



Health IT webinars Answers to frequently asked questions¹

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General

1. What is the American Recovery and Reinvestment Act (ARRA)?

The American Recovery and Reinvestment Act (ARRA) is the legislation that became law in 2009, also known as the "Stimulus Act," which among other things established Medicare and Medicaid incentive programs for health care professionals to adopt and use health information technology. The final regulation outlining the requirements for receiving the incentives was released on July 13, 2010, and defines how the incentive program works.

2. What type of timeline would a typical small practice use to progress through the EHR adoption stages?

There is no standard or typical timeframe. It depends on the structure of the practice and the commitment of the individuals in the practice. A rule of thumb to consider is six months for preparation and selection, and then six months for implementation and to get up to full speed on the EHR. Small practices are often more nimble and could require less time while larger practices are typically not as nimble and could require more time.

Eligibility/Participation

3. Who is eligible for the stimulus health information technology (Health IT) incentives?

Medicare and Medicaid professionals, including physicians, are eligible for the health IT incentives and are referred to in the law as "eligible professionals" (EPs). See the ARRA summary for eligibility details at: www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicare-incentive-summary.pdf and www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicare-incentive-summary.pdf and www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicare-incentive-summary.pdf.

4. What is a Medicare/Medicaid eligible professional (EP)?

For the purposes of the Medicare incentive program, the term eligible professional means a physician as defined in law as described 1861:

The term "physician," when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which s/he performs such function or action...

The following are also named as eligible professionals:

¹ The AMA is seeking clarification on some of the questions below. We may add more detail in the future.



- Doctor of dental surgery or medicine
- Doctor of podiatric medicine
- Doctor of optometry
- Chiropractor

Under the Medicaid program, the term, eligible professional is defined in law as a:

- (i) physician;
- (ii) dentist;
- (iii) certified nurse mid-wife;
- (iv) nurse practitioner; and
- (v) physician assistant insofar as the assistant is practicing in a rural health clinic that is led by a physician assistant or is practicing in a Federally qualified health center that is so led.

5. Do the professionals have to service both the Medicare and Medicaid markets?

No. See the eligibility requirements in the AMA's EHR incentive programs summaries (www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicare-incentive-summary.pdf and www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicaid-incentive-summary.pdf). In addition, eligible professionals cannot take advantage of incentives under both Medicare and Medicaid incentive programs.

6. Can you participate in both the Medicare and Medicaid EHR incentive programs?

No. You will need to pick one. If you qualify for both the Medicare and Medicaid EHR incentive programs, there is a one-time switch policy. Once you receive an incentive payment under one of the programs, you can switch to the other program, but the one-time switch must occur by 2015

7. Is someone who sees Medicare patients but is officially a Medicare "non-participant" still able to get incentive payments through Medicare?

Yes, so long as you submit claims to Medicare for treating Medicare patients and meet the other eligibility requirements you qualify for incentives. You do not have to be "participating" with Medicare to get incentives.

Additional information is available on the Medicare Incentive Payment Tip Sheet: http://www.cms.gov/MLNProducts/downloads/Medicare-Incentive-Payments_Tip-Sheet.pdf

8. Are all specialties eligible for the incentives?

Yes. All physician specialties are eligible for the incentive with the exception of most hospital-based EPs. See the eligibility requirements in the AMA's EHR incentive programs summaries (www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicare-incentive-summary.pdf and www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicaid-incentive-summary.pdf).

9. Will provider based clinics be eligible for available incentives?

No. Incentives are based on the individual professional, not the facility (with the exception of hospitals). However, a health care professional who is eligible for EHR incentives may "reassign" their incentives to a clinic.

10. My entire practice is comprised of nursing home work. Although I have been including all of my notes in an EMR program, I will not be able to enter the orders myself in the



computer. All medication orders are entered at the pharmacy. Does this inability to enter orders myself make me ineligible to participate in the incentive program?

No. The requirements for the incentive program dictate that medication orders must be entered directly by any licensed health care professional who can enter orders into the medical record per state, local, and professional guidelines.

11. Do physician assistants qualify for either program?

Physician Assistants (PAs) do not qualify under the Medicare incentive program. PAs are only eligible for Medicaid incentives if they practice in a PA-led Federally Qualified Health Center (FQHC) or rural health clinic (RHC).

12. Are physical therapists eligible for either program?

No.

13. Do part-time physicians qualify for partial money, or is there a threshold of patients you have to meet?

Under the Medicare program, physicians are eligible for incentives based on an amount equal to 75 percent of their allowed Medicare Part B charges for covered professional services subject to the annual maximum limits. There is no separate program for part-time physicians. See our summary for details regarding the Medicare eligibility requirements and incentive amounts at: <http://www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicare-incentive-summary.pdf>.

Under the Medicaid program, eligible physicians must meet patient volume thresholds. There is no separate program for part-time physicians. See our Medicaid fact summary document for details regarding the Medicaid eligibility requirements and incentive amounts at: <http://www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicare-incentive-summary.pdf>.

14. Do you know how “patient volume” is defined for the purposes of Medicaid eligibility?

The Medicaid incentive program is not based upon the number of patients you treat; rather it is based upon the percentage of Medicaid patients you treat. You must have a Medicaid patient volume of at least 30% (or if you are a pediatrician, your Medicaid patient volume must be at least 20%). Please refer to our Medicaid fact summary document at: <http://www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicare-incentive-summary.pdf>

15. Will a physician in the specialty of Oral and Maxillofacial surgery be eligible for reimbursements?

All physicians are eligible for Medicare and Medicaid EHR incentives (with the exception of hospital-based physicians). You must however, meet specific eligibility and other requirements (e.g., for Medicaid, you must meet patient volume threshold requirements). See the eligibility requirements in the AMA's EHR incentive programs summaries (www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicare-incentive-summary.pdf and www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicare-incentive-summary.pdf).

16. I'm in a specialty (dermatology) that has little to do with blood pressure taking, vital signs, immunizations, etc. How can someone in this specialty qualify for meaningful use?



Please review the AMA's summary document at: <http://www.ama-assn.org/ama1/pub/upload/mm/399/ehr-meaningful-use-criteria.pdf> that provides information on the meaningful use measures and exclusions that apply to some of the required measures. For example, there is an exclusion for recording and charting changes in vital signs for any eligible physician who either sees no patients 2 years or older or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice during the EHR reporting period.

17. Three of our offices are hospital-based, and our other five offices are freestanding private offices all under the same Tax Identification Number (TIN). Are we eligible? Would we need to separate our TINs?

Payments are made to individual eligible physicians not practices. So each eligible physician would have to provide a TIN that the incentive can be paid to.

18. Can a provider who works in an occupational setting get the incentive payment since the payment is to the provider not the practice?

