



NY Medicaid EHR Incentive Program

Frequently Asked Questions (FAQs)

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Disclaimer

This document serves as an informational reference for eligible providers participating in the NY Medicaid EHR Incentive Program. Although reasonable effort has been made to assure the accuracy of the information within these pages at the time of posting, it is the responsibility of each provider to comply with the current policies and requirements for the program.



Eligible Professionals (EPs)

Eligibility and Participation

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EP01 What types of Healthcare Professionals qualify as an Eligible Professional?

Published: 01/09/2012

The following types of Healthcare Professionals are eligible to apply for the Medicaid EHR Incentive Program as long as they meet other eligibility requirements including minimum Medicaid or needy patient volume.

Eligible Professional Types

- Physicians (M.D. and D.O.)
- Nurse Practitioners
- Certified Nurse–Midwives
- Dentists
- Physician assistants who practice in a Federally Qualified Health Center or Rural Health Clinic that is led by a physician assistant

EP02 What physician specialties can qualify as an Eligible Professional?

Published: 01/09/2012

Physicians (M.O. and D.O.) fall under the provider types that are eligible to apply for the Medicaid EHR Incentive Program as long as they meet other eligibility requirements including minimum Medicaid or needy patient volume. There is no restriction on specialty or location of clinical practice. The one exception that does exclude a physician from being eligible is that the physician cannot be "hospital–based". The term hospital–based can be defined as rendering 90% or more of covered professional services in the inpatient acute care or emergency department settings.

Eligible Professional Types

- Physicians (M.D. and D.O.)
- Nurse Practitioners
- Certified Nurse–Midwives
- Dentists
- Physician assistants who practice in a Federally Qualified Health Center or Rural Health Clinic that is led by a physician assistant

EP15 When can Eligible Professionals (EPs) participate in the Medicaid EHR Incentive Program? Are there any penalties if EPs do not participate immediately, or skip years?

Published: 01/09/2012

Updated: 02/06/2015

Eligible Professionals may begin participating in the NY Medicaid EHR Incentive Program immediately. Attestations for a given payment year (which, for Eligible Professionals, is the same as the calendar year) are accepted until 90 days after the payment year. EPs may begin participating in the Medicaid EHR Incentive Program as late as 2016 and still receive the full incentive payment amount. EPs may participate in non-consecutive years (i.e., skip years) without penalty; however, EPs may not begin participating after 2016, and no payments will be issued for payment years after 2021.

There is no penalty in the Medicaid program for providers who do not participate in the EHR Incentive Program. However, be advised that Medicare eligible professionals will be subject to payment adjustments unless they are meaningful users. Please visit the CMS website for more information about Medicare payment adjustments and hardship exceptions:

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PaymentAdj_Hardship.html

EP19 What is the definition of a group provider?

Published: 01/25/2012

Updated: 11/20/2014

The NY Medicaid EHR Incentive Program defines a group provider as a collection of providers operating under a single organizational National Provider Identifier (NPI) held by a legal entity with which the eligible professional (EP) has an employment or contractual arrangement allowing the entity to bill and receive payment for the EP's covered professional services. If a legal entity holds multiple NPIs representing different organizational levels (for example, if a large practice holds an NPI representing the overall practice as well as NPIs for each practice site), the provider group(s) may be defined at any organizational level so long as the definition is consistent and all providers in the organization are included in exactly one group.

For providers using the group proxy method of calculating Medicaid patient volume, all providers in the group must specify the same organizational NPI, patient volume reporting period, and patient volume calculation method and inputs.

Each provider using the group proxy method of calculating Medicaid patient volume must have sufficient evidence in the provider information on file with NY Medicaid to establish that the provider is part of the group.

- If the organizational NPI used to identify the group is an enrolled NY Medicaid group or facility, the provider must have an affiliation with that group or facility on file with NY Medicaid.
- If the organizational NPI is not an enrolled provider, it will be necessary to demonstrate some other common link among the providers using the same organizational NPI (for example, affiliation with one of a number of enrolled group providers all sharing the same federal tax ID number).

EP22 I work 90 percent or more in the hospital setting and I incurred the cost of the certified EHR technology. Am I excluded from the non-hospital based requirement?

Published: 04/01/2013

Starting in Payment Year 2013, Eligible Professionals (EP) who can demonstrate that the EP funds the acquisition, implementation, and maintenance of certified EHR technology, including supporting hardware and any interfaces necessary to meet meaningful use without reimbursement from an eligible hospital or CAH; and uses such Certified EHR Technology in the inpatient or emergency department of a hospital (instead of the hospitals CEHRT) are now eligible for EHR Incentive Payments.

EP26 Can an Eligible Professional (EP) switch from the CMS Medicare EHR Incentive Program to the NY Medicaid EHR Incentive Program and vice-versa after an incentive payment has been received?

Published: 04/26/2012

EPs may switch once between programs after a payment has been made and only before 2015. Switching between programs can be completed in the CMS Registration and Attestation System. For more information, please review the CMS Frequently Asked Questions.

EP27 What is the maximum EHR incentive payment amount that Eligible Professionals (EPs) can receive?

Published: 04/26/2012

Updated: 01/04/2019

Under the Medicare and Medicaid EHR Incentive Programs, EPs can receive up to a total \$63,750 over the 6 years that they choose to participate. Under the NY Medicaid EHR Incentive Program, an EP could receive up to \$21,250 for their first participation year and up to \$8,500 for each of the remaining 5 years. There are no payment adjustments under Medicaid for failure to participate all years of the EHR Incentive Programs.

Participation years do not need to be consecutive. However,

- EPs must begin participating in the NY Medicaid EHR Incentive Program by 2016.
- The last year to receive an incentive payment is 2021.

EP28 Is a pediatrician eligible to qualify and receive an incentive payment for the NY Medicaid EHR Incentive Program?

Published: 04/26/2012

Pediatricians are eligible to apply for the NY Medicaid EHR Incentive Program as an Eligible Professional (EP). A pediatrician is the only provider type allowed to meet a reduced Medicaid patient volume of 20%.

Pediatricians with a 30% Medicaid patient volume are eligible to receive the full Medicaid incentive payment amount of \$63,750. Pediatricians with a 20–29.99% Medicaid patient volume will receive 2/3 of these amounts (i.e., \$14,167 in the first year and \$5,667 in each subsequent year).

NY Medicaid EHR Incentive Program defines a pediatrician as an M.D. or D.O. who satisfies at least one of the following:

- Has a current board certification in pediatrics or a pediatric subspecialty from the American Board of Pediatrics (ABP) or the American Osteopathic Board of Pediatrics (AOBP)
- Focuses on treating patients 18 years old and younger, and attests that the majority of care (at least 50% of encounters) were for patients 18 years old or younger

EP29 What is an FQHC or RHC and how do I determine if I "practice predominantly in an FQHC or RHC" ?

Published: 04/26/2012

Updated: 08/19/2013

Predominantly is defined as 50% or more of patient encounters over a 6–month period in the prior calendar year or preceding 12 month period from the date of attestation were in one or multiple Federally Qualified Health Centers (FQHC) or Rural Health Centers (RHC).

The Social Security Act at section 1905(l)(2) defines an FQHC as an entity which, "(i) is receiving a grant under section 330 of the Public Health Service Act, or (ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant and (II) meets the requirements to receive a grant under section 330 of the Public Health Service Act, (iii) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, and is determined by the Secretary to meet the requirements for receiving such a grant including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity; or (iv) was treated by the Secretary, for purposes of Part B of title XVIII, as a comprehensive Federally–funded health center as of January 1, 1990, and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self–Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act for the provision of primary health services."

RHCs are defined as clinics that are certified under section 1861(aa)(2) of the Social Security Act to provide care in underserved areas, and therefore, to receive cost–based Medicare and Medicaid reimbursements.

In considering these definitions, it should be noted that programs meeting the FQHC requirements commonly include the following (but must be certified and meet all requirements stated above): Community Health Centers, Migrant Health Centers, Healthcare for the

Homeless Programs, Public Housing Primary Care Programs, Federally Qualified Health Center Look-Alikes, and Tribal Health Centers.

Practice Predominantly Calculation

It is not a requirement of the program that an Eligible Professional (EP) who works predominantly in an FQHC/RHC must use the needy patient volume. It is at the discretion of the provider to attest to the Medicaid patient volume or needy patient volume.

Practice Predominantly Calculation Guidance

Payment Year 2013 and beyond

To prove that an Eligible Professional (EP) practices predominantly in an FQHC/RHC, the EP must calculate 50% or more of the EPs individual patient encounters over a 6-month period in the prior calendar year or preceding 12 month period from the date of attestation were in one or multiple Federally Qualified Health Centers (FQHC) or Rural Health Centers (RHC).

Payment Years 2011–2012

To prove that an EP practices predominantly in an FQHC/RHC the EP must calculate 50% or more of the EPs individual patient encounters over a 6-month period in the prior calendar year were in one or multiple Federally Qualified Health Centers (FQHC) or Rural Health Centers (RHC).

For more information, please review the [CMS Frequently Asked Questions](#).

EP90 What are the participation requirements for Eligible Professionals (EPs) in Payment Year (PY) 2017 and beyond after a payment was recouped or returned for PY 2016 or earlier?

Published: 07/16/2018

Updated: 09/28/2018

Per 42 CFR 495.310, a provider may not begin receiving payments any later than payment year 2016. In other words, Eligible Professionals (EPs) participating in the NY Medicaid EHR Incentive Program must have received an incentive payment for at least one participation year in Payment Year (PY) 2016 or earlier to continue participation for PY 2017 and beyond.

This policy is reiterated in CMS FAQ 10755 which states:

"A provider's first participation year may be any year between 2011 through 2016. The last year a Medicaid EP or EH may begin receiving payments under the Medicaid EHR Incentive Program is 2016. Therefore, if 2016 was the providers' first year of participation in the Medicaid EHR Incentive Program and they fail a post payment audit of the 2016 attestation, the provider would lose eligibility to attest for 2017 and any subsequent years. If the provider already attested and received payment for any program year after 2016, all future payments should be recouped."

EPs that have payments recouped due to adverse audit findings and/or returned due to self-reporting are not considered as having been received for that payment year. Thus, if an EP subsequently has all of their payments recouped or returned for participation years prior to PY 2017, the EP is ineligible for any and all payments made for PY 2017 and beyond. i.e. The funds for those years would also be recouped or returned.

Ex 1. An EP receives a payment for participation year 1 for PY 2016 and a participation year 2 payment for PY 2017. Subsequently, an adverse audit finds the EP should not have received the PY 2016 payment. Therefore, recoupment of the PY 2017 payment will also be required, because the EP no longer received a payment for any participation years prior to PY 2017.

Ex 2. An EP receives a payment for participation year 1 for PY 2014, a payment for participation year 2 for PY 2016 and a payment for participation year 3 for PY 2018. Subsequently, an adverse audit finds the EP should not have received the PY 2014 payment and the EP self-reports and returns the PY 2016 payment. Therefore, return of the PY 2018 payment will also be required, because the EP no longer received a payment for any participation years prior to PY 2017.

Additional Resources:

- [CMS Stage 1 Final Rule](#) – See page 44579.
- [CMS FAQs for Medicaid](#) – See FAQ numbers 2625 and 10755.

EP93 How many years can an Eligible Professional (EP) participate in the NY Medicaid EHR Incentive Program?

Published: 08/15/2018

Updated: 01/04/2019

Under the Medicare and Medicaid EHR Incentive Programs, EPs can receive up to a total \$63,750 over the 6 years that they choose to participate. Under the NY Medicaid EHR Incentive Program, an EP could receive up to \$21,250 for their first participation year and up to \$8,500 for each of the remaining 5 years. There are no payment adjustments under Medicaid for failure to participate all years of the EHR Incentive Programs.

Participation years do not need to be consecutive. However,

- EPs must begin participating in the NY Medicaid EHR Incentive Program by 2016.
- The last year to receive an incentive payment is 2021.

See also: FAQ EP27

When an EP completes 6 participation years they do not have to do anything further to attest with the program. MEIPASS will not allow a provider to attest beyond 6 participation years.

[CMS FAQ 7737](#) – Is an eligible professional (EP) required to participate consecutively in the Medicaid Electronic Health Records (EHR) Incentive Program?

[CMS FAQ 2625](#) – What is the maximum incentive an eligible professional (EP) can receive under the Medicaid Electronic Health Records (EHR) Incentive Program?



Meaningful Use

- [EP12 When must Eligible Professionals \(EPs\) attest to being a "Meaningful EHR User"? Additionally I work in multiple locations, how does that impact the "Meaningful EHR User" requirement and how Meaningful Use objectives are calculated?](#)
- [EP41 How does an Eligible Professional \(EP\) report on meaningful use measures if the provider works in both the inpatient and outpatient setting?](#)
- [EP62 A provider works at multiple sites, but only one site \(with more than 50% of the provider's patient volume\) is fully live. The other site signed up with an EHR, but has not started using it. Since providers are supposed to combine the MU data from all locations where there is a certified EHR, does the provider have to wait until he/she is fully live at all locations before he/she can attest?](#)
- [EP86 An eligible professional \(EP\) demonstrated meaningful use but was unable to meet the Medicaid patient volume. Can the EP still attest?](#)
- [EP87 Due to NY Medicaid's delay in accepting meaningful use attestations for payment year 2015, may an eligible professional exercise the alternate attestation method with Medicare and then later attest with NY Medicaid for an incentive payment when the state is ready to accept those attestations?](#)
- [EP94 What is the PI reporting period?](#)

EP12 When must Eligible Professionals (EPs) attest to being a "Meaningful EHR User"? Additionally I work in multiple locations, how does that impact the "Meaningful EHR User" requirement and how Meaningful Use objectives are calculated?

