Old ID #	Question	Answer
9808	Can eligible professionals (EPs) receive electronic health record (EHR) incentive payments from both the Medicare and Medicaid programs?	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.
9809	My electronic health record (EHR) system is CCHIT certified. Does that mean it is certified for the Medicare and Medicaid EHR Incentive Programs?	program. The Certified Health IT Product List is available at http://www.healthit.gov/CHPL. This is a list of all complete EHRs and EHR modules that have been certified for the purposes of 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 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 web site – http://www.healthit.gov/CHPL. For more information, please visit the Office of the National Coordinator's website at http://healthit.hhs.gov/. For more information about the Medicare
9810	What is the maximum incentive an eligible professional (EP) can receive under the Medicaid Electronic Health Record (EHR) Incentive Program?	EPs who adopt, implement, upgrade, and meaningfully use EHRs can receive a maximum of $63,750 in incentive payments from Medicaid over a six year period (Note: There are special eligibility and payment rules for pediatricians). EPs must begin receiving incentive payments by calendar year 2016.
9811	What is the maximum electronic health record (EHR) incentive an eligible professional (EP) can earn under Medicare?	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.
9812	What if my electronic health record (EHR) system costs much more than the incentive the government will pay? May I request additional funds?	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.
9813	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?	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.

Source: File received directly from CMS.

Old ID #	Question	Answer
9814	How will eligible professionals (EPs) and eligible hospitals apply for incentives under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program?	Registration for the Medicare and Medicaid EHR Incentive Program is open and available online at https://ehrincentives.cms.gov. Please note that while most Medicaid EHR Incentive Programs are accepting registrations, launch dates will vary by State. Information on when registration will be available for Medicaid EHR Incentive Programs in specific States is posted at http://www.cms.gov/EHRIncentivePrograms/40_MedicaidStateInfo.asp.
9815	How will the public know who has received EHR incentive payments under Medicare and Medicaid EHR Incentive Program?	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, eligible hospitals and critical access hospitals (CAHs) that receive EHR incentive payments. There is no such requirement for CMS to publish information on eligible professionals and eligible hospitals receiving Medicaid EHR incentive payments, though individual States may opt to do so. To view a list of eligible professionals, eligible hospitals,and CAHs that have received Medicare EHR Incentive Payments, please http://www.cms.gov/EHRIncentivePrograms/56_DataAndReports.asp. We expect to update this list on a quarterly basis.
9843	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?	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.
9844	Are physicians who practice in hospital-based ambulatory clinics eligible to receive Medicare or Medicaid electronic health record (EHR) incentive payments?	A hospital-based eligible professional (EP) is defined as an EP who furnishes 90% 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.
9845	Will ambulatory surgical centers be eligible for incentive payments under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program?	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.
9957	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?	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.

Old ID #	Question	Answer
9958	Are Medicaid eligible professionals (EPs) and eligible hospitals subject to payment adjustments or penalties if they do not adopt electronic health record (EHR) technology or fail to demonstrate meaningful use?	There are no payment adjustments or penalties for Medicaid providers who fail to demonstrate meaningful use.
9959	What safeguards are in place to ensure that Medicaid electronic health record (EHR) incentive payments are used for their intended purpose?	Like the Medicare EHR incentive program, neither the statute nor the CMS Stage 1 final rule dictate 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.
9961	What is the reporting period for eligible professionals (EPs) participating in the electronic health record (EHR) incentive programs?	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.
9962	What is the reporting period for eligible hospitals participating in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program?	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 (except 2014), the EHR reporting period for eligible hospitals and critical access hospitals (CAHs) is the entire Federal fiscal year. In 2014, an eligible hospital or CAH can use either the entire Federal fiscal year or a 3-month period aligned with the quarters of the Federal fiscal year.
9963	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?	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.
9967	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?	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.

Old ID #	Question	Answer
10067	Do controlled substances qualify as "permissible prescriptions" for meeting the electronic prescribing (eRx) meaningful use objective under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?	The term "permissible prescriptions" refers to the restrictions that were established by the Department of Justice (DOJ) on electronic prescribing (eRx) for controlled substances in Schedule II-V. (The substances in Schedule II-V can be found at http://www.deadiversion.usdoj.gov/schedules/orangebook/e_cs_sched.pdf). Any prescription not subject to these restrictions would be a permissible prescription. Although DOJ recently published an Interim Final Rule that allows the electronic prescribing of these substances, we were unable to incorporate these recent guidelines into the Medicare and Medicaid EHR Incentive Programs. Therefore, the determination of whether a prescription is a ‘‘permissible prescription’’ for purposes of the eRx meaningful use objective should be made based on the guidelines for prescribing Schedule II-V controlled substances in effect on or before January 13, 2010, when the notice of proposed rulemaking was published in the Federal Register.
10068	For eligible professionals (EPs) who see patients in both inpatient and outpatient settings (e.g., hospital and clinic), and where certified electronic health record (EHR) technology is available at each location, should these EPs base their denominators for meaningful use objectives on the number of unique patients in only the outpatient setting or on the total number of unique patients from both settings?	In this case, EPs should base both the numerators and denominators for meaningful use objectives on the number of unique patients in the outpatient setting, since this setting is where they are eligible to receive payments from the Medicare and Medicaid EHR Incentive Programs.
10069	Are eligible professionals (EPs) who practice in State Mental Health and Long Term Care Facilities eligible for Medicaid electronic health record (EHR) incentive payments if they meet the eligibility criteria (e.g., patient volume, non-hospital based, certified EHR)?	The setting in which a physician, nurse practitioner, certified nurse-midwife, or dentist practices is 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.).
10070	If a patient is dually eligible for both Medicare and Medicaid, can they be counted twice by hospitals in their calculations if they are applying for electronic health record (EHR) incentive payments through both the Medicare and Medicaid EHR Incentive Programs?	For purposes of calculating the Medicaid share, a patient cannot be counted in the numerator if they would count for purposes of calculating the Medicare share. Thus, in this respect the inpatient bed day of a dually eligible patient could not be counted in the Medicaid share numerator. (See 1903(t)(5)(C), stating that the numerator of the Medicaid share does not include individuals "described in section 1886(n)(2)(D)(i).") In other respects; however, the patient would count twice. For example, in both cases, the individual would count in the total discharges of the hospital. To view the Stage 1 final rule for the Medicare and Medicaid EHR incentive programs, please visit: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf.