All physicians are eligible for EHR incentives but must meet the program's requirements. Please review our summary documents that detail the program requirements at: www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicare-incentive-summary.pdf and www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicaid-incentive-summary.pdf.

19. It is my understanding that only physicians will be eligible for the incentives. We are a behavioral health practice with licensed clinical social worker professionals. Is it correct that they will have to participate in the EMR but will not qualify for the incentives?

No. There is no requirement that social workers use EMRs nor are they among the professionals eligible for the Medicare EHR incentives. See the eligibility requirements in the AMA's EHR incentive programs summaries (www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicare-incentive-summary.pdf and www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicaid-incentive-summary.pdf).

20. Under the Medicaid incentive program, why are pediatricians eligible for fewer incentives than nurse practitioners and physician assistants?

Because the required volume of Medicaid patients is less for pediatricians – 20% for pediatricians compared to 30% for other Medicaid physicians - the incentive amount is lower. Under the Medicaid incentive program, eligible pediatricians (non-hospital based) could receive up to \$42,500, and other physicians (non-hospital based) could receive up to \$63,750, over a six-year period. However, pediatricians could be eligible for the full Medicaid incentive amount should they meet the 30 percent volume requirement of other Medicaid eligible professionals.

21. I am a family physician who has a large pediatric Medicaid population. Will my incentive be physician- or pediatrician-based?

Pediatricians could be eligible for the full Medicaid incentive amount should they meet the 30 percent Medicaid patient volume requirement.

22. Ophthalmology practices do not do vitals routinely; will this need to be done to qualify?

Any EP who either see no patients 2 years or older, or believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice during the EHR reporting period qualifies for an exclusion from this objective/measure. See the AMA's summary on the objectives and measures at: <http://www.ama-assn.org/ama1/pub/upload/mm/399/ehr-meaningful-use-criteria.pdf>.



23. Looks like the incentive program is focused on primary care. If you are a specialty provider, it appears that you will not be able to meet requirements (unless you track something that is not related to your specialty) and therefore no incentives are available. Is this correct?

While many of the quality measures are more applicable for primary care, the Centers for Medicare & Medicaid Services (CMS) intends to include more specialty measures in future stages.

24. I understand that there is a bill requesting the inclusion of mental health providers. Do you have any comments on this legislation?

The AMA supports expanding the incentive program to cover any physician who may not be eligible for participation today.

25. I am currently in medical school and will be in residency until 2014, are there plans for incentives for new graduates?

No. If your first payment year is 2015, you are not eligible for incentives. See the AMA's summary on the Medicare and Medicaid incentive programs at: www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicare-incentive-summary.pdf and www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicicaid-incentive-summary.pdf.

26. Does Medicare plan to pay providers for e-visits?

No. While there is a CPT® e-visit code and the AMA/Specialty Society RVS Update Committee (RUC) has recommended RVUs, but Medicare will not pay for it. The Medicare EHR incentive program does not change this payment policy.

Practices that want to offer e-visits should 1) establish written guidelines for physicians, practice staff, and patients and 2) determine appropriate reporting before the patient initiates a visit. To develop guidelines, practices should complete the following:

- Check local state law, as some states may require the physician to obtain a special/specific license for conduction of e-visits.
- Contact his/her participating contracted health plans to determine coverage, restriction and payment for these services.
- Contact online vendors to establish an account. This will ensure use of secure, encrypted and HIPAA-compliant secure messaging.
- Implement both practice and patient policies and guidelines for conducting e-visits.

Perhaps most important is that the guidelines set realistic expectations for both physicians and patients. AMA members can read more about establishing e-visit policy at: <http://www.ama-assn.org/ama1/x-ama/upload/mm/368/consultations.pdf>

Incentive Payments

27. Did you say that the stages of meaningful use criteria are based on calendar year and not the fiscal year?

Yes. For both Medicare and Medicaid EPs, the payment year is a calendar year beginning Jan. 1, 2011. However, there are some cases when a Medicaid EP could begin reporting in 2010 if CMS has approved a state's request to begin providing incentive payments that year.



For an eligible hospital or critical access hospital, a payment year is the federal fiscal year (October 1 - September 30) starting in fiscal year 2011, which begins Oct. 1, 2010.

28. What percent of your practice has to be Medicare in order to qualify for incentives?

Medicare incentives are not based on patient volume; they are based upon 75% of a physician's Part B allowable charges up to a maximum of \$18,000 for early adopters whose first payment year is 2011 or 2012. Eligible professionals (EPs) who furnish more than 50 percent of covered services in a geographic Health Professional Shortage Area (HPSA) are eligible for an additional 10 percent incentive on top of the maximum incentive payment amount.

29. The stimulus incentive is capped at 75 percent of allowable charges under Medicare. Is this figure strictly that which is paid to the professional or that which is billed to Medicare?

The 75 percent cap pertains to allowable charges. The estimated allowed charges for the qualifying eligible professional (EP's) covered professional services during the payment year are determined based on claims submitted no later than two months after the end of the payment year, and in the case of a qualifying EP who furnishes covered professional services in more than one practice, are determined based on claims submitted for the EP's covered professional services across all such practices.

30. Is the 75 percent of Medicare allowable charges for all Medicare allowable services or a specific range of CPT codes?

All allowed charges--not those within a specified range of CPT codes--count toward the EHR incentive program.

31. What is the maximum funding allowed per group?

Under the Medicare incentive program, each eligible professional (non-hospital based) —no matter what size the practice—could qualify for up to \$44,000 in Medicare incentives over a five-year period beginning in 2011. Eligible professionals (EPs) who furnish more than 50 percent of covered services in a geographic Health Professional Shortage Area (HPSA) are eligible for an additional 10 percent incentive on top of the maximum incentive payment amount.

Under the Medicaid incentive program, eligible pediatricians (non-hospital based), with at least 20 percent Medicaid patient volume, could receive up to \$42,500, and other physicians (non-hospital based), with at least 30 percent Medicaid patient volume, could receive up to \$63,750, over a six-year period.

If a physician were to switch from the Medicare to the Medicaid incentive program, under no circumstances may the total incentive payment received exceed the maximum Medicaid payment of \$63,750.

32. How will Medicare incentives be given to doctors? Will it be checks, additional payments, or other?

Incentive payments are tied to the individual EP, and not his/her place of practice. Both Medicare and Medicaid eligible professionals will receive a single, consolidated, annual incentive payment. Medicare EPs would be paid electronically through a single payment contractor. Medicaid EPs would receive payment from either the State Medicaid agency or their designated intermediary (i.e., a Medicaid HMO).



The payments would be distributed on a rolling basis, as soon as an EP has: 1) demonstrated meaningful use for the applicable reporting period (90 consecutive days for the first year or the entire calendar year for subsequent years); and 2) reached the threshold for maximum payment.

