in CY 2022 and subsequent years, the eligible hospital or CAH must attest that it did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology.

(ii) *Reporting clinical quality information.* Successfully report the clinical quality measures selected by CMS to CMS or the States, as applicable, in the form and manner specified by CMS or the States, as applicable.

(iii) [Reserved]

(iv) *Additional requirements for Medicaid eligible hospitals.* For Medicaid eligible hospitals if, in accordance with §§ 495.316 and 495.332, CMS has approved a State's revised definition for meaningful use, in addition to meeting paragraphs (b)(2)(i) through (iii) of this section, the eligible hospital must also demonstrate meeting the State's revised definition using the method approved by CMS.

(v) *Exception for Medicare EPs for 2012 and 2013—Participation in the Physician Quality Reporting System-Medicare EHR Incentive Pilot.* To satisfy the clinical quality measure reporting requirements of meaningful use, aside from attestation, an EP participating in the Physician Quality Reporting System may also participate in the Physician Quality Reporting System-Medicare EHR Incentive Pilot through one of the following methods:

(A) Submission of data extracted from the EP's certified EHR technology through a Physician Quality Reporting System qualified EHR data submission vendor; or

(B) Submission of data extracted from the EP's certified EHR technology, which must also be through a Physician Quality Reporting System qualified EHR.

(vi) *Exception for Medicare eligible hospitals and CAHs for FY 2012 and 2013—Participation in the Medicare EHR Incentive Program Electronic Reporting Pilot.* In order to satisfy the clinical quality measure reporting requirements of meaningful use, aside from attestation, a Medicare eligible hospital or CAH may participate in the Medicare EHR Incentive Program Electronic Reporting Pilot.

(vii) *Exception for dual-eligible eligible hospitals and CAHs beginning in CY 2019.* (A) Beginning with the EHR reporting period in CY 2019, dual-eligible eligible hospitals and CAHs (those that are eligible for an incentive payment under Medicare for meaningful use of CEHRT and/or subject to the Medicare payment reduction for failing to demonstrate meaningful use, and are also eligible to earn a Medicaid incentive payment for meaningful use) must satisfy the requirements under paragraph (b)(2) of this section by attestation and reporting information to CMS, not to their respective state Medicaid agency.

(B) Dual-eligible eligible hospitals and CAHs that demonstrate meaningful use to their state Medicaid agency may only qualify for an incentive payment under Medicaid and will not qualify for an incentive payment under Medicare and/or avoid the Medicare payment reduction.

(c) *Review of meaningful use.* (1) CMS (and in the case of Medicaid EPs and eligible hospitals, States) may review an EP, eligible hospital or CAH's demonstration of meaningful use.

(2) All EPs, eligible hospitals, and CAHs must keep documentation supporting their demonstration of meaningful use for 6 years.

[75 FR 44565, July 28, 2010. Redesignated at 80 FR 62943, Oct. 16, 2015]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 495.40, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.fdsys.gov.

§ 495.60 Participation requirements for EPs, eligible hospitals, and CAHs.

(a) An eligible hospital, CAH or EP must submit in a manner specified by CMS the following information in the first payment year:

(1) Name of the EP, eligible hospital or CAH.

(2) National Provider Identifier (NPI).

(3) Business address, business email address, and phone number.

(4) Such other information as specified by CMS.

(b) In addition to the information submitted under paragraph (a) of this section, an eligible hospital or CAH,

must, in the first payment year, submit in a manner specified by CMS its CMS Certification Number (CCN) and its Taxpayer Identification Number (TIN).

(c) Subject to paragraph (f) of this section, in addition to the information submitted under paragraph (a) of this section, an EP must submit in a manner specified by CMS, the Taxpayer Identification Number (TIN) which may be the EP's Social Security Number (SSN) to which the EP's incentive payment should be made.

(d) In the event the information specified in paragraphs (a) through (c) of this section as previously submitted to CMS is no longer accurate, the EP, eligible hospital or CAH must provide updated information to CMS or the State on a timely basis in the manner specified by CMS or the State.

(e) An EP that qualifies as both a Medicaid EP and Medicare EP—

(1) Must notify CMS in the manner specified by CMS as to whether he or she elects to participate in the Medicare or the Medicaid EHR incentive program;

(2) After receiving at least one EHR incentive payment, may switch between the two EHR incentive programs only one time, and only for a payment year before 2015;

(3) Must, for each payment year, meet all of the applicable requirements, including applicable patient volume requirements, for the program in which he or she chooses to participate (Medicare or Medicaid);

(4) Is limited to receiving, in total, the maximum payments the EP would receive under the Medicaid EHR program, as described in subpart D of this part; and

(5) Is placed in the payment year the EP would have been in had the EP begun in and remained in the program to which he or she has switched. For example, an EP that begins receiving Medicaid incentive payments in 2011, and then switches to the Medicare program for 2012, is in his or her second payment year in 2012.

(f) *Limitations on incentive payment reassignments.* (1) 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.

(2)(i) Assignments in Medicare must be consistent with Section 1842(b)(6)(A) of the Act and 42 CFR part 424 subpart F.

(ii) Medicaid EPs may also assign their incentive payments to a TIN for an entity promoting the adoption of EHR technology, consistent with subpart D of this part.

(3) Each EP may reassign the entire amount of the incentive payment to only one employer or entity.

[75 FR 44565, July 28, 2010, as amended at 77 FR 54157, Sept. 4, 2012. Redesignated at 80 FR 62943, Oct. 16, 2015]

Subpart B—Requirements Specific to the Medicare Program

§ 495.100 Definitions.

In this subpart unless otherwise indicated—

Covered professional services means (as specified in section 1848(k)(3) of the Act) services furnished by an EP for which payment is made under, or is based on, the Medicare physician fee schedule.

Eligible hospital means a hospital subject to the prospective payment system specified in § 412.1(a)(1) of this chapter, excluding those hospitals specified in § 412.23 of this chapter, excluding those hospital units specified in § 412.25 of this chapter, and including Puerto Rico eligible hospitals unless otherwise indicated.

Eligible professional (EP) means a physician as defined in section 1861(r) of the Act, which includes, with certain limitations, all of the following types of professionals:

(1) A doctor of medicine or osteopathy.

(2) A doctor of dental surgery or medicine.

(3) A doctor of podiatric medicine.

(4) A doctor of optometry.

(5) A chiropractor.

Geographic health professional shortage area (HPSA) means a geographic area that is designated by the Secretary under section 332(a)(1)(A) of the PHS Act as of December 31 of the year prior to the payment year as having a shortage of health professionals.