



# Achieving Meaningful Use

## Frequently Asked Questions

### The Massachusetts Medicaid EHR Incentive Payment Program

*The Massachusetts Medicaid EHR Incentive Payment Program has compiled a list of Frequently Asked Questions (FAQs) relating to Stage 1 Meaningful Use. Massachusetts has adopted the same Meaningful Use standards set forth by Centers for Medicare and Medicaid Services (CMS). Therefore, a link and the number that correlates to each CMS FAQ has been provided after each question (when applicable).*

*If you have any other questions about the requirements for the Massachusetts Medicaid EHR Incentive Payment Program or Meaningful Use, please contact the Massachusetts Medicaid EHR Incentive Payment Program staff by phone at **1-855-MassEHR (1-855-627-7347)** or via e-mail at [massehr@masstech.org](mailto:massehr@masstech.org).*

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## General Stage 1 Meaningful Use Questions

### **1. Q: What is Meaningful Use, and how does it apply to the Massachusetts Medicaid EHR Incentive Payment Program?**

**A:** Under the Health Information Technology for Economic and Clinical Health (HITECH Act), which was enacted under the American Recovery and Reinvestment Act of 2009 (Recovery Act), incentive payments are available to eligible professionals (EPs) and eligible hospitals (EHs) that successfully demonstrate meaningful use of certified EHR technology.

The Recovery Act specifies three main components of meaningful use.

- Use of a certified EHR in a meaningful manner (e.g.: e-Prescribing)
- Use of certified EHR technology for electronic exchange of health information to improve quality of health care
- Use of certified EHR technology to submit clinical quality and other measures

### **2. Q: Can an eligible hospital implement an electronic health record (EHR) system and satisfy Meaningful Use requirements at any time within the Federal fiscal year for the program?**

**A:** Eligible hospitals must have adopted, implemented, upgraded, or meaningfully used certified EHR technology during the first Federal Fiscal Year. If the Medicaid eligible hospital adopts, implements, or upgrades in the first year of payment, and demonstrates meaningful use in the second year of payment, then the EHR reporting period in the second year is a continuous 90-day period within the Federal fiscal year; subsequent to that, the EHR reporting period is then the entire Federal fiscal year. Please note that dually eligible hospitals that are deemed a Meaningful User by Centers for Medicare & Medicaid Services will not have that to report meaningful use data to the state Medicaid EHR Incentive Payment Program, but will still need to meet all programmatic requirements each year (Medicaid Patient Volume Threshold, etc.)

### **3. Q: What is the reporting period for eligible professionals (EPs) attesting to Meaningful Use?**

**A:** In order to attest to meaningful use, an EP must have adopted, implemented, or upgraded to certified EHR technology during their first year of participation. For demonstrating meaningful use through the Massachusetts or any other state Medicaid EHR Incentive Payment Program, the Stage 1 Meaningful Use reporting period is any continuous 90-day period within the current calendar year. In subsequent years, the EHR reporting period for EPs is the entire calendar year.

Meaningful Use Stage	Reporting Period
Adopt, Implement, Upgrade	No EHR reporting period
Stage 1 Meaningful Use	Continuous 90-day period – current calendar year
Stage 1 Meaningful Use	365 reporting period – current calendar year
Stage 2 Meaningful Use	365 reporting period – current calendar year
Stage 3 Meaningful Use	365 reporting period – current calendar year

### **4. Q: In order to meet the participation threshold of 50 percent of patient encounters in practice locations equipped with certified electronic health record (EHR) technology, how should patient encounters be calculated?**

**A:** 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. For the purpose of calculating this 50 percent threshold, any encounter where a medical treatment is provided and/or evaluation and management services are provided should be considered a “patient encounter.” Please note that this is different from the requirements for establishing patient volume for the program. For information on establishing patient volume for the program, please [click here](#).

**Text Keyword:** [FAQ10592](#)  
CMS FAQ# 3215

### **5. Q: Will eligible professionals (EPs) be required to submit supporting documentation showing that they have successfully achieved each Meaningful Use measure they've attested to?**

**A:** All EPs will be required to submit an acknowledgement that their EHR system has the capability to submit electronic immunization data to immunization registries or information systems according to the applicable law and practice and the program may ask EPs to submit additional supporting documentation. For example, an EP may be asked to submit a copy of their Security Risk Analysis report for Core Measure 15 if a discrepancy is found when validating the application. Also, EPs should save all information related to their Medicaid incentive program application and meaningful use attestations for at least six years in the event of an audit.

**6. Q: Do specialty providers have to meet all of the Meaningful Use objectives for the program both in Massachusetts and in any other state, or can they ignore the objectives that are not relevant to their scope of practice?**

**A:** For eligible professionals (EPs) who participate in the program in Massachusetts or any other state, there are a total of 26 meaningful use objectives. To qualify for an incentive payment, 20 of these 26 objectives must be met. There are 15 required core objectives. The remaining five objectives may be chosen from the list of 10 menu set objectives. Click [here](#) for a full list of the core and menu 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 on a particular meaningful use objective, or if the EP does not meet the criteria for an existing exclusion, then the EP must still 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 for the objective will prevent an EP from successfully demonstrating meaningful use and receiving an incentive payment.

**Text Keyword: [FAQ10469](#)**  
CMS FAQ# 3069

**7. Q: If a provider purchases a certified Complete Electronic Health Record (EHR) or has a combination of certified EHR modules that collectively satisfy the definition of certified EHR technology, but opts to use a different, uncertified EHR technology to meet certain meaningful use core or menu set objectives and measures, will that provider be able to successfully demonstrate meaningful use under the Medicaid EHR Incentive Payment Program in Massachusetts or any other state?**

**A:** No. The provider would not be able to successfully demonstrate meaningful use. To successfully demonstrate meaningful use, a provider must do three things.

1. Have certified EHR technology capable of demonstrating meaningful use, either through a complete certified EHR or a combination of certified EHR modules;
2. Meet the measures or exclusions for 20 Meaningful Use objectives (19 objectives for eligible hospitals); and
3. Meet those measures using the capabilities and standards that were certified to accomplish each objective.

A provider using uncertified EHR technology to meet one or more of the core or menu set measures would not be using the capabilities and standards that were certified to accomplish each objective. Please note that this does not apply to the use of uncertified EHR technology and/or paper-based records for purposes of reporting on certain meaningful use measures (i.e., measures other than clinical quality measures).