Published: 01/09/2012

Updated: 11/20/2014

The NY Medicaid EHR Incentive Program does not require EPs who have adopted, implemented, or upgrade (AIU) certified EHR technology in Participation Year 1 to additionally attest to becoming a "Meaningful EHR User" [1]. However, in Participation Year 2 and beyond the provider must attest to being a "Meaningful EHR User" to be eligible to participate in the NY Medicaid EHR Incentive Program [2].

1. The AIU exception for providers as defined at 42 CFR § 495.8(a)(2)(iv) of the final rule:

(iv) Exception for Medicaid EPs. If a Medicaid EP has adopted, implemented, or upgrade certified EHR technology in the first payment year, the EP need not demonstrate that it is a Meaningful EHR User until the second payment year, as described in §495.6 and §495.8 of this subpart.

2. "Meaningful EHR User" as defined at 42 CFR § 495.4 of the final rule:

(3) To be considered a Meaningful EHR User, at least 50 percent of an EP's patient encounters during an EHR reporting period for a payment year (or, in the case of a payment adjustment

year, during an applicable EHR reporting period for such payment adjustment year) must occur at a practice/location or practices/locations equipped with Certified EHR Technology.

Meaningful User and Multiple Locations: An EP for who does not conduct 50% of their patient encounters in any one practice/location would have to meet the 50% threshold through a combination of practices/locations equipped with certified EHR technology.

That said, the discussion of " EPs Practicing in Multiple Practices" on page 44329 of the Final Rule for the Medicare and Medicaid EHR Incentive Programs [1] makes it clear that in the calculation of meaningful use measures, each EP must include encounters that occur in any practice location equipped with certified EHR technology at the start of the EHR reporting period. Although we understand the desire on the part of health care facilities to leverage efficiencies of scale in calculating eligibility and meaningful use measures on behalf of their practitioners, the intent of the legislation enabling the incentive program was clear in that the determination of meaningful use is specific to each practitioner based on his or her own clinical practice. CMS has chosen to allow certain administrative simplifications (such as the use of group practice patient volume as a proxy for individual volume) – especially for criteria that must be satisfied before the EHR may be fully operational and able to provide system-generated reports – but meaningful use remains an individual determination.

Source:

<https://www.gpo.gov/fdsys/pkg/FR-2010-07-28/pdf/2010-17207.pdf>

EP41 How does an Eligible Professional (EP) report on meaningful use measures if the provider works in both the inpatient and outpatient setting?

Published: 12/14/2012

The NY Medicaid EHR Incentive Program recommends that EPs read the following two CMS FAQs for guidance on reporting meaningful use objectives for working in an inpatient and outpatient setting.

CMS FAQ 2765

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

In this case, EPs should base both the numerators and denominators for meaningful use objectives on the number of unique patients in the clinic setting, since this setting is where they are eligible to receive payments from the Medicare and Medicaid EHR Incentive Programs.

Source: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/FAQ_General.pdf

CMS FAQ 6421

Can an eligible professional (EP) use EHR technology certified for an inpatient setting to meet a meaningful use objective and measure?

Yes. For objectives and measures where the capabilities and standards of EHR technology designed and certified for an inpatient setting are equivalent to or require more information than EHR technology designed and certified for an ambulatory setting, an EP can use the EHR technology designed and certified for an inpatient setting to meet an objective and measure.

There are some EP objectives, however, that have no corollary on the inpatient side. As a result, an EP must possess Certified EHR Technology designed for an ambulatory setting for such objectives. Please reference ONC FAQ 12–10–021–1 and 9–10–017–2 and CMS FAQ 10162 for discussions on what it means to possess Certified EHR Technology, ONC FAQ 6–12–025–1 for a list of affected capabilities and standards, and how that relates to the exclusion and deferral options of meaningful use.

Source: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/FAQ_General.pdf

EP62 A provider works at multiple sites, but only one site (with more than 50% of the provider’s patient volume) is fully live. The other site signed up with an EHR, but has not started using it. Since providers are supposed to combine the MU data from all locations where there is a certified EHR, does the provider have to wait until he/she is fully live at all locations before he/she can attest?

Published: 02/06/2015

Meaningful use: Any eligible professional demonstrating meaningful use must have at least 50 percent of his/her patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with certified EHR technology capable of meeting all of the meaningful use objectives. An eligible professional does not need to wait until all practice locations are fully live with a certified EHR system as long as he/she meets this 50 percent threshold. Therefore, New York State will collect information on meaningful users’ practice locations in order to validate this requirement in an audit, see CMS FAQ #3077.

Patient volume: Eligible professionals may choose one (or more) clinical sites of practice in order to calculate their patient volume. This calculation does not need to be across all of an eligible professional’s sites of practice. However, at least one of the locations where the eligible professional is adopting or meaningfully using certified EHR technology should be included in the patient volume. In other words, if an eligible professional practices in two locations, one with certified EHR technology and one without, the eligible professional should include the patient volume at least at the site that includes the certified EHR technology. When making an individual patient volume calculation (i.e., not using the group/clinic proxy option), a professional may calculate across all practice sites, or just at the one site. For more information on applying the group/clinic proxy option, see CMS FAQ #2993 and CMS FAQ #10416.

EP86 An eligible professional (EP) demonstrated meaningful use but was unable to meet the Medicaid patient volume. Can the EP still attest?

Published: 02/12/2016

According to the [2015 final rule](#), beginning in 2015 eligible professionals (EPs) who are dually eligible, i.e. bill claims to both Medicare and Medicaid, and demonstrated meaningful use during the payment year but were unable to meet the Medicaid patient volume requirements, may attest for the Medicare EHR Incentive Program in order to avoid the Medicare payment adjustments.

EPs who exercise this alternate attestation option for meaningful use:

- would not receive an EHR incentive payment for that year
- would not be considered as switching to the Medicare EHR Incentive Program
- must comply with Medicare attestation requirements
- may not simultaneously attest to adopt, implement or upgrade (AIU) for the Medicaid EHR Incentive Program for the same year

An EP's use of this alternate attestation method would be treated the same as if the EP had not attested to meaningful use for that year in the Medicaid EHR Incentive Program. Furthermore, an EP's EHR reporting period in a subsequent year for the Medicaid EHR Incentive Program would be determined without regard to any previous attestations using this alternate method.

Medicare attestations must be completed in the CMS Registration and Attestation System at <https://ehrincentives.cms.gov/hitech/login.action>.

EP87 Due to NY Medicaid's delay in accepting meaningful use attestations for payment year 2015, may an eligible professional exercise the alternate attestation method with Medicare and then later attest with NY Medicaid for an incentive payment when the state is ready to accept those attestations?

Published: 03/09/2016

Yes, for payment year 2015 an eligible professional (EP) may exercise the alternate attestation method with Medicare in order to avoid 2017 Medicare payment adjustments and then later attest with NY Medicaid for an incentive payment. This only applies to EPs demonstrating meaningful use for payment year 2015.

Be advised that NY Medicaid reports to the Centers for Medicare & Medicaid Services (CMS) which providers have attested to meaningful use, and this data is used to exempt providers from the Medicare payment adjustments. Therefore, it is not required that providers attest twice for 2015 meaningful use.

As stated in the [2015 final rule](#), the EP would not receive an incentive payment for the alternate attestation with Medicare. If the EP wishes to receive an incentive payment, then he/she must attest with NY Medicaid.

EP94 What is the PI reporting period?

Published: 08/16/2018

On April 24, 2018, the Centers for Medicare & Medicaid Services (CMS) announced the renaming of the Medicaid and Medicare EHR Incentive Programs to the Promoting Interoperability Programs. As part of this change, CMS has renamed the EHR reporting period to the Promoting Interoperability (PI) reporting period.

CMS has updated their website and education materials, using the term "PI reporting period." The PI reporting period is the same as the EHR reporting period, the term previously used since the programs' inception in 2011. Eligible professionals and hospitals attesting in MEIPASS for the NY Medicaid EHR Incentive Program will continue to encounter the term "EHR reporting period." It is understood that the PI reporting period is the same as the EHR reporting period.



Medicaid Patient Volume (MPV)

- [EP05 Can Eligible Professionals \(EPs\) in a group practice use a common Medicaid patient volume?](#)
- [EP06 Would you please explain the Medicaid patient volume calculation and allowable reporting periods?](#)
- [EP07 What is a Medicaid Patient Encounter for Eligible Professionals?](#)
- [EP14 All of our practitioners are billed as institutional services. How do we determine a given practitioner's Medicaid patient volume to become eligible for the Medicaid EHR Incentive Program?](#)
- [EP20 Would the provider use the clinic National Provider Identifier \(NPI\) or organization NPI when calculating the aggregate patient volume?](#)
- [EP21 The provider works under multiple group clinic National Provider Identifiers \(NPIs\). On which group NPI would the provider choose to base the aggregate patient volume?](#)
- [EP31 I work predominantly at a Federally Qualified Health Center \(FQHC\) or a Rural Health Clinic \(RHC\), is it required that I use the needy patient volume or can I attest using the Medicaid patient volume methodology?](#)
- [EP32 Some providers in our Federally Qualified Health Center \(FQHC\) or Rural Health Clinic \(RHC\) cannot obtain or do not have 6 months of prior calendar year data to attest to "practice predominantly in a FQHC/RHC". How can the providers attest to the NY Medicaid EHR Incentive Program?](#)
- [EP34 Should I include out-of-state encounters in my Medicaid patient volume encounter data?](#)
- [EP35 Eligible professional \(EPs\) working in our Federally Qualified Health Center \(FQHC\) or Rural Health Clinic \(RHC\) would like to attest as a group to the NY Medicaid EHR Incentive Program under the aggregate patient volume. Some of those EPs do not work predominantly at the FQHC or RHC but would be eligible to attest under the FQHC or RHC's NPI using the aggregate Medicaid patient volume to exclude the practice predominantly requirement. Is it required that all group providers use the aggregate needy patient volume or can some group providers use the aggregate Medicaid patient volume methodology while others use the aggregate needy patient volume methodology?](#)
- [EP36 Can an Eligible Professional attest using a group's aggregate patient volume if the provider was part of the group during the patient volume reporting period but is no longer part of the group at the time of attestation?](#)
- [EP39 An Eligible Professional \(EP\) is new to our group and did not practice in the prior calendar year. Can the EP use the group's aggregate Medicaid patient volume to satisfy the Medicaid patient volume requirement?](#)
- [EP40 How does an Eligible Professional \(EP\) count encounters for a service or procedure that is billed once or "globally" but represents multiple patient encounters on different days?](#)



- [EP42 When eligible professionals work at more than one clinical site of practice, are they required to use data from all sites of a practice to support their demonstration of meaningful use and the minimum patient volume thresholds for the Medicaid EHR Incentive Program?](#)
- [EP55 Why is Child Health Plus not included as a Medicaid patient encounter for the Medicaid EHR Incentive Program?](#)
- [EP56 In what situation can Child Health Plus be included as a Medicaid patient encounter for the EHR Incentive Program?](#)
- [EP85 Is an eligible professional \(EP\) allowed to include home health encounters in the calculation of Medicaid patient volume?](#)
- [EP92 Can an Eligible Professional \(EP\) utilize the same Medicaid Patient Volume \(MPV\) Reporting Period or overlapping MPV Reporting Periods for multiple Payment Years \(PYs\)?](#)

EP05 Can Eligible Professionals (EPs) in a group practice use a common Medicaid patient volume?

Published: 01/09/2012

Updated: 11/20/2014

Providers in a group practice or clinic may use the practice or clinic's aggregate patient volume as a proxy for their individual Medicaid patient volume, subject to the following restrictions:

1. To take advantage of this option, all the EPs in the practice/clinic (regardless of how much of their overall practice volume is within the practice/clinic) must use the group numbers (i.e., if one EP uses the group's aggregate numbers, another EP in the practice may not use his/her individual values, and vice-versa).
2. EPs for whom the aggregate patient volume is not an appropriate proxy (for example, providers who exclusively see Medicare or self-pay patients) may not use the aggregate patient volume.
3. Aggregate values must represent the entire practice's patient volume and not limit it in any way (including not limiting it to only patients seen by Eligible Professionals).

A group opting to use the aggregate patient volume may use either the standard or alternative methods (as described in EP06) for calculating patient volume. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) may use their aggregate needy patient volume, but only for providers who practice predominately in the FQHC/RHC.

EP06 Would you please explain the Medicaid patient volume calculation and allowable reporting periods?

Published: 01/09/2012

Updated: 11/20/2014

Eligible Professionals (EPs) who wish to enroll in the Medicaid EHR Incentive Program must demonstrate that at least 30% of their patient volume over a 90–day reporting period is attributed to Medicaid. The NY Medicaid EHR Incentive Program considers Medicaid Fee–For–Service, Medicaid Managed Care and Family Health Plus as eligible Medicaid encounter types.

Please see below for guidance on acceptable Patient Volume reporting methods:

Standard Patient Volume Method (Recommended)

An EP counts the number of patient encounters during the 90–day reporting period that were paid all or in part by Medicaid, and divides that number by the total number of patient encounters over the same period.

Alternative Patient Volume Method

EPs who have significant managed care populations might use a more complex calculation that takes into account the number of managed care patients on their patient panel during the 90–day reporting period, whether or not the EP actually had an encounter with those patients during the period. For more information on this method please go to our healthcare practitioner eligibility page.

