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Health Care Access for All

The Latest on Meaningful Use

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Andie Martinez Patterson, MPP
Assistant Director of Policy
California Primary Care Association

Big Picture

Background

Why?

- The Medicare and Medicaid EHR incentive programs will provide incentive payments to eligible professionals and eligible hospitals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

- These incentive programs are designed to support providers in this period of Health IT transition and instill the use of EHRs in meaningful ways to help our nation to improve the quality, safety and efficiency of patient health care.

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Federal Chain of Command

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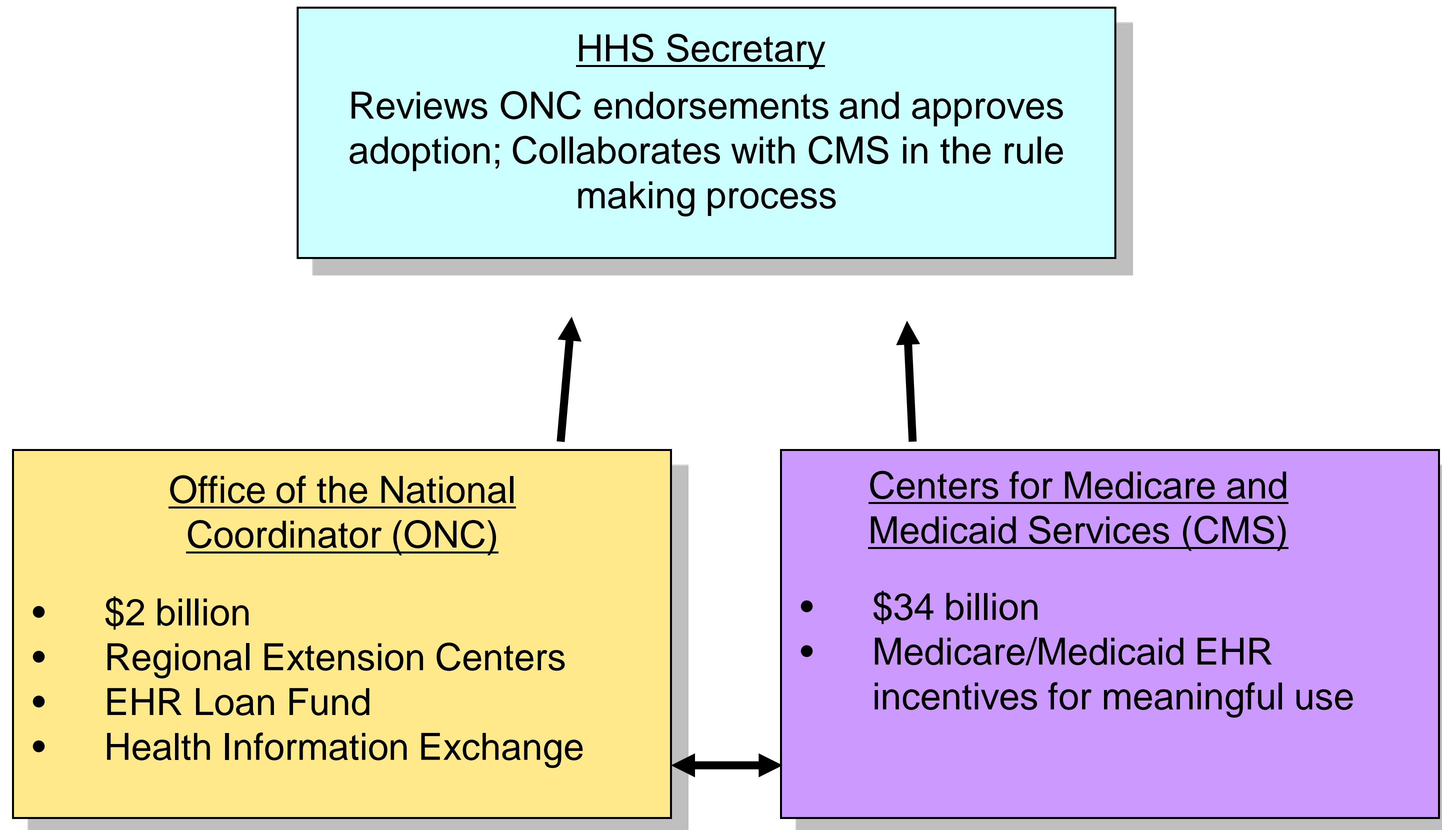
What the HITECH Act funded…..