**Text Keyword: [FAQ10590](#)**  
CMS FAQ# 3211

**8. Q: If an eligible professional (EP) sees a patient in a setting that does not have certified 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 Medicaid EHR Incentive Payment Program in Massachusetts or any other state?**

**A:** Yes. An EP may include patients seen in locations without certified EHR technology in the numerators and denominators of meaningful use measures if the patients' information is entered into certified EHR technology at another practice location. However, EPs should be aware that it is unlikely that they will be able to include such patients in the numerator for the measure of the "use computerized provider order entry (CPOE)" objective or for the e-prescribing measure. CPOE must be entered by someone who can exercise clinical judgment in the case that the entry generates any alerts about possible interactions or other clinical decision support aides.

This necessitates that CPOE occur when the order first becomes part of the patient's medical record and before any action can be taken on the order. Because information for patients seen in locations without certified EHR technology will be transcribed at a later date into the certified EHR system, it is unlikely that CPOE could occur before any action is taken on the order. For the e-prescribing measure, it is unlikely that EPs will be able to electronically transmit prescriptions for patients in locations without certified EHR technology.

**Text Keyword: [FAQ10590](#)**  
CMS FAQ# 3077

**9. Q: What are the Meaningful Use requirements for dentists participating in the Massachusetts Medicaid EHR Incentive Payment Program?**

**A:** Dentists must meet the same eligibility requirements as other eligible professionals (EPs) in order to qualify for payments under the Massachusetts Medicaid EHR Incentive Payment Program. This also means that they must demonstrate all 15 of the core meaningful use objectives and five from the menu of their choosing. The core set includes reporting of six clinical quality measures (three core and three from the menu of their choosing). Several meaningful use objectives have exclusion criteria that are unique to each objective. EPs will have to evaluate whether they individually meet the exclusion criteria for each applicable objective as there is no blanket exclusion by type of EP.

**10. Q: If an eligible professional (EP) is unable to meet the measure of a Meaningful Use objective because it is outside of the scope of his or her practice, will the EP be excluded from meeting the measure of that objective under the Massachusetts Medicaid EHR Incentive Payment Program?**

**A:** Some meaningful use objectives provide exclusions and others do not. Exclusions are available only when our regulations specifically provide for an exclusion. EPs may be excluded from meeting an objective if they meet the circumstances of the exclusion. If an EP is unable to meet a meaningful use objective for which no exclusion is available, then that EP would not be able to successfully demonstrate meaningful use and would not receive incentive payments under the Medicaid EHR Incentive Payment Program in Massachusetts or any other state.

**Text Keyword: [FAQ10151](#)**  
CMS FAQ # 2883

**11. Q: If data is captured using certified electronic health record (EHR) technology, can an eligible professional or eligible hospital use a different system to generate reports used to demonstrate Meaningful Use for the Medicaid EHR Incentive Payment Program?**

**A:** Certified EHR technology must include the capability to electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage for all percentage-based meaningful use measures. However, the meaningful use measures do not specify that this capability must be used to calculate the numerators and denominators. Eligible professionals (EPs) and eligible hospitals (EHs) may use a separate, non-certified system to calculate numerators and denominators and to generate reports on the measures of the core and menu set meaningful use objectives. EPs and EHs must fill in numerators and denominators for meaningful use objectives, indicate if they qualify for exclusions to specific objectives, report on clinical quality measures, and legally attest that they have successfully demonstrated meaningful use. Please note that EPs and EHs cannot use a noncertified system to calculate the numerators, denominators, and exclusion information for clinical quality measures. Numerator, denominator, and exclusion information for clinical quality measures must be reported directly from certified EHR technology. For additional clarification about this, please refer to the following FAQ from the Office of the National Coordinator of Health Information Technology:

[http://healthit.hhs.gov/portal/server.pt/community/onc\\_regulations\\_faqs/3163/faq\\_13/20775](http://healthit.hhs.gov/portal/server.pt/community/onc_regulations_faqs/3163/faq_13/20775).

**Text Keyword: [FAQ10465](#)**  
CMS FAQ# 3063

## Stage 1 Meaningful Use Core Measure Questions

**12. Q: 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 Massachusetts Medicaid EHR Incentive Payment Program?**

**A:** A Clinical Summary is defined as “an after-visit summary that provides a patient with relevant and actionable information and instructions containing, but not limited to, the patient name, provider’s office contact information, date and location of visit, an updated medication list, updated vitals, reason(s) for visit, procedures and other instructions based on clinical discussions that took place during the office visit, any updates to a problem list, immunizations or medications administered during visit, summary of topics covered/considered during visit, time and location of next appointment/testing if scheduled, or a recommended appointment time if not scheduled, list of other appointments and tests that the patient needs to schedule with contact information, recommended patient decision aids, laboratory and other diagnostic test orders, test/laboratory results (if received before 24 hours after visit), and symptoms.”

The EP 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 cannot populate all of the above fields, then at a minimum, the EP must provide the following data elements for which all EHR technology is certified for the purposes of this program.

- Problem List
- Diagnostic Test Results
- Medication List
- Medication Allergy List

This answer applies to clinical summaries generated by certified EHR technology for electronic or paper dissemination. Also, if one form of 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 may be capable of populating a clinical summary with a greater number of data elements when the clinical summary is provided to the patient electronically than when the clinical summary is printed on paper. When the clinical summary in this example is provided electronically, it should include all of the above elements that can be populated by the certified EHR technology. The clinical summary would not be limited by the data elements that are capable of being displayed on a paper printout.

**Text Keyword:** [FAQ10558](#)

**CMS FAQ#** [5989](#)

**13. Q: If a patient visit spans several days and the patient is seen by multiple eligible professionals (EPs) during that time period, does each EP need to provide a separate clinical summary or can the provision of a single clinical summary at the end of the visit meet the Meaningful Use objective for "provide clinical summaries for patients after each office visit" for the Massachusetts Medicaid EHR Incentive Payment Program?**

**A:** When a patient visit lasts several days and the patient is seen by multiple EPs, a single clinical summary at the end of the visit can be used to meet the meaningful use objective for "provide clinical summaries for patients after each office visit."

**Text Keyword: [FAQ10166](#)**

**CMS FAQ# 2911**

**14. Q: To meet the Meaningful Use objective "provide patients with an electronic copy of their health information" for the Medicaid EHR Incentive Payment Program in Massachusetts or any other state, how should the numerator and denominator be calculated for patients who see multiple eligible professionals (EPs) in the same practice (e.g., in a multi-specialty group practice)?**

**A:** If the request for an electronic copy of their health information is made by a patient to a specific EP, then the patient should be counted in the numerator and denominator for that specific EP. If the patient makes a request for an electronic copy of their health information that is not to a specific EP (e.g., by request to the practice's administrative staff), then the patient should be counted in the numerators and denominators for all EPs with whom the patient has had an office visit.