33. When do the doctors expect to get payment?

According to CMS, EPs could receive payments as early as May 2011 if they begin reporting meaningful use objectives on January 1, 2011. CMS will issue payments once it is clear they have met the requirements.

34. If my Medicare charges are below the incentive payments, do I only receive the amount I have billed?

No. You are eligible for incentives based upon 75% of your Medicare Part B allowed charges. In order to receive the maximum payment of \$18,000 for year 1 of participation (2011 or 2012), you would need to bill Medicare approximately \$24,000.

35. How much of a Medicare incentive would I get each year?

Under the Medicare EHR Incentive Program, physicians who demonstrate meaningful use of certified EHR technology can receive up to a total of \$44,000 over five consecutive years. An additional 10 percent incentive on top of the maximum incentive payment amount is available for physicians who practice in a Health Professional Shortage Area (HPSA).

36. If I participate in the incentive program in the first quarter of 2011, do I have to wait until the end of the year for my payment so they can see how much I billed?

Not necessarily. As soon as you attest and reach the threshold, you will get the payment. It is our understanding that Medicare will hold payments until you hit the maximum annual payment cap. Physicians who start in January 1, 2011, and bill enough to hit the cap by March 31, 2011, can expect to see a payment in May 2011.

37. Will there be a schedule for the payment disbursements?

No. Payments will not be based on a schedule. Payments will be made as soon as physicians have successfully demonstrated meeting the meaningful use requirements.

38. If the physician works for Practice A three days a week and Practice B two days a week (separate TINs), will both practices be eligible to receive the incentive or will the physician have to dictate which TIN should receive the incentive payments?

In cases where the EP is associated with more than one practice, EPs must select one TIN to receive any applicable EHR incentive payment. Only one payment under a single TIN will be made. Incentives are based upon the individual physician's Tax ID (TIN) number. During the registration process, you must provide one tax identification number (TIN) which you would like the incentive payment to be made.

39. What happens if the physician is working for Practice A for year one and two but moves to a new practice having a separate TIN? Does Practice A receive the entire incentive payment over the 5-year period?

The incentives are paid according to the tax identification number (TIN) that the EP provides via registration. The law authorizes the payments to be made directly to the EP or to an employer or other



entity to which the EP has reassigned the incentive payment. Reassignment of the incentive payment must be consistent with applicable Medicare and other applicable laws, rules, and regulations.

40. If you apply for the Medicaid incentive and you see Medicare patients, is your reimbursement reduced for the Medicare patients.

The government has not yet announced how the penalties will be structured. More information will be forthcoming.

41. You stated that hospitals could have incentives assigned to them, but how do Federally Qualified Health Centers (FQHCs) do it? Do FQHCs use a TIN to register so that the incentives will be paid directly to the FQHC or will the incentives go directly to the physician practicing in the FQHC and the physician would have to assign the monies back to the FQHC?

The only ones who are eligible to receive incentives are the types of health care professionals named in the law. FQHCs are not eligible to receive EHR incentives directly. In addition to physicians, physician assistants (PAs) that work predominantly at a FQHC led by a physician assistant are eligible for incentives under Medicaid. Therefore, an eligible PA or EP could receive the incentive based upon their own TIN and could reassign the incentive to the FQHC. CMS has a slide deck devoted to the Medicaid incentive program that can be found here:

http://www.cms.gov/MLNProducts/downloads/EHR_Final_Rule-Medicaid.pdf.

42. How will the state count whether I've hit the threshold to participate in the Medicaid incentives?

Thirty percent of all your patient encounters must be attributable to Medicaid over any continuous 90-day period within the most recent calendar year. They will apply a plain meaning test. Short-term temporary Medicaid outreach programs do not count. Medicaid EPs are also required to annually re-attest to patient volume thresholds.

43. Is funding pro-rated if a physician meets only some of the objectives/measures?

The rule does not include the option of pro-rated incentive amounts for partial compliance. However, the rule does account for exceptions to certain objectives/measures. For example, an EP who writes fewer than 100 prescriptions during the EHR reporting period qualifies for an exclusion for the medication ordering objective. For an exclusion to apply, the EP must meet all of the following requirements:

- Must ensure that the objectives list under the core and menu sets include an option for the EP to attest that the objective is not applicable;
- Meets the criteria for an exemption; and
- Attests that the exclusion applies.

See the AMA's summary of the health IT measures / objectives at: <http://www.ama-assn.org/ama1/pub/upload/mm/399/ehr-meaningful-use-criteria.pdf>, as well as, the AMA's summary of the quality measures at: <http://www.ama-assn.org/ama1/pub/upload/mm/399/ehr-clinical-quality-measures.pdf>.

Medicare Advantage

44. What if most of our Medicare patients are really Medicare Advantage (MA) patients?



The Medicare Advantage (MA) EHR incentive program is structured differently than the EHR incentive program for Medicare Fee For Service (FFS) providers. You must be enrolled in Medicare Fee For Service or Medicare Advantage (MA). See last page of Medicare incentive summary document at <http://www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicare-incentive-summary.pdf>.

45. For MA, will all the EHR incentive program aspects function through them?

According to CMS, under the MA program, EHR incentive payments are made only to MA organizations that are licensed as HMOs, or in the same manner as HMOs, by a State. These MA organizations are potentially entitled to EHR incentive payments by way of MA-affiliated hospitals (that is, hospitals that are under the same ownership and control as the MA organization) and MA eligible professionals. For the MA incentive program, incentive payments will be made directly to the qualifying MA organizations that function as an HMO for the adoption and meaningful use of EHR technology by their affiliated EPs. For the MA incentive program, incentive payments would be made directly to the qualifying MA organizations that function as an HMO for the adoption and meaningful use of EHR technology by their affiliated EPs.

46. Do all of the existing Medicare PPO plans count as Medicare or not?

Incentive payments are available to qualifying MA organizations for the adoption and meaningful use of EHR technology by their affiliated eligible professionals (EPs). MA-Affiliated EPs must be employed or subcontracted by an MA organization and on average provide at least 20 hours of patient care services per week. For a subcontracted EP, at least 80 percent of his/her professional services have to be furnished to enrollees of the qualifying MA organization.

Registration

47. What is the registration process?

CMS plans to open registration in January 2011. According to CMS they will manage a virtual location for registration of both the Medicare and Medicaid incentive programs. At present, the formal registration process has not been finalized.

48. How do I notify Medicare or Medicaid that I'm applying for this reimbursement?

Hospitals and eligible professionals (EPs) are expected to be able to register for the program in January 2011. The registration process will be the same for the Medicare and Medicaid programs. You will be able to find registration and other program information at <http://www.cms.gov/EHRIncentivePrograms> when it becomes available.