Old ID #	Question	Answer
10071	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?	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.
10072	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?	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 we 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." To view the Stage 1 final rule, please visit: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf
10073	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.	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.
10074	Are physicians who work in hospitals eligible to receive Medicare or Medicaid electronic health record (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.

Old ID #	Question	Answer
10075	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?	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. To view the Stage 1 final rule for the Medicare and Medicaid EHR incentive programs, please visit: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf.
10076	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?	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). To view the Stage 1 final rule for the Medicare and Medicaid EHR incentive programs, please visit: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf.
10077	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 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.
10082	Are mental health practitioners eligible to participate in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?	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/15_Eligibility.asp#TopOfPage.

Old ID #	Question	Answer
10083	Do I need to have an electronic health record (EHR) system in order to register for the Medicare and Medicaid EHR Incentive Programs?	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.
10084	What is meaningful use, and how does it apply to the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?	Under the Health Information Technology for Economic and Clinical Health (HITECH Act), which was enacted under the American Recovery and Reinvestment Act of 2009 (Recovery Act), incentive payments are available to eligible professionals (EPs), critical access hospitals, and eligible hospitals that successfully demonstrate are meaningful use of certified EHR technology. The Recovery Act specifies three main components of meaningful use: The use of a certified EHR in a meaningful manner (e.g.: e-Prescribing); The use of certified EHR technology for electronic exchange of health information to improve quality of health care; The use of certified EHR technology to submit clinical quality and other measures. In the final rule Medicare and Medicaid EHR Incentive Program, CMS has defined stage one of meaningful use. To view the final rule, please visit: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf. In August 2012, CMS issued a final rule that outlines the criteria that EPs, eligible hospitals and CAHs must meet for Stage 2. To view the Stage 2 final rule, please visit: http://www.ofr.gov/(X(1)S(uzclbwrx5fwqm2w2mipkysrh))/OFRUpload/OFRData/2012-21050_PI.pdf

Old ID #	Question	Answer
10085	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?	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/.
10086	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?	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.
10087	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?	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.
10088	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?	No, if an eligible professional (EP) earns an incentive under the Medicare EHR Incentive Program, he or she cannot receive an incentive payment under the eRx Incentive Program in the same program year, and vice versa. However, if an EP earns an incentive under the Medicaid EHR Incentive Program, he or she can receive an incentive payment under the eRx Incentive Program in the same program year.

Old ID #	Question	Answer
10089	How much are the Medicare and Medicaid Electronic Health Record (EHR) incentive payments to eligible professionals (EPs)?	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 (HPSA) 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 program. EPs may switch once between programs after a payment has been made and only before 2015.
10090	Are there any special incentives for rural providers in the Medicare and Medicare Electronic Health Record (EHR) Incentive Programs?	Under the Medicare EHR Incentive Program, the maximum allowed charge threshold for 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 rural or urban geographic Health Professional Shortage Area (HPSA). 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 the Medicaid EHR Incentive Program, there are no additional incentives for rural providers, beyond the incentives already available.
10092	Where can I get answers to my privacy and security questions about electronic health records (EHRs)?	The Office for Civil Rights (OCR) is responsible for enforcing the Privacy and Security rules related to the HITECH program. More information is available at OCR's website at http://www.hhs.gov/ocr/.
10093	What is the purpose of certified electronic health record (EHR) technology?	Certification of EHR technology will provide assurance to purchasers and other users that an EHR system or product offers the necessary technological capability, functionality, and security to help them satisfy the meaningful use objectives for the Medicare and Medicaid EHR Incentive Programs. Providers and patients must also be confident that the electronic health information technology (IT) products and systems they use are secure, can maintain data confidentially, and can work with other systems to share information. Confidence in health IT systems is an important part of advancing health IT system adoption and realizing the benefits of improved patient care. For more information, please visit the Office of the National Coordinator's website at http://healthit.hhs.gov/certification.

Old ID #	Question	Answer
10094	How do I know if my electronic health record (EHR) system is certified? How can I get my EHR system certified?	The Medicare and Medicaid EHR Incentive Programs require the use of certified EHR technology, as established by a new set of standards and certification criteria. Existing EHR technology needs to be certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB) to meet these new criteria in order to qualify for the incentive payments. The Certified Health IT Product List (CHPL) is available at http://www.healthit.hhs.gov/CHPL. This is a list of complete EHRs and EHR modules that have been certified for the purposed of this program. 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 web site: http://www.healthit.hhs.gov/CHPL. For more information, please visit the Office of the National Coordinator's website at http://healthit.hhs.gov/certification.
10095	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?	There are 15 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 Stage 1 final rule, please visit: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf.

Old ID #	Question	Answer
10097	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.	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, tThe 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.
10098	The billing provider on a claim is an eligible professional (EP) but the performing provider type is not an EP. If we use claims to validate patient volume or meaningful use for the Medicaid Electronic Health Record (EHR) Incentive Program, should we count performing providers (person rendering the service) or the billing provider?	In establishing an encounter for purposes of patient volume, please see the regulations at 495.306(e)(2)(i)-(ii) at 75 FR 44579. Furthermore, in estimating patient volume for any EP or hospital, we do not specify any requirements around billing, but rather we discuss patients. For example, if a physician's assistant (PA) provides services, but they are billed through the supervising physician, it seems reasonable that a State has the discretion to consider the patient as part of the patient volume for both professionals. However, this policy would need to be applied consistently. In this scenario, using services provided by the PA but billed under the physician in the physician's numerator (e.g., Medicaid encounters) also would increase the physician's denominator (all encounters), because the State would need to adequately reflect the total universe of patients (both Medicaid and non-Medicaid) who the PA saw, but for whom the physician billed. In terms of meaningful use, because each eligible professional must demonstrate meaningful use of certified EHR technology him or herself, if the State cannot not distinguish between the physician's claims and the PA's individual claims, then this would not be an adequate audit methodology. To view the final rule, please visit: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf.