**Text Keyword: [FAQ10269](#)**

**CMS FAQ# 2935**

**15. Q: Is the physician the only person who can enter orders in the EHR in order to qualify for the Medicaid EHR Incentive Payment Program?**

**A:** No. 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.

**Text Keyword: [FAQ10071](#)**

**CMS FAQ# 2771**

**16. Q: For the Medicaid EHR Incentive Payment Program in Massachusetts or any other state, how should an eligible professional (EP) who orders medications infrequently, calculate the measure for the "computerized provider order entry (CPOE)" objective if the EP sees patients whose medications are maintained in the medication list by the EP but were not ordered or prescribed by the EP?**

**A:** The CPOE measure is structured to minimize reporting burden. However, if all of the following conditions are met it can also create a unique situation that could prevent an EP from successfully demonstrating meaningful use. An EP who:

- 1) prescribes more than 100 medications during the EHR reporting period;
- 2) maintains medication lists that include medications that they did not order; and
- 3) orders medications for less than 30 percent of patients with a medication in their medication list during the EHR reporting period.

In these circumstances, an EP may be unable to meet this measure and also to qualify for the exclusion. In the unique situation where all three criteria listed above apply, an EP may limit the denominator to only those patients for whom the EP previously ordered medication, if they so choose. EPs who do not meet the three criteria listed above must still base their calculation on the number of unique patients seen by the EP with at least one medication in their medication list during the EHR reporting period regardless of who ordered the medication(s) in the patient's medication list.

**Text Keyword: [FAQ10639](#)**

**CMS FAQ# 3257**

**17. Q: Who can enter medication orders in order to meet the measure for the computerized provider order entry (CPOE) Meaningful Use objective under the Medicaid EHR Incentive Payment Program in Massachusetts or any other state? When must these medication orders be entered?**

**A:** Any licensed healthcare professional can enter orders into the medical record for purposes of including the order in the numerator for the measure of the CPOE objective if they can enter the order per state, local, and professional guidelines. The order must be entered by someone who could exercise clinical judgment in the case that the entry generates any alerts about possible interactions or other clinical decision support aides. This dictates that CPOE occurs when the order first becomes part of the patient's medical record and before any action can be taken on the order. Each provider will have to evaluate on a case-by-case basis whether a given situation is entered according to state, local, and professional guidelines, allows for clinical judgment before the medication is assumed, and is the first time the order becomes part of the patient's medical record.

**Text Keyword:** [FAQ10134](#)  
CMS FAQ# 2851

**18. Q: To meet the Meaningful Use objective, "use computerized provider order entry (CPOE)" for the Medicaid EHR Incentive Payment Program in Massachusetts or any other state, should eligible professionals (EPs) include hospital-based observation patients [billed under Place of Service (POS) 22] whose records are maintained using the hospital's certified EHR system in the numerator and denominator calculation?**

**A:** If the patient has records that are maintained in both the hospital's certified EHR system and the EP's certified EHR system, the EP should include patients seen in locations billed under POS 22 in the numerator and denominator calculation for this measure. If the patient's records are maintained only in a hospital-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.

**Text Keyword:** [FAQ10462](#)  
CMS FAQ# 3057

**19. Q: In recording height as part of the core Meaningful Use objective "recording vital signs" for eligible professionals (EPs) and eligible hospitals (EHs), how should providers account for patients who are too sick or otherwise cannot be measured safely?**

**A:** In cases where taking an actual height measurement is inappropriate, self-reported or estimated height can be used.

**Text Keyword:** [FAQ10156](#)  
CMS FAQ# 2891

**20. Q: For the Meaningful Use objective to "record and chart changes in vital signs" for the Medicaid EHR Incentive Payment Program in Massachusetts or any other state, can an eligible professional (EP) claim an exclusion if the EP regularly records only one or two of the required vital signs but not all three?**

**A:** An exclusion for this objective is provided only for EPs who either see no patients 2 years or older, or who believe that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice. If an EP believes that one or two of these vital signs are relevant to their scope of practice, then they must record all three vital signs in order to meet the measure of this objective and successfully demonstrate meaningful use.

**Text Keyword:** [FAQ10593](#)  
CMS FAQ# 3217

**21. Q: For the Meaningful Use objective of "record demographics" for the Medicaid EHR Incentive Payment Program in Massachusetts or any other state, what documentation is required when recording the preliminary cause of death in the event of mortality?**

**A:** Eligible hospitals (EHs) must record the clinical impression and preliminary assessment of the cause of death in the patient's EHR. No further documentation is required. This measure does not require the cause of death to be updated if the case is referred to the Department of Health or the Coroner's office.

**Text Keyword:** [FAQ10165](#)  
CMS FAQ# 2909

**22. Q: For the Meaningful Use objective of "generate and transmit prescriptions electronically (eRx)" for the Medicaid EHR Incentive Payment Program in Massachusetts or any other state, how should the numerator and denominator be calculated? Should electronic prescriptions fulfilled by an internal pharmacy be included in the numerator?**

**A:** According to CMS FAQ10284, the denominator for this objective includes the number of prescriptions written for drugs requiring a prescription in order to be dispensed, other than controlled substances, during the EHR reporting period. The numerator includes the number of prescriptions in the denominator generated and transmitted electronically using certified EHR technology.

In order to meet the measure of this objective, 40 percent of all permissible prescriptions written by the EP must be generated and transmitted electronically according to the applicable certification criteria and associated standards adopted for certified EHR technology as specified by the Office of the National Coordinator for Health IT (ONC). The term "permissible prescriptions" refers to the restrictions that were established by the Department of Justice (DOJ) on electronic prescribing (eRx) for controlled substances in Schedule II-V. (The substances in Schedule II-V can be found at [http://www.deadiversion.usdoj.gov/schedules/orangebook/e\\_cs\\_sched.pdf](http://www.deadiversion.usdoj.gov/schedules/orangebook/e_cs_sched.pdf)).

Any prescription not subject to these restrictions would be a permissible prescription. Although DOJ recently published an Interim Final Rule that allows the electronic prescribing of these substances, we were unable to incorporate these recent guidelines into the Medicare and Medicaid EHR Incentive Programs. Therefore, the determination of whether a prescription is a "permissible prescription" for purposes of the eRx meaningful use objective should be made based on the guidelines for prescribing Schedule II-V controlled substances in effect on or before January 13, 2010, when the notice of proposed rulemaking was published in the Federal Register.

