Navigating Meaningful Use: Are You Ready?

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Agenda For This Segment

ARRA, HITECH, and “Meaningful Use”
  What is Meaningful Use?
  Progress to Date
  How providers meet Meaningful Use
  Meaningful Use Audits
  Red Flags
  What if I fail an Audit?
  Client Experiences:
  Things to Think About

ARRA, HITECH, and “Meaningful Use”

- The Health Information Technology for Economic and Clinical Health (HITECH) Act was enacted as part of the American Recovery and Reinvestment Act of 2009 (ARRA).
- The HITECH Act includes more than $19 billion to help develop a robust IT infrastructure and data exchange capabilities for healthcare, as well as to assist providers in adopting and using Health Information Technology, including the implementation of Electronic Health Records (EHRS).
- The Medicare and Medicaid EHR Incentive Program, a.k.a. “Meaningful Use” is born!
  The goal of this program is to increase EHR adoption, and support the “meaningful use” of EHR technology in order to improve safety, quality and reduce the cost of care.
Government Warns Physicians They Will Be Penalized For Not Using Electronic Medical Records.

- In a 1,500-word article, USA Today (2/2, Ungar, O'Donnell) reports that physicians "are being warned by the federal government that they'll soon be penalized for not using electronic medical records, prompting a backlash from those who say the technology is fraught with problems." Recently, "a group of 37 medical societies led by the American Medical Association sent a letter to Health and Human Services...saying the certification program is headed in the wrong direction, and that today's electronic records systems are cumbersome, decrease efficiency and, most importantly, can present safety problems for patients." The CMS "responded to the criticism late last week, saying it would ease reporting burdens on doctors in a proposed rule to come this spring," but penalties would not be eliminated.

ARRA, HITECH, and “Meaningful Use”

Yes, there are incentives!

- Eligible Hospitals (EHs) can receive several million in incentives (dependent upon various factors)
- Eligible Professionals (EPs) can receive up to $44k under Medicare or up to $63,750 under Medicaid

“Meaningful Use”:

The term “Meaningful Use” means that providers need to show they’re using certified EHR technology in ways that can be measured significantly in quality and in quantity.

- Stage 1 (2011) sets the baseline for electronic data capture and information sharing using EHRs.
- Stage 2 (2014) focuses on data sharing, patient engagement, and Health Information Exchange.
  - Eligible Hospitals can begin reporting period in October 2013
  - Eligible Professionals can begin reporting period in January 2014
- Stage 3 (expected to begin in 2016) will continue to expand on previous baselines to improve clinical outcomes.
“Meaningful Use”:

What do EP’s and EH’s have to do?

It’s not enough just to own a certified EHR. Providers have to show CMS that they are using their EHRs in ways that can positively affect the care of their patients. To do this, providers must meet objectives established by CMS. Then they will be able to demonstrate, or “attest” that they met the applicable measures.

- EPs and EHs must meet all “Core Set” Objectives to successfully attest to Meaningful Use. Some core objectives have exclusions that can be taken, which indicates that the EP or EH does not have to actually meet that objective, based on a particular circumstance or exception.
- EPs and EHs must also meet a specified number of “Menu Set” Objectives (varies by EP/EH and MU stage).

“Meaningful Use”:

What do EP’s and EH’s have to do?

- Most objectives are based on how the EHR is used for patient care:
  - E.g., “More than 30% of unique patients with at least one medication in their medication list seen by the EP or admitted to the eligible hospital’s or CAH’s inpatient or emergency department have at least one medication order entered using CPOE.”
- However there are other measures related to data sharing:
  - E.g., Public Health objectives where EPs/EHs have to prove they have the ability to send data to various Public Health agencies (e.g., immunization data to state immunization registries)
- One measure is related to security of patient information:
  - “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 its risk management process.”
- Measures are generally “Yes/No” or “Percentage-based”

Meaningful Use: Progress to Date

From a CMS Fact Sheet, released 4/23/2013:

- **Hospital Participation:** More than 85 percent of eligible hospitals are participating in the Medicare and Medicaid EHR Incentive Programs, and more than 75 percent have received incentive payments for meaningfully using EHR technology.
- **Physicians and other Health Care Provider Participation:** More than 388,000 of the nation’s eligible professionals have registered to participate in the Medicare and Medicaid EHR Incentive Programs, representing 73 percent of all providers eligible to participate. More than 230,000, or 44 percent of all eligible professionals, have received an EHR incentive payment for meaningfully using EHR technology.
In For A Penny In For A Pound

- Any provider attesting to receive an EHR incentive payment for either the Medicare or Medicaid EHR Incentive Program potentially can be subject to an audit. Here’s what you need to know to make sure you’re prepared:

Meaningful Use Audits

- Audits
  In early 2012, the U.S. Government Accountability Office (GAO) looked at steps taken by the federal government and the states to verify participants meet criteria for receiving payments and are putting computerized information to “meaningful use.”

