonstration project designed to encourage small to medium-sized primary care physician practices to adopt and use EHRs to improve the quality of patient care. Practices participating in the EHR Demonstration that meet specified requirements are eligible to receive two types of incentive payments: one for the adoption and use of an EHR and one for the reporting of and performance on 26 clinical quality measures related to the care of diabetes mellitus (DM), congestive heart failure (CHF), coronary artery disease (CAD) and preventive care services. The demonstration was implemented on June 1, 2009 in the following 4 sites: Louisiana, Southwest Pennsylvania, South Dakota (and some counties in bordering states), and Maryland and the District of Columbia. After careful consideration, plans to add 8 additional sites to the demonstration one year later were discontinued due to the creation of the Medicare and Medicaid EHR incentive programs. The EHR Demonstration will continue through May 31, 2014. CMS has no plans to add sites or additional primary care physician practices to the EHR Demonstration.

The Medicare and Medicaid EHR Incentive Programs was established under the Health Information Technology for Economic and Clinical Health Act, or the “HITECH Act,” which is part of the Recovery Act. The EHR Incentive Programs under Medicare and Medicaid will provide incentive payments for the “meaningful use” of certified EHR technology. The Medicare and Medicaid EHR Incentive Programs will provide incentive payments to eligible professionals (EPs), critical access hospitals, and eligible hospitals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. The programs will begin in 2011.
Q: The meaningful use standards for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program require interoperability. Who will pay for ensuring connectivity between physician practices and hospitals? Will there be federal guidance, or will this be hashed out at a local/community level?

A: 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/.

Q: 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?

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

Q: Can I receive the maximum allowable electronic health record (EHR) incentive payments if they total more than the purchase cost of my EHR system?

A: Yes. As long as an eligible professional (EP) or eligible hospital meets all necessary requirements for qualifying for incentive payments, they will receive the maximum incentive payment amount, regardless of the purchase or implementation costs of their EHR system. For Medicaid, there is a requirement that an EP is responsible for at least 15% of net average allowable costs in each year. In the first year, this means the EP is responsible for expenditures of at least $3,750. The final rule for the Medicare and Medicaid EHR incentive programs provides additional explanation of what it means for the EP to be "responsible" for such amount, including allowing an employer of the EP to incur the $3,750 on the EP employee’s behalf. However, theoretically, there could be a situation where neither the EP, nor his or her employer expends more than $3,750 in total costs on the certified EHR technology.

Q: 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?

A: 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 distinguish between the physician's claims and the PA's individual claims, then this would not be an adequate audit methodology.

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

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

Q: When do the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs start?

A: Participation in the Medicare EHR Incentive Program can begin as early as 2011; The incentive program ends in 2016. Registration for the Medicare EHR Incentive Program is expected to begin in January 2011, with attestation beginning in April 2011. The earliest incentive payments to eligible professionals (EPs) and eligible hospitals are expected to be made in May 2011.

Medicaid EHR Incentive Program is voluntarily offered by individual states and may begin as early as 2011 and will end in 2021. Registration for the Medicaid incentive program is expected to begin in January 2011. Participants in the Medicaid EHR Incentive Program should consult their State for specific information regarding attestation and payment.
Q: Are there any special incentives for rural providers in the Medicare and Medicare Electronic Health Record (EHR) Incentive Programs?

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

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

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

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

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

Q: Under the Medicaid Electronic Health Record (EHR) Incentive Program, if a provider adopts, implements or upgrades (AIU) certified EHR technology in their first year, the provider will not have to demonstrate meaningful use in order to receive payment; in the second year they will have to demonstrate MU for a 90 day period only. Whereas a provider that is already a meaningful user would have to demonstrate for a 90 day period the first year and subsequent years they would have to demonstrate it for the full year. Is this correct?

A: This is correct.

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

A: Under the Medicare EHR Incentive Program, EPs who demonstrate meaningful use of certified EHR technology can receive up to a total of $44,000 over 5 consecutive years. Additional incentives are available for Medicare EPs who practice in a Health Provider Shortage Area (HPSPA) and meet the maximum allowed charge threshold. Under the Medicaid EHR Incentive Program, EPs can receive up to a total $63,750 over the 6 years that they choose to participate in...
Q: For calculation of a Medicaid hospital’s electronic health record (EHR) incentive payment, is the estimated growth rate for hospitals most recent three years based on growth in total days or growth in discharges? (The data sources for these are different.)

A: 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.

