



The Latest on Meaningful Use

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

Certified EHR

Health Care Access for All

- In order to receive incentive payments the eligible professional must use certified EHR technology.
- Certification is defined by the Office of the National Coordinator (ONC) and is required in the HITECH Act.
- The ONC approved a number of entities to certify EHR technology:
 - CCHIT
 - Drummond Group Inc.
 - InfoGuard
 - Sure Scripts, and more...

Certified EHR

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- 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.

Certified EHR

Health Care Access for All

Is your EHR certified? Find out by visiting

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

Eligible Professionals in the Medicaid Program

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Hospital Based: 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

- 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:
 - 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

In California

Eligible Professionals in the Medicaid Program

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Physician Assistant Led

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

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- When a PA is an owner of a RHC

Eligible Professionals in the Medicaid Program

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Who are Eligible Professionals?

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

Eligible Professionals in the Medicaid Program

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Who are Eligible Professionals?

- Needy: Medi-Cal, Healthy Families, 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.
- Patient encounters counted over any continuous 90-day period within the most recent calendar year prior to reporting.

Group Practice Eligibility

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Criteria to meet group practice eligibility

CMS will allow clinics and group practices to use the clinic Medicaid patient volume (or need individual patient volume, insofar as it applies) and apply it to all EPs in their practice 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. the clinic doesn't have some EPs only serving Medicare patients).
2. There is an auditable data source to support the clinic's or group practice's patient volume determination.

Group Practice Eligibility

Health Care Access for All

Criteria to meet group practice eligibility

3. All EPs in the group practice or clinic must use the same methodology for the payment year.
4. The clinic or group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way.
5. 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 EPs outside encounters.

Group Practice Eligibility

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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% Medi-Cal
 - **It's ALL or NOTHING**, i.e. all the EPs do the group practice or none of the EPs do the group practice

Group Practice Eligibility

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Things to consider:

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.

Individual EP

- 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]

Individual EP

- 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% Medi-cal encounter rate.
 - [Medi-cal encounters across all organizations / total encounters across all organizations]
 - OR
 - [Medi-cal encounters across all organizations + Medi-Cal managed care panel members seen / total encounters across all organizations + Medi-Cal managed care panel members assigned]

Formulas

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Group

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

Group

- The FQHC can choose to use group practice eligibility with 30% Medi-Cal eligibility, and could include more than just the EPs that practice predominantly.
 - [Medi-cal encounters / total encounters]
- OR
 - [Medi-cal encounters + Medi-Cal managed care panel members seen / total encounters + Medi-Cal managed care panel members assigned]

Medicaid Incentive Payments

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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

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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.
- Allowable cost items for the 15% match include:
 - hardware, software, training, bandwidth, design services, workflow, loss of productivity, other

Medicaid Incentive Payments

Health Care Access for All

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 providers 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 and Meaningful Use 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

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- There are two steps: National Level Registry (NLR) and State Level Registry (SLR)
 - NLR- Centers for Medicare and Medicaid Services
 - SLR- Department of Health Care Services, California Department of Health and Human Services
- The NLR must be done first

Registering for the Incentives

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- A clinic or group can register as a group on the SLR, not on the NLR
- All EPs must have their own accounts, even if the clinic applies as a group
- EPs must sign an attestation form at the end, even if the clinic registers on his/her behalf

Registering for the Incentives

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National level registry (NLR)

The following information will be required:

- Name of EP
- Medicare or Medicaid Program
- State of participation
- Participation Year
- National Provider Identifier (NPI)

Registering for the Incentives

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National level registry (NLR)

- 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

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National level registry (NLR)

- Payee National Provider Identifier (NPI) if the EP is reassigning the payment.
- Certified EHR information

Registering for the Incentives

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State level registry (SLR)

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 address²⁶

Attestation

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In the first year of payment an EP must choose to either

1. Attest to Adopting/implementing/upgrading an EHR
2. Attest to achieving the meaningful use objectives and clinical measures over a continuous 90 day period within a calendar year.