  “The EHR programs may be at greater risk of improper payments than other, more established CMS programs because they are new programs with complex requirements that providers must meet to qualify for incentive payments.”

  Robert Anthony—deputy director of CMS’s Health IT Initiatives Group—said that CMS aims to audit about 5% of all meaningful use program participants.

- CMS will look to conduct the same amount of pre-payment audits and post-payment audits
- A majority of these will be via “desk audits,” but that on-site audits could occur
- Other sources have this number as high as 10% for EHs and 20% for EPs!

Meaningful Use Audits

March, 2013: CMS Issues FAQ #7711

- Re-asserts that any single shortfall results in recoupment
- “To ensure you are prepared for a potential audit, save the electronic or paper documentation that supports your attestation.”

- “An audit may include a review of any of the documentation needed support the information that was entered in the attestation. The level of the audit review may depend on a number of factors, and it is not possible to include an all-inclusive list of supporting documents.”
Meaningful Use Audits

The same CMS guidance also stated:

- The accounting firm Figliozzi & Company will be the designated contractor performing audits on behalf of CMS, and will perform audits on Medicare EPs and eligible hospitals, as well as on hospitals that are dually-eligible for both the Medicare and Medicaid EHR Incentive Programs.
- The individual states and their contractors will perform audits on Medicaid providers.

Overview of the CMS EHR Incentive Programs Audits

- All providers attesting to receive an EHR incentive payment for either the Medicare or Medicaid EHR Incentive Programs should retain all relevant supporting documentation (in either paper or electronic format) used in the completion of the Attestation Module responses. Documentation to support the attestation should be retained for six years post-attestation. Documentation to support payment calculations (such as cost report data) should continue to follow the current documentation retention processes.
- CMS and its contractors will perform audits on Medicare and dually-eligible (Medicare and Medicaid) providers.
- States and their contractors will perform audits on Medicaid providers.
- CMS and states will also manage appeals processes.
- Preparing for an Audit
  - To ensure you are prepared for a potential audit, save the electronic or paper documentation that supports your attestation. Also save the documentation that supports the values you entered in the Attestation Module for Clinical Quality Measures (CQMs). Hospitals should also maintain documentation that supports their payment calculations.
  - Upon audit, the documentation will be used to validate that the provider accurately attested and submitted CQMs, as well as to verify that the incentive payment was accurate.

Details of the Audits

- There are numerous pre-payment edit checks built into the EHR Incentive Programs' systems to detect inaccuracies in eligibility, reporting, and payment.
- Post-payment audits will also be completed during the course of the EHR Incentive Programs.
- If, based on an audit, a provider is found to not be eligible for an EHR incentive payment, the payment will be recouped.
- CMS has an appeals process for eligible professionals, eligible hospitals, and critical access hospitals that participate in the Medicare EHR Incentive Program.
- States will implement appeals processes for the Medicaid EHR Incentive Program. For more information about these appeals, please contact your State Medicaid Agency.
When Selected for Audit

- For Medicare eligible professionals and for hospitals that are eligible for both Medicare and Medicaid EHR incentive payments: When a provider is selected for an audit, they will receive an initial request letter from the audit contractor. The request letter will be sent electronically by the audit contractor from a CMS email address and will include the audit contractor’s contact information. The email address provided during registration for the EHR Incentive Program will be used for the initial request letter.
- The initial review process will be conducted at the audit contractor’s location, using the information received as a result of the initial request letter. Additional information might be needed during or after this initial review process, and in some cases an on-site review at the provider’s location could follow. A demonstration of the EHR system could be requested during the on-site review. A secure communication process has been established by the contractor, which will assist the provider to send any information that could be considered sensitive. Any questions pertaining to the information request should be directed to the audit contractor.
- States will have separate audit processes for their Medicaid EHR Incentive Program. For more information about these audit processes, please contact your State Medicaid Agency.