ONC has released an FAQ stating that "with respect to the capability a Complete EHR or EHR Module must demonstrate in order to be certified to the certification criterion adopted at [170.304\(b\)](#), a Complete EHR or EHR Module must be capable of electronically transmitting prescriptions to external recipients according to NCPDP SCRIPT 8.1 or 10.6 in addition to the adopted vocabulary standard for medications (45 CFR 170.207(d))." Given such FAQ, prescriptions transmitted electronically within an organization (the same legal entity) would not need to use these NCPDP standards. However, an EP's EHR must meet all applicable certification criteria and be certified as having the capability of meeting the external transmission requirements of §170.304(b). In addition, the EHR that is used to transmit prescriptions within the organization would need to be Certified EHR Technology.

The EP would include in the numerator and denominator both types of electronic transmissions (those within and outside the organization) for the measure of this objective. We further clarify that for purposes of counting prescriptions "generated and transmitted electronically," we consider the generation and transmission of prescriptions to occur simultaneously if the prescriber and dispenser are the same person and/or are accessing the same record in an integrated EHR to creating an order in a system that is electronically transmitted to an internal pharmacy.

**Text Keyword: [FAQ10284](#)**  
CMS FAQ# 2939

**23. Q: In order to satisfy the Meaningful Use objective for electronic prescribing (eRx) in the Medicaid EHR Incentive Payment Program in Massachusetts or any other state, can providers use intermediary networks that convert information from the certified EHR into a computer-based fax for sending to the pharmacy? Should these transactions be included in the numerator for the measure of this objective?**

**A:** The meaningful use measure for e-prescribing is the electronic transmission of 40 percent of all permissible prescriptions. If the EP generates an electronic prescription and transmits it electronically to either a pharmacy or an intermediary network using the standards of certified EHR technology, and this results in the prescription being filled without the need for the provider to communicate the prescription in an alternative manner, then the prescription would be included in the numerator.

**Text Keyword: [FAQ10137](#)**  
CMS FAQ# 2857



**24. Q: Can the drug-drug and drug-allergy interaction alerts of my electronic health record (EHR) also be used to meet the Meaningful Use objective for implementing one clinical decision support rule for the Medicaid EHR Incentive Payment Program in Massachusetts or any other state?**

**A:** No. The drug-drug and drug-allergy checks and the implementation of one clinical decision support rule are separate core meaningful use objectives. Eligible professionals (EPs) and eligible hospitals (EHs) must implement one clinical decision support rule in addition to drug-drug and drug-allergy interaction checks.

**Text Keyword: [FAQ10077](#)**  
CMS FAQ# 2783

**25. Q: To meet the Meaningful Use objective "maintain an up-to-date problem list of current and active diagnoses" for the Massachusetts or any other state Medicaid EHR Incentive Payment Program, are eligible professionals (EPs) and eligible hospitals (EHs) required to use ICD-9 or Systematized Nomenclature of Medicine-Clinical Terms (SNOMED-CT®)?**

**A:** The Medicaid EHR Incentive Payment Program does not specify the use of ICD-9 and SNOMED-CT® to meet the measure for the Meaningful Use objective "maintain an up-to-date problem list of current and active diagnoses." However, the Office of the National Coordinator for Health Information Technology (ONC) has adopted ICD-9 and SNOMED-CT® as a standard for the entry of structured data in certified EHR technology. Therefore, EPs and EHs will need to maintain an up-to-date problem list of current and active diagnoses using ICD-9 and SNOMED-CT® in order to meet the measure for this objective.

**Text Keyword: [FAQ10150](#)**  
CMS FAQ# 2881

**26. Q: For Meaningful Use objectives of the Massachusetts or any other state Medicaid EHR Incentive Payment Program that require a provider to test the transfer of data, such as "capability to exchange key clinical information" and testing submission of data to public health agencies, can the eligible professional (EP) or eligible hospital (EH) conduct the test from a test environment or test domain of its certified EHR technology in order to satisfy the measures of these objectives?**

**A:** According to CMS FAQ10978, it is acceptable to conduct a test of information exchange from a test environment or test domain of certified EHR technology in order to satisfy the measures of the objective for "capability to exchange key clinical information" or any of the public health objectives (e.g., immunization registry, syndromic surveillance, or reportable lab results). A provider can also use simulated data when conducting these tests—the use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy these objectives.

However, it is important to note that in order to meet the objective for "capability to exchange key clinical information," the provider must conduct the test with another provider of care with distinct certified EHR technology or other system capable of receiving the information. Simulated transfers of information or transfers of information through means that do not reach another provider of care (e.g., "dummy" websites that exist solely for providers to send information) are not acceptable to satisfy this objective.

Similarly, to meet any of the public health objectives, the provider's test must involve the actual submission of information to public health agencies, and follow up submission is required if the test is successful. Please note that some public health agencies will not allow providers to submit test information about fictional patients. Providers submitting information to public health agencies that do not allow test information must submit actual patient information as a test in order to satisfy the measures of these objectives.

**Text Keyword: [FAQ10978](#)**  
CMS FAQ# 3817

**27. Q: For the Meaningful Use objective of "capability to exchange key clinical information" for the Medicaid EHR Incentive Payment Program in Massachusetts or any other state, does exchange of electronic information using physical media, such as USB, CD-ROM, or other formats, meet the measure of this objective?**

**A:** No, the use of physical media such as a CD-ROM, a USB or hard drive, or other formats to exchange key clinical information would not utilize the certification capability of certified EHR technology to electronically transmit the information, and therefore would not meet the measure of this objective.

For the purposes of the "capability to exchange key clinical information" measure, exchange is defined as electronic transmission and acceptance of key clinical information using the capabilities and standards of certified EHR technology (as specified at 45 CFR 170.304(i) for eligible professionals (EPs) and 45 CFR 170.306(f) for eligible hospitals (EHs)). We expect that this information (e.g., drug or clinical lab data) would be exchanged in structured electronic format when available. However, where 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 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](http://questions.cms.hhs.gov/app/answers/detail/a_id/10270/kw/10270).

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 the summary of care record is not a requirement but an option. To satisfy the measure of the "provide a summary of care record for each transition of care" objective, a provider is permitted to send an electronic or paper copy of the summary care record directly to the next provider or can provide it to the patient to deliver. In this case, the use of physical media such as a CD-ROM, a USB or hard drive, or other formats could satisfy the measure of this objective.