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

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

For more complete information about eligibility requirements, please refer to the Eligibility section of the CMS website at http://www.cms.gov/EHRIncentivePrograms/20_Eligibility.asp#TopOfPage.

Q: Can eligible professionals (EPs) count their costs towards the initial purchase of the electronic health record (EHR) technology, not just what they will spend to upgrade it to the newly certified version, for purposes of 15% of the net average allowable cost (NAAC) under the Medicaid EHR Incentive Program? How far back in time can an EP count their contribution towards EHR technology for the purposes of demonstrating 15% of the NAAC ($3750 in year 1; $1500 in years 2-6)? Can they “carry-over” those expenses for the subsequent years?

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

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

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

Q: If a State had their Medicaid Electronic Health Record (EHR) Incentive Program approved and ready to go by 1/1/2011, could a provider use for their 90-day patient volume period 10/1-12/31/2010 to qualify for a payment as of 1/1/2011?

A: Yes. We specify that the volume period needs to be any 90-day period in the preceding calendar year. The provider would also need to demonstrate adopt, implement, upgrade of certified EHR technology (AIU) in order to qualify for an incentive payment.

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

A: 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.

Q: 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? If this is the case, does “preceding year” mean that the number of patient encounters in any 90 day period in CY 2012 will be used? If so, why not use the number of patient encounters during CY 2013?

A: The payment year is the year for which the payment is made (see 42 CFR 495.4 and the definition of “First, second, third, fourth, fifth, or sixth payment years.”). So, the questioner is correct that if the EHR reporting period is in CY 2013, the payment year also refers to 2013. Using the patient encounters from the year preceding the payment year, when the EP is adopts, implements, or upgrades (AIU) certified EHR technology, or in the first year of demonstrating meaningful use, when the EHR reporting period is 90 days, allows the EP to receive an incentive early in the payment year, such as when their EHR reporting period occurs during the first 90 days of CY 2012).

Q: If I am participating in the Medicare Electronic Health Records (EHR) Demonstration Program, can I also participate in the Medicare and Medicaid EHR Incentive Programs?

A: Yes, if the eligible professional (EP) is eligible they may simultaneously participate in the Medicare EHR Demonstration and the Medicare or Medicaid EHR Incentive Program.
Q: Are pediatric subspecialists considered pediatricians for purposes of qualifying under the Medicaid Electronic Health Record (EHR) Incentive Program? In other words, if I am an otolaryngologist who only sees children, can I qualify under Medicaid if I only have 20% of patient volume as Medicaid?

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

Q: Under the Medicaid Electronic Health Record (EHR) Incentive Program, in the event an eligible professional (EP) has more than the allowable cost of their EHR in a given year, can they carry-over excess costs to future years?

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

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

A: There are 16 measures for EPs and 14 measures for eligible hospitals that require the collection of data to calculate a percentage, which will be the basis for determining if the Meaningful Use objective was met according to a minimum threshold for that objective.

Objectives requiring a numerator and denominator to generate this calculation are divided into two groups: one where the denominator is based on patients seen or admitted during the EHR reporting period, regardless of whether their records are maintained using certified EHR technology; and a second group where the objective is not relevant to all patients either due to limitations (e.g., recording tobacco use for all patients 13 and older) or because the action related to the objective is not relevant (e.g., transmitting prescriptions electronically). For these objectives, the denominator is based on actions related to patients whose records are maintained using certified EHR technology. This grouping is designed to reduce the burden on providers. Table 3 in the Medicare and Medicaid EHR Incentive programs final rule (FR 75 44376 - 44380) lists measures sorted by the method of measure calculation. To view the final rule, please visit: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf.

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

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

Q: 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?

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

Q: If I am receiving payments under the CMS Electronic Prescribing (eRx) Incentive Program, can I also receive Medicare and Medicaid Electronic Health Record (EHR) incentive payments?

A: If the eligible professional (EP) chooses to participate in the Medicare EHR Incentive Program, they cannot participate in the eRx Incentive Program in the same program year. If the EP chooses to participate in the Medicaid EHR Incentive Program, they can participate in the Medicare eRx Incentive Program simultaneously.

Q: 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?

A: 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.

Q: 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?

A: 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 to 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."

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

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

Q: 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?

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

Q: When will the Centers for Medicare & Medicaid Services (CMS) begin to pay incentives to eligible professionals (EPs) and eligible hospitals and critical access hospitals (CAHs) for using certified electronic health record (EHR) technology?

A: Payments for the Medicare EHR Incentive Program are expected to be available as early as May 2011. Attestation for the Medicare EHR Incentive Program is expected to begin in April 2011. Registration for both the Medicare and Medicaid incentive programs is expected to begin in January 2011.