Documentation

- An audit may include a review of any of the documentation needed to support the information that was entered in the attestation. The level of the audit review may depend on a number of factors, and it is not possible to include an all-inclusive list of supporting documents.
- The primary documentation that will be requested in all reviews is the source document(s) that the provider used when completing the attestation. This document should provide a summary of the data that supports the information entered during attestation. Ideally, this would be a report from the certified EHR system, but other documentation may be used if a report is not available or the information entered differs from the report.

Summary Documentation

- This summary document will be the starting point of most reviews and should include, at minimum:
  - The numerators and denominators for the measures
  - The time period the report covers
  - Evidence to support that it was generated for that eligible professional, eligible hospital, or critical access hospital.
- Although the summary document is the primary review step, there could be additional and more detailed reviews of any of the measures, including review of medical records and patient records. The provider should be able to provide documentation to support each measure to which he or she attested, including any exclusions claimed by the provider.
Document Retention For Audit

- What information should an eligible professional, eligible hospital, or critical access hospital participating in the Medicare or Medicaid Electronic Health Record (EHR) Incentive Programs maintain in case of an audit?

Meaningful Use Audits

CMS guidance, issued in February of 2013 states the following in regards to supporting documentation for audits:

- Providers who receive an EHR incentive payment for either the Medicare or Medicaid EHR Incentive Program potentially may be subject to an audit. Eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) should retain ALL relevant supporting documentation (in either paper or electronic format) used in the completion of the Attestation Module responses.

- Documentation to support attestation data for meaningful use objectives and clinical quality measures should be retained for six years post-attestation.

A Few Examples of Additional Support are as Follows:

- Drug-Drug/Drug-Allergy Interaction Checks and Clinical Decision Support – Proof that the functionality is available, enabled, and active in the system for the duration of the EHR reporting period.

- Electronic Exchange of Clinical Information – Screenshots from the EHR system or other documentation that document a test exchange of key clinical information (successful or unsuccessful) with another provider of care. Alternatively, a letter or email from the receiving provider confirming the exchange, including specific information such as the date of the exchange, name of provider, and whether the test was successful.

- Protect Electronic Health Information – Proof that a security risk analysis of the certified EHR technology was performed prior to the end of the reporting period (e.g., report which documents the procedures performed during the analysis and the results).

- Drug Formulary Checks – Proof that the functionality is available, enabled, and active in the system for the duration of the EHR reporting period.

- Immunization Registries Data Submission, Reportable Lab Results to Public Health Agencies, and Syndromic Surveillance Data Submission – Screenshots from the EHR system or other documentation that document a test submission to the registry or public health agency (successful or unsuccessful), including the date of submission, name of parties involved, and whether the test was successful.

- Exclusions – Documentation to support each exclusion to a measure claimed by the provider.
Red Flags

- Elements of provider attestation
  - Inconsistency between numerator / denominators that should be related
  - Exclusions that may be inconsistent with other measures

- CMS Data supplemental to attestations
  - Measures or exclusions inconsistent with patient mix (both hospital and EP specialty)
  - Peer group comparisons
  - State and local public health capabilities

- EHR Vendor characteristics
  - Providers who indicated use of multiple EHR products to meet requirements
  - EHRs with capability of collecting data for only a few CQMs (ambulatory only)
  - Representative sample of Certified EHR vendors

What Happens if I Fail an Audit?

- Appeal?
  - What caused the fail?
    - E.g., audit logs – EHR certification process did not require this for specific functionality
      - Core Objective 2: Drug-drug and drug-allergy interaction checks
      - Core Objective 11: Clinical decision support rule
      - Menu Objective 1: Drug formulary checks
  - or… Do nothing
    - Learn from mistakes, return the incentive money and move forward!

Review, Withdrawal and Appeal

- To date the review standard is Pass/Fail
- Documentation for attestation and core measures are reviewed.
- All measures must be accomplished and documented to pass.
- A properly performed and documented risk assessment must be presented to the auditor.
- You can withdraw and pay the funds back prior to being audited if you believe this is a proper business decision.
- You cannot pay them back during an audit.
- You can appeal the audit but you must have sufficient documentation to support your appeal.
Client Experiences: Best Practices

- Designate a person to be in charge in the event of an audit, and to own the “Book of Evidence”
- Keep internal teams informed, and aware of procedures
- Establish contact with auditor
- Monitor the deadlines established by the auditor
- Seek the EHR vendor for support
- Seek counsel if needed!