**Text Keyword: [FAQ10638](#)**

CMS FAQ# 3255

**28. Q: To meet the Meaningful Use objective, "capability to exchange key clinical information," for the Medicaid EHR Incentive Payment Program in Massachusetts or any other state, can different providers of care (e.g., physicians, hospitals, etc.) share EHR technology and successfully meet this objective?**

**A:** In order to meet this objective, clinical information must be sent between different legal entities with distinct certified EHR technology and not between organizations that share a certified EHR technology or organizations that are part of the same legal entity, since no actual exchange of clinical information would take place in these latter instances. Distinct certified EHR technologies are those that can achieve certification and operate independently of other certified EHR technologies. It is possible for different legal entities to meet this objective by using separate instances of the same certified EHR technology (e.g. both entities using separate license of the same program), subject to the following limitations:

- A different legal entity is an entity that has its own separate legal existence. Indications that two entities are legally separate would include (1) they are each separately incorporated; (2) they have separate Boards of Directors; and (3) neither entity is owned nor controlled by the other.
- In order to be distinct certified EHR technology, each instance of certified EHR technology must be able to be certified and operate independently from all others. Separate instances of certified EHR technology that must link to a common database in order to gain certification would not be considered distinct. However, instances of certified EHR technology that link to a common, uncertified system or component would be considered distinct. Instances of certified EHR technology can be from the same vendor and still be considered distinct.
- The exchange of key clinical information requires that the eligible professional or eligible hospital must use the standards of certified EHR technology as specified by the Office of the National Coordinator for Health IT, not the capabilities of uncertified or other vendor-specific alternative methods for exchanging clinical information.

**Text Keyword: [FAQ10270](#)**

CMS FAQ# 5985

**29. Q: For the Meaningful Use objective of "capability to exchange key clinical information" for the Medicaid EHR Incentive Payment Program in Massachusetts or any other state, what forms of electronic transmission can be used to meet the measure of the objective?**

**A:** For the purposes of the "capability to exchange key clinical information" measure, exchange is defined as electronic transmission and acceptance of key clinical information using the capabilities and standards of certified EHR technology (as specified at 45 CFR 170.304(i) for eligible professionals (EPs) and 45 CFR 170.306(f) for eligible hospitals (EHs)). There are many acceptable transmission methods for conducting a test of the electronic exchange of key clinical information with providers of care and patient authorized entities (see [FAQ 10270](#)).

To meet the measure of this objective, a provider must complete the following steps:

- Step 1: Use certified EHR technology to generate a continuity of care document (CCD)/continuity of care record (CCR); and
- Step 2: Electronically transmit the CCD/CCR.

To complete step 2, an EP or EH may use any means of electronic transmission according to any transport standard(s) (SMTP, FTP, REST, SOAP, etc.) regardless of whether it was included by an EHR technology developer as part of the certified EHR technology in the EP's or EH's possession. If the test involves the transmission of actual patient information, all current privacy and security regulations must be met.

Please note that the use of a USB drive, CD-ROM, or other physical media or electronic fax would not meet the measure of this objective and has been addressed in another FAQ (see [FAQ 10638](#)). If the test involves the transmission of actual patient information, all current privacy and security regulations must be met.

**Text Keyword:** [FAQ10691](#)  
CMS FAQ# 3359

**30. Q: How should eligible professionals (EPs) select menu objectives for the Massachusetts Medicaid EHR Incentive Payment Program?**

**A:** EPs are required to report on a total of 5 meaningful use objectives from the menu set. When selecting five objectives from the menu set, EPs must choose at least one option from the public health menu set. Please note that Massachusetts does not currently accept syndromic surveillance data, so as an EP, immunization reporting is your only means to meet your public health objective, with the exception of Boston-based providers who can submit syndromic surveillance data to the Boston Public Health Commission (BPHC). Please contact the BPHC at 617-534-5395 for more information.

We encourage EPs to select menu objectives that are relevant to their scope of practice, and claim exclusion for a menu objective only in cases where there are no remaining menu objectives for which they qualify or if there are no remaining menu objectives that are relevant to their scope of practice. Please note that EPs must have complete certified EHR technology (or a complete set of certified EHR modules) capable of supporting all of the core and menu set objectives, including any objectives for which the EP can claim an exclusion and menu set objectives the EP does not select.

**31. Q: For the Meaningful Use objective of "provide summary care record for each transition of care or referral" for the Medicaid EHR Incentive Payment Program in Massachusetts or any other state, should transition of care between eligible professionals (EPs) within the same practice who share certified EHR technology be included in the numerator or denominator of the measure?**

**A:** No. Patients who transition between EPs within the same practice and who share the same certified EHR technology should not be included in the numerator or denominator of the measure of this objective. Since these transitions occur within the same practice between EPs who share certified EHR technology, they do not meet the definition of transition of care as the movement of a patient from one setting of care (for example, hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, or rehabilitation facility) to another. Also, because EPs sharing the same certified EHR technology already have complete access to the patient's electronic record, providing a summary of care document would serve no purpose. Therefore, these patients should be excluded from the calculation of this measure.

**Text Keyword:** [FAQ10980](#)  
CMS FAQ# 3281

**32. Q: What lab tests should be included in the denominator of the measure for the “incorporate clinical lab-test results” objective under the Medicaid EHR Incentive Payment Program in Massachusetts or any other state?**

**A:** For the “incorporate clinical lab-test results” objective, the denominator consists of the number of lab tests ordered during the EHR reporting period by the eligible professional (or authorized providers of the eligible hospital for patients admitted to an eligible hospital’s or CAH’s inpatient or emergency department (POS 21 and 23)) whose results are expressed as a positive or negative affirmation or as a number. Providers may limit the denominator to only those lab tests that were ordered during the EHR reporting period and for which results were received during the same EHR reporting period.

**Text Keyword: [FAQ10642](#)**  
CMS FAQ# 3263

**33. Q: One of the menu set Meaningful Use objectives for the Medicaid EHR Incentive Payment Program in Massachusetts or any other state requires eligible hospitals (EHs) to incorporate clinical lab-test results into EHR as structured data. Must there be an explicit linking between structured lab results received into the EHR and the order placed by the physician for the lab test in order to count a structured lab result, in the numerator for the measure of this objective?**

**A:** The only requirement to meet the measure of this objective is that more than 40 percent of all clinical lab tests results ordered during the EHR reporting are incorporated in certified EHR technology as structured data. Provided the lab result is recorded as structured data and uses the standards to which certified EHR technology is certified, there does not need to be an explicit linking between the lab result and the order placed by the physician in order to count it in the numerator for the measure of this objective.