Group Patient Volume Methods

Group practices may choose to use the overall practice’s aggregate patient volume numbers as a proxy for the individual EPs within the practice, but to take advantage of this option all the EPs in the practice must use the group encounter values (i.e., if one EP uses the group’s aggregate numbers, another EP in the practice may not use his or her individual values, and vice–versa). A group opting to use the aggregate patient volume may use either the standard or alternative methods (as described above) for calculating patient volume.

90 Day Reporting Period Guidance:

Payment Year 2013 and beyond

The patient volume reporting period must be derived from any consecutive 90 day period within the calendar year (CY) prior to the payment year or preceding 12 month period from the date of the attestation. The patient volume recorded within this 90 day period must be representative of the provider’s overall practice. For further assistance, utilize the 90 Day MPV Period Calculator.

Payment Years 2011–2012

The patient volume reporting period must be derived from any consecutive 90 day period within the calendar year (CY) prior to the payment year. The patient volume recorded within this 90 day period must be representative of the provider’s overall practice.

EP07 What is a Medicaid Patient Encounter for Eligible Professionals?

Published: 01/09/2012

Updated: 12/19/2019

According to the final rule for the Medicare and Medicaid EHR Incentive Programs (Published in the Federal Register on July 28, 2010), the following are considered Medicaid encounters for Eligible Professionals:

1. Services rendered on any one day to an individual where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid for part or all of the service; or
2. Services rendered on any one day to an individual for where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid all or part of their premiums, co-payments, and/or cost-sharing.

Under this definition, services rendered to an individual where Medicare or private insurance was the primary payer may still be considered Medicaid encounters if Medicaid was a secondary or tertiary payer and made a payment for the service. Also, services rendered to an individual where Medicaid paid premiums or co-payments for Medicare or private insurance are also considered Medicaid encounters.

Payment Year 2013 and beyond

Medicaid encounters now include service rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability. This new definition expands the Payment Year 2011–2012 guidance to include zero-pay claims and encounters with patients in Title XXI-funded Medicaid expansions, but not separate CHIP programs.

PLEASE NOTE: *If a claim was submitted multiple times for a service rendered on one day to a Medicaid-enrolled individual, this still only counts as one encounter.*

Payment Year 2011–2012

Medicaid must have issued a non-zero payment for the service (or premium, co-pay, etc.). Instances where the service was rendered to a Medicaid beneficiary, but Medicaid did not make a payment – where for example, Medicaid was not billed or issued zero payment due to the allowable amount being exhausted by the primary insurance – do not count as Medicaid encounters.

PLEASE NOTE: *If a claim was submitted multiple times for a service rendered on one day to a Medicaid-enrolled individual, this still only counts as one encounter.*

The following table shows the types of services that may be counted towards Medicaid and needy encounters:

Type of Service	Medicaid Encounter	Needy Encounter
Medicaid Fee-for-service	X	X
Medicaid Managed Care	X	X
Family Health Plus	X	X
Child Health Plus		X
Uncompensated Care		X
Sliding Scale		X

Note: 2014 was the last year that Family Health Plus encounters counted toward Medicaid Patient Volume. Starting in payment year (PY) 2015 only Medicaid Fee-for-service and Medicaid Managed Care encounters can be included in your MPV calculation.

EP14 All of our practitioners are billed as institutional services. How do we determine a given practitioner’s Medicaid patient volume to become eligible for the Medicaid EHR Incentive Program?

Published: 01/09/2012

Updated: 08/19/2013

It doesn’t matter how Medicaid is billed for the services a practitioner renders to Medicaid beneficiaries. As long as the services rendered on any one day were to a Medicaid–enrolled individual, the service counts as a Medicaid encounter towards the practitioner’s minimum Medicaid patient volume. A provider can reach the 30% minimum Medicaid patient volume without ever billing Medicaid directly or even being an enrolled provider.

EP20 Would the provider use the clinic National Provider Identifier (NPI) or organization NPI when calculating the aggregate patient volume?

Published: 01/25/2012

Updated: 06/13/2012

The choice is at the discretion of the Eligible Professional and group provider to determine if the aggregate patient volume is based on the clinic’s NPI or the parent organization’s NPI.

Group NPI / Aggregate Patient Volume Requirements

- The aggregate patient volume must be representative of the group NPI.
- Eligible professionals within that organization must all use the same group NPI methodology.

EP21 The provider works under multiple group clinic National Provider Identifiers (NPIs). On which group NPI would the provider choose to base the aggregate patient volume?

Published: 01/25/2012

Updated: 06/13/2012

The choice is at the discretion of the Eligible Professional to adopt the group NPI’s aggregate patient volume when attesting for the NY Medicaid EHR Incentive Program.

Group NPI / Aggregate Patient Volume Requirements

- The aggregate patient volume must be representative of the group NPI.
- Eligible Professionals within that organization must all use the same group NPI methodology.

EP31 I work predominantly at a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC), is it required that I use the

needy patient volume or can I attest using the Medicaid patient volume methodology?

Published: 04/26/2012

Updated: 08/19/2013

It is at the discretion of the Eligible Professional (EP) to choose the needy patient volume methodology or the Medicaid patient volume methodology when attesting to the NY Medicaid EHR Incentive Program.

EP32 Some providers in our Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) cannot obtain or do not have 6 months of prior calendar year data to attest to "practice predominantly in a FQHC/RHC". How can the providers attest to the NY Medicaid EHR Incentive Program?

Published: 04/26/2012

Updated: 04/26/2016

Please see the following scenarios:

Scenario 1: Provider did not practice in the prior calendar year.

In this scenario, the Eligible Professionals (EPs) who do not have 6 months of prior calendar year data to attest to satisfy the "practice predominantly in a FQHC/RHC" requirement can attest to the NY Medicaid EHR Incentive Program. Using the group's aggregate Medicaid patient volume from the prior calendar year to satisfy the 90-day reporting period, assuming the FQHC/RHC used the aggregate Medicaid or needy patient volume for the same 90-day period.

Scenario 2: Provider practiced at another clinic and can't obtain data.

Eligible Professionals (EPs) who cannot obtain 6 months of prior calendar year data to satisfy the "practice predominantly in a FQHC/RHC" requirement can attest under the standard methodology to the NY Medicaid EHR Incentive Program.

2.a FQHC/RHC providers adopted individual Medicaid or needy patient volume method

The EP must use individual Medicaid patient volume from the prior calendar year to satisfy the 90-day reporting period.

2.b FQHC/RHC providers adopted aggregate Medicaid or needy patient volume method

The EP must use group's aggregate Medicaid patient volume from the prior calendar year to satisfy the 90-day reporting period.

EP34 Should I include out-of-state encounters in my Medicaid patient volume encounter data?

Published: 04/26/2012

If an Eligible Professional (EP) cannot meet the minimum Medicaid patient volume requirement using New York encounter data, an EP is allowed to include all encounters from out-of-state. An EP that includes out-of-state encounters must use a consistent approach when including encounters in the Total Medicaid Encounters (numerator) and Total Patient Encounters (denominator) of the Medicaid patient volume calculation.

EP35 Eligible professional (EPs) working in our Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) would like to attest as a group to the NY Medicaid EHR Incentive Program under the aggregate patient volume. Some of those EPs do not work predominantly at the FQHC or RHC but would be eligible to attest under the FQHC or RHC's NPI using the aggregate Medicaid patient volume to exclude the practice predominantly requirement. Is it required that all group providers use the aggregate needy patient volume or can some group providers use the aggregate Medicaid patient volume methodology while others use the aggregate needy patient volume methodology?

Published: 02/10/2014

The NY Medicaid EHR Incentive Program recommends that EPs working within a FQHC or RHC who can meet the minimum 30% Medicaid patient volume under the standard aggregate Medicaid patient volume methodology select this method over the aggregate needy patient volume methodology due to the reduced eligibility requirements.

The Program does allow EPs working within a FQHC or RHC to individually choose which aggregate patient volume methodology enables the healthcare practitioner to be eligible to attest to the NY Medicaid EHR Incentive Program. Please be aware that the organization NPI, patient volume reporting period and aggregate Medicaid encounters must be identical for EPs attesting under the aggregate Medicaid patient volume or the aggregate needy patient volume. EP aggregate patient volume values that do not align across the group must be remediated prior to payment and will cause delays in the review process.

The aggregate patient volume methodology must abide by all program rules outlined in FAQs EP05, EP19, EP20, EP21 and EP36.

EP36 Can an Eligible Professional attest using a group's aggregate patient volume if the provider was part of the group during the patient volume reporting period but is no longer part of the group at the time of attestation?

Published: 05/09/2012

An Eligible Professional (EP) may attest using group aggregate patient volume as long as the provider held a contractual arrangement with the group during the aggregate patient volume reporting period. If the EP chooses to use the aggregate Medicaid patient volume adopted by the group then the EP must use the same organizational NPI, patient volume reporting period, and patient volume data as the other members of the group. If the EP chooses to not use the aggregate Medicaid patient volume then the provider must exclude all group encounters from the individual Medicaid patient volume.

Please view FAQ EP19 for more information on how NY Medicaid EHR Incentive Program defines a group provider.

Please view FAQ EP5 for more information on aggregate Medicaid patient volume.

EP39 An Eligible Professional (EP) is new to our group and did not practice in the prior calendar year. Can the EP use the group's aggregate Medicaid patient volume to satisfy the Medicaid patient volume requirement?

Published: 07/18/2012

Updated: 11/20/2014

Yes, an EP can use the group's aggregate patient volume to satisfy the Medicaid patient volume requirement. The below two scenarios describes the scenarios that are available to the EP when attesting to the NY Medicaid EHR Incentive Program.

Individual Patient Volume Scenario: The EP **would not** meet the 90 day–prior year data requirement because no individual data exists for the provider. The EP can wait until the next participation year of the program and attest using data when it is available.

Aggregate Patient Volume Scenario: The EP **would** meet the 90 day–prior year data requirement by leveraging the prior year group's data.

For further information on how NY Medicaid defines group provider and aggregate Medicaid patient volume please see FAQ EP19, EP20 and EP21.

EP40 How does an Eligible Professional (EP) count encounters for a service or procedure that is billed once or "globally" but represents multiple patient encounters on different days?

Published: 09/06/2012

Updated: 01/14/2014

Some procedures or types of care (such as obstetrics or orthodontia) are billed to NY Medicaid once for a period of care (e.g, quarterly) or an entire course of treatment. In calculating the number of encounters in such a scenario, NY Medicaid will allow the EP to count each such claim as a single encounter, or may count one encounter for each visit on which the patient received care under the claim, so long as the same approach is used for all such claims

(regardless of payer) in both Total Medicaid Encounters (numerator) and Total Patient Encounters (denominator) of the Medicaid patient volume calculation.

EP42 When eligible professionals work at more than one clinical site of practice, are they required to use data from all sites of a practice to support their demonstration of meaningful use and the minimum patient volume thresholds for the Medicaid EHR Incentive Program?

Published: 12/14/2012

Updated: 01/30/2017

CMS FAQ 10416

CMS considers these two separate, but related issues.

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

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

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

Source: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/FAQ_General.pdf

EP55 Why is Child Health Plus not included as a Medicaid patient encounter for the Medicaid EHR Incentive Program?

Published: 05/14/2014

The reason Child Health Plus is not included as a Medicaid patient encounter is because funding for the Child Health Plus program does not come from Title 19, which funds the Medicaid program. Child Health Plus is funded by the Children's Health Insurance Program (CHIP) which is funded by **Title 21**, making it **not funded by Medicaid**. So, since the Child Health Plus program is not funded by Title 19 (Medicaid Funding) **it cannot be considered a Medicaid patient encounter.**

EP56 In what situation can Child Health Plus be included as a Medicaid patient encounter for the EHR Incentive Program?

Published: 05/14/2014

Updated: 11/20/2014

In order to count Child Health Plus encounters, an EP must practice predominantly as part of a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC). The Social Security Act at section 1905(l)(2) defines an FQHC as an entity which:

"(i) is receiving a grant under section 330 of the Public Health Service Act, or (ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under section 330 of the Public Health Service Act, (iii) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, and is determined by the Secretary to meet the requirements for receiving such a grant, including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity; or (iv) was treated by the Secretary, for purposes of Part B of title XVIII, as a comprehensive Federally-funded health center as of January 1, 1990, and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act for the provision of primary health services."

EP85 Is an eligible professional (EP) allowed to include home health encounters in the calculation of Medicaid patient volume?

Published: 10/06/2015

Yes, an eligible professional may include home health encounters. These encounters may represent home health services rendered by clinical staff under the EP's direct supervision (such as a physician assistant) or services rendered by a home health agency (such as private duty nursing) that is acting on a referral from the EP. NY Medicaid allows an EP to include data from home health claims wherein the EP is listed as the attending provider.

If EPs opt to use the group aggregate method including home health encounters, then all EPs of that group must attest to the same methodology.

EP92 Can an Eligible Professional (EP) utilize the same Medicaid Patient Volume (MPV) Reporting Period or overlapping MPV Reporting Periods for multiple Payment Years (PYs)?

Published: 07/16/2018

An Eligible Professional (EP) may **not** utilize the same Medicaid Patient Volume (MPV) Reporting Period or overlapping MPV Reporting Periods for multiple Payment Years (PYs).

Ex 1. An EP is attesting for PY 2016 on 5/1/2017 and selects a MPV Reporting Period of 1/1/2017 through 3/31/2017, utilizing the previous 12 months to attestation MPV reporting period selection method. For PY 2017 the EP is attesting on 3/1/2018 and selects a MPV

Reporting Period of 1/1/2017 through 3/31/2017, utilizing the previous calendar year MPV reporting period selection method.