Old ID #	Question	Answer
10100	Do States need to verify the "installation" or "a signed contract" for adopt, implement, or upgrade (AIU) in the Medicaid EHR Incentive Program?	States should make clear to providers when they attest for AIU what documentation they must maintain, and for how long, in case of audit. If States determine that certain provider types are a high risk for potential fraud/abuse for AIU, then they can ask for some verification of adopting, implementation or upgrading but CMS encourages that this be done in a targeted manner, with the most electronic and simple means possible and not in such a way that would be burdensome to providers. For AIU, a provider does not have to have installed certified EHR technology. The definition of AIU in 42 CFR 495.302 allows the provider to demonstrate AIU through any of the following: (a) acquiring, purchasing or securing access to certified EHR technology capable of meeting meaningful use; (b) installing or commencing utilization of certified EHR technology capable of meeting meaningful use requirements; or (c) expanding the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the EHR certification criteria published by the Office of the National Coordinator of Health Information Technology (ONC). Thus, a signed contract indicating that the provider has adopted or upgraded would be sufficient.
10101	When we count encounters in a clinic or medical group (or medical home model) for purposes of the Medicaid Electronic Health Record (EHR) Incentive Program, are we able to include the encounters of ancillary providers such as pharmacists, educators, etc. when determining if the eligible professionals (EPs) are eligible, per patient volume requirements?	Our regulations did not address whether these non-EP encounters could be considered in the estimate of patient volume for the clinic. However, we believe a State would have the discretion to include such non-EP encounters in its estimates. Again, if these non-EP encounters are included in the numerator, they must be included in the denominator as well. States also must ensure that their methodology adheres to the conditions in 42 CFR 495.306(h), and specifically 495.306(h)(4), which says: “(4) The clinic or group practice uses the entire practice or clinic’s patient volume and does not limit patient volume in any way.” To view the Stage 1 final rule, please visit: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf.

Old ID #	Question	Answer
10102	For the Medicaid Electronic Health Record (EHR) Incentive Program, if the EHR Reporting Period is calendar year (CY) 2013, then the payment year also refers to 2013 even though an eligible professional (EP) may receive the actual incentive payment in early 2014, correct?	The payment year is the year for which the payment is made (see 42 CFR 495.4 and the definition of “First, second, third, fourth, fifth, or sixth payment years.”). So, the questioner is correct that if the EHR reporting period is in CY 2013, the payment year also refers to 2013.
10104	It seems that each State has the latitude to define the 12-month period from which to derive the Medicaid share data for the purposes of the Medicaid Electronic Health Record (EHR) Incentive Program. Neither the preamble nor the regulatory text of the Stage 1 final rule explicitly stipulate that the 12-month period selected by the state for the Medicaid share data needs to be in the federal fiscal year (FY_ before the hospital's FY that serves as the first payment year. Am I correct in this interpretation? In other words, a state could use two different 12-month periods to calculate the discharge-related amount and the Medicaid share?	No, this is not correct. The regulation is clear that the discharge-related amount must be calculated using a 12-month period that ends in the Federal fiscal year before the hospital’s fiscal year that serves as the first payment year. 42 CFR 495.310(g)(1)((i)(B). This statement also was made in the preamble, where we stated: “For purposes of administrative simplicity and timeliness, we require that States use data on the hospital discharges from the hospital fiscal year that ends during the Federal fiscal year prior to the fiscal year that serves as the first payment year” 75 FR 44498. In addition, the regulation indicates that the period that is used for the Medicaid share is the same period as that used for the discharge-related amount. See 42 CFR 495.310(g)(2)(i) referring to “the 12-month period selected by the State.” Use of “the” in 495.310(g)(2) indicates that this is the same 12-month period that is used under 495.310(g)(1). In addition, we believe that using different periods for the Medicaid share versus the discharge-related amount would lead to inaccurate estimates, as data would be drawn from inconsistent periods. To view the Stage 1 final rule, please visit: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf.

Old ID #	Question	Answer
10106	If patients are dually eligible for Medicare and Medicaid, can they be counted twice by hospitals in their calculations for incentive payment if they are applying for both Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?	For purposes of calculating the Medicaid share, a patient cannot be counted in the numerator if they would count for purposes of calculating the Medicare share. Thus, in this respect the inpatient bed day of a dually eligible patient could not be counted in the Medicaid share numerator. (See 1903(t)(5)(C), stating that the numerator of the Medicaid share does not include individuals "described in section 1886(n)(2)(D)(i)."") In other respects; however, the patient would count twice. For example, in both cases, the individual would count in the total discharges of the hospital. To view the Stage 1 final rule, please visit: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf.
10108	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.)	The average annual growth rate should be for discharges (see 1903(t)(5)(B), referring to the annual rate of growth of the most recent 3 years for "discharge data.") We agree that the sources are different. Hospitals would probably have to use MMIS or auditable hospital records to get accurate discharge data rate of growth. To view the Stage 1 final rule, please visit: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf.
10109	Is data sharing with neighboring States permitted regarding total Medicaid days for purposes of paying full incentives to hospitals or eligible professionals (EPs) with utilization in multiple states under the Medicaid Electronic Health Record (EHR) Incentive Program?	Yes. The CMS Stage 1 final rule clarifies the policy about calculating patient volume for Medicaid providers with clinical practices in more than one State, both in terms of what is "Medicaid patient volume" and about the cross-border issue. See 75 FR 44503, stating: "[W]e recommend that States consider the circumstances of border State providers when developing their policies and attestation methodologies. To afford States maximum flexibility to develop such policies, we will not be prescriptive about whether a State may allow a Medicaid EP to aggregate his/her patients across practice sites, if the State has a way to verify the patient volume attestation when necessary. States will propose their policies and attestation methodologies to CMS for approval in their State Medicaid HIT plans." However, as stated in the Stage 1 final rule, EPs and hospitals are permitted to receive payment from only one State in a payment year (495.310(e)). To view the Stage 1 final rule, please visit: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf.
10110	Does a State have the option of solely using a state-submitted alternative methodology (pending CMS approval) for determining patient volume, or is the State additionally required to use one of the CMS specified methodologies (patient encounter or patient volume) for the Medicaid Electronic Health Record (EHR) Incentive Program?	Yes, the State can submit to us for approval only the alternative methodology that meets the requirements of 495.306(g). As we stated in the preamble to the Stage 1 final rule, we believe most States will not submit alternative methodologies until after the first year of the program, allowing for alternatives to recognize evolving State and provider experience with patient volume estimate methodologies. We recommend that States consider the methodologies that were put forward in the Stage 1 final rule, prior to proposing only an alternative in their State Medicaid Health Information Technology Plans (SMHPs). If a State alternative methodology is approved by us, we will post this methodology on our website, so that other States may adopt the methodology as well.
10111	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?	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.