Client Experiences: Lessons Learned

The most common points of interest for audits include:

- Core Measure #15 – Security Risk Analysis
  - Have to have this and has to cover specific areas
  - Refer to the OCR Guidance on Risk Analysis
- Method used to incorporate Emergency Department (ED) patients
  (All ED Visits or Observation Services)
- Yes/No measures
- “Proof of Possession”

Client Experiences: Lessons Learned

Recommended “Book of Evidence” includes, but is not limited to:

- EHR vendor purchase agreements
- EHR implementation documents (project plans, configuration documents, etc.)
- Attestation reports generated from the EHR which reconcile exactly to the attestations made for each Core and Quality measure
- Documentation for Public Health measures with confirmation emails from contacts at the Public Health Agencies (where applicable)
- A statement about change control and source code control systems which documents that functionality such as Drug/Allergy Interaction Checking, which medications and Clinical Decision Support Rules were enabled for the entire reporting period
- Documentation that explains the interpretations made by management for measures where exclusions were taken
- Complete Security Risk Analysis documentation – including identified threats and mitigation plans (as per OCR guidance)
- Screenshots, screenshots, screenshots
Confusing Advice

Important Payment Adjustment Information For Medicare EPs
Eligible professionals (EPs) participating in the Medicare EHR Incentive Program may be subject to payment adjustments beginning on January 1, 2015.

CMS will determine the payment adjustment based on meaningful use data submitted prior to the 2015 calendar year. EPs must demonstrate meaningful use prior to 2015 to avoid payment adjustments.

Determine how your EHR Incentive Program participation start year will affect the 2015 payment adjustments:

If you began in 2011 or 2012...

If you first demonstrated meaningful use in 2011 or 2012, you must demonstrate meaningful use for a full year in 2013 to avoid the payment adjustment in 2015.

If you began in 2013...

If you first demonstrate meaningful use in 2013, you must demonstrate meaningful use for a 90-day reporting period in 2013 to avoid the payment adjustment in 2015.

If you plan to begin in 2014...

If you first demonstrate meaningful use in 2014, you must demonstrate meaningful use for a 90-day reporting period in 2014 to avoid the payment adjustment in 2015. This reporting period must occur in the first 9 months of calendar year 2014, and EPs must attest to meaningful use no later than October 1, 2014, to avoid the payment adjustment.

Avoiding Payment Adjustments in the Future

You must continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years.

If you are eligible to participate in both the Medicare and Medicaid EHR Incentive Programs, you MUST demonstrate meaningful use to avoid the payment adjustments. You may demonstrate meaningful use under either Medicare or Medicaid.
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Avoiding Payment Adjustments in the Future
You must continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years.

If you are eligible to participate in both the Medicare and Medicaid EHR Incentive Programs, you**MUST** demonstrate meaningful use to avoid the payment adjustments. You may demonstrate meaningful use under either Medicare or Medicaid.

If you are only eligible to participate in the Medicaid EHR Incentive Program, you are not subject to these payment adjustments.

CMS and ONC announced the intent to change the Stage 3 timeline and extend Stage 2 of meaningful use through 2016.

What this Means for You:
- If you begin participation with your first year of Stage 1 for the Medicare EHR Incentive Program in 2014:
  - You will demonstrate Stage 1 of meaningful use no later than July 1, 2014 and submit attestation by October 1, 2014 in order to avoid the 2015 payment adjustment.
- If you have completed 1 year of Stage 1 of meaningful use:
  - You will demonstrate a second year of Stage 1 of meaningful use in 2014 for a three-month reporting period fixed to the quarter for Medicare or any 90 days for Medicaid.
  - You will demonstrate Stage 2 of meaningful use for two years (2015 and 2016). You will begin Stage 3 of meaningful use in 2017.
  - If you have completed two or more years of Stage 1 of meaningful use:
    - You will demonstrate Stage 2 of meaningful use in 2014 for a three-month reporting period fixed to the quarter for Medicare or any 90 days for Medicaid.

Things to Think About
Law360, New York (January 26, 2015, 6:11 PM ET) -- The U.S. Department of Health and Human Services on Monday announced a timeline for moving doctors and hospitals into new payment systems and tying Medicare reimbursement to quality of care, the first time regulators have laid out specific goals for such reforms... HHS described its announcement as a "historic" development in the country's ongoing efforts to base payments on the efficiency with which health care providers operate and the extent to which they are successful in healing patients...