In this example, the EP is not eligible to utilize 1/1/2017 through 3/31/2017 as their PY 2017 MPV Reporting Period and they would need to select a different period that does not overlap the PY 2016 MPV Reporting Period.

Ex 2. An EP is attesting for PY 2016 on 5/1/2017 and selects a MPV Reporting Period of 1/1/2017 through 3/31/2017, utilizing the previous 12 months to attestation MPV reporting period selection method. For PY 2017 the EP is attesting on 3/1/2018 and selects a MPV Reporting Period of 3/1/2017 through 5/29/2017, utilizing the previous calendar year MPV reporting period selection method.

In this example, the EP is not eligible to utilize 3/1/2017 through 5/29/2017 as their PY 2017 MPV Reporting Period and they would need to select a different period that does not overlap the PY 2016 MPV Reporting Period.

Additional Resources:

- NY Medicaid EHR Incentive Program FAQ EP06
- NY Medicaid EHR Incentive Program FAQ EP71

Pre-payment

- [EP03 How can a provider assign the incentive payment to an employer, practice, or clinic?](#)
- [EP04 If a provider practices in more than one location, can the incentive payment be shared between these locations?](#)
- [EP57 What is pre-validation?](#)

EP03 How can a provider assign the incentive payment to an employer, practice, or clinic?

Published: 01/09/2012

Under the rules of the Medicaid EHR Incentive Program, Eligible Professionals (EPs) are permitted to completely reassign their incentive payments to an employer or entity with which they have a contractual arrangement allowing the employer or entity to bill and receive payment for the EP's covered professional services. This assignment must be voluntary.

It will be the decision of the EP as to what entity they wish to reassign their payment to or if they choose to just receive it individually. EPs will have the ability to edit the entity to which they assign their payment up until the payment is processed by modifying their reassignment information on the CMS Medicare & Medicaid EHR Incentive Registration & Attestation System. The reassignment information on record with NY Medicaid at the time of payment processing will determine the entity to whom the payment is made.

The EP's registration (including the assignment of the incentive payment) can be modified by the EP up to the point that the State receives final approval from CMS to pay the incentive to the EP. This is the last step before the payment is issued (i.e., the check is cut or the EFT is transmitted). The EP will know when this step occurs because it generates a notification that is sent to the EP.

EP04 If a provider practices in more than one location, can the incentive payment be shared between these locations?

Published: 01/09/2012

Updated: 06/13/2012

Eligible Professionals (EPs) are permitted to reassign their incentive payments to their employer or to an entity with which they have a contractual arrangement allowing the employer or entity to bill and receive payment for the EP's covered professional services.

Payments will be issued directly to the individual provider, unless the provider voluntarily chooses to reassign the payment to his or her employer during the process of registering in the incentive program.

Reassignment of the incentive payment is limited to totally assigning the payment to a single entity – it will not be possible to reassign only part of the incentive payment or to split the reassignment among multiple entities.

EP57 What is pre-validation?

Published: 02/06/2015

Updated: 04/26/2016

Individual and group eligible professionals (EPs) who have already determined their Medicaid patient volume may utilize the pre-validation services offered by the NY Medicaid EHR Incentive Program. Pre-validation enables EPs to submit their data prior to attesting for preliminary review.

Pre-validation prior to submitting the complete attestation may subsequently reduce the time of state review.

Post-payment

- [EP48 Are the auditors particular about the options for attesting to adopt, implement, and upgrade \(AIU\)? For example, if a provider clicked on implement, but actually adopted the EHR, will that be an issue in any way?](#)
- [EP49 Does a practice have a contact person at the auditing contractor?](#)
- [EP50 What are the details of the appeals process for providers who disagree with the outcome of their audit? Can providers appeal a failed audit?](#)
- [EP51 What is the typical duration of an audit for small practices/large practices? How long does it take for a practice to be notified of a "pass/fail" audit?](#)



- [EP52 What should a provider do if he/she realizes that they've falsely attested?](#)
- [EP53 How should HIPAA documentation be sent to OMIG?](#)
- [EP54 Will all of my documents be saved from previous audits if I am audited for MU?](#)
- [EP58 How should providers prepare for an audit? What documentation is needed?](#)
- [EP59 How are providers chosen for an audit?](#)
- [EP60 It seems to be unclear whether or not there is a rule for Medicaid Year 1 Attestation \(AIU\) about the percentage of patients \(i.e. 50%, as with MU\) seen in a location that has acquired an EHR. Can you provide clarity about this for us? And if there is a rule, to what extent it is included in the audit and/or how it would be proved?](#)
- [EP61 Are Clinical Quality Measures being audited too, or are only Core & Menu Measures being audited?](#)
- [EP63 How are Core measures such as Drug-Drug/Drug-Allergy Interaction Checks \(Core 2\) and Clinical Decision Support Rule \(CDS\) \(Core 11\) audited? How can "yes/no" measures be satisfied during an audit? Is a statement from the EHR vendor sufficient? What are examples of "proof" that are acceptable?](#)
- [EP64 How will Meaningful Use audits be conducted? Who will conduct the audits?](#)
- [EP65 I have heard that the ONC audits are going into details regarding the Risk Assessment. They are actually reviewing and checking up on practices' P&P's. They are asking providers to prove items they outlined in their SRA. What is OMIG doing with regards to the SRA?](#)
- [EP66 It's been noted that for MU stage 1, Core 14- HIE \(health information exchange\) is not a requirement for payment year 2013, but providers are still asked if they've completed this core requirement during the attestation process. Will providers be excluded from having to show documentation that supports this core measure?](#)
- [EP67 How do you verify the total patient volume?](#)
- [EP68 If a provider uses an incorrect CMS EHR Certification ID for his/her attestation but he/she is on a certified EHR, and can prove it, will he/she pass an audit? For example, if a provider accidentally used a 2011/2014 combination or 2014 certification ID instead of the simple 2011 certification, or if he/she used the correct vendor/product, but incorrect version number.](#)
- [EP69 If a provider has to repay his/her incentive money due to a failed audit, does he/she repay the full amount of the incentive or just the amount after taxes? Assuming he/she paid taxes on the incentive in the payment year.](#)
- [EP70 How are providers contacted when they are chosen for a Meaningful Use audit?](#)
- [EP71 I made a mistake on my attestation and should not have received the incentive payment. How do I return the incentive payment? Will I be ineligible to participate in subsequent years of the program?](#)
- [EP72 If a provider can only get a Meaningful Use \(MU\) dashboard in Excel, is this acceptable?](#)
- [EP73 What do auditors expect to see for public health measure documentation?](#)



- [EP74 If a provider cannot provide documentation, can they return the funds and re-attest?](#)
- [EP75 How does a provider who left a larger group get the documentation to show the financial commitment to the EHR system?](#)
- [EP76 Do auditors ask for documentation regarding inpatient and outpatient encounters?](#)
- [EP77 Why do providers have to provide a reason for the exclusion they attested to?](#)
- [EP78 If a provider says he/she is eligible for an exclusion, but in fact is not, what would happen during the audit?](#)
- [EP79 Should the actual risk assessment and policy be sent to the auditor?](#)
- [EP80 What is the look-back period for hospital-based documentation?](#)
- [EP81 If a provider passes a Pre-Payment Validation, can he/she get the file from that and submit it to OMIG?](#)
- [EP82 What will happen in a Meaningful Use audit if a provider working at multiple locations did not realize he/she had to combine the data?](#)
- [EP83 Does OMIG offer support for large organizations that are attesting for AIU?](#)
- [EP84 What documentation do Eligible Professionals and Eligible Hospitals need to submit to demonstrate that they qualify for the CMS 2014 CEHRT Flexibility Rule?](#)

EP48 Are the auditors particular about the options for attesting to adopt, implement, and upgrade (AIU)? For example, if a provider clicked on implement, but actually adopted the EHR, will that be an issue in any way?

Published: 05/14/2014

Updated: 11/20/2014

Providers are required to submit documentation to support their attestation. If during the audit process it is uncovered that an incorrect selection was made for adopt, implement or upgrade (AIU), the auditor will communicate this with the provider. Any errors in attestations made by the providers will be reviewed on a case-by-case basis at the discretion of OMIG management.

EP49 Does a practice have a contact person at the auditing contractor?

Published: 05/14/2014

Each audit is assigned a specific auditor who will serve as the main point of contact throughout the course of the audit. The auditor's contact information (name, phone number, email, address, and drop box link) is listed in the Audit Notification Letter. The provider, or an appointed contact person, should reach out to the assigned auditor with any questions.

EP50 What are the details of the appeals process for providers who disagree with the outcome of their audit? Can providers appeal a failed audit?

Published: 05/14/2014

If a provider chooses not to settle through repayment, they have the right to challenge findings by requesting an administrative hearing. Issues raised shall be limited to those issues relating to determinations contained in the Final Audit Report. Providers may only request a hearing to challenge specific audit adjustments which they challenged in a response to the Draft Audit Report. A hearing request may not address issues regarding the methodology used to determine any rate of payment or fee. Providers must make a request for a hearing, in writing, **within 60 days of the date on the Final Audit Report.**

EP51 What is the typical duration of an audit for small practices/large practices? How long does it take for a practice to be notified of a "pass/fail" audit?

Published: 05/14/2014

Once an initial Audit Notification Letter has been mailed to the point of contact listed on the signed attestation, no less than 30 calendar days are provided to supply the requested documentation. If additional time is needed to compile the information that is pertinent to the audit, a deadline extension may be requested by the provider. The approval of the extension will be at the discretion of the audit staff assigned to the particular audit and OMIG management. After the auditor has received all necessary information, he or she will spend time analyzing it to ensure it is in compliance with all program requirements. The practice will be notified of the audit's pass/fail status as soon as the auditor has reached a decision and forwarded the audit through the standard approval process. There are many factors that affect the duration of an audit, so a "*customary audit duration*" does not exist.

EP52 What should a provider do if he/she realizes that they've falsely attested?

Published: 05/14/2014

Updated: 03/16/2015

If a provider wishes to self-report that they have falsely attested prior to receiving an Audit Notification Letter, they should contact the NY Medicaid EHR Incentive Program Support Team at 1-877-646-5410 (option #2), or email HIT@health.ny.gov for assistance. If based on an audit, a provider is found to not be eligible for an EHR incentive payment, the payment will be recouped and providers will be ineligible to re-attest for that payment year.

EP53 How should HIPAA documentation be sent to OMIG?

Published: 05/14/2014

HIPAA-sensitive information can be sent in any secure method of the provider's choosing such as encrypted email or certified mail. We highly recommend using OMIG's secure HIPAA-

compliant drop box known as Hightail. This drop box will allow supporting documentation to be securely uploaded to the auditor.

EP54 Will all of my documents be saved from previous audits if I am audited for MU?

Published: 05/14/2014

Updated: 06/28/2014

Documentation from previous audits will be retained. The documentation that was used for an AIU audit can be used again for an MU audit if it is relevant to the MU audit. All supporting documentation should be retained for each attestation for 6 years from the date of attestation.

EP58 How should providers prepare for an audit? What documentation is needed?

Published: 02/06/2015

Updated: 06/28/2014

The documentation providers may submit for AIU includes, but is not limited to: NYS professional license and registration, documentation demonstrating AIU of the certified EHR system identified by the EHR Certification Number on the attestation, signed contract with vendors, vendor invoices, payment receipts, and screenshots showing the product name and version number. A system generated report or other documentation is required to support the total Medicaid encounters and total encounters that were attested to for the 90 day reporting period.

Examples of documentation to demonstrate the MU portion include: any EHR or ancillary system reports which support the conclusion that you have met one of the exclusions or objectives for attested Core or Menu measures, and/or a record to support the numerator and denominator values for the attested Menu and Core measures. Additional information may be requested as needed during the review process. The level of the audit may depend on a number of factors; therefore, it is not possible to provide an all-inclusive list of supporting documents. Providers should retain documentation 6 years from the date of attestation.

EP59 How are providers chosen for an audit?

Published: 02/06/2015

Any provider attesting to receive an EHR incentive payment for either the Medicare or Medicaid EHR Incentive Program potentially can be subject to an audit. Audit candidates will be identified using a variety of analytical tools, data mining techniques, and random selection.

EP60 It seems to be unclear whether or not there is a rule for Medicaid Year 1 Attestation (AIU) about the percentage of patients (i.e. 50%, as with MU) seen in a location that has acquired an EHR. Can you provide clarity about this for us? And if there is a rule, to what extent it is included in the audit and/or how it would be proved?

Published: 02/06/2015

For Payment Year 1 (AIU), there is no rule or threshold regarding the percentage of patients that need to be seen at a location equipped with certified EHR technology.

EP61 Are Clinical Quality Measures being audited too, or are only Core & Menu Measures being audited?

Published: 02/06/2015

Audits of a provider's first Meaningful Use payment will focus on Core and Menu Measures. OMIG reserves the right to request supporting documentation for all attested to measures and CQMs.

EP63 How are Core measures such as Drug–Drug/Drug–Allergy Interaction Checks (Core 2) and Clinical Decision Support Rule (CDS) (Core 11) audited? How can "yes/no" measures be satisfied during an audit? Is a statement from the EHR vendor sufficient? What are examples of "proof" that are acceptable?

Published: 02/06/2015

Proof that the functionality was available, enabled, and active in the certified EHR system for the duration of the EHR reporting period will be requested. Providers are advised to retain electronic date–stamped screen shots displaying that the functions were enabled during the EHR reporting period. Additionally, providers should be prepared to produce any source reference documentation used at the time of their attestation for the attested–to measure(s).