Old ID #	Question	Answer
10112	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?	This is correct. 24 CFR 495.4 establishes a one-time exception for providers attesting to meaningful use in 2014 during which the reporting period for Medicaid providers is any continuous 90-day period within the reporting year.
10126	A number of measures for Meaningful Use objectives for eligible hospitals and critical access hospitals (CAHs) include patients admitted to the Emergency Department (ED). Which ED patients should be included in the denominators of these measures for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?	There are two methods for calculating ED admissions for the denominators for measures associated with Stage 1 of Meaningful Use objectives. Eligible hospitals and CAHs must select one of the methods below for calculating ED admissions to be applied consistently to all denominators for the measures. That is, eligible hospitals and CAHs must choose either the “Observation Services method” or the “All ED Visits method” to be used with all measures. Providers cannot calculate the denominator of some measures using the “Observation Services method,” while using the “All ED Visits method” for the denominator of other measures. Before attesting, eligible hospitals and CAHs will have to indicate which method they used in the calculation of denominators. Observation Services method. The denominator should include the following visits to the ED: The patient is admitted to the inpatient setting (place of service (POS) 21) through the ED. In this situation, the orders entered in the ED using certified EHR technology would count for purposes of determining the computerized provider order entry (CPOE) Meaningful Use measure. Similarly, other actions taken within the ED would count for purposes of determining Meaningful Use The patient initially presented to the ED and is treated in the ED’s observation unit or otherwise receives observation services. Details on observation services can be found in the Medicare Benefit Policy Manual, Chapter 6, Section 20.6. Patients who receive observation services under both POS 22 and POS 23 should be included in the denominator. All ED Visits method. An alternate method for computing admissions to the ED is to include all ED visits (POS 23 only) in the denominator for all measures requiring inclusion of ED admissions. All actions taken in the inpatient or emergency departments (POS 21 and 23) of the hospital would count for purposes of determining meaningful use.

Old ID #	Question	Answer
10127	How does CMS define Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) for the purposes of the Medicaid EHR Incentive Program?	The Social Security Act at section 1905(l)(2) defines an FQHC as an entity which, "(i) is receiving a grant under section 330 of the Public Health Service Act, or (ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant and (II) meets the requirements to receive a grant under section 330 of the Public Health Service Act, (iii) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, and is determined by the Secretary to meet the requirements for receiving such a grant including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity; or (iv) was treated by the Secretary, for purposes of Part B of title XVIII, as a comprehensive Federally-funded health center as of January 1, 1990, and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act for the provision of primary health services." RHCs are defined as clinics that are certified under section 1861(aa)(2) of the Social Security Act to provide care in underserved areas, and therefore, to receive cost-based Medicare and Medicaid reimbursements. In considering these definitions, it should be noted that programs meeting the FQHC requirements commonly include the following (but must be certified and meet all requirements stated above): Community Health Centers, Migrant Health Centers, Healthcare for the Homeless Programs, Public Housing Primary Care Programs, Federally Qualified Health Center Look-Alikes, and Tribal Health Centers.
10128	We are a tribal clinic with: one full-time physician, one part-time pediatrician, one part-time physicians assistant (PA). Are we going to receive electronic health record (EHR) incentive payments directly from Medicaid?	Clinics are not directly eligible for the Medicaid EHR Incentive Program payments, however if the practitioners at your clinic meet the eligibility criteria and successfully adopt, implement, upgrade or meaningfully use certified EHR technology, they may choose to reassign their incentive payments to your clinic. Your clinic would need to have a taxpayer identification number (TIN) that is already established with the State Medicaid agency. A PA is eligible only if your FQHC or RHC is led by a PA. Our Stage 1 final rule preamble discusses what it means for a PA to have lead role in an FQHC or RHC at page 44483.
10129	What provisions are there for tribal clinics to receive payments from the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program, rather than the physicians themselves - especially when it is a family medicine practice? I heard there were certain percentage of patients that had to be either Medicare or Medicaid and that a physician had to decide which they were going to apply for. What if their practice includes both types of patients?	Clinics are not eligible for EHR incentive payments. However, eligible professionals who qualify for an EHR incentive payment may reassign that payment to the taxpayer identification number (TIN) of their employer, if they so choose. You are correct that eligible professionals must choose either the Medicare or the Medicaid EHR Incentive Program, and may not simultaneously receive payments from both programs if they qualify for both. They may make a one-time switch after having received an incentive payment, but the switch must occur before 2015.