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Federal to State to Provider Flow of Funds

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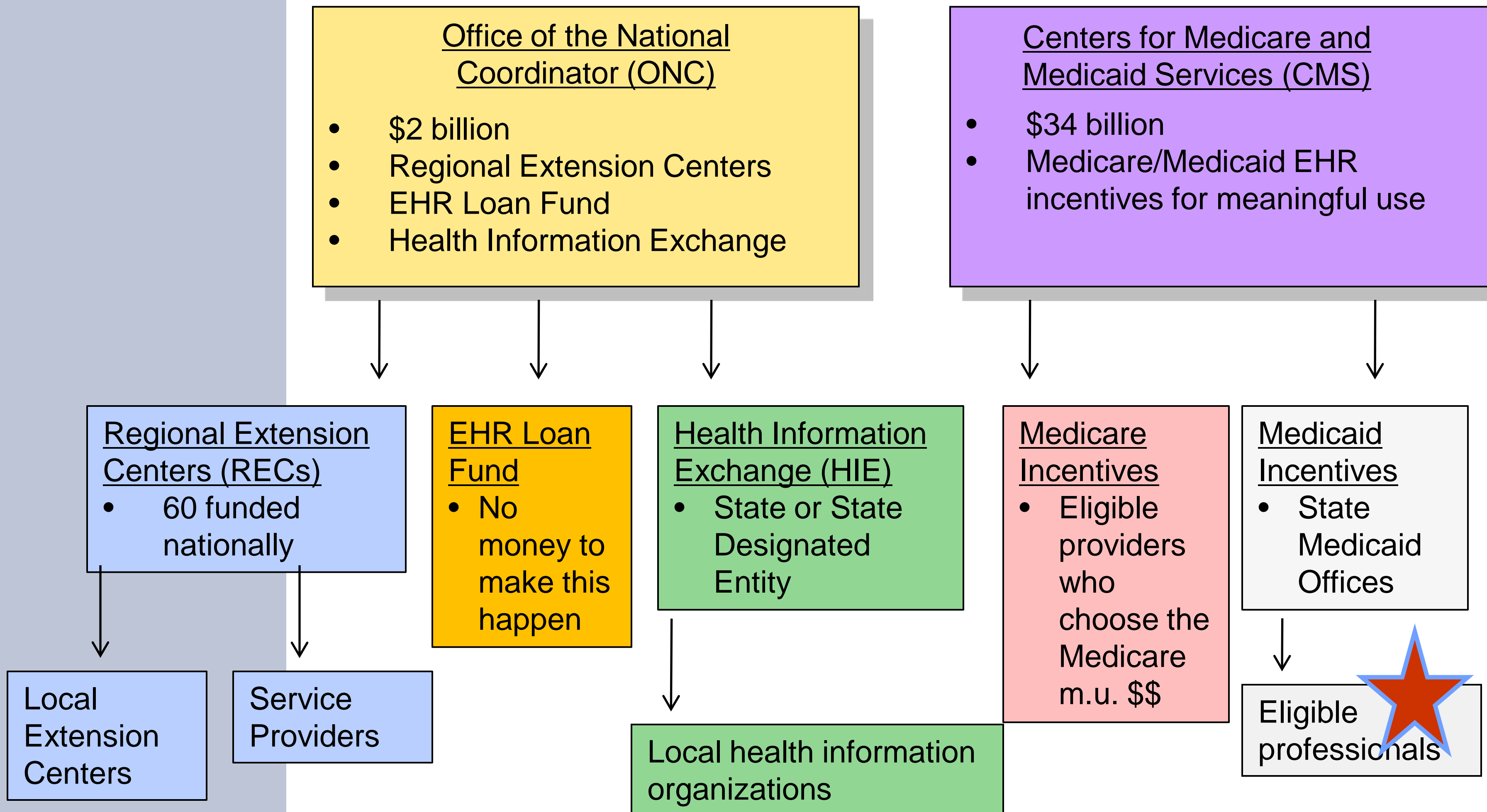

