Question: What are the major changes to the EHR Incentive Program from the Inpatient Prospective Payment System Final Rule?

- For 2018, modified the meaningful use reporting period from the full year to a minimum of any continuous 90-day period during the calendar year
  - Made 2018 Meaningful Use measures the same as 2017 meaningful use measures and delayed planned threshold increases from 2018 to 2019
  - Specifically, the threshold for EP and hospital Objective 6 (Coordination of Care through Patient Engagement), Measures 1 and 2 are 5% in 2018 and will rise in 2019.
- For 2017, aligned CQM reporting to the Quality Payment Program for Medicare providers (see below)
- New Medicare Payment Adjustment Exceptions:
  - For EPs, eligible hospitals, and CAHs, that demonstrate through an application process, that compliance with the requirement for being a meaningful EHR user is not possible because their certified EHR technology has been decertified under ONC’s Health IT Certification Program.
  - For ambulatory surgical center (ASC)-based EPs and defining ASC-based EPs as those who furnish 75 percent or more of their covered professional services in an ASC, using Place of Service (POS) code 24 to identify services furnished in an ASC.
Question: What are providers options for using 2014 Edition CEHRT, a combination of 2014 and 2015 Edition CEHRT or 2015 Edition CEHRT in relation to their ability to attest to Modified Stage 2 or Stage 3 in 2017 and 2018?

Answer: See the below graphic.
**Question:** What are the new requirements for the number of CQMs providers must report and reporting period?

Answer: See the following graphic. Note that IPPS also removed the domain requirements for EPs, who may select any 6 CQMs relevant to their practice.

<table>
<thead>
<tr>
<th># of CQMs</th>
<th>Reporting Method</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 relevant to their practice of 53*</td>
<td><strong>Attestation</strong></td>
<td>16 of 16</td>
<td>TBD</td>
</tr>
<tr>
<td>4 of 16*</td>
<td><strong>Electronically</strong></td>
<td></td>
<td>16 of 16</td>
</tr>
<tr>
<td>90 days*</td>
<td><strong>Attestation</strong></td>
<td>four quarters (except first-time MUers)</td>
<td>TBD</td>
</tr>
<tr>
<td>one quarter*</td>
<td><strong>Electronically</strong></td>
<td></td>
<td>TBD</td>
</tr>
</tbody>
</table>

**Question:** The eCQM specifications are updated each year. Which year(s) specifications can/should a state accept from providers?

Answer: Vendors are not required to update CEHRT each year to the latest specifications in order to remain certified (for more information see [https://questions.cms.gov/faq.php?id=5005&faqld=8896](https://questions.cms.gov/faq.php?id=5005&faqld=8896) and [https://www.healthit.gov/policy-researchers-implementers/42-question-06-13-042](https://www.healthit.gov/policy-researchers-implementers/42-question-06-13-042)). Therefore, it is possible that providers will have CEHRT that produce eCQMs specified to variety of years. States should always be able to accept the most recent version for each eCQM, but must also allow providers to report on older versions (electronically or through attestation), if that is what their CEHRT is able to produce.
For example, CMS146 (Appropriate Testing for Children with Pharyngitis) was updated to version 5 with the 2017 updates. Because the earliest version of the eCQM that 2014 Edition CEHRT could be certified with is 2012 (CMS146v1), states must accept manual attestation from providers using 2014 Edition CEHRT who are able to produce CMS146v1-v5. Note that each of these versions has one numerator and one denominator and therefore the logic in the state's attestation system would not need to vary. States may, but are not required to, gather information from providers about which version of the eCQM their CEHRT produces and they are reporting. If a state is collecting eCQMs electronically, the state must be able to collect the latest version (CMS146v5) and may choose how many previous versions they wish to collect. For example, a state may decide that the previous two years of specifications will still provide useful data and therefore collect CMS146v3-5 electronically, but providers whose 2014 Edition CEHRT can only produce CMS146v1-2 would have to attest manually. Note that the earliest eCQM specifications that 2015 Edition CEHRT could have been certified to is 2016.

For more information:

- Fact Sheet
- Press Release
- Federal Register