Below please find a list of common questions in regards to this new rule. These responses were culled from the comment section of the final rule published 9/4/2014.

**Q: What timing options do entities have for attesting in 2014?**
A: Regardless of the attestation option chosen by the entity (i.e. 2011 CEHRT, 2011/14 CERHT...), attestation must occur for a calendar quarter in 2014 (FY 2014 for EH/CAH). It is feasible for an entity to attest now, taking advantage of the flexibility offered through this NPRM, for a quarter that occurred earlier in 2014, such as January-March 2014. Note: Medicaid providers can attest for any continuous 90-day period.

**Q: What does ONC consider a “vendor delay”?**
A: Vendor delays include scenarios in which the vendor was not able to become certified and release the related modules to entities in time for a successful quarter of attestation. Issues arising during the implementation of the product also could be included in the term “vendor delay” as long as it still presented challenges to meeting the objectives. Potential scenarios that would be included in the issues category include software updates, patches to fix issues, situations where a problem in the software creates functionality issues or safety concerns, or when the software itself does not include all of the required components.

The final rule calls out certain scenarios that would NOT be considered a vendor delay. Those include:

- Entities that did not implement 2014 CEHRT due to financial issues.
- Inability to meet the Stage 2 MU measures for reasons outside of vendor delays (such as inability to meet measure thresholds due to inadequate planning at the entity level).
- Situations stemming from a provider’s inaction or delay in implementing 2014 CEHRT (i.e. financial issues, staff turn-over, late request of upgrade).

**Q: Implementing portals in conjunction with 2014 CEHRT is challenging. Does this count as a vendor delay?**
A: If your entity struggles with implementing portals due to issues related to your vendor (i.e. timing of receipt from vendor, vendor issues in pushing data to the portal, etc.), these may count as a vendor delay. If your entity chose to delay implementation because of workload issues, this would not count as a delay based on the ONC’s guidance of what constitutes a delay.

**Q: What if the providers in my community are not on 2014 CEHRT or are experiencing a vendor delay, and that impedes my ability to complete the transition of care measure item #2?**
A: If an entity has successfully implemented 2014 CEHRT and is attempting to meet the Stage 2 Meaningful Use measures, but the providers in whom the entity commonly transitions their patients can’t receive the document electronically due to the unavailability of 2014 CEHRT, an exception may be
available. This, however, does not pertain to entities struggling because the providers they transition to do not own any CEHRT. In this scenario, the sending entity with 2014 CEHRT could attest to Stage 1 2014 MU since they are affected by another entity’s lack of available 2014 CEHRT. Note: The referring provider will need to maintain adequate documentation clearly demonstrating their inability to reach the 10% threshold.

Q: If an organization takes advantage of this flexibility in 2014, what impact does that have on their 2015 attestation?
A: Entities who use the flexibility of the NPRM in 2014 will continue on their previously scheduled attestation timing. For instance, if a provider is attesting to Stage 1, Year 1 in 2014, he/she will do 365-days of Stage 1, Year 2 in 2015. If a provider was supposed to attest to Stage 2 in 2014, but takes advantage of the flexibility and attests to Stage 1, he/she will be required to attest to 365-days of Stage 2 in 2015.

Q: What software version will I need in 2015 and how long will my reporting period be?
A: In 2015, all entities are required to be on 2014 CEHRT and must attest to 365-days of Meaningful Use. The only exception is first-time attesters who only need to submit for a 90-day reporting period.

Q: If my entity opts to attest to a previous stage of Meaningful Use, how does that impact my public health measures?
A: Entities who attest to Stage 1 Meaningful Use in 2014 under this rule and have previously submitted a test message to a public health agency in a previous EHR reporting period are not required to submit another test message to meet the public health measure for 2014.

Q: What type of documentation should I save if I use the 2014 NPRM flexibility?
A: Maintain written documentation explaining your situation. The ONC will instruct auditors to work closely with providers on the necessary supporting documentation applicable to the provider’s individual case.

Q: Does an organization need 2014 CEHRT to complete Medicaid adopt/implement/upgrade (AIU) in 2014?
A: Yes, only 2014 CEHRT will be acceptable for providers completing the AIU process in 2014 or 2015.

Q: Will attesting to an earlier stage of Meaningful Use impact my incentives?
A: No. Incentives are paid for each year that a provider/entity successfully attests and will not be directly tied to the stage that was attested for. See chart below for the updated payment schedule for Eligible Professionals as an example.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1 or 2*</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>2012</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1 or 2*</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>2013</td>
<td>1*</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>1*</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>TBD</td>
<td>TBD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>TBD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*3-month quarter EHR reporting period for Medicare and continuous 90-day EHR reporting period (or 3 months at State option) for Medicaid EPs. All providers in their first year in 2014 use any continuous 90-day EHR reporting period.