**Text Keyword: [FAQ10136](#)**  
CMS FAQ# 2855

## Calculating Core and Menu Set Measures

**34. Q: What do the numerators and denominators mean in measures that are required to demonstrate Meaningful Use for the Medicaid EHR Incentive Payment Program in Massachusetts or any other state?**

**A:** There are 15 measures for eligible professionals (EPs) and 14 measures for eligible hospitals (EHs) that require the collection of data to calculate a percentage, which will be the basis for determining if the meaningful use objective was met according to a minimum threshold for that objective. Objectives requiring a numerator and denominator to generate this calculation are divided into two groups: one where the denominator is based on patients seen or admitted during the EHR reporting period, regardless of whether their records are maintained using certified EHR technology, and a second group where the objective is not relevant to all patients either due to limitations (e.g., recording tobacco use for all patients 13 and older) or because the action related to the objective is not relevant (e.g., transmitting prescriptions electronically). For these objectives, the denominator is based on actions related to patients whose records are maintained using certified EHR technology.

This grouping is designed to reduce the burden on providers. Table 3 in the Medicare and Medicaid EHR Incentive programs final rule (FR 75 44376 - 44380) lists measures sorted by the method of measure calculation. To view the final rule, please visit: <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

**Text Keyword: [FAQ10095](#)**  
CMS FAQ# 2813

**35. Q: For the Medicaid Electronic EHR Incentive Payment Program in Massachusetts or any other state, how should an eligible professional (EP) or eligible hospital (EH) that sees patients in multiple practice locations equipped with certified EHR technology calculate numerators and denominators for the Meaningful Use objectives and measures?**

**A:** EPs and EHs should look at the measure of each meaningful use objective to determine the appropriate calculation method for numerators and denominators. For objectives that require a simple count of actions (e.g., number of permissible prescriptions written, for the objective of "generate and transmit permissible prescriptions electronically (eRx)"; number of patient requests for an electronic copy of their health information, for the objective of "Provide patients with an electronic copy of their health information"; etc.), EPs and EHs can usually add the numerators and denominators calculated by each certified EHR system in order to arrive at an accurate total for the numerator and denominator of the measure.

For objectives that require an action to be taken on behalf of a percentage of "unique patients" (e.g., the objectives of "record demographics", "record vital signs", etc.), EPs and EHs may not be able to simply add the numerators and denominators calculated by each certified EHR system. The EP or EH must include only unique patients in the numerators and denominators of each objective, and it is the responsibility of the EP or EH to reconcile information from multiple certified EHR systems in order to ensure that each unique patient is counted only once for each objective.

Please keep in mind that patients whose records are not maintained in certified EHR technology will need to be added to denominators where applicable in order to provide accurate numbers. For more information about which objectives require a simple count of actions and which require an action taken on behalf of a percentage of unique patients, please consult our Meaningful Use Specification Sheets for EPs and EHs.

- **EPs:** <http://www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf>
- **EHS:** [http://www.cms.gov/EHRIncentivePrograms/Downloads/Hosp\\_CAH\\_MU-TOC.pdf](http://www.cms.gov/EHRIncentivePrograms/Downloads/Hosp_CAH_MU-TOC.pdf)

To report clinical quality measures, EPs who practice in multiple locations that are equipped with certified EHR technology, should generate a report from each of those certified EHR systems and then add the numerators, denominators, and exclusions from each generated report in order to arrive at a number that reflects the total data output for patient encounters at those locations. To report clinical quality measures, EHs that have multiple systems should generate a report from each of those certified EHR systems and then add the numerators, denominators, and exclusions from each generated report in order to arrive at a number that reflects the total data output for patient encounters in the relevant departments of the EH (e.g., inpatient or emergency department (POS 21 or 23)).

**Text Keyword: [FAQ10843](#)**  
CMS FAQ# 3609

**36. Q: For eligible professionals (EPs) who see patients in both inpatient and outpatient settings (e.g., hospital and clinic), and where certified EHR technology is available at each location, should these EPs base their denominators for Meaningful Use objectives on the number of unique patients in only the outpatient setting or on the total number of unique patients from both settings?**

**A:** In this case, EPs should base both the numerators and denominators for meaningful use objectives on the number of unique patients in the clinic setting, since this setting is where they are eligible to receive payment from the Massachusetts Medicaid EHR Incentive Payment Program.

**Text Keyword: [FAQ10068](#)**  
CMS FAQ# 2765

**37. Q: For the Medicaid EHR Incentive Payment Program in Massachusetts or any other state, how does an eligible professional (EP) determine whether a patient has been "seen by the EP" in cases where the service rendered does not result in an actual interaction between the patient and the EP, but minimal consultative services such as just reading an Electrocardiogram (EKG)? Is a patient seen via telemedicine included in the denominator for measures that include patients "seen by the EP"?**

**A:** According to CMS FAQ 10664, all cases where the EP and the patient have an actual physical encounter with the patient in which they render any service to the patient should be included in the denominator as seen by the EP. Also a patient seen through telemedicine would still count as a patient "seen by the EP." However, in cases where the EP and the patient do not have an actual physical or telemedicine encounter, but the EP renders a minimal consultative service for the patient (like reading an EKG), the EP may choose whether to include the patient in the denominator as "seen by the EP" provided the choice is consistent for the entire EHR reporting period and for all relevant meaningful use measures.

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

**Text Keyword:** [FAQ10664](#)

CMS FAQ# 3307

**38. Q: For the Medicaid EHR Incentive Payment Program in Massachusetts or any other state, when a patient is only seen by a member of the eligible professional's (EP's) clinical staff during the EHR reporting period and not by the EP themselves, do those patients count in the EP's denominator?**

**A:** The EP can include or not include those patients in their denominator as long as the decision applies universally to all patients for the entire EHR reporting period and the EP is consistent across meaningful use measures. In cases where a member of the EP's clinical staff is eligible for the Medicaid EHR incentive in their own right (NPs and physician assistants (PAs) practicing predominately at a Federally Qualified Health Center or Rural Health Clinic, so led by a PA), patients seen by NPs or PAs under the EP's supervision can be counted by both the NP or PA and the supervising EP as long as the policy is consistent for the entire EHR reporting period.

**Text Keyword:** [FAQ10665](#)

CMS FAQ# 3309

**39. Q: How should patients in swing beds be counted in the denominators of Meaningful Use measures for eligible hospitals (EHs) for the Medicaid EHR Incentive Payment Program in Massachusetts or any other state?**

**A:** A number of the meaningful use measures for EHs require the denominator to be based on the number of unique patients admitted to the inpatient or emergency department during the EHR reporting period. Unique swing bed patients who receive inpatient care should be included in the denominators of meaningful use measures. However, if the EH's certified EHR technology cannot readily identify and include unique swing bed patients who have received inpatient care, those patients may be excluded from the calculations for the denominators of meaningful use measures.

