On September 4, 2012, the Centers for Medicare & Medicaid Services (CMS) published a Final Rule which specifies the Stage 2 meaningful use criteria that eligible professionals (EPs), eligible hospitals (EHs), and critical access hospitals (CAHs) must meet in order to continue to participate in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. As part of the Stage 2 Final Rule, some changes to Stage 1 were also included. Some of the Stage 1 changes are effective in 2013; others are effective in 2014 and only optional in 2013.

Below are summaries of 2013 changes to the Texas Medicaid EHR Incentive Program.

Changes Effective in 2013 – Policies:

1. Expanded definition of patient encounter: Encounters will now include any service rendered on any one day to an individual enrolled in a Medicaid program. This may include certain **"zero pay" or denied claims**. For example, a claim that was denied because of late filing on behalf of the provider could still count toward the provider's total Medicaid volume. A claim that was denied because the patient was not enrolled in Medicaid at the time of service would not count toward the provider's Medicaid volume.

2. Patient volume look-back period: In the calculation of Medicaid patient volume, the EP or EH can choose a 90-day period **in the last 12 months immediately preceding attestation**. They can also use the previous method, which is using a 90-day period in the last calendar year (for EPs) or federal fiscal year (for EHs).

   This change also applies to FQHCs and RHCs as they calculate Needy Individual patient volume.

   For EPs using the panel methodology to calculate patient volume, you can include any Medicaid panel members with at least one Medicaid encounter taking place in the 24 months prior to the 90-day period (expanded from 12 months prior).

3. Use of certified EHR technology in at least one practice location: At least one of the clinical locations used for the calculation of an EP's Medicaid patient volume must have certified EHR technology during the *payment year* for which the EP is attesting to AIU or Meaningful Use.

4. FQHC / RHC "Practices Predominantly" definition: The current definition requires an EP enrolling for incentives as a provider at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) to have more than 50% of his/her total encounters at an FQHC / RHC in a six-month period *in the most recent calendar year*. The new policy allows for an additional option – EPs can use *the most recent 12 months prior to attestation to determine his/her "practices predominantly" status*.

Changes Effective in 2013 – Meaningful Use and Clinical Quality Measures:

Stage 1 Measure	Changes	Effective Year (CY/FY)
CPOE: Use CPOE (Computerized Provider Order Entry) for medication orders	Change: Addition of an alternative denominator. Current Measure: More than 30 percent of unique patients with at least one medication in their medication list. **New Measure:** More than 30 percent of **medication orders created by the EP or authorized providers** of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.	2013 (Stage 1 – use either measure) (Stage 2 – required to use new measure)
E-Prescribing: Generate and transmit >40 percent of permissible prescriptions electronically (eRx)	Change: Addition of an additional exclusion. Current: Exclusion for any EP who writes fewer than 100 prescriptions during the EHR reporting period. **New Exclusion:** Any EP who: does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period.	2013 – Both exclusions are available
Vital Signs Measure: Record and chart changes in vital signs	Change: Age Limitations on Growth Charts and Blood Pressure. Current: Applies to patients age 2 and over. **New Measure:** More than 50 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department during the EHR reporting period have blood pressure (**for patients age 3 and over only**) and height and weight (**for all ages**) recorded as structured data.	2013 – Optional 2014 – Required
Vital Signs Exclusion: Record and chart changes in vital signs	Change: Changing the age and splitting the EP exclusion. **New Exclusions:** Any EP who: (1) Sees no patients 3 years or older (excluded from recording blood pressure); (2) Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice (the EP would not record any vital signs); (3) Believes that height and weight are relevant to their scope of practice, but blood pressure is not (EP would not have to record blood pressure); or (4) Believes that blood pressure is relevant to their scope of practice, but height and weight are not (the EP would not have to record height and weight).	2013 – Optional 2014 – Required

Stage 1 Measure	Changes	Effective Year (CY/FY)
Public Health Objectives	Change: Same requirement but addition of "except where prohibited" to the objective regulation text for the public health objectives under § 495.6. Applies to immunization, syndromic surveillance, and lab reporting measures. Therefore, if providers are authorized to submit the data, they should do so even if it is not required by either law or practice.	2013 – Required
Electronic Exchange of Key Clinical Information: Capability to exchange key clinical information (for example, problem list, medication list, etc.) electronically among providers of care and patient authorized entities	Change: Objective is no longer required. Stage 2 will include an objective for providing a summary of care record following a transition of care or referral.	2013 – Measure no longer required in Stage 1 Stage 2 – new objective (summary of care record)
Clinical Quality Measures: Report ambulatory / hospital clinical quality measures to CMS or the State	Change: Objective is incorporated directly into the definition of a meaningful EHR user and eliminated as an objective.	2013 – Objective removed

Changes Effective in 2014:

There are some changes that will not be implemented until 2014 (even in an optional format):

1. Exclusions for Menu Objectives: Providers will no longer be permitted to count an exclusion toward the minimum of 5 menu objectives on which they must report if there are other menu objectives which they can select. In other words, a provider cannot select a menu objective and claim an exclusion for it if there are other menu objectives they can meet. They will not be penalized for claiming an exclusion if they would also qualify for the exclusions for all the remaining menu objectives.

2. Providing patients with electronic copy of and electronic access to health information: These measures will be replaced in 2014 with a new comprehensive measure. No change in 2013.

Additional Resources:

To learn more about the program and how to participate, visit www.texasehrincentives.com for a user-friendly e-learning tool, and http://www.tmhp.com/Pages/HealthIT/HIT_Home.aspx for the latest program news and resource documents.

For additional assistance on this and other aspects of the Texas Medicaid EHR Incentive Program, email HealthIT@tmhp.com or call the Contact Center at 1-800-925-9126 (option 4).