Hospitals and hospital-based professional

49. Hospital-based eligible professionals are not eligible for incentives. How is this term defined?

CMS defines hospital-based physicians as those who furnish at least 90 percent of their professional services in a hospital setting, either inpatient or emergency room, in the year preceding the payment year. CMS will determine non-eligibility based upon site of service codes (code 21 for inpatient hospital and code 23 for emergency room, hospital). Physicians providing services in outpatient settings, including ambulatory clinics, are eligible for incentives.



50. If a physician does not meet the definition of a hospital-based eligible professional, are his/her allowed charges with place of service code 21 or 23 excluded from the calculation of the bonus payment?

The AMA is unclear about this and is requesting clarification from CMS.

51. How does CMS expect to treat physicians who are considered hospital-based eligible professionals for some but not all of the EHR incentive program with respect to receipt of penalties?

Whether an EP is considered hospital-based or not will be determined annually. Hospital based EPs are not subject to the adjustment. CMS has said it is conceivable that

physicians who are eligible in 2011-2014 for incentives and thus are not considered hospital-based eligible professional, but then in 2015 are determined to be hospital based, the negative payment adjustment will not be applied. Conversely, if a physician is determined to be hospital-based in 2011-2014 but then in 2015 they are 89% inpatient, then it is also conceivable that the negative payment adjustment would be applicable under this scenario. At this time no policy on penalties has been finalized and CMS expects to include a proposal about how EHR penalties will be handled in a notice of proposed rulemaking in early 2012, therefore, more details on the how the penalties will be forthcoming.

52. I am an employed physician with a local hospital. Are the incentive programs the same for me as for privately owned practices?

Hospital-based EPs (i.e., inpatient and emergency room departments) are not eligible for the Medicare incentive payments nor are the majority of hospital-based EPs eligible for Medicaid incentive payments (the only exception to this rule is for those EPs practicing predominantly in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)). The Continuing Extension Act of 2010 that was signed into law in April 2010 clarified that the definition of a hospital-based EP does not cover outpatient settings. CMS defines hospital-based EPs as those who furnish at least 90 percent of their professional services in a hospital setting, either inpatient or emergency room, in the year preceding the payment year. CMS will determine non-eligibility based upon site of service codes (code 21 for inpatient hospital and code 23 for emergency room, hospital). EPs providing services in outpatient settings, including ambulatory clinics, are eligible for incentives.

53. Does "hospital-based" include ambulatory practices that are hospital owned, i.e. freestanding clinics in the community?

No. The Medicare EHR incentive program provides incentive payments to eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) that are meaningful users of certified EHR technology, not free-standing clinics.

54. For providers with Medicare patients in both an outpatient office and a hospital, are the percentages based on charges or volume? Could not having meaningful use in the hospital prevent a provider from qualifying for meaningful use if they have an approved EMR and are using it meaningfully in the office?

The incentives will be based upon 75 percent of the allowed Medicare Part B charges; it does not matter which setting the Part B services were supplied. However, physicians who are hospital-based such as pathologists, anesthesiologists, or emergency physicians, who provide at least 90 percent of their care in the hospital (based on site of service codes) would not be eligible for the incentives.



55. What happens if a physician who works in multiple ambulatory settings has access to certified EHR technology in only one location?

First, Medicare and Medicaid EHR incentives are not attached to a location. The incentives are determined on a per provider basis, using the provider's National Provider Identifier (NPI) number. According to the final regulation, a provider may qualify for the incentive program based on their patient panel at the location that provides access to certified EHR technology.

Second, to be a meaningful EHR user an EP must have 50 percent or more of their patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with certified EHR technology. An EP for who does not conduct 50 percent of their patient encounters in any one practice/location would have to meet the 50 percent threshold through a combination of practices/locations equipped with certified EHR technology.

Rural health clinics

56. Are there any differences in the way the meaningful use incentives work for rural health clinics?

Possibly, under the Medicaid program. For eligible EPs, states are allowed to add additional objectives and measures.

Meaningful use (EHR Objectives / Measures)

57. When do we start the documentation process?

EPs under both the Medicare and Medicaid incentive programs for the first year would be any continuous 90-day period within a calendar year. For the second, third, fourth, and the fifth years, it would be the entire calendar year. The 90-day reporting period may not start before Jan. 1, 2011 or cross over into the next year. For example, a reporting period beginning in November would cross over to January of 2012 and would thus be ineligible. Therefore, the documentation process for demonstration of Stage 1 meaningful use for the first year could begin as soon as Jan. 1, 2011 or as late as Oct. 1, 2011.

Note that in the second, third, fourth, and fifth years, Medicare EPs must report on the entire calendar year.

58. How many health IT functionality objectives/measures must a physician meet to be eligible for funding?

For Stage 1 EPs must meet 20 health IT functionality objectives/measures (with some exceptions), 15 core measures and an additional five selected from a menu. The core set includes 15 measures/objectives that comprise basic functions of EHRs. An EP must meet all 15 core measures/objectives to qualify for incentives. One of these objectives requires a physician to report ambulatory clinical quality measures - three core measures and three additional measures relevant to the practice.

See the AMA's summary of the health IT measures / objectives at: <http://www.ama-assn.org/ama1/pub/upload/mm/399/ehr-meaningful-use-criteria.pdf>, as well as, the AMA's summary of the quality measures at: <http://www.ama-assn.org/ama1/pub/upload/mm/399/ehr-clinical-quality-measures.pdf>.



59. Do you have to accomplish these measures for all patients or only Medicare patients?

You will need to accomplish these measures for all Medicare or Medicaid patients seen/provided services for during the reporting period. Certain Stage 1 meaningful use criteria specify that an EP will need to report on all "unique patients" seen by the EP. Please note, a "unique patient" means that even if a patient is seen multiple times during the EHR reporting period they are only counted once. See the AMA's summary of the measures / objectives at: <http://www.ama-assn.org/ama1/pub/upload/mm/399/ehr-meaningful-use-criteria.pdf>.

60. Where can we find the clinical decision support rule that we must measure ourselves against?

The proposed rule described clinical decision support as "health information technology functionality that builds upon the foundation of an EHR to provide persons involved in care processes with general and person-specific information, intelligently filtered and organized at appropriate times, to enhance health and health care." The final rule further specified that the description of clinical decision support is intentionally broad to provide enough leeway for providers to use clinical decision support that is most relevant to their scope of practice and that would benefit their patients. The clinical decision support logic should be built into the EHR and might include alerts and reminders, diagnostic support, or documentation templates.

All certified EHRs are required to contain the clinical decision support functionality needed by physicians to meet the clinical decision support objective and measure. We recommend physicians contact their vendor and ask about this functionality for more information.