**Text Keyword:** [FAQ10640](#)

CMS FAQ# 3259

**40. Q: How should nursery day patients be counted in the denominators of Meaningful Use measures for eligible hospitals (EHs) for the Medicaid EHR Incentive Payment Program in Massachusetts or any other state?**

**A:** Nursery day patients are excluded from the calculation of hospital incentives because they are not considered inpatient-bed-days based on the level of care provided during a normal nursery stay. In addition, nursery day patients should not be included in the denominators of meaningful use measures. However, if the EH's certified EHR technology cannot readily identify and exclude nursery day patients, those patients may be included in the calculations for the denominators of meaningful use measures.

**Text Keyword:** [FAQ10641](#)

CMS FAQ# 3261

**41. Q: For the Medicaid EHR Incentive Payment Program in Massachusetts or any other state, does an eligible hospital (EH) have to count patients admitted to both the inpatient and emergency departments in the denominator of Meaningful Use measures, or can they count only emergency department patients?**

**A:** For the hospital meaningful use objectives, the denominator is all unique patients admitted to an inpatient (POS 21) or emergency department (POS 23), which means all patients admitted to POS 21 and all patients admitted to POS 23. If the eligible hospital elects to use the alternate method for calculating emergency department patients, the denominator is all unique patients admitted to an inpatient department (POS 21) and all patients that initially present to the emergency department and are treated in the emergency department's observation unit or otherwise receive observation services, which includes patients who receive observation services under both POS 22 and POS 23. Patients admitted to the inpatient department must be included in the denominator of all applicable measures.

**Text Keyword:** [FAQ10468](#)

CMS FAQ# 3067

**42. Q: For the Medicaid EHR Incentive Payment Program in Massachusetts or any other state, should patient encounters in an ambulatory surgical center [Place of Service (POS 24)] be included in the denominator for calculating that at least 50 percent or more of an eligible professional's (EP's) patient encounters during the reporting period occurred at a practice/location or practices/locations equipped with certified EHR technology?**

**A:** Yes. EPs who practice in multiple locations must have 50 percent or more of their patient encounters during the reporting period at a practice/location or practices/locations equipped with certified EHR technology. Every patient encounter in all POSs except a hospital inpatient department (POS 21) or a hospital emergency department (POS 23) should be included in the denominator of the calculation, which would include patient encounters in an ambulatory surgical center (POS 24).

**Text Keyword:** [FAQ10466](#)  
CMS FAQ# 3065

**43 Q: If an eligible hospital (EH) has a rehabilitation unit or a psychiatric unit that is part of the inpatient department and bills under Place of Service (POS) code 21, but is excluded from the inpatient prospective payment system (IPPS), should patients from these units be included in the denominator for the measures of Meaningful Use objectives for the Medicaid EHR Incentive Payment Program in Massachusetts or any other state?**

**A:** No. CMS specified in the final rule that the statutory definition of “hospital” used in the EHR Incentive Program does not apply to hospitals and hospital units excluded from IPPS, such as rehabilitation or psychiatric units (75 FR 44448). Therefore, patients treated in these units should not be included in the denominators of measures. If patients are treated in either an inpatient rehabilitation or inpatient psychiatric unit but are also admitted to areas of the inpatient department that are part of the “subsection (d) hospital,” then those patients and the actions taken for those patients outside of the inpatient rehabilitation or inpatient psychiatric units should be counted in the numerators and denominators for the meaningful use measures.

**Text Keyword:** [FAQ10591](#)  
FAQ# 3213

## Public Health Measures

**44. Q: What are the public health measures for the Massachusetts Medicaid EHR Incentive Payment Program?**

**A:** The final rule for Stage 1 Meaningful Use requires eligible professionals and hospitals to choose at least one public health objective from the set of menu objectives, which includes submitting one of the following.

- Immunization Information
- Syndromic Surveillance
- Reportable Electronic Laboratory Results (Eligible Hospitals only)

Recently the Massachusetts Department of Public Health (MDPH) successfully launched its Massachusetts Immunization Information System (MIIS), a statewide immunization registry, which is ready to receive patient immunization data both through a web interface and via HL7 data exchange. Massachusetts does not currently accept syndromic surveillance data, so as an eligible professional, immunization reporting is your only means to meet your public health objective, with the exception of Boston based providers who can submit syndromic surveillance data to the Boston Public Health Commission (BPHC). Please contact the BPHC at 617-534-5395 for more information.

**45. Q: If my certified EHR technology only includes the capability to submit information to an immunization registry using the HL7 2.3.1 standard but the immunization registry only accepts information formatted in the HL7 2.5.1 or some other standard, will I qualify for an exclusion because the immunization registry does not have the capacity to receive the information electronically?**

**A:** The meaningful use requirement for Public Health specifies that providers must be able to submit immunization data electronically in a standardized format. Certified Electronic Health Record (EHR) systems should be able to create the immunization message containing CVX codes in one of two formats (HL7 2.3.1 or HL7 2.5.1). The MIIS accepts only the HL7 2.5.1 format. Contact your EHR vendor if you are uncertain which message version your system generates. The immunization registry does not accept information in the standard to which your EHR technology has been certified. That is, if your EHR is certified to the HL7 2.3.1 standard and the immunization registry only accepts HL7 2.5.1, then you can claim an exclusion to this Meaningful Use objective because the immunization registry does not have the capacity to receive the information electronically.

**46. Q: How do I send a Valid Test Message to the Massachusetts Immunization Information System?**

**A:** The Stage 1 Meaningful Use Requirement specifies that you need to send a valid test message to the immunization registry. Because you are using certified EHR technology, your EHR system should be able to generate a valid test message in either HL7 2.3.1 or HL7 2.5.1. However, the MIIS only accepts HL7 2.5.1 (Please see MDPH's [HL7 Transfer Specifications](#).) You will need to contact the MIIS Help Desk ([MIISHelpDesk@state.ma.us](mailto:MIISHelpDesk@state.ma.us); Ph: 617-983-4335) for the routing information once you are ready to send the test message. Your EHR vendor will be able to provide instructions that are specific to your installation.

**Q: Who can I contact if I have further questions regarding Transfer Specifications or Soap message requirements for electronically submitting immunization data to the Massachusetts Department of Public Health?**

**A:** The Massachusetts Department of Public Health Immunization Information Team holds weekly IT technical discussions on Thursdays from 10:00 am – 11:00 am. The information to participate in the call is as follows:

- **Web:** <https://www3.gotomeeting.com/join/312380934>
- **Phone:** Dial +1 (312) 878-3081; Access Code: 312-380-934

**47. Q: Will I receive any documentation that shows my test message was valid? What if my valid test message fails?**

**A:** Upon receipt of a valid test message, MDPH will send you an automated generic technical acknowledgment. *You will need to save this message for verification purposes.* Once the test message sent to MDPH is successful, your organization can continue to work with MDPH on your HL7 production readiness. Once your organization is ready for HL7 production, you will be put in a queue. MDPH will prioritize the order in which they will work with providers to move them into the production environment, but that will not prevent you from attesting to Stage 1 Meaningful Use, as only the message needs to be sent. When your organization is prioritized and you have support from the leadership and/or administrators to integrate the MIIS at an organization-wide level, MDPH will work with you to validate all message content, so the data can be submitted properly to their live system.