EP64 How will Meaningful Use audits be conducted? Who will conduct the audits?

Published: 02/06/2015

Audits will be conducted by the New York State Office of Medicaid Inspector General. Auditors will review provider–submitted documents to support all attested–to Meaningful Use measures and eligibility requirements. In some cases, the audit will include an on–site review at the provider's location for a demonstration of the EHR system and to verify Meaningful Use.

EP65 I have heard that the ONC audits are going into details regarding the Risk Assessment. They are actually reviewing and checking up on practices' P&P's. They are asking providers to prove items they outlined in their SRA. What is OMIG doing with regards to the SRA?

Published: 02/06/2015

To meet the "Protect Electronic Health Information" core objective for Stage 1, eligible professionals (EP), eligible hospitals (EH), or critical access hospitals (CAH) must conduct or

review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), implement security updates as necessary, and correct identified security deficiencies as part of the provider's risk management process.

A Security Risk Analysis needs to be conducted or reviewed during each program year for Stage 1 and Stage 2. These steps may be completed outside OR during the EHR reporting period timeframe. *However, these steps must take place no earlier than the start of the EHR reporting year and no later than the date the provider submits its attestation for that EHR reporting period.*

For example, an eligible professional who is reporting for a 90-day EHR reporting period in 2014 may complete the appropriate security risk analysis requirements outside of this 90-day period as long as it is completed between January 1st of the EHR reporting year and no later than the date the eligible professional submits the attestation for that EHR reporting period.

1. While it is recommended that the security risk analysis be done within each program year, *the security risk analysis may be completed after the end of the program year as long as it is completed before the attestation.*
2. *The security risk analysis requirements must be met for each program year.* It is not acceptable to use the same security risk analysis (a new security risk analysis or a review) for more than one program year.

In the event of an audit, providers should be prepared to submit a report that documents the procedures performed during the analysis and the results. This report should be dated no earlier than the start of the EHR reporting year and no later than the date the provider submits their attestation. Additionally, all reports should include evidence to support that it was generated for that provider's system (e.g., identified by National Provider Identifier (NPI), CMS Certification Number (CCN), provider name, practice name, etc.)

Source: <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/F?isDept=0&search=10754&searchType=faqId&submitSearch=1&id=5005>

EP66 It's been noted that for MU stage 1, Core14– HIE (health information exchange) is not a requirement for payment year 2013, but providers are still asked if they've completed this core requirement during the attestation process. Will providers be excluded from having to show documentation that supports this core measure?

Published: 02/06/2015

Providers that attested in the early stages of Meaningful Use (years 2011 & 2012), will still have to provide supporting documentation that HIE was completed during the EHR reporting period. It's important that providers understand that the exchange of clinical information didn't necessarily have to be done successfully; documentation that supports that the attempt of exchanging clinical information was made, is sufficient.

HIE (health information exchange) is not a requirement for the 2013 EHR reporting period. Although providers may have attested to completing Core 14 for 2013, they would be excluded from having to provide supporting documentation for this measure during an audit.

EP67 How do you verify the total patient volume?

Published: 03/16/2015

Providers will be required to supply documentation containing the Medicaid and non-Medicaid encounters that they attested to. Auditors will then review and analyze this information. If during the audit process discrepancies in the patient volume are uncovered, the auditor will communicate this with the provider and work with him/her to determine if other forms of documentation can be provided.

EP68 If a provider uses an incorrect CMS EHR Certification ID for his/her attestation but he/she is on a certified EHR, and can prove it, will he/she pass an audit? For example, if a provider accidentally used a 2011/2014 combination or 2014 certification ID instead of the simple 2011 certification, or if he/she used the correct vendor/product, but incorrect version number.

Published: 03/16/2015

During an audit providers will be required to submit documentation to support their attestation. If during the audit process it is uncovered that an incorrect selection was made for the Certification ID, the auditor will communicate this to the provider and request an explanation on the circumstances surrounding the error. Any errors in attestation values will be reviewed on a case-by-case basis at the discretion of OMIG management.

EP69 If a provider has to repay his/her incentive money due to a failed audit, does he/she repay the full amount of the incentive or just the amount after taxes? Assuming he/she paid taxes on the incentive in the payment year.

Published: 03/16/2015

If during the course of an audit a provider is found to be ineligible for payment, he/she would be required to re-pay the full amount paid by the EHR incentive program for the appropriate payment year, and the provider will be ineligible to re-attest for that payment year.

EP70 How are providers contacted when they are chosen for a Meaningful Use audit?

Published: 03/16/2015

Each provider selected for audit is sent an Audit Notification Letter through certified mail. An auditor will then follow up with providers by email to confirm receipt.

EP71 I made a mistake on my attestation and should not have received the incentive payment. How do I return the incentive payment? Will I be ineligible to participate in subsequent years of the program?

Published: 04/09/2015

For providers that need to self-report that they were unable to meet the program requirements and had received the incentive payment in error, please contact NY Medicaid EHR Incentive Program Support at hit@health.ny.gov.

Self-reporting is by payment year. Although a provider may return the incentive payment for a particular payment year, that does not forfeit the provider's eligibility to participate in subsequent years. If the provider meets program requirements for subsequent years, then the provider may continue participating in the NY Medicaid EHR Incentive Program.

Please note that inquiries related to recoupments of incentive payments due to post-payment audits should be directed to the Office of the Medicaid Inspector General at hitech@omig.ny.gov.

EP72 If a provider can only get a Meaningful Use (MU) dashboard in Excel, is this acceptable?

Published: 05/11/2015

Ideally, a provider should retain a copy of the source documents used when completing his/her attestation. If a dashboard report from the provider's CEHRT was used, the report should be generated in PDF format. If the CEHRT is unable to generate the report in PDF format (i.e. CEHRT can only export into excel), providers should retain screenshots of the dashboard report used when completing their attestation. In both cases, the dashboard report and/or screenshots should clearly identify that the documentation is from the CEHRT (i.e. CEHRT logo is displayed or step-by-step screenshots which demonstrate how the report is generated by the CEHRT should be retained), reporting period and provider's name.

EP73 What do auditors expect to see for public health measure documentation?

Published: 05/11/2015

The providers should retain all correspondence with the public health registries. If providers do not have correspondence or a screenshot showing the upload was successful, they should reach out to the appropriate registry for additional assistance.

EP74 If a provider cannot provide documentation, can they return the funds and re-attest?

Published: 05/11/2015

No. The provider cannot self-report once an Audit Notification Letter has been issued. However, if a provider is found to be ineligible for payment due to audit finding(s) for a specific payment year, he/she may still participate in subsequent program participation years.

EP75 How does a provider who left a larger group get the documentation to show the financial commitment to the EHR system?

Published: 05/11/2015

The provider would need to work with the vendor or previous group to obtain the required supporting documentation.

EP76 Do auditors ask for documentation regarding inpatient and outpatient encounters?

Published: 05/11/2015

Yes. Providers are asked to provide Medicaid inpatient encounters (Place of Service 21) and emergency department encounters (Place of Service 23) of a hospital, as well as all Medicaid encounters for the year preceding the payment year to determine if a provider is considered hospital-based. Failure to provide this information will result in an audit determination made solely on Medicaid claims data. This is part of the patient volume documentation requested in the Audit Notification Letter.

EP77 Why do providers have to provide a reason for the exclusion they attested to?

Published: 05/11/2015

If a provider decides to take an exclusion from any of the meaningful use (MU) objectives, he/she should maintain documentation that supports his/her eligibility for that exclusion. Example documentation to support exclusions includes, but is not limited to, a report from the providers' certified EHR showing a zero denominator for the measure. If a report from the certified EHR is not an option, then providers should retain any applicable documentation to confirm that they qualified for the exclusion.

EP78 If a provider says he/she is eligible for an exclusion, but in fact is not, what would happen during the audit?

Published: 05/11/2015

The provider would be allowed to provide documentation for the full measure for which the exclusion was taken.

EP79 Should the actual risk assessment and policy be sent to the auditor?

Published: 05/11/2015

During an audit, a provider will be asked to submit documentation supporting security policies and the risk assessment.

EP80 What is the look–back period for hospital–based documentation?

Published: 06/04/2015

All eligible professionals (EPs) participating in the Medicaid EHR Incentive Program must render less than 90 percent of his/her covered Medicaid services in the inpatient (IP) and emergency department (ED) settings. This determination is measured per individual provider over the entire calendar year (CY) preceding the attested to payment year (PY).

For example, a provider attesting to payment year (PY) 2014 would make his/her determination based on the total covered Medicaid IP and ED services against the total covered Medicaid services for the 2013 CY (1/1/2013–12/31/2013).

EP81 If a provider passes a Pre–Payment Validation, can he/she get the file from that and submit it to OMIG?

Published: 06/04/2015

All source documentation used by providers in the completion of their attestations to the Medicaid EHR Incentive Program must be retained for a period of six years. Documentation submitted for a pre–payment validation may also be sent to OMIG during an audit; however, the provider would send this documentation with the understanding that additional documentation may be requested by the auditor.

EP82 What will happen in a Meaningful Use audit if a provider working at multiple locations did not realize he/she had to combine the data?

Published: 06/04/2015

During an audit, providers must submit documentation to support their Meaningful Use measures from all locations equipped with certified EHR technology, even if the additional locations were erroneously not included in the providers' attestation.

Please refer to the CMS Guide for Eligible Professional Practicing in Multiple Locations:
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EP_MultipleLocationsTipsheet.pdf

EP83 Does OMIG offer support for large organizations that are attesting for AIU?

Published: 06/04/2015

Providers with questions while attesting should contact the NY Medicaid EHR Incentive Program Support team at:

Email: hit@health.ny.gov

Phone Number: 877-646-5410 Option #2

Providers with questions specific to Medicaid EHR Incentive Program Audits should contact the OMIG auditing team at:

Email: hitech@omig.ny.gov

Mailing Address:

NYS Office of the Medicaid Inspector General

Division of Medicaid Audits

Attn: EHR Incentive Program Audits

800 North Pearl Street

Albany, New York 12204

EP84 What documentation do Eligible Professionals and Eligible Hospitals need to submit to demonstrate that they qualify for the CMS 2014 CEHRT Flexibility Rule?

Published: 06/04/2015

Eligible Professionals and Eligible Hospitals are required to retain documentation which clearly demonstrates that due to delays in 2014 Edition CEHRT availability they were unable to fully implement 2014 Edition CEHRT.

Examples that do not count as delays in availability include:

- **Financial Issues** – Financial issues, such as inability to meet the costs associated with implementing, upgrading, installing, testing, or other similar issues of a financial nature, do not qualify the provider to use the options outlined in the CMS 2014 CEHRT Flexibility Rule.
- **Difficulty Meeting Measures** – Issues related to meeting meaningful use objectives and measures do not constitute an inability to fully implement 2014 Edition CEHRT. Providers who simply cannot meet one or more measures cannot use the options and must attest to their stage of meaningful use using 2014 Edition CEHRT as originally intended.
- **Staffing Issues** – Staff turnover and changes, as well as any other similar situations, are considered normal situations during the course of business and are, therefore, insufficient grounds for a provider to use the options.
- **Provider Delays** – Situations stemming from providers' inactions or delays in implementing 2014 Edition CEHRT are not sufficient cause to use one of the options. Other disqualifying situations include providers waiting too long to engage a vendor or a provider's inability or refusal to purchase the requisite software update.

For reference, please see [42 CFR § 495.8 \(a\)\(2\)\(i\)\(D\)](#)



Eligible Hospitals (EHs)

- [EH01 What is the formula for determining if an acute care hospital meets the 10% minimum threshold patient encounters for Medicaid EHR Incentive Payments?](#)
- [EH02 What is the allowable range of dates for the 90–day patient volume period for Eligible Hospitals?](#)
- [EH04 What is a Medicaid Patient encounter for Eligible Hospitals?](#)
- [EH05 Is my hospital eligible for the EHR incentive?](#)
- [EH06 How does the NY Medicaid EHR Incentive Program define a children´s hospital?](#)
- [EH07 May outpatient clinics, diagnostic and treatment centers \(D&TCs\), community health centers, rural health clinics, etc. qualify as an Eligible Hospital in order to receive direct incentive payments?](#)
- [EH08 Can you please define the term "acute care"?](#)
- [EH09 When can a hospital receive an incentive payment?](#)
- [EH10 How is the hospital incentive payment calculated?](#)
- [EH11 Where do the numbers for the hospital incentive payment calculation come from?](#)
- [EH12 Can services rendered to dual–eligible patients be included when calculating a hospital´s Medicaid patient volume and incentive payment amount?](#)
- [EH13 How should hospitals take into account swing bed patients in the calculations of total encounters and Medicaid encounters?](#)
- [EH14 Why does the State require providers to re–enter data from the Institutional Cost Report \(ICR\) in attesting for the incentive payment? The Medicare program does not require this.](#)
- [EH15 How does a hospital merger affect the calculation of the incentive payment?](#)
- [EH16 When can Eligible Hospitals \(EHs\) participate in the Medicaid EHR Incentive Program? Are there any penalties if EHs do not participate immediately, or skip years?](#)
- [EH17 How does participating in the Medicare EHR Incentive Program affect my ability to receive the Medicaid EHR Incentive?](#)
- [EH18 When can Eligible Hospitals begin meaningful use attestation for the New York Medicaid EHR Incentive Program?](#)

EH01 What is the formula for determining if an acute care hospital meets the 10% minimum threshold patient encounters for Medicaid EHR Incentive Payments?