Old ID #	Question	Answer
10134	Who can enter medication orders in order to meet the measure for the computerized provider order entry (CPOE) meaningful use objective under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs? When must these medication orders be entered?	Any licensed healthcare professional can enter orders into the medical record for purposes of including the order in the numerator for the measure of the CPOE objective if they can enter the order per state, local, and professional guidelines. The order must be entered by someone who could exercise clinical judgment in the case that the entry generates any alerts about possible interactions or other clinical decision support aides. This necessitates that CPOE occurs when the order first becomes part of the patient's medical record and before any action can be taken on the order. Each provider will have to evaluate on a case-by-case basis whether a given situation is entered according to state, local, and professional guidelines, allows for clinical judgment before the medication is given, and is the first time the order becomes part of the patient's medical record.
10135	If a provider purchases a Complete Electronic Health Record (EHR) but opts to use alternate certified EHR modules for certain Meaningful Use functionality, will that provider qualify as a Meaningful User under the Medicare and Medicaid EHR Incentive Programs?	To successfully demonstrate meaningful use a provider must do three things: 1. Have certified EHR technology capable of demonstrating meaningful use, either through a complete certified EHR or a combination of certified EHR modules; 2. Meet the measures or exclusions for 20 Meaningful Use objectives (19 objectives for eligible hospitals and Critical Access Hospitals (CAHs)); and 3. Meet those measures using the capabilities and standards that were certified to accomplish each objective. If a provider can meet all of these requirements, that provider may qualify for an incentive payment under the Medicare and Medicaid EHR Incentive Programs.
10136	One of the menu set Meaningful Use objectives for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs requires eligible professionals (EPs), eligible hospitals and Critical Access Hospitals (CAHs) to incorporate clinical lab-test results into EHR as structured data. Must there be an explicit linking between structured lab results received into the EHR and the order placed by the physician for the lab test in order to count a structured lab result in the numerator for the measure of this objective?	The only requirement to meet the measure of this objective is that more than 40 percent of all clinical lab tests results ordered during the EHR reporting are incorporated in certified EHR technology as structured data. Provided the lab result is recorded as structured data and uses the standards to which certified EHR technology is certified, there does not need to be an explicit linking between the lab result and the order placed by the physician in order to count it in the numerator for the measure of this objective in the Medicare and Medicaid EHR Incentive Programs.
10137	In order to satisfy the Meaningful Use objective for electronic prescribing (eRx) in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, can providers use intermediary networks that convert information from the certified EHR into a computer-based fax for sending to the pharmacy? Should these transactions be included in the numerator for the measure of this objective?	The meaningful use measure for e-prescribing is the electronic transmission of 40 percent of all permissible prescriptions. If the EP generates an electronic prescription and transmits it electronically using the standards of certified EHR technology to either a pharmacy or an intermediary network, and this results in the prescription being filled without the need for the provider to communicate the prescription in an alternative manner, then the prescription would be included in the numerator.

Old ID #	Question	Answer
10138	Are payments from the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs subject to federal income tax?	We note that nothing in the Act excludes such payments from taxation or as tax-free income. Therefore, it is our belief that incentive payments would be treated like any other income. Providers should consult with a tax advisor or the Internal Revenue Service regarding how to properly report this income on their filings.
10140	Do providers register only once for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, or must they register every year?	Providers are only required to register once for the Medicare and Medicaid EHR Incentive Programs. However, they must successfully demonstrateattest that they have either adopted, implemented or upgraded (first participation year for Medicaid), or meaningfully usedsuccessfully demonstrated meaningful use of certified Certified EHR technology Technology each year in order to receive an incentive payment for that year. Additionally, providers seeking the Medicaid incentive must annually re-attest to other program requirements, such as meeting the required patient volume thresholds. Providers will register using the Medicare and Medicaid EHR Incentive Program Registration & Attestation System, a web-based system. Providers who have elected to participate in the Medicare EHR Incentive Program will also use this system to attest to their program eligibility and meaningful use. Providers who select the Medicaid EHR Incentive Program will demonstrate their eligibility and attest via their State Medicaid Agency's system. If any basic registration information changes, the provider will need to update their information in the Medicare and Medicaid EHR Incentive Program Registration & Attestation System.
10141	For large practices, will there be a method to register all of the Eligible Professionals (EPs) at one time for the Medicare or Medicaid Electronic Health Record (EHR) Incentive Programs? Can EPs allow another person to register or attest for them?	In April 2011, CMS implemented functionality that allows an EP to designate a third party to register and attest on his or her behalf. To do so, users working on behalf of an EP must have an Identity and Access Management System (I&A) web user account (User ID/Password) and be associated to the EP's NPI. If you are working on behalf of an EP(s) and do not have an I&A web user account, please visit https://nppes.cms.hhs.gov/NPPES/IASecurityCheck.do to create one. States will not necessarily offer the same functionality for attestation in the Medicaid EHR Incentive Program. Check with your State to see what functionality will be offered.
10142	One of the measures for the core set of clinical quality measures for eligible professionals (EPs) is not applicable for my patient population. Am I excluded from reporting that measure for the Medicare or Medicaid Electronic Health Record (EHR) Incentive Programs?	An eligible professional (EP) is not excluded from reporting core clinical quality measures. However, zero is an acceptable value to report for the denominator of a clinical quality measure if there is no patient population within the EHR to whom that clinical quality measure applies. If an EP reports a zero denominator for one of the core measures, then the EP is required to report results for up to three alternate core measures (possibly reporting denominators of 0 for all three alternate core measures). We refer readers to pp. 44409-10 of the preamble to our final rule for our discussion of this issue.