61. Could the same functionality (checking drugs for interactions against other drugs) be used for meeting two different objectives (drug-drug/drug-allergy and the clinical decision support rule)?

No. The drug-drug and drug-allergy checks and the implementation of one clinical decision support rule are separate core meaningful use objectives. You must implement one clinical decision support rule in addition to drug-drug and drug-allergy interaction checks. CMS has indicated that they would not have listed these core requirements as separate measures, nor required that eligible physicians and hospitals meet all core objectives and measures listed in the regulation, had CMS intended for them to be met simultaneously.

62. To fulfill 5 out of the 10 objectives and measures in the menu set, could I satisfy 3 of them and attest that an exclusion applies for 2 measures in order to meet a total of 5, even if I could meet 2 other menu objectives/measures (without applying an exclusion)?

The answer to this is unclear. The AMA is checking with CMS on this.

63. To meet certain objectives/measures, 80% of patients must have records in the certified EHR technology. Is the 80% based on:

- a. Total patient population or only 80% of Medicare patients?
- b. Patients seen in that calendar year or total patients?

We only see some of our patients every 2-3 years. Does that mean that we have to go back and scan documents for 80% of our total patient base?

Percentages for meeting measures are based on your total Medicare or Medicaid patient populations for the EHR reporting period. The reporting period for the first year is 90 days; for subsequent years, the



reporting period is an entire calendar year. Some measures only involve counting records in the EHR while other measures may require counting of EHR records and manual counting of paper records for patients treated in the reporting period in order to meet the threshold. We strongly encourage physicians to review our summary document that reviews the requirements for meeting each objective/measure. See the AMA's summary on the program's objectives / measures at: <http://www.ama-assn.org/ama1/pub/upload/mm/399/ehr-meaningful-use-criteria.pdf>.

64. If we tell the patient to check our website for patient education material, would that count for meeting menu objective number 6?

There are no specific guidelines on this. The AMA recommends you document in the medical record that you referred the patient to your website for educational materials. We will seek clarification from CMS on this.

65. In order to meet the percentage threshold for a measure involving "unique patients" (e.g., 30% of unique patients for Computerized Physician Order Entry (CPOE), would this include all unique patients regardless of place of service or will eligible professionals count on what is in the certified outpatient EHR while the hospital counts the inpatient and ER only but not outpatient records?

We are unclear on this and will consult with CMS.

66. If I am unable to enter orders myself because it is in a nursing home setting, can the CPOE criteria be excluded?

No. The exclusion for CPOE only covers any eligible professional who writes fewer than 100 prescriptions during the EHR reporting period. The final rule for the Medicare and Medicaid EHR incentive programs specifies that in order to meet the meaningful use objective for CPOE for medication orders, any licensed healthcare professional can enter orders into the medical record per state, local, and professional guidelines.

67. What is the specific definition of e-prescribing?

In order to take advantage of the Medicare or Medicaid EHR Incentive Program, an eligible physician must use a certified EHR or certified EHR module that enables electronic prescribing (e-prescribing).

The e-prescribing functionality includes ALL of the following capabilities:

- Generating a complete active medication list incorporating electronic data received from applicable pharmacies and benefit managers (PBMs) if available
- Selecting medications, printing prescriptions, electronically transmitting prescriptions, and conducting all alerts
- Providing information related to lower cost, therapeutically appropriate alternatives (if any)
- Providing information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan, if available

68. Are the requirements for patient's access to their record different for specialists and primary care physicians?

No. The core objective indicates that upon a patient's request an EP must provide a patient an electronic copy of their health information (including diagnostic test results, problem list, medication lists, and allergies) in three business days (electronic copy must be in an electronic form – patient portal, PHR, CD, USB, etc.). According to the CMS website, Stage 2 will expand on multiple criteria, including patient access to their health information.



69. What qualifies as "provide electronic copy of health record" to patients within 48 hours? Fax, email CD?

The proposed rule called for requiring physicians to provide patients with an electronic copy of their medical record within 48 hours, however, the requirement changed in the final rule. The final rule adopted a period of three business days instead.

Currently the method by which you could provide this documentation is flexible. The final regulation says, "Electronic copies may be provided through a number of secure electronic methods (for example, personal health record (PHR), patient portal, CD, USB drive)." This objective is limited to health information maintained and provided electronically. The Health Insurance Portability and Accountability Act (HIPAA), on the other hand, requires physicians to provide copies of medical records that are both maintained in paper and electronic forms to patients upon request within 30 days of the request.

70. Is it true that there are no meaningful use requirements for Medicaid? If I buy or upgrade to a certified EHR software, I get the bonus for the first year?

Yes, but just for first year of participation under the Medicaid program. For this first year, you are only required to show proof of adoption (e.g., evidence that you have purchased and installed a certified EHR in your practice), proof of implementation (e.g., indicate that you have trained your office staff, have begun to enter patient demographic information into your certified EHR), or proof that you upgraded to a certified EHR. After the first year of participation, you must comply with the Medicare meaningful use requirements. Please note that after your first year, your State may add additional meaningful use core measures that you must meet under the Medicaid program so check with your State Medicaid Agency for details.

71. What prevents Medicaid eligible professionals from adopting/implementing/ upgrading in year 1, getting \$21,000, and then not doing anything in future years to demonstrate meaningful use?

Nothing prevents an eligible professional from deciding not to take part in the incentive program in subsequent years. It is important to keep in mind that physicians are supportive of and committed to incorporating well-developed EHRs into their practices to improve quality of care delivery, enhance patient safety, as well as support practice efficiencies. It is unlikely that after physicians make a significant up front investment in health IT and changes to their workflow that they will revert back to manual processes.

72. Is 2015 the soonest one can submit for Stage 3?

At this time, only Stage 1 meaningful use criteria have been finalized. Criteria for Stage 2 and 3 meaningful use of EHRs will be defined in future CMS rulemaking.

Clinical quality measurement

73. What are the three core clinical quality measures that we must report?

EPs are required to submit information using their certified EHR technology on three core clinical quality measures. These include:

- blood pressure measurement,
- tobacco use assessment and tobacco cessation intervention, and



- adult weight and screening and follow-up

For more information about these and the other clinical quality measures finalized for Stage 1. See the [AMA's clinical quality summary](#) for details.

74. Which specialties are covered by the proposed clinical quality measures?

All EPs have to report on the three core measures that apply to their patients or substitute from three alternative core measures. In addition, EPs must report on three additional clinical quality measures that are most appropriate given the physician's specialty. The three additional measures cannot be core or alternate core measures. See the [AMA's clinical quality measure summary](#) for details.

75. Out of the 44 possible clinical quality measures, what if only one is relevant to my practice and we're required to report on three?