Published: 01/09/2012

In addition to the NY–SMHP (which discusses the patient volume calculation on pages C–10 through C–17), many of the details of the patient volume calculation are specified in federal

rules and regulations [42 CFR § 495.306](#) and the [Final Rule for the Electronic Health Record Incentive Program](#).

According to the State's proposed implementation plan, providers, including acute care hospitals, will have a certain amount of flexibility in how they demonstrate that they meet the patient volume requirements for eligibility. Essentially, hospitals have two options for calculating the Medicaid patient volume:

1. Dividing the number of Medicaid patient encounters in a given 90-day period* by the total number of patient encounters in the same period.
2. Adding the number of Medicaid patients current on the hospital's managed care patient panel in a given 90-day period* plus the number of Medicaid patient encounters during the period for patients not on the managed care patient panel, and dividing that by the sum of the total number of patients current on the hospital's managed care patient panel during the period and the number of patient encounters during the period for patients not on the managed care patient panel.

*The 90-day Patient Volume Period is dependent upon the Hospital's Cost Reporting Schedule and payment year. Please see FAQ EH02 for allowable dates to determine the hospital's 90-day Patient Volume Period.

Medicaid providers will have the freedom to select the 90-day period they wish to use for the patient volume calculation, although it must be representative of their overall patient volume. For the purposes of the second patient volume methodology, patients on the provider's patient panel are deemed to be "current" if they had an encounter with the provider within the previous year prior to the 90-day period.

Note that the requirement to meet the 10% Medicaid patient volume applies only to acute care hospitals, which for this program are defined in federal regulation as "those hospitals with an average patient length of stay of 25 days or fewer, and with a CCN" (i.e., CMS Certification Number, formerly known as Medicare Provider Number or OSCAR number) "that falls in the range 0001–0879 or 1300–1399." Children's hospitals, defined as "a hospital that is separately certified as a children's hospital, with a CCN in the 3300–3399 series and predominantly treats individuals under the age of 21", do not have any Medicaid patient volume requirement.

EH02 What is the allowable range of dates for the 90-day patient volume period for Eligible Hospitals?

Published: 01/09/2012

Updated: 02/06/2015

The 90-day patient volume period used to determine a hospital's eligibility for the Medicaid EHR Incentive Program in a given payment year must be entirely within the hospital cost reporting year that ended during the Federal Fiscal Year (FFY) prior to that payment year. The following chart illustrates the specific cost reporting period within which the 90-day patient volume period must be contained, according to the payment year and the hospital's cost reporting period.

For Payment Year 2015 (10/1/2014–9/30/2015):

Hospital Cost Reporting Schedule	Allowable Dates for 90 day Patient Volume Period
Calendar Year (January 1–December 31)	January 1, 2013–December 31, 2013
State Fiscal Year (April 1–March 31)	April 1, 2013–March 31, 2014
School Year (July 1–June 30)	July 1, 2013–June 30, 2014
Federal Fiscal Year (October 1–September 30)	October 1, 2013–September 30, 2014

Note that the 90–day patient volume period is not the same as the period used for determining the hospital’s average length of stay or calculating the hospital’s incentive payment amount. The average length of stay and incentive payment amount are based on a full 12–month base year.

Hospitals participating simultaneously in the Medicare and Medicaid EHR Incentive Programs should also note that this 90–day patient volume period for establishing Medicaid patient volume is not the same as the 90–day meaningful use reporting period required in the first year of the Medicare EHR Incentive Program. That 90–day meaningful use reporting period must be entirely within the payment year.

EH04 What is a Medicaid Patient encounter for Eligible Hospitals?

Published: 01/09/2012

Updated: 04/01/2013

According to the final rule for the Medicare and Medicaid EHR Incentive Programs (published in the Federal Register on July 28, 2010), the following are considered Medicaid encounters for Eligible Hospitals:

1. Services rendered to an individual per inpatient discharges where Medicaid or a Medicaid demonstration project under section 1115 paid for part or all of the service;
2. Services rendered to an individual per inpatient discharge where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid all or part of their premiums, co–payments, and/or cost–sharing;
3. Services rendered to an individual in an emergency department on any one day where Medicaid or a Medicaid demonstration project under section 1115 of the Act either paid for part or all of the service; or
4. Services rendered to an individual in an emergency department on any one day where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid all or part of their premiums, co–payments, and/or cost sharing.

Note that for a service to be considered a Medicaid encounter, the service must be rendered on any one day to a Medicaid–enrolled individual, regardless of payment liability. Medicaid

encounters include zero–pay claims and encounters with patients in Title XXI–funded Medicaid expansions, but not separate CHIP programs (see below).

The following table shows the types of services that may be counted towards Medicaid and needy encounters:

Type of Service	Medicaid Encounter	Needy Encounter
Medicaid Fee–for–service	X	X
Medicaid Managed Care	X	X
Family Health Plus	X	X
Child Health Plus		X
Uncompensated Care		X
Sliding Scale		X

EH05 Is my hospital eligible for the EHR incentive?

Published: 01/09/2012

According to the rules of the Medicaid EHR Incentive Program, the following facilities may be eligible to receive direct incentive payments:

1. **Acute Care Hospitals**, which are defined as those facilities operating under a CMS Certification Number (CCN, otherwise known as Medicare Provider Number or OSCAR Number) whose last four digits are in the range 0001–0879 or 1300–1399 and which have an average length of stay of 25 days or less. Acute care hospitals must have a minimum 10% Medicaid patient volume.
2. **Children’s Hospitals**, which are defined as separately–certified facilities with a CMS Certification Number whose last four digits are in the range 3300–3399, and which focus on treating patients under 21 years of age. Children’s hospitals have no minimum Medicaid patient volume.

EH06 How does the NY Medicaid EHR Incentive Program define a children’s hospital?

Published: 01/09/2012

Updated: 04/01/2013

Starting in Payment Year 2013, the children’s hospital definition includes any separately certified hospital, either freestanding or hospital within hospital that predominately treats individuals under 21 years of age; and does not have a CMS certification number (CCN) because they do not serve any Medicare beneficiaries but has been provided an alternative number by CMS for purposes of enrollment in the Medicaid EHR Incentive Program.

Any other type of children’s facility does not qualify as a "children’s hospital" and therefore must satisfy the definition of "acute care hospital" and demonstrate a minimum 10% Medicaid patient volume. The only benefit of qualifying as a children’s hospital is the exemption from the minimum Medicaid patient volume, all other aspects of the program are identical for all facilities.

EH07 May outpatient clinics, diagnostic and treatment centers (D&TCs), community health centers, rural health clinics, etc. qualify as an Eligible Hospital in order to receive direct incentive payments?

Published: 01/09/2012

Updated: 06/13/2012

If your facility does not qualify as an Eligible Hospital based on the published ranges of CMS Certification Numbers, then the individual practitioners in the facility may be able to qualify for the Medicaid EHR Incentive as eligible professionals. These practitioners may then voluntarily assign their incentive payments to the facility, assuming there is an existing employer–employee or billing relationship between the facility and the practitioners.

Even if your facility qualifies as an Eligible Hospital, any practitioners who provide more than 10% of their covered professional services outside the inpatient or hospital emergency department settings, defined as place of service (POS) codes 21 and 23, respectively, may also be eligible to receive the individual incentive.

EH08 Can you please define the term "acute care"?

Published: 01/09/2012

Generally, acute care is a term used for immediate short–term treatment or stabilization of a disease, injury, or disorder. Acute care is generally provided in settings such as emergency, intensive care, coronary care, and cardiology departments. In contrast, sub–acute care is provided in units and facilities such as long–term care, skilled nursing, and rehabilitation.

The Medicaid EHR Incentive Program provides incentives only to acute care facilities and children’s hospitals. Even within an eligible acute care or children’s hospital, there are some units that are not considered acute care and are not counted in the calculations for determining eligibility or calculating the incentive payment. The following types of services are considered sub–acute and should be excluded from all calculations:

- Nursery care, although neonatal intensive care services are acute care and should be counted
- Skilled nursing or long term care
- Rehabilitation
- Psychiatric services

EH09 When can a hospital receive an incentive payment?

Published: 01/09/2012

Updated: 04/26/2016

In order to receive the incentive, providers will need to register first with the [CMS Medicare and Medicaid EHR Incentive Program Registration and Attestation System](#) and then attest to their patient volume and other eligibility criteria with the NY Medicaid EHR Incentive Program. Once

a provider's attestations are complete and accepted by the state, payment will be made within 45 days.

Hospital participation in the incentive program is based on the federal fiscal year (FFY), which runs from October 1 to September 30. All qualifying activities for a given payment year such as adopt/implement/upgrade of certified EHR technology and meaningful use activities must be completed within that year; however, attestation may be completed up to 90 days after the end of the payment year.

EH10 How is the hospital incentive payment calculated?

Published: 01/09/2012

Updated: 06/05/2012

The total value of the Medicare and Medicaid EHR Incentive payments that an Eligible Hospital receives is determined by a formula set forth in federal law. The State has no latitude to change the formula. The Medicaid incentive payment is calculated as:

1. The sum of:
 - a. A base amount of \$2 million, plus
 - b. A differential based on the number of acute care discharges from the hospital,
2. Multiplied by a fraction representing the proportion of Medicaid bed days relative to overall bed days over the previous year called the "Medicaid share".

Any charity care furnished by the hospital increases the Medicaid share, and thus the overall incentive payment. The Medicare incentive payment uses a similar formula, substituting Medicare bed days for Medicaid bed days.

Some educational material published by CMS and stakeholder organizations did not emphasize the Medicaid share part of the calculation, which may have led hospitals to believe that the minimum they would receive was the base amount (\$2 million). In fact, according to our estimates, total Medicaid EHR Incentive payments to an Eligible Hospital in New York may range from \$25,000 to \$11.5 million.

The total amount of the hospital incentive is calculated when the hospital attests to AIU (Adopt, Implement, Upgrade) in the first year. Thereafter, the incentive is paid in three annual lump sum payments:

- 50% of the total amount is paid in the first year when the hospital attests to AIU.
- 40% of the total is paid in the second program participation year, when the hospital attests to meaningful use based on a 90-day reporting period.
- 10% of the total is paid in the third program participation year, when the hospital attests to meaningful use based on a full-year reporting period.

EH11 Where do the numbers for the hospital incentive payment calculation come from?

Published: 01/09/2012

Updated: 12/05/2013

New York has identified locations in the Institutional Cost Report (ICR) where each input to the hospital incentive payment calculation may be found. New York will use the data from the hospital's submitted ICR for the period in question to ensure consistency between the values used for the Medicaid EHR Incentive Program and the values the hospital has previously certified in the ICR submission. This approach is consistent with the approach CMS is adopting for the Medicare EHR Incentive Program, which will use the values reported in CMS Form 2552 to calculate the Medicare incentive amount. Hospitals will be required to attest that the values they provide are correct according to the definitions set forth in the Medicaid EHR Incentive Program; in instances where these definitions differ from the definitions used by the hospital in preparing the ICR, the hospital will be responsible for attesting to the correct values and providing documentation as requested by the State to justify the deviation from the values provided in the ICR.

According to federal regulations, New York must derive the hospital incentive payment amount from hospital cost reports for the cost reporting period ending in the federal fiscal year (FFY) prior to the FFY that serves as the first payment year. The following chart illustrates the specific cost report from which the inputs to the incentive payment calculation must be drawn, according to the first payment year in which the hospital participates in the program and the hospital's cost reporting period.

For Payment Year 2014 (10/1/2013–9/30/2014):

(Attestations accepted 12/30/2013–01/31/2014)

Hospital Cost Reporting Schedule	Cost Reporting Used in Calculating Incentive Payment
Calendar Year (January 1–December 31)	January 1, 2012–December 31, 2012
State Fiscal Year (April 1–March 31)	April 1, 2012–March 31, 2013
School Year (July 1–June 30)	July 1, 2012–June 30, 2013
Federal Fiscal Year (October 1–September 30)	October 1, 2012–September 30, 2013

EH12 Can services rendered to dual-eligible patients be included when calculating a hospital's Medicaid patient volume and incentive payment amount?

Published: 01/09/2012

In the case where Medicaid is a secondary payer to Medicare, the inpatient discharge or emergency department service can be counted as a Medicaid encounter towards the 10% patient volume requirement. However, the associated bed days should NOT be counted as Medicaid Inpatient Bed Days in the calculation of the Medicaid Share, as these bed days would already be counted towards the Medicare Share in the calculation of the Medicare EHR Incentive Payment, and the bed days cannot be double-counted.

In cases where Medicaid is secondary only to private insurance, these services may be counted toward both the Medicaid patient volume and the incentive payment amount.

EH13 How should hospitals take into account swing bed patients in the calculations of total encounters and Medicaid encounters?

Published: 01/09/2012

Updated: 06/13/2012

Swing beds come into play in the calculation of Medicaid patient volume both in the numerator (Medicaid Inpatient Hospital Encounters) and denominator (Acute Care Inpatient Hospital Encounters). In general, a swing bed is considered part of the Eligible Hospital whenever it is used to provide acute care, but when it is used to provide sub-acute care (for example, skilled nursing services), it is not considered part of the Eligible Hospital and should not be included in the calculation of Medicaid patient volume.

In the calculation of Acute Care Inpatient Hospital Encounters (which are based on discharges), a discharge from a swing bed used for acute care constitutes an encounter in the Eligible Hospital. This includes cases where a patient transitions from acute care to skilled nursing service and remains in the swing bed – the transition of care is considered a discharge from the Eligible Hospital. In the case where the acute care is paid (all or in part) by Medicaid, this discharge would also constitute a Medicaid Inpatient Hospital Encounter toward the numerator of the patient volume calculation.