Under one element of Monday's announcement, HHS said it will try to link 85 percent of payments in Medicare Parts A and B to quality or value by 2016 and to link 90 percent of payments by 2018, compared with about 80 percent of payments that currently have some sort of link.
“New Medicare Demands Spell Doom For Old Payment System”

Law360, New York (January 27, 2015, 6:08 PM ET) -- Medicare’s newly announced plans to condition more payments on quality and value is another nail in the coffin of traditional reimbursement, …

What is virtually certain is that Medicare’s move will spur similar changes in how private insurance plans structure their payments. According to the nonprofit Catalyst for Payment Reform, 40 percent of private insurance reimbursements last year were linked to quality, compared with about 10 percent the year prior, an increase that dovetails with Medicare’s rising quality requirements.…

And CMS explicitly says it wants private plans to copy its approach. The agency on Monday announced it’s creating a task force of sorts — formally called the Health Care Payment Learning and Action Network — to bring together government officials, private insurers, large employers, providers and other stakeholders to get in sync on quality-based payments.

BEGINNING IN 2015, MEDICARE ELIGIBLE PROFESSIONALS WHO DO NOT SUCCESSFULLY DEMONSTRATE MEANINGFUL USE WILL BE SUBJECT TO A PAYMENT ADJUSTMENT. THE PAYMENT REDUCTION STARTS AT 1% AND INCREASES EACH YEAR THAT A MEDICARE ELIGIBLE PROFESSIONAL DOES NOT DEMONSTRATE MEANINGFUL USE, TO A MAXIMUM OF 5%.

QRURs (Quality and Resource Use Reports) and the Value Modifier

- Medicare’s version of physician profiling and P4P
  - First QRURs went to large physician groups in 2012.
  - Physicians in practices of 1-10 about to get first QRURs
  - VM applies to entire Medicare revenue- 9% swing?
- 100 or more physicians- subject to the VM in 2015, based on CY 2013 performance
- 10 or more physicians- subject to the VM in 2016, based on CY 2014 performance.
- VM does not apply to groups where any physician member in an ACO or CPPI in CY 2013 and 2014
- All physicians in Fee-For-Service Medicare will be affected by the VM starting in 2017, based on CY 2015 performance

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Value Modifier: Quality composite and cost composite

- Use domains to combine each quality measure into a quality composite and each cost measure into a cost composite

CY 2017 Value-Based Payment Modifier Amounts

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<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
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<td>+6%</td>
<td>+2%</td>
<td>+4%</td>
</tr>
<tr>
<td>Average Cost</td>
<td>-2%</td>
<td>+4%</td>
<td>+2%</td>
</tr>
<tr>
<td>High Cost</td>
<td>-4%</td>
<td>-2%</td>
<td>+0%</td>
</tr>
</tbody>
</table>

- Groups and solo practitioners eligible for an additional +1.0% if reporting Physician Quality Reporting System quality measures and average beneficiary risk score is in the top 25% of all beneficiary risk scores

What Information Is Included on the Performance Highlights Page?

1. Your Quality Composite Score
2. Your Cost Composite Score
3. Your Beneficiaries’ Average Risk Score
4. Your Quality Tiering Performance Graph
5. Your Payment Adjustment Based on Quality Tiering
### Access to accurate, comprehensive data is increasingly key

- Only way to manage new payment models
  - Economic results depend on the variation between projected and actual experience, rather than on maximizing volume
- Only way to respond effectively to profiling
  - To ensure publicly reported practice profiles are accurate,
  - To use the data to improve practice quality and efficiency
- Only way to eliminate the currently inexplicable variation in treatment patterns

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**Former CFO indicted over fraudulent meaningful use claims - February 11, 2014**

- White faces up to seven years in prison - CFO of now-closed Shelby Regional Medical Center in Texas, has been indicted for allegedly defrauding the federal government of nearly $800,000.
  - Shelby was among thousands of providers that received payments through the government's meaningful use program.
  - Under the program, health care providers who demonstrate meaningful use of certified electronic health record (EHR) systems can qualify for Medicaid and Medicare incentive payments.
- The indictment states that Shelby was granted $785,655 in January 2013 for successful demonstration of meaningful use during the 2012 full-year reporting period. In addition, the hospital had received $1.17 million in meaningful use payments from CMS in November 2011.
- He pled guilty November 12, 2014
- The indictment alleges that he:
  - Submitted the attestation while knowing the hospital did not meet the program’s requirements and “only minimally used the EHR platform and continued to use paper records and charts as well as older, uncertified technology”;
  - Directed the hospital's EHR vendor to input data into the system manually from paper records and other sources, even after the FY 2012 reporting period; and
  - “[K]nowingly and willingly made materially false, fictitious and fraudulent statements and representations, and made and used false writings and documents” to defraud the EHR incentive program.