Participants in the Medicaid EHR Incentive Program should consult their State for specific information regarding attestation and payment.

Q: 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?

A: Yes, the State can submit to us for approval only the alternative methodology that meets the requirements of 495.306(g). As we stated in the preamble to the final rule, we believe most States will not submit alternative methodologies until after the first year of the program, allowing for alternatives to recognize evolving State and provider experience with patient volume estimate methodologies. We recommend that States consider the methodologies that were put forward in the final rule, prior to proposing only an alternative in their 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.
Q: Where can I get answers to my privacy and security questions about electronic health records (EHRs)?

A: 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/.

Q: 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 final rule explicitly stipulate that the 12-month period selected by the state for the Medicaid share data needs to be in the federal fiscal year (FY) before the hospital's FY that serves as the first payment year. Am I correct in this interpretation? In other words, a state could use two different 12-month periods to calculate the discharge-related amount and the Medicaid share?

A: 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.

Q: Our practice is interested in participating in the upcoming Physician Quality Reporting Initiative (PQRI) and the Electronic Prescribing Incentive Program (eRx) via a qualified EHR product. Where can I find the list of qualified EHR vendors?


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

A: Information on registration for EHR incentive programs will be available toward the end of 2010 on the website at http://www.cms.gov/EHRIncentivePrograms. Registration for the Medicare EHR Incentive Program will begin in January 2011 and will be available online. Registration for the Medicaid EHR Incentive Program may also begin in January 2011, but the timing will vary by State.
Q: Will long term care providers such as nursing homes be eligible for incentive payments under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program?

A: Nursing homes, per se, are not eligible. The following types of institutional providers are eligible for EHR incentive payments under Medicare and/or Medicaid, provided they meet the applicable criteria. Under Medicare, institutional providers eligible for the EHR incentive payments include "subsection (d) hospitals," as defined under section 1886(d) of the Social Security Act, and critical access hospitals (CAHs). Under Medicaid, institutional providers eligible for the EHR incentive payments are acute care hospitals (which include CAHs and cancer hospitals) and children’s hospitals. However, under Medicare, eligible professionals (EPs) may choose to assign their incentive payments to their employer or entity with which the EP has a contractual arrangement. Under Medicaid, EPs also can choose to assign their incentive payments to their employer or to other state-designated entities.

Q: If an eligible professional (EPs) is currently receiving an incentive payment for e-prescribing under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), are they also eligible to receive incentive payments under the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program?

A: The American Recovery and Reinvestment Act of 2009 specifically states that under the Medicare EHR Incentive Program, EPs cannot receive a payment under both the MIPPA E-Prescribing Incentive Program and the Medicare EHR Incentive Program for the same year. However, EPs may receive payments from both the MIPPA E-Prescribing Incentive Program and the Medicaid EHR Incentive Program for the same year.

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

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

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

A: 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.

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

A: The Medicare and Medicaid EHR Incentive Programs provide incentives for the meaningful use of certified EHR technology. Under the Medicaid program, there is also an incentive for the adoption, implementation, or upgrade of certified EHR technology in the first year of participation. The incentives are not a reimbursement of costs, and maximum payments have been set.
Q: Are physicians who practice in hospital-based ambulatory clinics eligible to receive Medicare or Medicaid electronic health record (EHR) incentive payments?

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

Q: Do practices need to have and use an electronic health record (EHR) in order to participate in the Physician Quality Reporting Initiative (PQRI) or the Electronic Prescribing Incentive Program (eRx)?

A: No. Practices do not need electronic health records (EHR) to participate in PQRI or eRx. If a practice does have an EHR system that has the capability to interface with its practice management system, these systems may be modified to capture PQRI quality-data codes for submission through claims, qualified registry, or qualified EHR.

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

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

Q: What does CCHIT-certification mean? How can you tell if an EHR is CCHIT-certified?

A: The Certification Commission for Healthcare Information Technology or CCHIT is an independent, voluntary, private-sector initiative whose mission is to accelerate the adoption of health information technology by creating an efficient, credible and sustainable certification program. They are currently the only recognized certification body for electronic health records and have established a testing program for determining which EHRs meet their certification standards. A list of CCHIT-certified EHRs is available on their web site: http://www.cchit.org.

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

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

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

A: Yes. EPs who meet the eligibility requirements for both the Medicare and Medicaid incentive programs must elect the program in which they wish to participate when they register. After the initial designation, EPs can only change their program selection once after they have received payment before 2015.
Q: What is the maximum electronic health record (EHR) incentive an eligible professional (EP) can earn under Medicare?