If your valid test message fails, you will receive an automated generic technical acknowledgment from MDPH reflecting that your message failed. Although you have received a failed message from MDPH, *you will still have met your immunization registry Stage 1 Meaningful Use requirement.* Please note, although a failed test meets Stage 1 Meaningful Use requirements, you must be in production with MIIS in order to meet Stage 1 Meaningful Use requirements.

Please visit our [website](#) for more information about the Massachusetts Immunization Information System (MIIS).



## Clinical Quality Measures

**48. Q: 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 Medicaid EHR Incentive Payment Program in Massachusetts or any other state?**

**A:** The Centers for Medicare & Medicaid Services (CMS) recognizes that providers are continuing to implement new workflow processes to accurately capture clinical data in their certified EHR technology, but many providers are not able to capture all data at this time. Although we encourage providers to capture complete clinical data in order to provide the best care possible for their patients, for the purpose of reporting clinical quality measure data, the Medicaid EHR Incentive Payment Program in Massachusetts or any other state, does not require providers to record all clinical data in their certified EHR technology at this time. This may yield numerator, denominator, and exclusion values for clinical quality measures in the certified EHR technology that are not identical to the values generated from other methods (such as record extraction). However, at this time, Massachusetts requires providers to report the clinical quality measure data exactly as it is generated as output from the certified EHR technology in order to successfully demonstrate meaningful use.

**Text Keyword:** [FAQ10839](#)  
FAQ# 3601

**49. Q: If a provider feeds data from certified EHR technology to a data warehouse, can the provider report on Meaningful Use objectives and clinical quality measures from the data warehouse?**

**A:** To be a meaningful EHR user a provider must do three things.

1. Have the complete certified EHR technology for all meaningful use objectives either through a complete EHR or a combination of modules.
2. Meet 20 measures (19 for eligible hospitals), including all of the core and five (5) menu-set measures associated with the objectives (unless excluded). Core measures include reporting clinical quality measures.
3. Use the capabilities and standards of certified EHR technology in meeting the measure of each objective.

If the conditions above are met and data is transferred from the certified EHR technology to a data warehouse, the provider can use information from the data warehouse to report on meaningful use objectives and clinical quality measures. However, in order to report calculated clinical quality measures, the data warehouse has to be federally certified.

The Office of the National Coordinator of Health Information Technology has addressed the issue of certification of a data warehouse in the following Frequently Asked Questions:

<http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3163&PageID=20775>

For more information about certification, you can contact ONC directly at [onc.certification@hhs.gov](mailto:onc.certification@hhs.gov)

**Text Keyword:** [FAQ10153](#)  
FAQ# 2885

**50. Q: Can eligible professionals (EPs) use clinical quality measures from the alternate core set to meet the requirement of reporting three additional measures for the Medicaid EHR Incentive Payment Program in Massachusetts or any other state?**

**A:** No. If EPs report data on all three clinical quality measures from the core set, they would not report on any from the alternate core set. The three additional clinical quality measures must come from [Table 6](#) of the final rule (75 FR 44398-44408), excluding those clinical quality measures included in either the core set or the alternate core set. To view the final rule for the Medicare and Medicaid EHR incentive programs, please visit: <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

**Text Keyword:** [FAQ10075](#)  
FAQ# 2779

**51. Q: One of the measures for the core set of clinical quality measures for eligible professionals (EPs) is not applicable for my patient population. Am I excluded from reporting that measure for the Medicaid EHR Incentive Payment Program in Massachusetts or any other state?**

**A:** An eligible professional (EP) is not excluded from reporting core clinical quality measures. However, zero (0) is an acceptable value to report for the denominator of a clinical quality measure if there is no patient population within the EHR to whom that clinical quality measure applies. If an EP reports a zero denominator for one of the core measures, then the EP is required to report results for up to three alternate core measures (possibly reporting denominators of 0 for all three alternate core measures).

**Text Keyword:** [FAQ10142](#)  
FAQ# 2865

**52. Q: I am an eligible professional (EP) for whom none of the core, alternate core, or additional clinical quality measures adopted for the Medicaid EHR Incentive Payment Program in Massachusetts or any other state apply. Am I exempt from reporting on all clinical quality measures?**

**A:** In the event that none of the 44 clinical quality measures applies to an EP's patient population, the EP is still required to report a zero for the denominators for all six of the core and alternate core clinical quality measures. If all of the remaining 44 clinical quality measures included in [Table 6 of the final rule](#) do not apply to the EP, then the EP is still required to report on at least three of the additional clinical quality measures of their choosing from the list of [38 CQMs](#). If the EP reports zero values for these three additional menu-set clinical quality measures, then for the remaining menu-set clinical quality measures, the EP will also have to attest that all the other menu-set quality measures calculated by the certified EHR technology have a value of zero in the denominator. In other words, the EP is required to try to find at least three measures in the menu set for which the denominator is other than zero. If EP cannot, then the EP must still choose three menu-set measures on which to report. The EP may report zero denominators for some or all of these measures, but must accompany such "zero denominator" reporting with an attestation that all of the other menu-set measures calculated by the certified EHR technology have a value of zero in the denominator. A zero report in the menu-set is not sufficient without such accompanying attestation.

**Text Keyword:** [FAQ10144](#)  
FAQ# 2869

**Q: If the denominators for all three of the core clinical quality measures are zero, do I have to report on the additional clinical quality measures for eligible professionals (EPs) under the Massachusetts Medicaid EHR Incentive Payment Program?**

**A:** If the denominator value for all three of the core clinical quality measures is zero, an EP must report a zero denominator for all such core measures, and then must also report on all 3 alternate core clinical quality measures. If the denominator values for all three of the alternate core clinical quality measures is also 0, an EP still needs to report on three additional clinical quality measures. Zero is an acceptable denominator provided that this value was produced by certified EHR technology.

**Text Keyword:** [FAQ10145](#)  
FAQ# 2871

**Source:**

1. Centers for Medicare and Medicaid Services, "Electronic Health Record Incentive Programs: Meaningful Use and Clinical Quality Measure Frequently Asked Questions." Accessed June 29, 2012. <https://questions.cms.gov/faq.php>