Old ID #	Question	Answer
10143	Can I use the electronic specifications for clinical quality measures to satisfy both the Physician Quality Reporting System (PQRS) and the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?	No. Each program has specific specifications for reporting. In the future CMS expects to harmonize specifications between PQRS (formerly known as the Physician Quality Reporting Initiative, or PQRI) and the Medicare and Medicaid EHR Incentive Programs. Therefore if a provider is reporting under the PQRI EHR program, they must refer to the PQRS EHR specifications found at http://www.cms.gov/PQRI/20_AlternativeReportingMechanisms.asp. Providers are required to report using the specifications for clinical quality measures found at http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage.
10144	I am an eligible professional (EP) for whom none of the Stage 1 core, alternate core, or additional clinical quality measures adopted for the Medicare and Medicaid Electronic Health Record (EHR) incentive programs apply. Am I exempt from reporting on all clinical quality measures?	In the event that none of the 44 clinical quality measures applies to an EP's patient population, the EP is still required to report a zero for the denominators for all six of the core and alternate core clinical quality measures. If all of the remaining 44 clinical quality measures included in Table 6 of our final rule do not apply to the EP, then the EP is still required to report on at least three of the additional clinical quality measures of their choosing from Table 6 of the final rule (other than the six core/alternative core measures). If the EP reports zero values for these three additional, menu-set clinical quality measures, then for the remaining menu-set clinical quality measures, the EP will also have to attest that all the other menu-set quality measures calculated by the certified EHR technology have a value of zero in the denominator. In other words, the EP is required is required to try to find at least three measures in the menu set for which the denominator is other than zero. If s/he cannot, then the EP must still choose three menu-set measures on which to report. S/he may report zero denominators for some or all of these measures, but must accompany such "zero denominator" reporting with an attestation that all of the other menu-set measures calculated by the certified EHR technology have a value of zero in the denominator. A zero report in the menu-set is not sufficient without such accompanying attestation. We refer readers to page 44410 of the preamble to the Stage 1 final rule.
10145	If the denominators for all three of the core clinical quality measures are zero, do I have to report on the additional clinical quality measures for eligible professionals (EPs) under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?	If the denominator value for all three of the core clinical quality measures is zero, an EP must report a zero denominator for all such core measures, and then must also report on all 3 alternate core clinical quality measures. If the denominator values for all three of the alternate core clinical quality measures is also '0,' an EP still needs to report on 3 additional clinical quality measures. Zero is an acceptable denominator provided that this value was produced by certified EHR technology. Please see question number 10144 for a discussion of zero denominator reporting in the menu set.
10146	For eligible hospitals and critical access hospitals (CAHs) under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, will the clinical quality measure results be calculated similar to the Hospital Inpatient Quality Reporting (IQR) Program (Formerly known as Reporting Hospital Quality Data for Annual Payment Update program)?	No. For all clinical quality measures reported for the Medicare and Medicaid EHR Incentive Programs, the certified EHR must report the numerator, denominator, and exclusion results. Providers will report their aggregate results for clinical quality measures during attestation to CMS or the States.

Old ID #	Question	Answer
10148	Will the resident physicians be eligible to participate in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?	For the Medicaid EHR Incentive Program, all eligible professionals must meet their state's scope of practice rules to participate. For physicians, this typically includes education, licensure, and board certification. For the Medicare EHR Incentive Program, a resident must meet the definition of a Medicare eligible professional, be in the Provider Enrollment and Chain Ownership System (PECOS), with an enrollment status of APPROVED and have Part B allowed charges to be eligible for the Medicare EHR incentives.
10149	Will academic physicians employed by an academic medical center billing under the same CMS facility number as the hospital be allowed to participate as eligible professionals (EPs) in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs if they qualify in all other aspects?	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 considered to be hospital-based and are therefore not eligible for incentive payments under the Medicare and Medicaid EHR Incentive Programs. If an academic physician is employed by an academic medical center, bills under the same CCN, and is considered hospital-based according to the definition above, then the academic physician would not be eligible to participate as an eligible professional in the Medicare and Medicaid EHR Incentive Programs.
10150	To meet the Stage 1 Meaningful Use objective "maintain an up-to-date problem list of current and active diagnoses" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, are eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) required to use ICD-9 or SNOMED-CT®?	The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs do not specify the use of ICD-9 and SNOMED-CT® to meet the measure for the Meaningful Use objective "maintain an up-to-date problem list of current and active diagnoses." However, the Office of the National Coordinator for Health Information Technology (ONC) has adopted ICD-9 and SNOMED-CT® as a standard for the entry of structured data in certified EHR technology. Therefore, EPs, eligible hospitals, and CAHs will need to maintain an up-to-date problem list of current and active diagnoses using ICD-9 and SNOMED-CT® in order to meet the measure for this objective.
10151	If an eligible professional (EP) is unable to meet the measure of a Meaningful Use objective because it is outside of the scope of his or her practice, will the EP be excluded from meeting the measure of that objective under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?	Some Meaningful Use objectives provide exclusions and others do not. Exclusions are available only when our regulations specifically provide for an exclusion. EPs may be excluded from meeting an objective if they meet the circumstances of the exclusion. If an EP is unable to meet a Meaningful Use objective for which no exclusion is available, then that EP would not be able to successfully demonstrate Meaningful Use and would not receive incentive payments under the Medicare and Medicaid EHR Incentive Programs.

Old ID #	Question	Answer
10153	If a provider feeds data from certified electronic health record (EHR) technology to a data warehouse, can the provider report on Meaningful Use objectives and clinical quality measures from the data warehouse?	To be a meaningful EHR user a provider must do three things: 1. Have complete certified EHR technology for all meaningful use objectives either through a complete EHR or a combination of modules; and 2. Meet 20 measures (19 for eligible hospitals and CAHs), including all of the core and five (5) menu-set measures associated with the objectives (unless excluded). Core measures include reporting clinical quality measures. 3. Use the capabilities and standards of certified EHR technology in meeting the measure of each objective If the conditions above are met and data is transferred from the certified EHR technology to a data warehouse, the provider can use information from the data warehouse to report on Meaningful Use objectives and clinical quality measures. However, in order to report calculated clinical quality measures, the data warehouse may need to be certified. The Office of the National Coordinator of Health Information Technology has addressed the issue of certification of a data warehouse in the following Frequently Asked Question: http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3163&PageID=20775. For more information about certification, you can contact ONC directly at onc.certification@hhs.gov.