A: EPs who successfully demonstrate meaningful use certified EHR technology as early as 2011 or 2012 may be eligible for up to $44,000 in Medicare incentive payments spread out over five years. EPs who predominantly furnish services in a Health Professional Shortage Area (HPSA) are eligible for a 10 percent increase in the maximum incentive amount.

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

A: Ambulatory surgical centers are not eligible for EHR incentive payments. The following types of institutional providers are eligible for EHR incentive payments under Medicare and/or Medicaid, provided they meet the applicable criteria. Under Medicare, institutional providers eligible for the EHR incentive payments include "subsection (d) hospitals," as defined under section 1886(d) of the Social Security Act, and critical access hospitals. Under Medicaid, institutional providers eligible for the EHR incentive payments are acute care hospitals (which include critical access hospitals and cancer hospitals) and children's hospitals.

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

A: As required by the American Recovery and Reinvestment Act of 2009, CMS will post the names, business addresses, and business phone numbers of all Medicare eligible professionals and hospitals who receive EHR incentive payments. There is no such requirement for CMS to publish information on eligible professionals and hospitals receiving Medicaid EHR incentive payments, though individual States may opt to do so.

Q: If I already have an electronic health record (EHR) that has been certified by the Certification Commission for Healthcare Information Technology (CCHIT), will I have to buy a new system if the government mandates that only EHRs that meet a higher certification level are considered certified EHRs?

A: All EHRs will need to be certified for the EHR Incentive Programs by an Office of the National Coordinator for Health Information Technology Authorized Testing and Certification Body (ONC-ATCB). ONC-ATCBs will test and certify that complete EHRs and EHR modules are compliant with the standards, implementation specifications, and certification criteria adopted by the Secretary of Health and Human Services. It is expected that the first EHRs will be certified in the fall of 2010.

Q: What is the earliest date the payment adjustments will start to be imposed on Medicare eligible professionals (EPs) and eligible hospitals that do not demonstrate meaningful use of certified electronic health record (EHR) technology?

A: Medicare payment adjustments will begin in 2015 for EPs and eligible hospitals that do not demonstrate meaningful use of certified EHR technology. There are no payment adjustments associated with the Medicaid provisions under Section 4201 of the American Recovery and Reinvestment Act of 2009.
Q: What safeguards are in place to ensure that Medicaid electronic health record (EHR) incentive payments are used for their intended purpose?

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

Q: 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?

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

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

A: For an eligible hospital or critical access hospital's first payment year, the EHR reporting period is a continuous 90-day period within a Federal fiscal year. In subsequent years, the EHR reporting period for eligible hospitals and critical access hospitals (CAHs) is the entire Federal fiscal year.

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

A: Hospitals in the U.S. Territories cannot receive incentive payments under the Medicare EHR Incentive Program. For the purposes of the Medicare EHR Incentive Program, the Social Security Act defines an eligible hospital as a "subsection (d) hospital" that is located in "one of the fifty States or the District of Columbia." This does not include hospitals located in the U.S. territories. Therefore, hospitals in the U.S. territories do not qualify for the Medicare EHR Incentive Program. However, under the Medicaid EHR Incentive Program, hospitals located in the U.S. Territories are eligible to participate in the Medicaid incentive program as long as they meet all other eligibility requirements.

Q: Can eligible professionals (EPs) in the U.S. Territories (Puerto Rico, Guam, Virgin Islands, Northern Mariana Islands, and American Samoa) qualify for electronic health record (EHR) incentive payments?

A: Yes, EPs in the U.S. Territories can receive EHR incentive payments under both the Medicare and Medicaid EHR Incentive Programs as long as they meet the applicable requirements. EPs must choose whether to participate in the Medicare or Medicaid EHR Incentive Program.

Q: Can eligible professionals (EPs) in Washington, D.C. receive electronic health record (EHR) incentive payments?

A: Yes, EPs in the District of Columbia can receive EHR incentive payments under the Medicare or Medicaid program as long as they meet the program's requirements. EPs in D.C. are subject to the same requirements as EPs in the 50 States and thus may not concurrently receive payments from both the Medicare and Medicaid EHR Incentive Programs.
Q: Can hospitals in Washington, D.C. receive the electronic health record (EHR) incentive payments?

A: Yes, hospitals in the District of Columbia can receive the Medicare and/or Medicaid EHR incentive payments as long as the hospitals meet the requirements for each program.