The Details on Eligibility

Certified EHR

Is your EHR certified? Find out by visiting

http://onc-chpl.force.com/ehrcert

Certified EHR

- NO Electronic Dental Records are certified, because there are no standards to certify them against.
- Non-certified technology can interface with a certified EHR. The only requirement is that the meaningful use reporting is done out of the certified EHR.

What about dentists?

Concerns

- While the dentists qualify, there are no standards crafted for EDRs so certification bodies can’t certify EDR products.
- There are no oral health measures.

- Dentists can participate in year one A/I/U with a clinic/group practice that has a certified EHR.
- Year two is tricky because a dentist must use a certified EHR.

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Eligible Professionals in the Medicaid Program

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<u>Hospital Based:</u> 90% or more of the provider's services are provided in an inpatient hospital or emergency room hospital setting.

Who are Eligible Professionals?

Non-hospital based

In some states

- Physicians (MD, DO, or Optometrist)
- Dentists (DDS or DMD)
- Certified nurse-midwives
- Nurse practitioners
- Physician assistants (PAs) who are practicing in a Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs) led by a physician assistant:

Eligible Professionals in the Medicaid Program

Physician Assistant Led

Physician assistants (PAs) who are practicing in a Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs) led by a physician assistant:

- When a PA is the primary provider in the clinic
  - It counts if the PA providing more encounters or spending more time at the site than the physician with the next most encounters or hours.
- When a PA is a clinical or medical director at the clinical site of practice
- When a PA is an owner of a RHC

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Eligible Professionals in the Medicaid Program

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Who are Eligible Professionals?

1. Who have at least 30% of their encounters attributable to Medicaid, or
   - Pediatricians have a benchmark of 20% of their encounters attributable to Medicaid
2. Who practices predominantly at an FQHC or RHC and has at least 30% of their encounters attributable to “needy” individuals.

- Patient encounters counted over any continuous 90-day period within the most recent calendar year prior to reporting.

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Eligible Professionals in the Medicaid Program

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Who are Eligible Professionals?

- Needy: Medicaid, CHIP, uncompensated care, sliding fee scale.

- Practices Predominantly- Clinical location for over 50 percent of his/her patient encounters over a period of 6 months in the most recent calendar year occurs at the FQHC or RHC.

- Full or part-time status is not relevant, its about percentage of encounters.

Group Practice Eligibility

Criteria to meet group practice eligibility

CMS will allow providers to use their clinic’ s Medicaid patient volume (or needy individual patient volume, insofar as it applies) as proxy for their own under the following conditions:

1. The clinic or group practice’s patient volume is appropriate as a patient volume methodology calculation for the EP (i.e. if an EP only sees Medicare, commercial or self-pay patients this is not an appropriate calculation).
2. There is an auditable data source to support the clinic’s or group practice’s patient volume determination.

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Group Practice Eligibility

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Criteria to meet group practice eligibility

3. All EPs in the group practice or clinic must use the same methodology for the payment year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data). The clinic or group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way. If an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the EP's outside encounters.

