Medi-Cal
Electronic Health Record
INCENTIVE PROGRAM

Changes to the Medi-Cal EHR Incentive Program in 2013

In response to recent changes in regulations issued by the Centers for Medicare and Medicaid Services (CMS), the Department of Health Care Services (DHCS) has made changes to the Medi-Cal EHR Incentive Program for the 2013 program year. Most changes are mandatory but some changes have been made as state options. This statement delineates the changes that DHCS has implemented or plans to implement for the Medi-Cal EHR Incentive Program in 2013.

Changes Affecting Eligibility

- **Definition of Medicaid Encounter**. Effective January 1, 2013 providers may count "billable" services provided to Medi-Cal-enrolled patients as Medicaid encounters regardless of whether Medicaid paid for any portion of the services. To be considered "billable" the services must be covered by Medi-Cal. Providers rendering services to Medi-Cal-enrolled patients, regardless of whether they are approved by Medi-Cal as fee-for-service or managed care providers, may be eligible for Medi-Cal EHR Incentive Program payments. Medicaid encounters must still constitute at least 30% (or 20% in the case of pediatricians) of total encounters.
- **Healthy Families**. Beginning January 1, 2013 patients in California's Healthy Families program will begin transitioning to enrollment in Medi-Cal. After patients transition to Medi-Cal their encounters will count as Medi-Cal encounters for the purposes of the Medi-Cal EHR Incentive Program. Because of the requirement that the 90-day representative period must occur in the prior calendar year, these encounters will begin to assist providers and hospitals become eligible for the program in 2014. Encounters for a patient before transitioning to Medi-Cal cannot be counted retrospectively as Medi-Cal encounters. More specific information on how to count Healthy Families encounters will be issued by DHCS in the future as more details of the program transition become available.
- **Waiver of Hospital-Based Exclusion.** Beginning in 2013 providers will be able to apply for a waiver of the rule that prohibits providers from participating in EHR incentive programs if 90% or more of their professional services are delivered in an inpatient hospital or emergency room setting. To qualify for this waiver, providers will be required to upload documentation into the State Level Registry demonstrating that they have personally funded the acquisition, installation, and maintenance of hardware and certified EHR technology software that they use in the inpatient or emergency room setting. It is anticipated that the State Level Registry will have the ability to accept applications for this waiver beginning April 1, 2013. Providers needing to use this waiver in 2013 should wait to apply until the State Level Registry has the ability to accept the application.
- **Definition of Active Panel Patient.** Beginning January 1, 2013 panel patients only need to have been treated once in the 24 month period prior to the 90-day representative period. Previously they needed to have been seen at least once in the 12 month period prior to the 90-day representative period.
- **Definition of Practicing Predominantly.** Beginning January 1, 2013 providers can be considered to practice predominantly in an FQHC or RHC if 50% or more of their professional services were delivered in an FQHC or RHC during a 6 month period either in the previous calendar year or the 12 months prior to attestation. Previously the practicing predominantly look-back period was restricted to the previous calendar year.

- **Definition of Hospital Base Year**. Effective January 1, 2013 newly applying hospitals should use as their base year the most recent 12 month period prior to the payment year for which data is available. This replaces the prior requirement to use as the base year the hospital fiscal year that ends in the federal fiscal year prior to the federal fiscal year that serves as the payment year.
- **Definition of PA-led.** In order for physician assistants (PAs) to be eligible for the program, the FQHC or RHC in which they practice must be considered "PA-led" for the entire day that the PA submitted the attestation into the State Level Registry. Previously the clinic had been required also to be "PA-led" for at least 25% of the time during the previous 12 months. The requirement for the previous 12 months has been removed.
- **Representative Period Look-Back Period**. DHCS has decided not to exercise the option to expand the look back period for the 90-day representative period to include the most recent 12 months prior to attestation. The 90-day representative period must continue to occur only in the prior calendar year (for providers) and the prior federal fiscal year (for hospitals).

Changes Affecting Meaningful Use

CMS requires a number of changes to meaningful use measures in 2013. These changes will make it easier for providers and hospitals to achieve meaningful use. Because these changes require reprogramming the State Level Registry, DHCS will not be able to implement these changes until April 1, 2013. Providers and hospitals that will not be able to achieve meaningful use without these changes should wait to apply for 2013 until they are implemented in the State Level Registry.

- **Hospital CQM exemptions.** Hospitals will be exempt from reporting on any CQMs for which they have 5 or fewer patients in the denominator for a 90-day reporting period or 20 or fewer patients in the denominator for a one year reporting period.
- **CPOE Entered by CMA.** A credentialed medical assistant (CMA) will be considered a "licensed health care professional" for purpose of computerized provider order entry (CPOE). The CMA must still adhere to State, local and professional guidelines regarding order entry. CMA credentialing must be obtained from an organization other than the employing organization.
- **CPOE New Alternate Measure**: Providers will be able to satisfy the CPOE requirement if more than 30% of the medication orders created by the provider during the meaningful use reporting period are recorded using CPOE.
- **Generate & Transmit eRx New Exclusion.** Providers and hospitals will be excluded from reporting this measure if during the meaningful use reporting period no pharmacy existed within the organization and there was no pharmacy within 10 miles that accepted electronic submissions**.**
- **Electronic Transmission of Clinical Information.** Reporting on this measure will no longer be required or supported by the State Level Registry.
- **Report Clinical Quality Measures (CQMs).** This measure will be removed from core objectives, although reporting of CQMs will still be required.
- **Vital Signs New Alternate Measure**. Providers and hospitals will be able to use a new alternate measure:

  More than 50 percent of all unique patients seen by the provider or treated in the hospital during the MU reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data.
- **Vital Signs New Exclusion**. A provider will be excluded from reporting all or part of the new vital signs measure as follows:

  (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--excluded from recording any aspect of this measure;

(3) believes that height and weight are relevant to their scope of practice, but blood pressure is not--excluded from reporting blood pressure;
(4) believes that blood pressure is relevant to their scope of practice, but height and weight are not--excluded from reporting height and weight.

- **Public Health Objectives: Reporting of Immunizations, Syndromic Surveillance, and Lab Results.** The language “according to applicable law and practice” will be added to these measures.