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West Virginia Medicaid Electronic Health Record Incentive Program Frequently Asked Questions

WEST VIRGINIA Department of Health & Human Resources

BUREAU FOR MEDICAL SERVICES

Medicaid EHR Incentive Program Frequently Asked Questions

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The State of West Virginia has consolidated the following Frequently Asked Questions (FAQs) regarding the West Virginia Medicaid Electronic Health Record (EHR) Provider Incentive Payment Program. The FAQs include all questions and responses (that are still valid with current program regulations) collected from the Center for Medicare and Medicaid Services (CMS) website, the CMS Health Information Technology for Economic and Clinical Health Act (HITECH) website, Community of Practice Calls, and State regulations that affect the program. If you have additional questions regarding the information contained in the FAQs, please contact Sam Stout at (304) 558-1700, or email at dhhrbms@wv.gov.

1 General Questions

If I have questions regarding the letter and questionnaire, who should I contact?

Questions can be directed to dhhrehr@wv.gov. When contacting this email, please be sure to provide your case number, provider National Provider Identifier (NPI) number, and the provider name used in the attestation.

What are the requirements/guidelines for acceptable screenshots of documentation for the audit?

The screenshot should:

- Show that it is from the Certified Electronic Health Record Technology (CEHRT), such as a vendor logo or the provider/practice name.
- Provide the date of the screenshot, especially if the documentation is used to verify a function that occurred previously.
- Include the information related to what is being verified.

Is this audit going to be completed remotely or on-site?

A desk audit will be performed where supporting documentation is received and reviewed remotely. Based on these results, additional review may be required, which could include an on-site visit. Hospitals or providers will be notified in advance of any on-site audits.

If data is in the CEHRT, can a different system be used to generate reports to provide documentation for this audit?

The CEHRT must be able to record the numerator and denominator and generate a report. However, non-certified systems can be used to calculate numerators and denominators and to generate reports regarding the measures.

If an Eligible Professional (EP) sees a patient in a setting that does not have CEHRT but enters all of the patient's information into CEHRT at another practice location, can the patient be counted in the numerators and denominators of MU 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 2016, what alternate exclusions are available for the public health reporting objective?

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: • May claim an Alternate Exclusion for Measure 2 and Measure 3 • 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 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 Certified EHR Technology

Can an EP use Electronic Health Record (EHR) technology certified for an inpatient setting to meet a MU 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 CEHRT designed for an ambulatory setting for such objectives. Please reference the Office of the National Coordinator for Health Information (ONC) FAQ 12-10-021-1 and 9-10-017-2 and Center for Medicare and Medicaid Services (CMS) FAQ 10162 for discussions on what it means to possess CEHRT; 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 MU.

How do I know if my EHR system is certified? How can I get my EHR system certified?

The Medicare and Medicaid EHR Incentive Programs require the use of CEHRT, 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 https://chpl.healthit.gov/#/resources. This is a list of complete EHRs and EHR modules that have been certified for the purposed of this program.

Through the temporary certification program, new certification bodies have been established to test and certify EHR technology. Vendors can submit their EHR products to the certifying bodies to be tested and certified. Hospitals and practices who have developed their own EHR systems or products can also seek to have their existing systems or products tested and certified. Complete EHRs may be certified, as well as EHR modules that meet at least one of the certification criteria. Once a product is

certified, the name of the product will be published on the ONC website: https://chpl.healthit.gov/#/resources.

Must providers have their EHR technology certified prior to beginning the EHR reporting period in order to demonstrate MU under the Medicare and Medicaid EHR Incentive Programs?

No. An EP or EH may begin the EHR reporting period for demonstrating MU before their EHR technology is certified. Certification need only be obtained prior to the end of the EHR reporting period. However, MU must be completed using the capabilities and standards outlined in the ONC Standards and Certification Regulation for CEHRT. 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 MU 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 MU will be demonstrated. This does not apply to changes made to EHR technology that were not necessary for certification.

2 Eligible Professionals—Eligibility

If I didn't contract with a third party to conduct a security risk assessment, do I still need to provide my results and documentation?

Yes, all providers attesting with MU need to undergo a security risk assessment and all findings and associated documentation must be provided regardless of the use of a third party.

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, 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 addition to meeting the same security risk analysis requirements as, 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 time frame but must take place no earlier than the start of the EHR reporting year and no later than the provider attestation date. For example, an 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 of meaningful use to ensure the privacy and security of their patients' protected health information.