Interesting FAQs

- What does it mean to “possess” EHR technology as mentioned in FAQ 9-10-017?
  - Answer: We consider “possession” of EHR technology certified to an edition of EHR certification criteria to be either the physical possession of the medium on which a certified Complete EHR or certified EHR Module resides, or a legally enforceable right by an eligible health care provider to access and use, at its discretion, the capabilities of a certified Complete EHR or certified EHR Module. An eligible health care provider may determine the extent to which it will implement or use these capabilities, which will not affect the provider’s possession of the certified Complete EHR or certified EHR Module.

- An EP, EH, or CAH must possess all of a certified Complete EHR or certified EHR Module (i.e., the capabilities for which certification is required) in order to receive the benefit of such certification. An EP, EH, or CAH cannot purchase or possess only “components” of a certified Complete EHR or certified EHR Module for the purposes of meeting the CEHRT definition. Unless independently certified, those “components” could not be used to meet the CEHRT definition. We further explain this policy in FAQ 5 and in the 2014 Edition EHR certification criteria final rule (77 FR 54266). In the final rule, we also note that the possession policy does not apply to those capabilities that an EHR technology developer may include with those that constitute a certified Complete EHR or certified EHR Module but for which certification is not required. In those instances, because these other included capabilities are not required for certification, an EP, EH, or CAH would not necessarily need to possess them if the EHR technology developer would separately sell them.

- If an eligible professional (EP) sees a patient in a setting that does not have certified electronic health record (EHR) technology but enters all of the patient's information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of meaningful use measures for the Medicare and Medicaid EHR Incentive Programs?
  - Starting in 2013, an EP must have access to Certified EHR Technology at a location in order to include patient encounters in locations that do not have certified EHR Technology in order to be eligible for the EHR Incentive Programs. However, if the EP meets the 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 more information about the Medicare and Medicaid EHR Incentive Programs, please visit http://www.healthit.gov/policy-researchers-implementers/21-question-12-10-021.
2. When eligible professionals work at more than one clinical site of practice, are they required to use data from all sites of practice to support their demonstration of meaningful use and the minimum patient volume thresholds for the Medicaid EHR Incentive Program?

CMS considers these two separate, but related issues.

Meaningful use: Any eligible professional demonstrating meaningful use must have at least 50% of their patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with certified EHR technology capable of meeting all of the meaningful use objectives. Therefore, States should collect information on meaningful users' practice locations in order to validate this requirement in an audit.

Patient volume: Eligible professionals may choose one (or more) clinical sites of practice in order to calculate their patient volume. This calculation does not need to be across all eligible professionals' sites of practice. However, at least one of the locations where the eligible professional practices in order to adopt or meaningfully use certified EHR technology should be included in the patient volume. In other words, if an eligible professional practices in two locations, one with certified EHR technology and one without, the eligible professional should include the patient volume at least at the site that includes the certified EHR technology. When making an individual patient volume calculation (i.e., not using the group/clinic proxy option), a professional may calculate across all practice sites, or just at the one site. For more information on applying the group/clinic proxy option, see FAQ #10362 or click here.

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

3. Do specialty providers have to meet all of the meaningful use objectives for the Medicare and Medicaid EHR Incentive Programs, or can they ignore the objectives that are not relevant to their scope of practice?

For eligible professionals (EPs) who participate in the Medicare and Medicaid EHR Incentive Programs, there are a total of 25 meaningful use objectives. To qualify for an incentive payment, 20 of these 25 objectives must be met. There are 15 required core objectives. The remaining 5 objectives may be chosen from the list of 10 menu set objectives. Certain objectives do provide exclusions. If an EP meets the criteria for that exclusion, then the EP can claim that exclusion during attestation. However, if an exclusion is not provided, or if the EP does not meet the criteria for an existing exclusion, then the EP must meet the measure of the objective in order to successfully demonstrate meaningful use and receive an EHR incentive payment. Failure to meet the measure of an objective or to qualify for an exclusion will prevent an EP from successfully demonstrating meaningful use and receiving an incentive payment.