The same rationale should be used when assessing swing beds relative to the incentive payment calculation: if the swing bed is used to provide acute care, it is part of the Eligible Hospital and this care would be included in values such as Total Acute Discharges and Acute Inpatient Bed Days. When the swing bed is used to provide sub-acute care, it is not part of the Eligible Hospital and should not be included.

EH14 Why does the State require providers to re-enter data from the Institutional Cost Report (ICR) in attesting for the incentive payment? The Medicare program does not require this.

Published: 01/09/2012

Updated: 06/13/2012

In order to receive an incentive payment for any given year, the hospital must legally attest to the value of each of the required inputs according to the definitions in the program. NY Medicaid has attempted to map each of the inputs to the closest possible location on the Institutional Cost Report; however, we are aware that in some cases the definitions do not perfectly match any of the values on the ICR. For example, encounters where Medicaid is secondary to private insurance may be counted as Medicaid encounters, but there is no location on the ICR where these services are reported.

For any given hospital, there may be deviations between the values reported on the ICR and the values reported in the attestation for the EHR Incentive Program resulting entirely from these differences in the definitions. For this reason, hospitals are required to exercise their own judgment in deciding what the most accurate value is for each of the required inputs.

References to locations in the ICR are only recommendations on where the information may be found.

EH15 How does a hospital merger affect the calculation of the incentive payment?

Published: 01/09/2012

Updated: 06/13/2012

Payments to Eligible Hospitals are keyed to the CMS Certification Number (CCN, otherwise known as Medicare Provider Number or OSCAR number) of the hospital that is applying for the incentive. When hospitals merge, only data associated with the CCN of the hospital that is receiving payment can be used in the calculation. Data from hospitals with different CCNs, even if those hospitals have become part of the hospital applying for the incentive, may not be used in calculating the incentive payment. This is a rule that is common to both the Medicaid and Medicare EHR Incentive programs and it is not within the State's prerogative to modify this approach.

The inputs to the hospital incentive payment calculation must be drawn from the hospital cost report for the period ending in the federal fiscal year (FFY) prior to the FFY that serves as the first payment year. This cost report must reflect a 12-month period. If, due to a merger, the hospital applying for the EHR Incentive Payment submitted a cost report during the time in question for a period of less than 12 months, the hospital may not use that cost report as the basis for the incentive payment amount. If no cost report was submitted for a 12-month period that ended in the FFY prior to the FFY that serves as the first payment year, the hospital may not participate in the Medicaid EHR Incentive Program until the following year.

If, due to a merger, a hospital obtains a new CCN that is not associated with any previously-submitted cost reports, the hospital will not be able to participate in the Medicaid EHR Incentive Program until such a time as the hospital has submitted at least one cost report under the new CCN.

EH16 When can Eligible Hospitals (EHs) participate in the Medicaid EHR Incentive Program? Are there any penalties if EHs do not participate immediately, or skip years?

Published: 01/09/2012

Updated: 02/06/2015

Eligible Hospitals may begin participating in the NY Medicaid EHR Incentive Program immediately. Attestations for a given payment year (which, for Eligible Hospitals, is the same as the Federal fiscal year) are accepted from December 30 of the payment year until December 29 of the following year.

EHs may begin participating in the Medicaid EHR Incentive Program as late as 2016 and still receive the full incentive payment amount. Up until 2016, EHs may participate in non-consecutive years (i.e., skip years) without penalty. EHs may not begin participating after 2016, and to continue receiving payments after 2016 they must receive a payment in 2016 and each consecutive year thereafter. No payments will be issued for payment years later than 2018.

There is no penalty in the Medicaid program for hospitals that do not participate in the EHR Incentive Program. However, be advised that Medicare eligible hospitals will be subject to payment adjustments unless they are meaningful users. Please visit the CMS website for more information about Medicare payment adjustments and hardship exceptions:

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PaymentAdj_Hardship.html

EH17 How does participating in the Medicare EHR Incentive Program affect my ability to receive the Medicaid EHR Incentive?

Published: 01/09/2012

Hospitals may participate in both the Medicare and Medicaid EHR Incentive Programs, in contrast to Eligible Professionals who must select one or the other of the programs. The Medicare program does not provide incentives for adoption, implementation, or upgrade of certified EHR technology in the first program participation year – participants must demonstrate meaningful use in the first year. In both programs, the first year of meaningful use is based on a 90-day reporting period within the payment year, and subsequent years of meaningful use are based on a full-year reporting period.

In any year when a hospital participating in both the Medicare and Medicaid EHR Incentive Programs is required to be a meaningful user for both programs, the Medicare EHR Incentive Program will be the program that determines whether the hospital has successfully demonstrated meaningful use. A hospital in such a scenario will perform the required meaningful use attestation in the Medicare program, and Medicare will subsequently notify NY Medicaid of its determination.

Dual-eligible hospitals who participate in both programs in a single year may not necessarily be in the same participation year in each program. For example:

- A hospital may choose to apply only to Medicaid in the first year if it is not ready to demonstrate meaningful use, and then apply to both programs in the following year. At that point, the hospital will be in the first year of the Medicare program and the second year of the Medicaid program, which is the first year of meaningful use for both programs. The hospital could attest to meaningful use in both programs after a 90-day reporting period.
- A hospital that is ready to demonstrate meaningful use now may apply to both programs in the first year attesting to Meaningful use in the Medicare program and AIU in the Medicaid program. The following year, the hospital would then be in its second year of meaningful use for Medicare but only the first year of meaningful use for Medicaid. Since the hospital is required to demonstrate meaningful use to Medicare first, the hospital must wait until after the end of the payment year and attest to Medicare for the full year of meaningful use before receiving the incentive payment from either program.

EH18 When can Eligible Hospitals begin meaningful use attestation for the New York Medicaid EHR Incentive Program?

Published: 01/09/2012

Updated: 02/06/2015

The NY Medicaid EHR Incentive Program is now accepting attestations from eligible hospitals (EHs) for both adoption/implementation/upgrade (in providers' first year of participation) and meaningful use (for providers' second and third participation years).

Hospitals who are participating in both the Medicare and Medicaid EHR Incentive Programs will be required to complete their meaningful use attestation for the Medicare EHR Incentive Program using the CMS Registration & Attestation System prior to attesting with the NY Medicaid EHR Incentive Program.



Both EPs and EHs

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- [EPH02 What is a "patient encounter"?](#)
- [EPH03 Where can I get more information about the Medicaid EHR Incentive Program?](#)
- [EPH04 Do providers need to meet the meaningful use criteria in order to receive payments from the NY Medicaid EHR Incentive Program?](#)
- [EPH05 What is the meaning of the terms "adopt", "implement", and "upgrade"?](#)
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- [EPH12 What is the CMS Registration ID?](#)
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- [EPH31 Our Hospital/Practice cannot attest to 2014 Meaningful Use Stage 1 or Stage 2 objectives in Payment Year 2014 as scheduled because we are unable to fully implement 2014 edition CEHRT due to issues related to 2014 edition CEHRT availability delays. Is it possible to still attest using 2011 edition CEHRT or a combination of 2011/2014 edition CEHRTs and what is the Centers for Medicare and Medicaid Services \(CMS\) plan going forward?](#)
- [EPH32 What supporting documentation does an Eligible Professional and Eligible Hospital need to save to support an audit of the Meaningful Use Public Health Measures and Objectives?](#)
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EPH01 What types of services may be counted towards a provider’s Medicaid or needy patient encounters?

Published: 01/09/2012

Updated: 12/19/2019

The following chart shows the services that may be counted towards Medicaid and needy patient encounters.

Type of Service	Medicaid Encounter	Needy Encounter
Medicaid Fee-for-service	X	X
Medicaid Managed Care	X	X
Family Health Plus	X	X
Child Health Plus		X
Uncompensated Care		X
Sliding Scale		X

Note: 2014 was the last year that Family Health Plus encounters counted toward Medicaid Patient Volume. Starting in payment year (PY) 2015 only Medicaid Fee-for-service and Medicaid Managed Care encounters can be included in your MPV calculation.

EPH02 What is a "patient encounter"?

Published: 01/09/2012

For the purposes of the Medicaid EHR Incentive Program, a patient encounter means one or more services rendered to an individual on a given day. Multiple services on a single day constitute a single encounter.

EPH03 Where can I get more information about the Medicaid EHR Incentive Program?

Published: 01/09/2012

Updated: 02/06/2015

The New York State Medicaid HIT Plan (NY-SMHP) can be found on the DOH website at the following address:

http://health.ny.gov/regulations/arra/docs/medicaid_health_information_technology_plan.pdf

Additional information on the program can be found at the CMS website for the Medicare and Medicaid EHR Incentive Programs <http://www.cms.gov/ehrincentiveprograms/>

Information on meaningful use can be found on the website of the Office of the National Coordinator for Health IT <http://healthit.gov/providers-professionals/meaningful-use-definition-objectives>

EPH04 Do providers need to meet the meaningful use criteria in order to receive payments from the NY Medicaid EHR Incentive Program?

Published: 01/09/2012

Updated: 12/19/2019

Once a provider has demonstrated that he or she has met all the eligibility criteria to participate in the Medicaid EHR Incentive Program (including minimum Medicaid patient volume and other criteria such as provider type and hospital-based status), the provider will need to attest to the following:

1. In the first year the provider must attest to having adopted, implemented, or upgraded certified EHR technology. This certification is conducted by various organizations according to a procedure established by the Office of the National Coordinator for HIT (ONC). Note that these organizations certify complete EHR systems as well as EHR modules which meet some, but not all, of the certification criteria. In order to meet the AIU (Adopt, Implement, Upgrade) requirement, the provider must have a complete system or a combination of modules that together form a complete system. For a list of products that have been certified or to verify that your product is certified, please consult ONC's Certified Health IT Product List (CHPL) at <https://chpl.healthit.gov/>.
2. In their second and subsequent years of participation, providers must demonstrate that they are "meaningful users" of the certified EHR technology. In order to do this, they will need to attest to meeting a number of meaningful use objectives, which become more rigorous over the course of the six-year incentive program.

Only after demonstrating both eligibility and either AIU or Meaningful Use (depending on the participation year) will a provider be deemed eligible to receive the incentive payment. The process by which a provider applies for the incentive payment begins by registering at the federal level in the [CMS Medicare & Medicaid EHR Incentive Program Registration and Attestation System](#). The provider then attests to eligibility and AIU or Meaningful Use with the NY Medicaid EHR Incentive Program.

EPH05 What is the meaning of the terms "adopt", "implement", and "upgrade"?

Published: 01/09/2012

Updated: 05/11/2015

In their first payment year, providers will be required to attest that they have either adopted, implemented, or upgraded certified EHR technology in order to be eligible to receive the EHR incentive payment. During the attestation process, providers will only select which of the three categories they completed, and will not be required to submit explanation or documentation of their activities. However, all providers should be prepared to supply documentation upon request that proves that their activities during the payment year met the definition of the activity to which they attested.

Below are explanations of the terms "adopt," "implement," and "upgrade":

Adopt means to acquire, purchase, or secure access to certified EHR technology. It is not necessary that the certified EHR technology be installed or in active use in the clinical setting, so long as the provider can demonstrate a financial commitment to purchasing or using the certified EHR technology. Examples of documentation that would be sufficient to demonstrate adoption include:

- ✓ Signed contract with a vendor for purchase or installation of certified EHR technology
- ✓ Copy of paid invoice that clearly indicates the certified EHR product to which the charges apply

Documents that are not sufficient to demonstrate adoption include:

- ✓ Vendor letter verifying purchase
- ✓ Letter of Intent

In cases where a financial commitment cannot be demonstrated (for example, a product that is offered at no cost), the provider will be required to demonstrate installation (for an installed product) or access (for an externally-hosted product).

Implement means to install or commence utilization of certified EHR technology capable of meeting meaningful use requirements. It is not necessary to demonstrate that implementation is complete or that the EHR system is in active use in the clinical setting; however, plans to implement the certified EHR technology are not sufficient actual progress towards implementation is required. Examples of activities that would be sufficient to demonstrate implementation include:

- ✓ Progress in integrating the certified EHR system with existing systems
- ✓ Execution of staff training on the certified EHR technology
- ✓ Progress in transition to the certified EHR technology, such as entry of existing patient data into the EHR

Upgrade means to expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria. If the provider is upgrading from a previous version of the EHR technology to an ONC-certified version, or adding modules to achieve a complete certified system, the same documentation criteria apply as for adoption of a new EHR system. If the provider is upgrading custom EHR technology to achieve ONC certification, the following are examples of documentation that would be sufficient to demonstrate upgrade:

- ✓ Signed contract with vendor, developer, or systems integrator for services to upgrade the EHR technology

IMPORTANT: The attestation and supporting documentation must accurately reflect the AIU activity performed by the provider during the payment year.

EPH08 Where can I locate the official guidance on New York State legislative requirements concerning laboratory test results and authorized ordering sources?

Published: 02/10/2014

Electronic Health Records (EHRs) are real-time, patient-centered records that make information available to those who are involved in the care of a patient and to the patients themselves. The Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule and the Health Information Technology for Economic and Clinical Health (HITECH) Act are driving the establishment of EHRs and patient portals, which are secure online websites that provide patients access to personal health records.