Security Risk Analysis Tip Sheet: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2016ProgramRequirements.html

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016_SecurityRiskAnalysis.pdf

A 10 Step Plan: http://www.healthit.gov/providers-professionals/ehr-privacy-security/10-step-plan

How does the Center for Medicare and Medicaid Services (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 in section 1905(l)(2) defines a FQHC as an entity which, "(i) is receiving a grant under section 330 of the Public Health Service Act; (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) is 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, FQHC Look-Alikes, and Tribal Health Centers.

When EPs 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 MU and the minimum patient volume thresholds for the Medicaid EHR Incentive Program?

CMS considers these two separate but related issues.

MU: Any EP demonstrating MU must have at least 50% of their patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with CEHRT capable of meeting all of the MU objectives. Therefore, WV will collect information on meaningful users' practice locations in order to validate this requirement in an audit.

Patient volume: EPs 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 EP’s practice sites. However, at least one of the locations where the EP is adopting or meaningfully using CEHRT should be included in the patient volume. In other words, if an EP practices in two locations, one with CERHT and one without, the EP should include the patient volume at least at the site that includes the CEHRT. 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.

How is hospital-based status determined for EPs in the Medicare and Medicaid EHR Incentive Programs?

A hospital-based EP is defined as an EP who furnishes 90% or more of their covered professional services in either the inpatient (POS 21) or emergency department (POS 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 POS 21 or POS 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 Current Procedure Terminology (CPT) billing code counting as a single service. West Virginia will use encounter data to make this determination for Medicaid. States may use data from either the prior fiscal or calendar year.

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

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

For the Medicare and Medicaid EHR Incentive Programs, when a patient is only seen by a member of the 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 MU measures. In cases where a member of the EP's clinical staff is eligible for the Medicaid EHR incentive in their own right (Nurse Practitioners [NP]s and certain Physician Assistants [PA]s), 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.

When calculating Medicaid patient volume or needy patient volume for the Medicaid EHR Incentive Program, are 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.

For the Medicaid EHR Incentive Program, how are the reporting periods for Medicaid patient volume and for demonstrating MU affected if an 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 EP should use any continuous, representative 90-day period in the prior calendar year.
- For demonstrating they are a meaningful users of EHRs, EPs should use the EHR reporting period associated with that payment year (for the first payment year that an EP is demonstrating MU, the reporting period is a continuous 90-day period within the calendar year; for subsequent years the period is the full calendar year).

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

Yes, an EP who sees patients in an inpatient setting, and is not hospital based, can include the inpatient encounter in their Medicaid patient volume calculation. Both an EH 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 EH. Section 495.306 of the final rule defines an encounter as a service rendered to an individual enrolled in a Medicaid program by either an EP or an EH. An EP who sees patients in an inpatient 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 EH and the EP can count them as an encounter for Medicaid patient volume if they happened to select the same 90-day period.

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?

EPs 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.

Are EPs who practice in State mental health and long-term care facilities eligible for Medicaid 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 CEHRT, patient volume, etc.).

Are the criteria for needy patient volumes under the Medicaid EHR Incentive Program only applied to EPs practicing predominantly in FQHCs and/or 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.

Can providers participating in the Medicare or Medicaid EHR Incentive Programs update their information (for example, if an address was mistakenly entered?

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

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. West Virginia defines “pediatricians” as any provider who is licensed as a pediatrician.

Are physicians who work in hospitals eligible to receive Medicare or Medicaid EHR incentive payments?

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

3 Meaningful Use and Clinical Quality

What type of detail is required in the "detail of the numerator and denominator for the different measures"?

The detail is a list of the elements that the numerator or denominator is comprised of, such as a list of patients, number of prescriptions, etc. Each element included should have a unique identifier so that the count can be verified.

What if you don't have the capability in your EHR reporting system to provide a list of the patients included in your numerator or denominator counts?

You should work with your vendor to try to obtain the requested information. There may be reporting capabilities you are not aware of or special reporting options only available through the vendor. A local Regional Extension Center (REC) may also be able to intervene and assist the provider to better understand the program and the CEHRT if the vendor is unable to do so.

Who can enter medication orders in order to meet the measure for the computerized provider order entry (CPOE) MU objective under the Medicare and Medicaid EHR Incentive Programs?