Group Practice Eligibility

Things to consider:

3. *All EPs in the group practice or clinic must use the same methodology for the payment year.*
    - If you are an FQHC, and you want to use the 30% needy criteria, only the EPs that practice predominantly can be part of the group.
    - Any group (including an FQHC) can use 30% Medicaid
    - If some of your providers use the clinic patient volume as a proxy then all of them have to . But a provider can choose which group to be associated with without hurting the other group (s)he is associated with.

Group Practice Eligibility

Things to consider: IN CALIFORNIA

3. *All EPs in the group practice or clinic must use the same methodology for the payment year.*
   - If you choose group practice, you will have to add all the EPs you are including in your group. You cannot delete an EP once added (at least not easily).
   - If an EP you add to your group goes and applies on his/her own, it will eliminate your clinic's ability from applying with group practice.

Group Practice Eligibility

More details on using group as a proxy can be found at the CMS Q and A site:

http://questions.cms.hhs.gov/app/answers/detail/a_id/10362/p/21

Encounter Definition

Definition of Encounter (30% Medicaid)

CMS has allowed the following to be considered Medicaid encounters:

1) Services rendered on any one day to an individual where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid for part or all of the service; or

2) Services rendered on any one day to an individual for where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid all or part of their premiums, co-payments, and/or cost-sharing.

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Encounter Definition

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Definition of Encounter (30% Needy)

CMS has allowed the following to be considered needy patient encounters:

1) Services rendered on any one day to an individual where Medicaid or CHIP or a Medicaid or CHIP demonstration project under section 1115 of the Act paid for part or all of the service;

2) Services rendered on any one day to an individual where Medicaid or CHIP or a Medicaid or CHIP demonstration project under section 1115 of the Act paid all or part of their premiums, co-payments, and/or cost-sharing; or

3) Services rendered to an individual on any one day on a sliding scale or that were uncompensated.

Formulas

Individual EP (over 90 day time period in previous CY)

- If the EP practices predominantly then (s)he can use 30% needy at the organization.
  - [needy encounters at FQHC/ total encounters at FQHC]

  OR
  - [needy encounters at FQHC + Medi-Cal managed care panel members seen / total encounters at FQHC + Medi-Cal managed care panel members assigned]

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Formulas

Health Care Access for All

Individual EP (over 90 day time period in previous CY)

- If the EP does not practice predominantly the EP must look across his/her entire patient panel at all places of practice and meet the 30% Medicaid encounter rate.
  - [Medicaid encounters across all organizations / total encounters across all organizations]

  OR
  - [Medicaid encounters across all organizations + Medicaid managed care panel members seen / total encounters across all organizations + Medicaid managed care panel members assigned]

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Formulas

Health Care Access for All

Group (over 90 day time period in previous CY)

- The FQHC can choose to use group practice eligibility with 30% needy for the EPs that practice predominantly.
  - o [needy encounters at FQHC/ total encounters at FQHC]

  OR

  - o [needy encounters at FQHC + Medicaid managed care panel members seen/ total encounters at FQHC + Medicaid managed care panel members assigned]

Formulas

Group (over 90 day time period in previous CY)

- The FQHC can choose to use group practice eligibility with 30% Medicaid eligibility, and could include more than just the EPs that practice predominantly.
  - [Medicaid encounters / total encounters]

  OR
  - [Medicaid encounters + Medicaid managed care panel members seen / total encounters + Medicaid managed care panel members assigned]

Medicaid Incentive Payments

Incentive Payments

- Eligible professionals can receive a maximum of $63,750 from the EHR incentive program over 6 payment years.
- Must start the program between 2011 and 2016.
- Based on a 100% scale: CMS pays 85% and EP or EP's employer contributes 15%.
  - EPs cannot receive more than 85% of $25,000 ($21,250) in payment year 1, and 85% of $10,000 ($8,500) in the five subsequent payment years.

Medicaid Incentive Payments

Incentive Payments

- Or if the EP is a pediatrician 85% of $16,667 ($14,167) in payment year 1, and 85% of $6,667 or ($5,667) in the five subsequent payment years.

