

2013 Changes for **Eligible Hospitals**

These changes affect enrollments received on or after January 1, 2013:

Eligibility

- ❖ Patient volume will be calculated for either a three-month or 90-day period going back 12 months from the date of attestation. Previously this was based on a 90-day period in the previous Federal Fiscal Year.
- ❖ Patient volume can now include CHIP expansion programs. This is called Kids Connection in Nebraska. As there are still some Medicaid programs which cannot be included in the Medicaid encounters for the EHR Incentive Program, DHHS will continue to help providers with the allowable Medicaid encounters. Previously, encounters for services paid under the Kids Connection program were excluded.
- ❖ A Medicaid encounter can now be counted if the patient is enrolled in the state's Medicaid program (either through fee-for-service or managed care) at the time of service without the requirement of Medicaid payment liability. This would include a service where Medicare and/or insurance paid more than the Medicaid allowable so Medicaid paid zero or services that might not have been reimbursed by Medicaid (such as oral health services for adults). Previously only encounters where Medicaid paid greater than zero were included.
- ❖ The hospital base year will now be determined using the most recent continuous 12-month period for which data are available prior to the payment year. Previously, the base year was determined by the hospital fiscal year which ended in the federal fiscal year prior to the payment year. This change only affects hospitals whose first participation year is 2013 or later. For hospitals who attested in 2012, this will not change the calculation of the Year 2 and Year 3 payments.

Meaningful Use

- ❖ Stage 2 will not start until 2014 at the earliest. If a dually-eligible hospital started in 2011 with Medicare, they will remain in Stage 1 through 2013. All other hospitals will be in Stage 1 for two years before going into Stage 2.
- ❖ A new alternate measure is allowed for Computerized Provider Order Entry (CPOE) core measure. The current measure for CPOE is based on the number of unique patients with a medication in their medication list that was entered using CPOE. The new alternate measure is based on the total number of medication orders created during the EHR reporting period. An EH may select either measure for this objective in Stage 1.
- ❖ A new optional measure is being added for recording and charting vital signs. The current measure specified that vital signs must be recorded for more than 50% of all unique patients **ages 2 and over**. The new measure amends that age limit to recording blood pressure **ages 3 and over** and height and weight for patients of **all ages**. This measure is optional with 2013, but will be required in 2014 and beyond.
- ❖ The objective for electronic exchange of key clinical information will no longer be required for Stage 1. A more robust requirement for electronic health information exchange will be part of the Stage 2 objective.
- ❖ There will no longer be a separate objective for reporting ambulatory or hospital clinical quality measures (CQM). It is still a requirement that CQMs be reported, but the stand-alone objective is being removed since it is redundant.