Old ID #	Question	Answer
10154	In order to receive payments under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, does a provider have to be enrolled in the Provider Enrollment, Chain, and Ownership System (PECOS)?	In order to receive Medicare EHR incentive payments, EPs, eligible hospitals, and critical access hospitals must have an enrollment record in PECOS with an APPROVED status. Medicaid EPs do not have to be in PECOS. It is possible to receive payment for Medicare claims and not be in approved status. We encourage all providers to verify their status as soon as possible. There are three ways to verify that you have an enrollment record in PECOS: 1. Check the Ordering Referring Report on the CMS website. If you are on that report, you have a current enrollment record in PECOS. Go to http://www.cms.gov/MedicareProviderSupEnroll/, click on "Ordering Referring Report" on the left. 2. Use Internet-based PECOS to look for your PECOS enrollment record. If no record is displayed, you do not have an enrollment record in PECOS. Go to http://www.cms.gov/MedicareProviderSupEnroll/, click on "Internet-based PECOS" on the left. 3. Contact your designated Medicare enrollment contractor and ask if you have an enrollment record in PECOS. Go to http://www.cms.gov/MedicareProviderSupEnroll/, click on "Medicare Fee-For-Service Contact Information" under "Downloads." If you are not in PECOS, the best way to submit your application is through internet-based PECOS. For more information go to: http://questions.cms.hhs.gov/app/answers/detail/a_id/10038/kw/pecos/session/L3NpZC9qeG1GdDliaw%3D%3D Indian Health Service (IHS) providers who submit a paper CMS-855 will have their enrollment information entered into PECOS.
10155	Is my practice eligible to receive incentive payments through the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?	Incentive payments are not made to practices but to individual eligible professionals (EPs). For more information about who is eligible to participate, please visit http://www.cms.gov/EHRIncentivePrograms/15_Eligibility.asp#TopOfPage.
10156	In recording height as part of the Stage 1 core Meaningful Use objective "Recording vital signs" for eligible professionals (EPs), eligible hospitals, and Critical Access Hospitals (CAHs), how should providers account for patients who are too sick or otherwise cannot be measured safely?	In cases where taking an actual height measurement is inappropriate, self-reported or estimated height can be used.

Old ID #	Question	Answer
10157	Must providers have their electronic health record (EHR) technology certified prior to beginning the EHR reporting period in order to demonstrate Meaningful Use under the Medicare and Medicaid EHR Incentive Programs?	No. An EP or hospital may begin the EHR reporting period for demonstrating Meaningful Use before their EHR technology is certified. Certification need only be obtained prior to the end of the EHR reporting period. However, Meaningful Use must be completed using the capabilities and standards outlined in the ONC Standards and Certification Regulation for certified EHR technology. Any changes to the EHR technology after the beginning of the EHR reporting period that are made in order to get the EHR technology certified would be evidence that the provider was not using the capabilities and standards necessary to accomplish Meaningful Use because those capabilities and standards would not have been available, and thus, any such change (no matter how minimal) would disqualify the provider from being a meaningful EHR user. If providers begin the EHR reporting period prior to certification of their EHR technology, they are taking the risk that their EHR technology will not require any changes for certification. Any changes made to gain certification must be done prior to the beginning of the EHR reporting period during which Meaningful Use will be demonstrated. This does not apply to changes made to EHR technology that were not necessary for certification.
10158	Are professional services rendered by physicians or other eligible professional that are billed by the Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) included in the calculation of the Medicare eligible professional (EP) electronic health record (EHR) incentive payment?	No. The Health Information Technology for Economic and Clinical Health (HITECH) Act created an EHR incentive payment for EPs under Medicare based on the allowed charges for covered professional services furnished by the EP. Since services provided by eligible professionals while working in RHCs are not billed under the Part B physician fee schedule, they do not meet the HITECH Act definition of "covered professional services." As the HITECH Act bases the Medicare EHR incentive payment on a percentage of allowed charges for "covered professional services," services provided in the RHC by the eligible professional would not be included in the calculation for the Medicare EHR incentive. As the Medicaid EHR incentive payment is based on a different methodology, the eligible professionals in RHCs may still qualify for the Medicaid EHR incentive payment if they, or the whole RHC as a proxy, meet the 30 percent threshold for "needy individuals" as defined in statute and other program requirements.

Old ID #	Question	Answer
10160	How and when will incentive payments for the Medicare Electronic Health Record (EHR) Incentive Programs be made?	Incentive Program will be made approximately eight to twelve weeks after an EP successfully attests that they have demonstrated meaningful use of certified EHR technology. However, EPs will not receive incentive payments within that timeframe if they have not yet met the threshold for allowed charges for covered professional services furnished by the EP during the year. Payments will be held until the EP meets the threshold in allowed charges for the calendar year ($24,000 in the EP's first year) in order to maximize the amount of the EHR incentive payment they receive. Medicare EHR incentive payments are based on 75% of the estimated allowed charges for covered professional services furnished by the EP during the entire calendar year. If the EP has not met the threshold in allowed charges by the end of calendar year, CMS expects to issue an incentive payment for the EP in March of the following year (allowing two months after the end of the calendar year for all pending claims to be processed). Payments to Medicare EPs will be made to the taxpayer identification number (TIN) selected at the time of registration, through the same channels their claims payments are made. The form of payment (electronic funds transfer or check) will be the same as claims payments. Bonus payments for EPs who practice predominantly in a geographic Health Professional Shortage Area (HPSA) will be made as separate lump-sum payments no later than the end of the calendar year following the year in which the EP was eligible for the bonus payment. Medicare EHR incentive payments to eligible hospitals and critical access hospitals (CAHs) will also be made approximately four to eight weeks after the eligible hospital or CAH successfully attests to having demonstrated meaningful use of certified EHR technology. Eligible hospitals and CAHs will receive an initial payment and a final payment. Final payment will be determined at the time of settling the hospital cost report. CAHs will be paid
10161	After successfully demonstrating meaningful use for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program, will incentive payments be paid as a lump sum or in multiple installments?	Eligible professionals (EPs) participating in the Medicare EHR Incentive Program will receive a single lump sum payment for each year they successfully demonstrate meaningful use of certified EHR technology no later than the end of the calendar year following the year in which the EP was eligible for the bonus payment. Eligible hospitals and critical access hospitals (CAHs) participating in the Medicare EHR Incentive Program will first receive an initial payment. The final payment will be determined at the time of settling the hospital cost report. Payments to Medicare providers will be made to the taxpayer identification number (TIN) selected at the time of registration, through the same channels their claims payments are made. However, for EPs practicing in a health professional shortage area (HPSA), the additional incentive payment will be paid separately to the same TIN as the incentive payment. Medicaid incentives will be paid by the States. EPs, eligible hospitals, and CAHs participating in the Medicaid EHR Incentive Program should check with their State.