All EPs must attempt to report the core measures and if one or more core measures do not apply, must attempt to report on the alternate measures. If, after reviewing the specifications for the additional measures from Table 6 (excluding the core/alternate core), you find that fewer than 3 measures apply to your practice, you will be required to demonstrate that the measures do not apply by having zero patients in the denominator. However, there will be many instances where EPs participating in Stage 1 will not have clinically relevant measures.

76. Why are there so few specialty measures?

For Stage 1, CMS finalized those clinical quality measures with available electronic measure specifications for use in EHRs. According to CMS, they "expect to use a transparent process for clinical quality measure development that includes appropriate consultation with specialty groups and other interested parties, and we expect that electronic specifications will be developed for all of the measures that we originally proposed for Stage 1 or alternative related measures, which would allow for a broadly applicable set of specialty measures groups and promote consistency in reporting of clinical quality measures by EPs."

77. Can you use a combination of core measures and alternate core measures to satisfy the clinical quality reporting requirements?

All EPs are required to report on the three core measures. Insofar as the denominator for one or more of the core measures is zero, EPs will be required to report results for up to three alternate core measures. The EP will NOT be excluded from reporting any core or alternate clinical quality measure because the measure does not apply to the EPs scope of practice or patient population. The expectation is that the EHR will automatically calculate each core clinical quality measures, and when one or more of the core measures has a denominator of zero then the EP should attempt to report on the alternate core measure(s). 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 the Final Rule.

78. Will there be any exclusions allowed for the Clinical Quality Measures based on subspecialty?

No. However, if a measure is not clinically relevant you will need to indicate this. See above answers.

79. Of the 10 optional clinical measures, do immunizations apply to only pediatric patients in one's practice?



We recommend you review the specifications for the clinical quality measures (e.g., applicable patient population, CPT, and Dx codes, are available on the CMS website located at http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage). For additional information about Clinical Quality Measures for EPs, see our Clinical Quality Measures summary, found at <http://www.ama-assn.org/ama1/pub/upload/mm/399/ehr-clinical-quality-measures.pdf>.

80. To meet the requirement for reporting the six clinical quality measures, how do you count denominator, numerator and exclusions (or exceptions)? Are all EHR patients included in the denominator?

A certified EHR must have the ability to tabulate the numerators, denominators and exclusions (exceptions) stored in the EHR for clinical quality measure reporting. EPs will want to confirm the EHR performed the calculations accurately and ensure appropriate backup documentation for reporting purposes. For Stage 1 reporting purposes, EPs will provide a summary of this activity to CMS or the States. Keep in mind that the differences in the first year participation requirements for Medicaid. Please see our [Medicaid summary](#) for the details.

The denominator identifies to whom the measure applies, based on one or more of the following criteria: age, gender, Diagnosis Codes, CPT Codes. The numerator is the number of patients in the denominator who also have the clinical action that is the focus of the measure performed.

For example, for the Hypertension-Blood Pressure Measurement measure, the denominator is patients aged 18 and over with a diagnosis of hypertension who have been seen at least twice during the reporting period. The numerator is the number of patients (meeting denominator criteria) who have their blood pressure measured at each visit during the year.

These measures are not applicable to all EPs, which is why EPs need to be familiar with the electronic specifications for the clinical quality measures and enter the data into their system in the structured data fields for the designated information (eg, problem list, medication list). In order for the EHR to correctly calculate the clinical quality measures, the data need to be entered into the appropriate location within the EHR. Since certified EHRs are not required to contain all 44 possible measures, physicians are strongly encouraged to discuss which measures are included in an EHR when shopping for a product to ensure it will meet their needs. Physicians are also encouraged to query vendors on how their products will demonstrate that they have met the clinical quality reporting requirements.

81. To report clinical quality measure denominators, numerators, and exclusions (or exceptions), do I count every single patient visit toward denominator?

No. Each clinical quality measure specifies what the applicable patient population is, and the appropriate combination of CPT and Diagnosis codes that necessitate the reporting of the measure (e.g., measures have different age applicability, 2-17 years old, 21-64 years old etc). Each clinical quality measure has its own eligibility requirements, so it is important that the specifications are evaluated carefully to understand the patient population to whom the measure applies.

Qualified systems and systems certification

82. Is there an approved organization to certify EHR systems?

Yes. The Certification Commission for Health Information Technology (CCHIT), Chicago, Illinois, and the Drummond Group Inc. (DGI), Austin, Texas, were authorized on September 3, 2010, by the Office of the National Coordinator for Health Information Technology (ONC) as the first technology review bodies that have been authorized to test and certify EHR systems for compliance with the standards and certification



criteria. Most recently, ONC named four additional certification bodies—InfoGard Laboratories, Inc., San Luis Obispo, CA (Sept. 24, 2010), ICSA Labs, Mechanicsburg, PA (Dec. 10, 2010), SLI Global Solutions, Denver, CO, (Dec. 10, 2010) and Surescripts LLC, Arlington, VA (Dec. 23, 2010).

83. What does "certified" mean?

The U.S. Department of Health and Human Services (HHS) will be making available a list of EHR systems deemed "certified" that you must use in order to get incentives. No EHR products have been certified yet. CCHIT expects to begin certifying systems in fall 2010.

84. Will only large companies have certified products?

No. If you have a vendor in mind you should ask them about their plans for certification. EHR vendors of all sizes are all aware of the certification requirements.

85. I have my own in-house software and I meet a majority of the core objectives. How hard would it be for my software to be certified?

Hospitals and practices who have developed their own EHR systems or products must also seek to have their existing systems or products tested and certified if they want to participate in the incentive program. The ability to meet the certification standards will vary. More information on the certification process can be found at www.hhs.gov/healthit. Please note that only two bodies have been authorized by the government to certify products, CCHIT (http://www.cchit.org/get_certified) and the Drummond Group (<http://www.drummondgroup.com/html-v2/participate.html>). More bodies are expected to be approved in the future.

86. Where do we find a "certified EHR"?

Certified EHR products will be posted on the HHS website as they become available. Check www.hhs.gov/healthit for more information. The AMA will post information on our site at www.ama-assn.org/go/hit. We anticipate certified EHR products will be available in fall 2010.

87. How about if I buy a web-based EHR program? Am I still eligible for incentives?

Yes, so long as it has been certified as meeting the government's criteria for participation in the incentive program. Currently there are no certified EHR products that meet the certification requirements for the Medicare and Medicaid EHR incentive programs. EHR products will have to undergo certification. Vendors will have to submit their EHR products to be tested and certified. Hospitals and practices who have developed their own EHR systems or products must also seek to have their existing systems or products tested and certified. Once a product is certified, the name of the product will be published on the ONC web site. We expect the first EHRs to be certified and listed on the ONC Web site in fall 2010.