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Medicaid Incentive Payments

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Incentive Payments

- Changes to "net average allowable costs" in Medicare and Medicaid Extenders Act of 2010
- The new changes allow CMS to estimate the average payment that Medicaid providers will receive from other (non-governmental) sources. Each provider will use the average amount established by CMS.
- Under the change, as long as the State can verify that no more than 85% of the net average allowable cost was paid to the provider as an incentive payment, a provider is determined to have met the remaining 15% of the cost.

Medicaid Incentive Payments for Adoption/Implementation/Upgrade of Certified EHR

$21,250 = 85% of $25,000
$8,500 = 85% of $10,000

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total
2011	$21,250	$8,500	$8,500	$8,500	$8,500	$8,500	$0	$0	$0	$0	$0	$63,750
2012		$21,250	$8,500	$8,500	$8,500	$8,500	$8,500	$0	$0	$0	$0	$63,750
2013			$21,250	$8,500	$8,500	$8,500	$8,500	$8,500	$0	$0	$0	$63,750
2014				$21,250	$8,500	$8,500	$8,500	$8,500	$8,500	$0	$0	$63,750
2015					$21,250	$8,500	$8,500	$8,500	$8,500	$8,500	$0	$63,750
2016						$21,250	$8,500	$8,500	$8,500	$8,500	$8,500	$63,750

Registering for the Incentives

- There are two steps: National and State registration
  - National: Centers for Medicare and Medicaid Services
  - State
    - California expects to be live April 1
    - State's must have CMS approve their State Medicaid HIT Plans (SMHPs) and their Implementation and Advanced Planning Document (IAPD) before they go live
- The national side must be done first

Registering for the Incentives

- A clinic/practice can register as a group on the state side, not on CMS side (yet)
- All EPs must have their own accounts, even if the clinic/practice applies as a group
- EPs must sign an attestation form at the end, even if the clinic/practice registers on his/her behalf

Registering for the Incentives

CMS Portal

The following information will be required:

- Username/password of provider for NPPES
- Name of EP
- Medicare or Medicaid Program
- State of participation
- Participation Year
- National Provider Identifier (NPI)
- Certified EHR information

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Registering for the Incentives

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CMS Portal

- Taxpayer Identification Number (TIN), which can be the clinic or FQHCs
  - 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.
  - An EP may reassign the entire amount of the incentive payment to only one employer or entity.

Registering for the Incentives

State Portal

The following information will be required:

- License number
- Information on provider practice if in multiple states
- Medicaid or needy encounter data
- Total encounter data
- FQHC or RHC Practice information (if choosing to use needy encounter data)
- Specialty
- Contact name, phone number and email address

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Attestation

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In the first year of payment an EP must choose to

1. Attest to Adopting/implementing/upgrading an EHR

- Only this option available now

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Attestation to A / I / U

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All will require supporting documentation

- Adopting: acquire, purchase or secure access to certified EHR technology (signed contract counts)
- Implementing: install or commence utilization of certified EHR technology capable of meeting meaningful use requirements
- Upgrading: expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria.

Things to consider for next payment year

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Meaningful Use Stages

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Payment Year	Payment Year				
	2011	2012	2013	2014	2015
2011	Stage 1	Stage 1	Stage 2	Stage 2	TBD
2012		Stage 1	Stage 1	Stage 2	TBD
2013			Stage 1	Stage 1	TBD
2014				Stage 1	TBD

A meaningful user

EP eligibility

- EPs register once, but must apply and meet the eligibility criteria every year
- For an EP to be a meaningful user, the EP must have 50% or more of his/her patient encounters during the EHR reporting period at a practice(s)/location(s) equipped with certified EHR.
- Reporting is by EP NPI

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Questions?

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Andie Martinez Patterson, MPP

Assistant Director of Policy

California Primary Care Association

amartinez@cpca.org

916-440-8170