Old ID #	Question	Answer
10162	How should eligible professionals (EPs) select menu objectives for the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs?	report on a total of 5 meaningful use objectives from the menu set of 10. When selecting five objectives from the menu set, EPs must choose at least one option from the public health menu set. If an EP is able to meet the measure of one of the public health menu objectives but can be excluded from the other, the EP should select and report on the public health menu objective they are able to meet. If an EP can be excluded from both public health menu objectives, the EP should claim an exclusion from only one public health objective and report on four additional menu objectives from outside the public health menu set. EPs participating in Stage 2 are required to report 3 meaningful use objectives from the menu set of 6. We encourage EPs to select menu objectives that are relevant to their scope of practice, and claim an exclusion for a menu objective only in cases where there are no remaining menu objectives for which they qualify or if there are no remaining menu objectives that are relevant to their scope of practice. For example, we hope that EPs will report on 5 measures, if there are 5 measures that are relevant to their scope of practice and for which they can report data, even if they qualify for exclusions in the other objectives. Starting in 2014 for both Stage 1 and Stage 2, meeting the exclusion criteria will no longer count as reporting a meaningful use objective from the menu set. An EP must meet the measure criteria for 5 objectives in Stage 1 (3 objectives in Stage 2) or report on all of the menu set objectives through a combination of meeting exclusion and meeting the measure. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.

Old ID #	Question	Answer
10163	What is the definition of "reasonable cost" for critical access hospitals (CAHs) under the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs?	The reasonable costs for which a CAH may receive an EHR incentive payment are the reasonable acquisition costs for the purchase of certified EHR technology to which purchase depreciation (excluding interest) would otherwise apply. Section 495.106(a) of the regulations states that reasonable costs incurred for the purchase of certified EHR technology for a qualifying CAH means the reasonable acquisition costs incurred for the purchase of depreciable assets as described in part 413 subpart G of the regulations, such as computers and associated hardware and software, necessary to administer certified EHR technology as defined in section 495.4 excluding any depreciation and interest expenses associated with the acquisition. This EHR incentive payment provision allows a qualifying CAH to expense the acquisition costs of a qualifying asset in a single payment year instead of depreciating the acquisition costs over the useful life of the asset. If a qualifying CAH incurs non-depreciable expenses related to implementing/maintaining its EHR system, those expenses cannot be included in the EHR incentive payment. However, those expenses may be an allowable cost for Medicare payment purposes, under the current reasonable cost payment methodology for CAHs, in the cost reporting period in which such expenses are incurred. For example, if a qualifying CAH rents its EHR technology assets, instead of purchasing the assets, the rent expense cannot be included in the EHR incentive payment. However, the rent expense may be an allowable cost for Medicare payment purposes, under the current reasonable cost payment methodology for CAHs, in the cost reporting period in which such expense is incurred. Qualifying CAHs should contact their Medicare contractor to answer questions on reasonable costs that will be included in the calculation of the EHR incentive payment.
10164	To meet the meaningful use objective "use certified EHR technology to identify patient-specific resources and provide those resources to the patient" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, does the certified EHR have to generate the education resources or can the 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 certified EHR technology in a manner where the technology suggests patient-specific educational resources based on the information stored in the certified EHR technology. The provider can make a final decision on whether the education resource is useful and relevant to a specific patient.
10165	For the meaningful use objective of "record demographics" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program, what documentation is required when recording the preliminary cause of death in the event of mortality?	Eligible hospitals and critical access hospitals (CAHs) must record in the patient's EHR the clinical impression and preliminary assessment of the cause of death. No further documentation is required. This measure does not require the cause of death to be updated if the case is referred to the Department of Health or coroner's office.
10166	If a patient visit spans several days and the patient is seen by multiple eligible professionals (EPs) during that time period, does each EP need to provide a separate clinical summary or can the provision of a single clinical summary at the end of the visit meet the meaningful use objective for "provide clinical summaries for patients after each office visit" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?	When a patient visit lasts several days and the patient is seen by multiple EPs, a single clinical summary at the end of the visit can be used to meet the meaningful use objective for "provide clinical summaries for patients after each office visit."

Old ID #	Question	Answer
10167	If an eligible professional (EP) does not accept assignment for Medicare Part B, is the EP eligible for an incentive payment under the Medicare Electronic Health Records (EHR) Incentive Program?	An EP that is not a Medicare participating physician or supplier, but still submits claims to Medicare for Part B physician fee schedule services on behalf of Medicare patients to whom they furnish services would be eligible for Medicare EHR incentive payments. When the EP successfully registers and demonstrates meaningful use of certified EHR technology, the calculation of the EP's incentive payment will reflect claims for all services reimbursed under the Part B physician fee schedule regardless of whether the EP accepted assignment on those claims or not.
10267	If a dually-eligible hospital initially registers only for the Medicaid EHR Incentive Program, but later decides that it wants to also register for the Medicare EHR Incentive Program, can it go back and change its registration from Medicaid only to both Medicare and Medicaid?	Hospitals that are eligible for EHR incentive payments under both Medicare and Medicaid should select “Both Medicare and Medicaid” during the registration process, even if they plan to apply only for a Medicaid EHR incentive payment by adopting, implementing, or upgrading certified EHR technology. Dually-eligible hospitals can then attest through CMS for their Medicare EHR incentive payment at a later date, if they so desire. It is important for a dually-eligible hospital to select “Both Medicare and Medicaid” from the start of registration in order to maintain this option. Hospitals that register only for the Medicaid program (or only the Medicare program) will not be able to manually change their registration (i.e., change to “Both Medicare and Medicaid” or from one program to the other) after a payment is initiated and this may cause significant delays in receiving a Medicare EHR incentive payment.