Upgrading /selecting an EHR

88. Does everything have to be within one piece of software? Or, is it possible to use DrFirst for e-prescribing and my EMR for most everything else?

No, not everything needs to be contained within one piece of software. EPs are permitted to use different products to meet the requirements. Products which are not considered to be a "complete" EHR for the purposes of meeting the incentive program's requirements are being referred to as "EHR modules." Both complete EHRs and EHR modules will be certified. A list of certified EHR products, including modules,



will be posted on the HHS website at www.hhs.gov/healthit. Please see the Q's and A's under the certification section for more information.

89. Are certifications required for the modular approach?

Yes. The Office of the National Coordinator (ONC) issued a final rule on July 13, 2010 establishing an initial set of standards, implementation specifications, and certification criteria for electronic health record (EHR) technology. The regulation included definitions for "Complete EHRs" and "EHR Modules," both of which eligible professionals can use to receive incentives. Both technology types must be certified, including the individual EHR modules. Keep in mind however, that vendors (or EPs who have their own homegrown product and want to be eligible for participation in the incentive program) are responsible for obtaining product certification whereas physicians are required to ensure the module(s) they purchase together meet all of the requirements for obtaining the incentives.

90. We are on Allscripts; do you think that is the best EHR?

The "best" EHR will vary depending upon each EP's needs. Currently, there are no certified EHR products that meet the certification requirements for the Medicare and Medicaid EHR incentive programs. EHR products will have to undergo certification. Once a product is certified, the name of the product will be published on the ONC web site. We expect the first EHRs will be certified and listed on the ONC Web site in fall 2010. Please see the Q and A under the certification section for more information.

91. I have been using SOAP WARE for the past 10 years. Will I get help in upgrading to system?

All EPs are encouraged to discuss with their vendors the level of technical support available for upgrading or for new EHR purchases. Pursuant to ARRA, the government has awarded monies to Regional Extension Centers to help some physicians. Please see Q's and A's under the Regional Extension Center for more information.

Regional extension centers

92. Doesn't some of the ARRA money pay for consultants to help practices with EHR implementation and meaningful use reporting?

No. However, ARRA appropriates a total of \$2 billion in discretionary funding, in addition to incentive payments under the Medicare and Medicaid programs for EPs' and other providers' adoption and meaningful use of certified EHR technology. This funding will go to Health Information Technology Regional Extension Centers (Regional Centers) that will offer technical assistance, guidance and information on best practices to support and accelerate health care providers' efforts to become meaningful users of EHRs.

In March and April 2010, ONC awarded cooperative agreements to 60 Regional Extension Centers representing all the states and U.S. territories.

Locate your local REC at www.ama-assn.org/go/hit. For more information on the Regional Extension Centers visit <http://www.hhs.gov/recovery/programs/hitech/factsheet.html> and <http://www.hhs.gov/news/press/2010pres/02/20100212a.html>.

Reporting



93. How do we report our progress in meaningful use to CMS in order to get the ARRA funds?

EPs will be required to demonstrate to the government that they have achieved the requirements through an attestation process. More information on the attestation process will be forthcoming from CMS soon.

94. How will CMS track participation?

Tracking will be done at the unique National Provider Identifier (NPI) level. Both Medicare and Medicaid eligible professionals will need to furnish the following information to be paid accurately and quickly:

- Name;
- NPI;
- Business address and business phone; and
- Taxpayer Identification Number (TIN) to which you want the incentive payment made

CMS has proposed that Medicare and the states use a single program data repository to track participation in both Medicare and Medicaid.

95. Is the 90-day continuous period for which eligible professionals must report meaningful use just for 2011, or does it apply to the first year the professional chooses to participate? For instance, if the professional does not demonstrate meaningful use until 2012, does he/she just have to do it for 90 days or the whole calendar year?

The 90 consecutive days reporting period applies to the first year that you participate in the EHR incentive program. For the second, third, fourth and fifth payment years, the reporting period is the whole calendar year. Please review our summary documents at www.ama-assn.org/go/hit for more information.

96. Could you explain how the 20 proposed health IT functionality measures and objectives for the first year will be reported?

For 2011 and for 2012 EPs will be required to “attest” to meeting the criteria for being a meaningful user of an EHR. CMS has said EPs would have to conduct a one-time attestation through a “secure mechanism” following the completion of the EHR reporting period for a given payment year. See the AMA’s summary document on the health IT measures/objectives table for Stage 1 meaningful use criteria for more information about the reporting method for each objective measure at: <http://www.ama-assn.org/ama1/pub/upload/mm/399/ehr-meaningful-use-criteria.pdf>. CMS plans to announce more details about the attestation process in the future.

97. Is it true that CMS will not be able to receive required quality reports electronically in 2011 and possibly not in 2012?

Yes. For 2011, reporting quality will be done through attestation. If CMS is not ready to accept electronic measures/reports electronically by 2012, they will reassess. However, the plan for 2012, for quality reporting, is electronic.

98. Is there anything billing has to do on the claim in order to get incentives?

No. You do not have to submit information on your claims in order to qualify for Medicare or Medicaid EHR incentives. Please review our [summary documents](#) for more information.

Penalties



99. How do the penalties work?

Physicians who do not adopt/use an EHR system before 2015 will face a reduction in their Medicare fee schedule of -1% in 2015, -2% in 2016, and -3% in 2017 and beyond. The Secretary of HHS has the authority to make exceptions to this reduction on a case-by-case basis for physicians who demonstrate significant hardship (e.g., physicians who practice in rural areas without sufficient Internet access). See the AMA's Medicare and Medicaid summary documents at: <http://www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicare-incentive-summary.pdf> and <http://www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicare-incentive-summary.pdf> for details.

100. What percentage of deduction will be made if we don't have a certified EHR by 2015?

The penalties only apply to Medicare and they begin at a rate of 1% reduction in the physician fee schedule in 2015 going up to 2% in 2016, and 3% for 2017 and beyond if a physician has not successfully met the incentive requirements for being a "meaningful user" of a certified EHR. For more information, please link to page 3 of our chart at: <http://www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicare-incentive-summary.pdf>.

101. If an eligible professional successfully demonstrates meaningful use and gets paid in year 1 but does not successfully demonstrate meaningful use in subsequent years, will the eligible professional be subject to penalties in 2015 under Medicare?

Yes. According to the law, physicians who have not successfully become meaningful users of EHRs will be subject to penalties in 2015 for Medicare (penalties do not apply for Medicaid providers). CMS will be providing more details of the Medicare penalty program in the future.