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

4. 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.
EHR Incentive Programs: What information must an eligible professional (EP) provide in order to meet the measure of the meaningful use objective for "provide a clinical summary for patients for each office visit" under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program?

As our final rule, we defined "clinical summary" as: an after-visit summary that provides a patient with relevant and actionable information and instructions. An example includes information regarding a patient's health status, potential or active problems, medications, allergies, laboratory results, corresponding test orders, and self-care instructions. In our final rule, we stated that clinical summaries must include all of the above that can be populated into the clinical summary by certified EHR technology. If the EP's certified EHR technology is capable of being displayed on a paper printout, the information shall be presented in a legible manner. The clinical summary would not be limited by the data elements included in the clinical summary on paper. If there is a delay in dissemination (paper or electronic) has a more limited set of fields than the other, this does not serve as a limit on the other form. For example, certified EHR technology is capable of being displayed on a computer screen. The clinical summary on paper may include all of the above elements that can be populated by the certified EHR technology. The clinical summary in electronic form includes the data elements in which all EHR technology is certified for the purposes of this program (according to 45 CFR 170.304(h)).

To view the ONC FAQs, please visit: http://healthit.hhs.gov/portal/server.pt/community/onc_regulations_faqs/3163/faq_13/20775.

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

Office of the National Coordinator of Health Information Technology: 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 designated as certified for an inpatient setting to meet an objective and measure. Please reference ONC FAQ 12-10-021-1 and 9-10-017-2 and CMS FAQ 10162 for discussions on what it means to possess Certified EHR Technology, ONC FAQ 6-12-025-1 for a list of affected capabilities and standards, and how that relates to the exclusion and deferral options of meaningful use.

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

To view the ONC FAQs, please visit: http://healthit.hhs.gov/portal/server.pt/community/onc_regulations_faqs/3163/faq_13/20775.

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

Office of the National Coordinator of Health Information Technology: 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 inpatient setting, an EP can use the EHR technology designated as certified for an inpatient setting to meet an objective and measure. Please reference ONC FAQ 12-10-021-1 and 9-10-017-2 and CMS FAQ 10162 for discussions on what it means to possess Certified EHR Technology, ONC FAQ 6-12-025-1 for a list of affected capabilities and standards, and how that relates to the exclusion and deferral options of meaningful use.
8. [EHR Incentive Programs] To meet the meaningful use objective “use computerized provider order entry (CPOE)” for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, should eligible professionals (EPs) include hospital-based observation patients (billed under POS 22) whose records are maintained using the hospital’s certified EHR system in the numerator and denominator calculation for this measure?

If the patient’s records 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 the hospital certified EHR system, the EP does not need to include those patients in the numerator and denominator calculation to meet the measure of the “use computerized provider order entry (CPOE)” objective.

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

9. [EHR Incentive Programs] Does a provider have to record all clinical data in their certified EHR technology in order to accurately report complete clinical quality measure data for the Medicare and Medicaid EHR Incentive Programs?

We recognize that providers are continuing to implement new workflow processes to accurately capture clinical data in their certified EHR technology, but such processes are not yet available at this time. Although we encourage providers to capture clinical data in order to transition to EHR systems for their patients, for the purpose of reporting clinical quality measure data in 2015, CMS does not require providers to record all clinical data in certified EHR technology. Clinical data from certified EHR technology will be used to calculate clinical quality measure data for the purposes of the EHR Incentive Programs and the Meaningful Use Program. CMS recognizes that this may yield numerator, denominator, and exclusion values for clinical quality measures in the certified EHR technology that are not identical to values generated from other methods. However, at the time CMS will not require providers to record the clinical quality measure data in their certified EHR technology.

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

10. [EHR Incentive Programs] 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 meaningful EHR users, providers must do three things:

- Have complete certified EHR technology for all Meaningful Use objectives through a complete EHR or a combination of modules; and
- 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).

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 must meet certain criteria. The Office of the National Coordinator for Health Information Technology (ONC) has provided a Frequently Asked Questions document on Meaningful Use Certification (http://healthit.hhs.gov/穴?parent=3855&node=25050&范畴=3163&PageID=20775).