The establishment of EHRs and patient portals would provide direct access of laboratory test results to patients. In New York State, laboratory test results cannot be reported directly to the patient unless authorization is first provided by the physician or authorized person. The regulation describing this requirement is found in 10 NYCRR §58–1.8 (http://www.health.ny.gov/regulations/nycrr/title_10) which states the following:

58–1.8 Results of tests to be reported only to physicians or other authorized persons. No person shall report the result of any test, examination or analysis of a specimen submitted for evidence of human disease or medical condition except to a physician, his agent, or other person authorized by law to employ the results thereof in the conduct of his practice or in the fulfillment of his official duties. Reports shall not be issued to the patients concerned except with the written consent of the physician or other authorized person, except that information concerning blood type and Rh type factor may be provided in writing to the individual whose blood was testing without the consent of the individual’s physician.

As facilities establish and activate EHRs and patient portals, this regulatory requirement needs to be considered before lab results are made available to patients through patient portals. Below are frequently asked questions (FAQs) that will provide guidance on how to maintain compliance with 10 NYCRR §58–1.8 while also meeting Federal goals for access to medical records by patients.

FAQ1: Is there a Federal regulation that allows patients direct access to laboratory test results?

ANS1: The Department of Health and Human Services proposed a rule in 2011 that would amend the Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations to specify that, upon a patient’s request, the laboratory may provide access to completed test reports that, using the laboratory’s authentication process, can be identified as belonging to that patient (<http://www.gpo.gov/fdsys/pkg/FR-2011-09-14/html/2011-23525.htm>). At this time, the rule is not final, and the status of this proposed rule is unknown. If this rule were to become final, New York State would follow this federal rule and allow patients direct access to their laboratory test results.

FAQ2: Why can’t a laboratory that tests samples originating from New York State release laboratory results directly to a patient?

ANS2: Current New York State Regulation 10 NYCRR §58–1.8 (http://www.health.ny.gov/regulations/nycrr/title_10) states that reports shall not be issued to the patients concerned except with the written consent of the physician or other authorized person.

FAQ3: Can a laboratory release test results into an EHR for access by the patient through the patient portal?

ANS3: Since the patient would have direct access to the lab results, the laboratory would need to obtain written consent from the physician or other authorized person before the patient could access the laboratory test results via the patient portal.

FAQ4: 10 NYCRR §58–1.8 states that reports shall not be issued to the patients concerned except with the written consent of the physician or other authorized person. Who can be considered to be an authorized person?

ANS4: Authorized person refers to persons who have been authorized to order tests and receive directly the results of certain laboratory tests for specimens accepted from New York State.

FAQ5: How do we obtain written consent from the physician or other authorized person to allow a patient access to their lab results?

ANS5: The physician or other authorized person could provide consent when the lab tests are ordered. In this circumstance, consent can be given on the test requisition whether it is an electronic or paper based ordering system. Alternatively, the physician or other authorized person can give a onetime blanket approval to the laboratory that would allow the lab to release the lab results directly (and/or automatically) from the EHR to personal health records for all their patients. Email correspondence from the physician or authorized person would fulfill the requirement of obtaining written authorization.

FAQ6: Would consent from the physician or authorized person to release laboratory results still be required if there is a documented provider/patient encounter?

ANS6: Yes.

FAQ7: Whom do I contact if I have further questions?

ANS7: For further clarification on this guidance, please contact Division of Laboratory Quality Certification at dlcqinfo@health.state.ny.us

EPH12 What is the CMS Registration ID?

Published: 01/09/2012

Updated: 04/26/2016

An important prerequisite for participating in the NY Medicaid EHR Incentive Program is your initial registration with the Center for Medicare and Medicaid Services (CMS). Upon completion of your CMS registration, you will be provided with the 10–digit CMS Registration ID. You will use it to access and track your applications during each year of the EHR Incentive Payment Program.

EPH14 I have not registered at CMS – what is CMS?

Published: 01/09/2012

The Center for Medicare and Medicaid Services (CMS) is the agency within the federal government that is responsible for the ongoing operations of the Medicare and Medicaid programs.

If you have not begun the federal registration process please get information at the following web address: <http://www.cms.gov/EHRIncentivePrograms/>

When you are ready, you can begin the federal registration at:

<https://ehrincentives.cms.gov/hitech/login.action>

EPH15 If I receive an incentive payment and at a later date get audited, what documentation will I need to provide to state auditors?

Published: 01/09/2012

Updated: 06/28/2019

You should retain all documents associated with the transaction, such as your purchase order or requisition, the vendor's invoices, cancelled checks, etc.

Additionally, you should retain your records for each payment for 6 years from the date of attestation.

EPH25 Do I have to re-register with CMS for each payment year of the NY Medicaid EHR Incentive Program?

Published: 04/26/2012

A provider will only register once for the NY Medicaid EHR Incentive Program through the CMS Registration and Attestation System. CMS registration is on-going throughout the life of the NY Medicaid EHR Incentive Program and can be altered at any time to reflect the provider's current information.

EPH27 How does the Federal Department of Health and Human Services published amendments to 42 CFR Part 493 and 45 CFR Part 164 impact New York State legislative requirements concerning laboratory test results and authorized ordering sources?

Published: 03/10/2014

Please note this is updated guidance from FAQ EPH08.

Electronic Health Records and Access to Laboratory Test Results: Ensuring compliance with 10 NYCRR § 58-1.8

February 19, 2014

On January 17, 2014, the New York State Department of Health (the Department) posted frequently asked questions (FAQs) regarding patients' access to laboratory test results using electronic health records (EHRs) and steps that could be taken to ensure compliance with New York State (NYS) regulation 10 NYCRR § 58–1.8. This regulation states that laboratory test results cannot be reported directly to the patient "except with the written consent of the physician or other authorized person." On February 6, 2014, the Federal Department of Health and Human Services published amendments to 42 CFR Part 493 and 45 CFR Part 164 which give patients a right to access medical records directly from clinical laboratories, including completed laboratory test reports (<http://www.gpo.gov/fdsys/pkg/FR-2014-02-06/pdf/2014-02280.pdf>). The new Federal rule becomes effective on April 7, 2014, with a compliance date of October 6, 2014. To provide additional information on how this Federal rule affects NYS requirements related to patients' access to laboratory results, the Department is providing this guidance.

FAQ1: The Federal rule will allow an individual or an individual's personal representative to request and receive completed test reports directly from a laboratory that is a HIPAA covered entity. Current NYS regulations do not allow a laboratory that tests samples originating from New York State to release laboratory results directly to a patient unless written consent is first provided by the physician or other authorized person. Will the Department follow the amended Federal rule and allow patients direct access to their completed laboratory test results?

ANS1: Yes. Consistent with the amended Federal rule, the Department intends to repeal the State regulations requiring the written consent of the physician or other authorized person and to allow laboratories to provide patients with access to test reports without any consent from the practitioner who ordered the test.

FAQ2: The Federal rule states that HIPAA-covered laboratories will be required to provide individuals with access to their laboratory test reports within 30 days of the request from the patient. Can the laboratory release results sooner than 30 days without the written consent of the physician or other authorized person?

ANS2: Yes. Under the Federal rule, the laboratory generally must provide results to patients no later than 30 days after receipt of a request for test results. The laboratory may provide reports prior to the 30 days. The Department recommends that laboratories and/or EHR systems have a mechanism to ensure that the practitioner who ordered the test has the opportunity to review and discuss the test results with the patient. Thirty days is enough time for the practitioner who ordered the test to communicate with the patient regarding the test results. Good medical practice would be to allow the practitioner time to review the test results and contact the patient before providing the test results to the patient.

FAQ3: Are there circumstances where access to reports may be denied to patients?

ANS3: Yes. Both Federal and State laws will continue to allow health care professionals to deny patients access to laboratory test results on the grounds that the access requested is reasonably likely to endanger the life or physical safety of the patient or another person.

FAQ4: Whom do I contact if I have further questions?

ANS4: For further clarification on this guidance, please contact Division of Laboratory Quality Certification at dlcqinfo@health.state.ny.us

EPH29 If a provider Adopted, Implemented or Upgraded (AIU) to a 2011 edition Certified EHR Technology (CEHRT), can the provider attest to AIU in Payment Year 2014 and beyond?

Published: 04/16/2014

Updated: 02/06/2015

No. For Payment Year 2014 and beyond, the Centers for Medicare and Medicaid Services (CMS) requires all eligible professionals (EP) or eligible hospitals (EH) to AIU to a 2014 Edition CEHRT. For the purposes of AIU, 2011 Edition CEHRT no longer meets the standards outlined in the Meaningful Use Stage 2 Final Rule.

Resources:

- ✓ [FAQ EPH05 Adopt, Implement Upgrade \(AIU\) Definition](#)
- ✓ [CMS Meaningful Use Stage 2 Final Rule](#)

EPH30 Our Hospital/Practice cannot meet 2014 Meaningful Use Stage 2 objectives in Payment Year 2014 as scheduled because we were unable to fully implement all of the functionality of 2014 edition CEHRT. Is it possible to attest to 2014 Meaningful Use Stage 1 objectives instead using 2014 edition CEHRT?

Published: 09/30/2014

Updated: 10/22/2014

Per the [CMS CEHRT Flexibility Final Rule](#), "providers who are scheduled to begin Stage 2 for the 2014 EHR reporting period but are unable to fully implement all the functions of their 2014 Edition CEHRT required for Stage 2 objectives and measures due to delays in 2014 Edition CEHRT availability would have the option of using 2014 Edition CEHRT to attest to the 2014 Stage 1 objectives and measures for the 2014 EHR reporting period. Providers who are scheduled to begin Stage 2 in 2014 who choose this option must attest that they are unable to fully implement 2014 Edition CEHRT because of issues related to 2014 Edition CEHRT availability delays when they attest to the meaningful use objectives and measures." (79 FR 29735)

Resources:

- ✓ [CMS Flexibility Final Rule Press Release](#)
- ✓ [CMS CEHRT Flexibility Final Rule](#)
- ✓ [CMS Meaningful Use Stage 2 Final Rule](#)

EPH31 Our Hospital/Practice cannot attest to 2014 Meaningful Use Stage 1 or Stage 2 objectives in Payment Year 2014 as scheduled because we are unable to fully implement 2014 edition CEHRT due to

issues related to 2014 edition CEHRT availability delays. Is it possible to still attest using 2011 edition CEHRT or a combination of 2011/2014 edition CEHRTs and what is the Centers for Medicare and Medicaid Services (CMS) plan going forward?

Published: 09/30/2014

Updated: 10/22/2014

Providers using 2011 Edition CEHRT or a combination of 2011/2014 Edition CEHRT scheduled to attest to 2014 Meaningful Use Stage 1 objectives in Payment Year 2014

The CMS has released a [CMS CEHRT Flexibility Final Rule](#) to allow eligible professionals (EPs) or eligible hospitals (EHs) that are unable to fully implement 2014 Edition CEHRT because of issues related to 2014 Edition CEHRT availability delays, for Payment Year 2014 only, to attest to 2011 or 2013 Meaningful Use Stage 1 requirements using 2011 Edition CEHRT or a combination of 2011/2014 Edition CEHRTs in place of attesting to 2014 Meaningful Use Stage 1. All EPs and EHs are required to use 2014 Edition CEHRT in 2015.

Providers using 2011 Edition CEHRT or a combination of 2011/2014 Edition CEHRT scheduled to attest to 2014 Meaningful Use Stage 2 objectives in Payment Year 2014

The CMS has released a [CMS CEHRT Flexibility Final Rule](#) to allow EPs or EHs that are unable to fully implement 2014 Edition CEHRT because of issues related to 2014 Edition CEHRT availability delays, for Payment Year 2014 only, to attest to 2011 or 2013 Meaningful Use Stage 1 requirements using 2011 Edition CEHRT or a combination of 2011/2014 Edition CEHRTs in place of attesting to Meaningful Use Stage 2. All EPs and EHs are required to use 2014 Edition CEHRT in 2015.

CMS CEHRT Flexibility Final Rule

For assistance and further details, the NY Medicaid EHR Incentive Program support service highly recommends that you review the [CMS CEHRT Flexibility Final Rule](#). The rule also finalizes the extension of Meaningful Use Stage 2 through 2016 for certain providers and announces the Stage 3 timeline, which will begin in 2017 for providers who first became meaningful EHR users in 2011 or 2012.

Resources:

- ✓ [CMS Flexibility Final Rule Press Release](#)
- ✓ [CMS CEHRT Flexibility Final Rule](#)
- ✓ [CMS Meaningful Use Stage 2 Final Rule](#)

EPH32 What supporting documentation does an Eligible Professional and Eligible Hospital need to save to support an audit of the Meaningful Use Public Health Measures and Objectives?

Published: 06/04/2015

Eligible Professionals and Eligible Hospitals should retain the source documentation used while attesting to the Medicaid EHR Incentive Program Public Health Measures and Objectives. If documentation was not retained, Eligible Professionals and Eligible Hospitals should reach out

to the specific Public Health Registry(s) that they completed their required measures and objectives with in order to obtain supporting documentation.

EPH33 May a provider report zero for a clinical quality measure (CQM)?

Published: 08/12/2015

Providers are strongly encouraged to report clinical quality measures (CQMs) that are relevant to their patient population. Zero is an acceptable result provided that this value was produced by certified EHR technology. It is recommended that providers either save the report or print a screenshot of the resulting calculation from their certified EHR in case they are subject to audit and must produce supporting documentation for their attestation values.

For further guidance, please refer to CMS FAQs 12356 and 10072.

EPH34 Can an authorized representative attest on behalf of a provider?

Published: 12/11/2015

Yes. A provider may authorize a representative to act as his/her agent for the attestation. At the minimum, a representative attesting on behalf of a provider must have a web user account in the [Identity and Access Management System](#) that is associated with the provider for whom he/she is attesting. The associated web user account must be on file prior to the attestation. Both the provider and authorized representative could be held personally responsible for all information in the attestation.