102. What exactly is a payment adjustment?

"Adjustment" refers to a reduction in Medicare payments (or the so called "penalties") if an eligible physician does not successfully participate in the EHR incentive program by 2015. Please refer to one of the AMA's fact sheets found at: <http://www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicare-incentive-summary.pdf> that details the Medicare EHR penalty program. CMS will be providing more details of the Medicare penalty program in the future.

103. Will the payment reduction that begins in 2015 be permanent?

Yes, that date is set in law.

104. Will an EP who meets the EHR Incentive program requirements in one or more years but not all still going to get hit with a penalty?

CMS' current reading of the Stimulus law is that if an eligible professional (EP) is not a meaningful EHR user for a particular year then the adjustment would be applied. This could mean that if you were a meaningful user of an EHR in 2014 that this would prevent you from getting a penalty in 2015. At this time, CMS does not anticipate that just because a physician is a meaningful user of an EHR in say 2012, that this would prevent them from being penalized in 2015, the year the EHR program penalties begin. At this time no policy on penalties has been finalized and CMS expects to include a proposal about how EHR penalties will be handled in a notice of proposed rulemaking in early 2012, therefore, more details on the how the penalties will be forthcoming.



Attestation

105. How do we attest to all of the attestable criteria?

Yes. Some requirements have exceptions. If an EP determines they meet an exception they will need to attest to this as well. CMS will be providing more information in the future on the attestation process.

106. What if you exclude yourself from meeting a measure, and they do not like your answer and say you did not complete that measure. Will they give you time to start reporting so you can get incentives for that year?

You should make sure that the information you report via attestation is accurate. You should maintain evidence of qualifications to receive incentive payments for 10 years after the date you register for the incentive program. The AMA is advocating for CMS to support an appeals process so that physicians can appeal decisions that affect their eligibility to take part in the Medicare EHR incentive program or that affect their ability to get EHR incentives.

107. Will CMS require the same security application for attestation as is currently required for getting PQRI feedback reports, which everyone complains about?

Eligible physicians are required to demonstrate that they satisfy each of the proposed meaningful use objectives and measures through a secure, one-time attestation following the reporting period. CMS will provide more details regarding the attestation process in the future.

Privacy and security

108. Do you have any recommendations with respect to privacy and implementing electronic health records?

Currently, privacy and security standards under HIPAA require physicians to protect the privacy of patients' medical information for physicians who are conducting one or more of the HIPAA administrative transactions (i.e. claims) electronically. Physicians are therefore already required to control the ways in which they use and disclose patients' "protected health information" (PHI).

For more information on the HIPAA Privacy and Security Rules please check our website:

<http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/hipaahealth-insurance-portability-accountability-act.shtml>

Also visit the Office of Civil Rights website: <http://www.hhs.gov/ocr/privacy/index.html>

Personal health records and e-visits

109. What is the liability for reviewing and answering information placed on email that you might not get to until the next day?

The Medicare and Medicaid incentive programs requirements of physicians concerning how quickly they must respond to electronic inquiries from patients. The core measures associated with providing patients with electronic information are: 1) clinical summaries within three business days of the patient's office visit; and 2) an electronic copy of their health information upon the patient's request within three business days (applies only to information stored electronically; not paper). For more information on the measures link to www.ama-assn.org/go/hit.



Governance

110. Which federal government body audits the meaningful use requirements?

While audits were not discussed in the regulation, CMS will likely oversee audits associated with the Medicare incentive program. It is also possible that states would engage in this function with respect to the Medicaid incentive program. However, these details have not yet been announced. Regardless, EPs are required to maintain evidence of qualifications to receive incentive payments for 10 years after the date they register for the incentive program.

Also, as stated earlier, some states may begin their Medicaid incentive program in 2010. Further, unlike the Medicare incentive program, the Medicaid program allows eligible providers to receive an incentive payment even before they have begun to meaningfully use certified EHR technology. These EPs may receive a first year of payment if they are engaged in efforts to “adopt, implement, or upgrade” to certified EHR technology. EPs would have to attest to this.

111. Will all states have a reporting agency setup for the syndromic surveillance, and if so by what date?

State readiness varies. So please check with your state department of health for details.

Exchanging /sharing patient data

112. Do you have a date when providers will be able to share patients’ medical records electronically? For example, when will a primary care physician who refers a patient to a specialist be able to transmit the patient’s records electronically rather than as a fax.

There is no date certain when a physician will be able to share medical records with another provider. The AMA continues to press for the need for a nationwide electronic exchange infrastructure that enables health care providers to access medical records in a secure manner.

113. Why isn't there any incentive to develop truly centralized medical record systems rather than the current fragmented systems?

ARRA included provisions on the Medicare and Medicaid EHR Incentive Program, as well as, a grant program to support States or State Designated Entities (SDEs) in establishing health information exchange (HIE) capability among health care providers and hospitals in their jurisdictions.

114. How can I submit my patient data to an health information exchange (HIE) and how do I obtain information for a specific patient from an HIE?

Check ONC’s website for more information on State Health Information Exchanges (State HIE)
http://healthit.hhs.gov/portal/server.pt?open=512&objID=1488&parentname=CommunityPage&parentid=58&mode=2&in_hi_userid=11113&cached=true

Miscellaneous

115. What is PECOS?



PECOS is the Provider Enrollment, Chain and Ownership System, Medicare's provider enrollment database. Please see www.ama-assn.org/go/regrelief under "Medicare Enrollment" for more information.

116. What is the ONC website link?

<http://healthit.hhs.gov/portal/server.pt?open=512&objID=1263&mode=2>.

117. Is there a list of the key clinical information that requires electronic sharing?

Yes. In order to qualify for the Medicare or Medicaid EHR Incentive Program, you must use a certified EHR, as established by a new set of standards and certification criteria. For more information on the standards and certification criteria see ONC's webpage at: <http://healthit.hhs.gov/certification>. There are certain requirements for exchanging information and the AMA's summary document on the health IT objectives/measures at: <http://www.ama-assn.org/ama1/pub/upload/mm/399/ehr-meaningful-use-criteria.pdf>.

ADDITIONAL RESOURCES:

- **AMA Web site on EHR incentive programs** – www.ama-assn.org/go/hit.
- **CMS Web site on the EHR incentive programs** – http://www.cms.hhs.gov/Recovery/11_HealthIT.asp.
- **HHS Web site on health IT** - <http://healthit.hhs.gov/portal/server.pt>.



Glossary

ARRA = American Recovery and Reinvestment Act

CMS = Centers for Medicare & Medicaid Service

EHR = Electronic Health Record

EP = Eligible Professional (includes non-hospital based physicians)

FQHC = Federally Qualified Health Center

HIE = Health Information Exchange

MA = Medicare Advantage

ONC = Office of the National Coordinator for Health Information Technology

RHC = Rural Health Center