For more information about Meaningful Use Certification, you can contact ONC at onc.certification@hhs.gov.

For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRIncentivePrograms.
For the meaningful use objective of "capability to exchange key clinical information" for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, data exchange of unstructured information in electronic media, such as a CD-ROM, USB or hard drive, or other formats to exchange key clinical information would not satisfy this objective. Data exchange of information in electronic media, such as physical media as a CD-ROM, USB or hard drive, or other formats to exchange key clinical information would not satisfy this objective.

For the purposes of the Stage 1 "capability to exchange key clinical information" measure, exchange is defined as electronic transmission of unstructured data (e.g., free text or scanned images) or electronic transmission of structured data (e.g., lab results or drug data) using certified EHR technology. However, if the information is available only in unstructured electronic formats (e.g., free text or scanned images), the exchange of unstructured information would satisfy this measure.

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

Please note that this objective is distinct from objectives such as "provide a summary of care record for each transition of care," where electronic exchange of clinical information using physical media, such as USB, CD-ROM, or other formats could satisfy the measure of this objective.

For more information about electronic exchange of key clinical information, please refer to the following FAQ: http://questions.cms.hhs.gov/app/answers/detail/a_id/10270/kw/10270.

To meet the meaningful use objective "capability to exchange key clinical information" for the Medicare and Medicaid EHR Incentive Programs, data exchange of clinical information in electronic media, such as a CD-ROM, USB or hard drive, or other formats to exchange key clinical information would not satisfy this objective. Data exchange of information in electronic media, such as physical media as a CD-ROM, USB or hard drive, or other formats to exchange key clinical information would not satisfy this objective.

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

Please note that this objective is distinct from objectives such as "provide a summary of care record for each transition of care," where electronic exchange of clinical information using physical media, such as USB, CD-ROM, or other formats could satisfy the measure of this objective.

For more information about electronic exchange of key clinical information, please refer to the following FAQ: http://questions.cms.hhs.gov/app/answers/detail/a_id/10270/kw/10270.

To meet the meaningful use objective "capability to exchange key clinical information" for the Medicare and Medicaid EHR Incentive Programs, data exchange of clinical information in electronic media, such as a CD-ROM, USB or hard drive, or other formats to exchange key clinical information would not satisfy this objective. Data exchange of information in electronic media, such as physical media as a CD-ROM, USB or hard drive, or other formats to exchange key clinical information would not satisfy this objective.

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

Please note that this objective is distinct from objectives such as "provide a summary of care record for each transition of care," where electronic exchange of clinical information using physical media, such as USB, CD-ROM, or other formats could satisfy the measure of this objective.

For more information about electronic exchange of key clinical information, please refer to the following FAQ: http://questions.cms.hhs.gov/app/answers/detail/a_id/10270/kw/10270.

To meet the meaningful use objective "capability to exchange key clinical information" for the Medicare and Medicaid EHR Incentive Programs, data exchange of clinical information in electronic media, such as a CD-ROM, USB or hard drive, or other formats to exchange key clinical information would not satisfy this objective. Data exchange of information in electronic media, such as physical media as a CD-ROM, USB or hard drive, or other formats to exchange key clinical information would not satisfy this objective.

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

Please note that this objective is distinct from objectives such as "provide a summary of care record for each transition of care," where electronic exchange of clinical information using physical media, such as USB, CD-ROM, or other formats could satisfy the measure of this objective.

For more information about electronic exchange of key clinical information, please refer to the following FAQ: http://questions.cms.hhs.gov/app/answers/detail/a_id/10270/kw/10270.
For more information about the Medicare and Medicaid EHR Incentive Program, please visit [CMS website](http://www.cms.gov/EHRIncentivePrograms).

In order to provide complete and accurate information for certain of these measures, they may also have to include information from paper-based patient records or from separate, uncertified systems.

Please note that quality performance results for CQMs are not being assessed at this time under the EHR Incentive Programs. Complete and accurate information for the remaining meaningful use measures does not specify that this capability must be used to calculate the numerators and denominators. EPs, eligible hospitals, and CAHs can use core and menu set measures except CQMs.

### Questions?

For more information about the Medicare and Medicaid EHR Incentive Program, please visit [CMS website](http://www.cms.gov/EHRIncentivePrograms).
Hospital Appeal Filing Request

Hospital Appeal Filing Request (Cont'd)

Hospital Appeal Filing Request (Cont'd)