As mentioned in 80 FR 62798, a medical staff person who is a credentialed medical assistant or is credentialed 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 the Medicare and Medicaid EHR Incentive Programs, how should an EP, EH, or CAH that sees patients in multiple practice locations equipped with CEHRT calculate numerators and denominators for the MU objectives and measures?

EPs, EHs, 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, EHs, 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 MU objectives.

Please keep in mind that patients whose records are not maintained in CEHRT 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 CEHRT 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, EHs 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 EH or CAH (e.g., inpatient or emergency department [POS 21 or 23]).

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

All cases where the EP has an actual physical encounter with the patient in which they render any service to the patient should be included in the denominator as seen by the EP. Also a patient seen through telemedicine would still count as a patient "seen by the EP." However, in cases where the EP and the patient do not have an actual physical or telemedicine encounter, but the EP renders a minimal consultative service for the patient (like reading an EKG), the EP may choose whether to include the patient in the denominator as "seen by the EP," provided the choice is consistent for the entire EHR reporting period and for all relevant MU measures.

For example, a cardiologist may choose to exclude patients for whom they provide a one-time reading of an EKG sent to them from another provider, but include more involved consultative services as long as the policy is consistent for the entire EHR reporting period and for all MU measures that include patients "seen by the EP." EPs who never have a physical or telemedicine interaction with patients must adopt a policy that classifies at least some of the services they render for patients as "seen by the EP" and this policy must be consistent for the entire EHR reporting period and across MU measures that involve patients "seen by the EP"—otherwise, these EPs would not be able to satisfy MU, as they would have denominators of zero for some measures.

If data is captured using CEHRT, can an EP or EH use a different system to generate reports used to demonstrate MU for the Medicare and Medicaid EHR Incentive Programs?

By definition, CEHRT 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 MU measures (specified in the certification criterion adopted at 45 CFR 170.302(n)). However, the MU measures do not specify that this capability must be used to calculate the numerators and denominators. EPs and EHs may use a

separate, non-certified system to calculate numerators and denominators and to generate reports on the measures.

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

For the Medicare and Medicaid EHR Incentive Programs, should patient encounters in an ambulatory surgical center (POS 24) be included in the denominator for calculating that at least 50% or more of an EP's patient encounters during the reporting period occurred at a practice/location or practices/locations equipped with CEHRT?

Yes. EPs who practice in multiple locations must have 50% or more of their patient encounters during the reporting period at a practice/location or practices/locations equipped with CEHRT. 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 the Medicare and Medicaid EHR Incentive Programs, when a patient is only seen by a member of the 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 MU measures. In cases where a member of the EP's clinical staff is eligible for the Medicaid EHR incentive in their own right (nurse practitioners [NPs] and certain physician assistants [PAs]), 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.

In order to meet the participation threshold of 50% of patient encounters in practice locations equipped with CEHRT 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% or more of their patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with CEHRT. For the purpose of calculating this 50% 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.

To meet the MU objective "use CPOE" for the Medicare and Medicaid EHR Incentive Programs, should 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's 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.

If an EP is unable to meet the measure of an MU 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 EHR Incentive Programs?

Some MU 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 an MU objective for which no exclusion is available, then that EP would not be able to successfully demonstrate MU and would not receive incentive payments under the Medicare and Medicaid EHR Incentive Programs.

For the MU 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.

Do controlled substances qualify as "permissible prescriptions" for meeting the eRx MU objective under the Medicare and Medicaid EHR Incentive Programs?

The inclusion of controlled substances in the permissible prescriptions for the purposes of the eRx MU 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).

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.

Can the drug-drug and drug-allergy interaction alerts of my EHR also be used to meet the MU 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 EHs must implement five clinical decision support interventions in addition to CDS drug-drug and drug-allergy interaction.

To meet the MU objective "use CEHRT to identify patient-specific resources and provide those resources to the patient" for the Medicare and Medicaid EHR Incentive Programs, does the certified EHR have to generate the education resources or can the EHR simply alert the provider of available resources?

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

Under the Medicare and Medicaid EHR Incentive Program, who is responsible for demonstrating MU of CEHRT, the provider or the vendor?

To receive an EHR incentive payment, the provider (EP, EH, or CAH) is responsible for demonstrating MU of CEHRT under both the Medicare and Medicaid EHR incentive programs.

In order to satisfy the MU objective for eRx in the Medicare and Medicaid 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% for EPs and more than 10% for EHs and CAHs. If the EP generates an electronic prescription and transmits it electronically using the standards of CEHRT 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.

What is the reporting period for EPs participating in the EHR incentive programs?

For demonstrating MU 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 CEHRT, which does not have a reporting period.

In a group practice, will each provider need to demonstrate MU in order to get Medicare and Medicaid EHR incentive payments or can MU 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 MU in order to qualify for the EHR incentive payments or avoid a payment adjustment.

For the MU objective of "generate and transmit prescriptions electronically (eRx)" for the Medicare and Medicaid 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 EHs 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, EHs, 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.

How should patients in swing beds be counted in the denominators of MU measures for EHs and CAHs for the Medicare and Medicaid EHR Incentive Programs?

A number of the MU measures for EHs 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 MU measures. However, if the EH or CAH's CEHRT 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 MU measures.

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 CEHRT by a licensed healthcare professional or certified medical assistant?

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.

How should nursery day patients be counted in the denominators of MU measures for EHs and CAHs for the Medicare and Medicaid 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 MU measures. However, if the EH's or CAH's CEHRT cannot readily identify and exclude nursery day patients, those patients may be included in the calculations for the denominators of MU measures.

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

Providers are continuing to implement new workflow processes to accurately capture clinical data in their CEHRT, but many providers are not able to capture all data at this time. Although providers are encouraged 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 CEHRT at this time. CMS recognizes that this may yield numerator, denominator, and exclusion values for clinical quality measures in the CEHRT 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 CEHRT in order to successfully demonstrate MU. CMS will continue to collaborate with our partners in the ONC and with industry stakeholders to make further headways in system interoperability, standards for EHR data, as well as certification of vendor products.

For the Medicare and Medicaid EHR Incentive Programs, is an EP or EH limited to demonstrating MU 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 EP or EH required to use that specific workflow when it demonstrates MU? 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 healthcare provider is permitted to use when demonstrating MU?

In most cases, an EP or EH is not limited to demonstrating MU to the exact way in which the Complete EHR or EHR Module was tested and certified. As long as an EP or EH 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 MU objective and measure, they can successfully demonstrate MU 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 CFR 36188 and 76 CFR 1301, respectively), published by the ONC, acknowledged that EPs and EHs could, where appropriate, modify their certified Complete EHR or certified EHR Module to meet local healthcare 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 EP’s or EH’s ability to successfully demonstrate MU.

In instances where a certification criterion expresses a capability that could potentially be added to or enhanced by an EP or EH, 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 EP’s or EH’s ability to successfully demonstrate MU.

In instances where the EHR technology was tested and certified using a sample workflow and/or generic forms/templates, an EP or EH 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 EP or EH would follow when using one or more capabilities of the certified Complete EHR or certified EHR Module to meet MU objectives and associated measures. An eligible healthcare 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 EP's or EH's ability to successfully demonstrate MU.

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 MU (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 EHs 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 MU. We will allow Alternate Exclusions for the Public Health Reporting Objective in 2016 as follows:

- May claim an Alternate Exclusion for Measure 2 and Measure 3
- 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

EHs/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

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.

If the electronic health record (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.

4 Glossary of Terms

AIU	Adopt, Implement, Upgrade
CAH	Critical Access Hospital
CEHRT	Certified Electronic Health Record Technology
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHPL	Certified Health IT Product List
CMS	Center for Medicare and Medicaid Services
CPOE	Computerized Provider Order Entry
CPT	Current Procedure Terminology
CQM	Clinical Quality Measure
DHS	Designated Health Services
DOJ	Department of Justice
EH	Eligible Hospital
EHR	Electronic Health Record
EP	Eligible Professional
eRx	Electronic Prescriptions
FQHC	Federally Qualified Health Center
HIT	Health Information Technology
HITECH	The Health Information Technology for Economic and Clinical Health Act
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Area
MU	Meaningful Use
NCPDP	National Council for Prescription Drug Programs
NP	Nurse Practitioner
NPI	The National Provider Identifier
ONC	Office of the National Coordinator for Health Information
ONC-ATCB	Office of the National Coordinator for Health Information Authorized Testing and Certification Body

PIP	Provider Incentive Payment
PA	Physicians Assistant
PFS	Physician Fee Schedule
POS	Place of Service
REC	Regional Extension Center
Recovery Act	American Recovery and Reinvestment Act of 2009
RHC	Rural Health Center
SDE	State Designated Entities
SNF	Skilled Nursing Facility