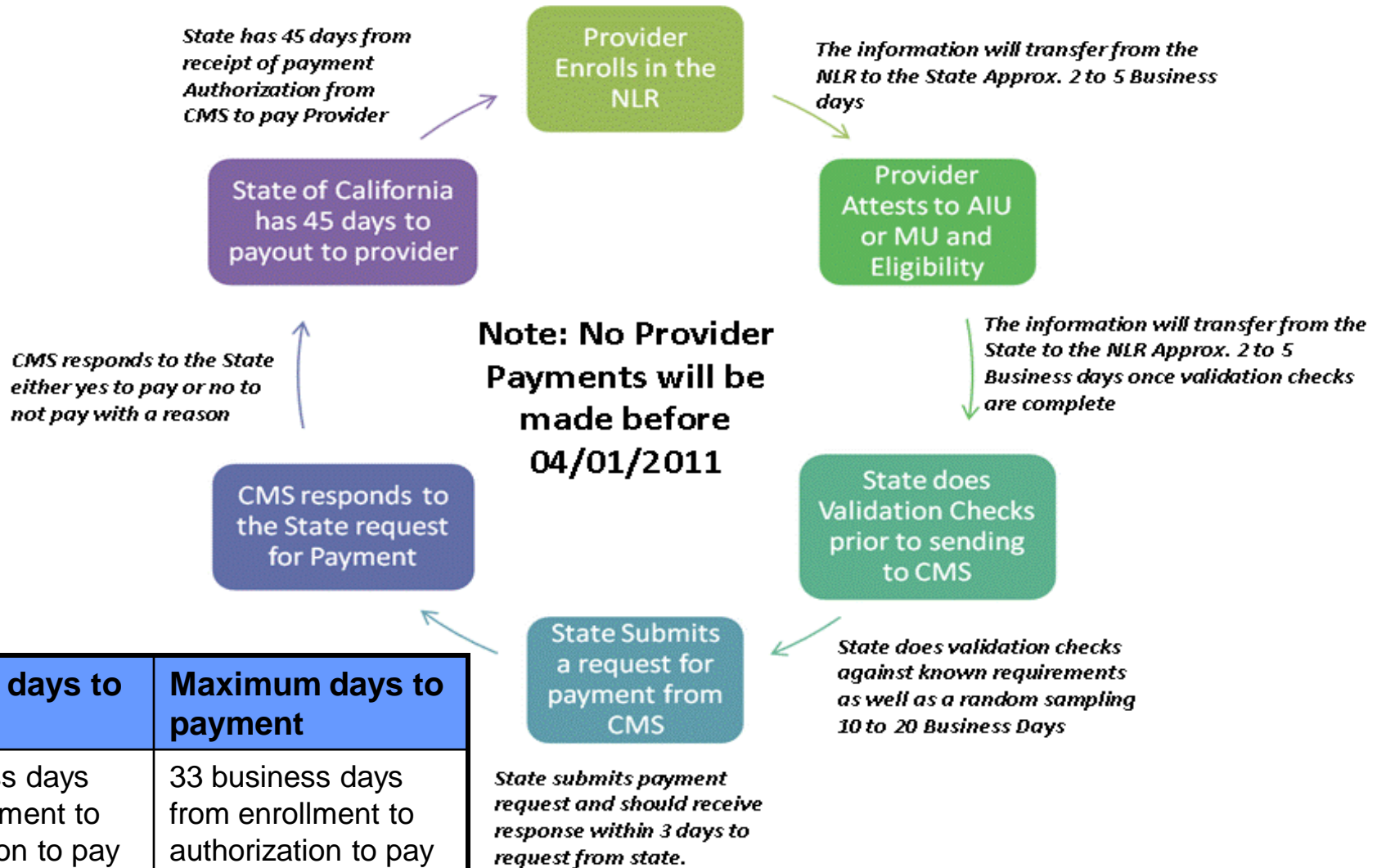
Attestation to A / I / U

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All will
require
supporting
documenta
tion

- 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.

Getting the Payments



Minimum days to payment	Maximum days to payment
17 business days from enrollment to authorization to pay	33 business days from enrollment to authorization to pay

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

What about dentists?

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Concerns

- While they qualify, there are no standards crafted for EDRs so certification bodies can't certify EDR products
- There are no dental specific measures
- From CMS Final Rule (pg. 603)
 - “In particular, we recognize the lack of endorsed oral health clinical quality measures, with identified and tested electronic specifications. This poses a challenge for dentists, who are eligible professionals for the Medicaid EHR incentives, to demonstrate meaningful use, other than with the general, profession-neutral measures.
 - While an eligible professional can report "zero" for the denominator of any measure for which s/he does not have any relevant patients, we will work to include in Stage 2 of meaningful use, clinical quality measures that would provide useful data to CMS and States on oral health care as reported by EHRs.”

What about dentists?

Health Care Access for All

From CMS Final Rule (pg. 603)

“We recognize the lack of endorsed oral health clinical quality measures, with identified and tested electronic specifications. This poses a challenge for dentists...

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We will work to include in Stage 2 of meaningful use, clinical quality measures that would provide useful data to CMS and States on oral health care”

CPCA

- HIT Newsletter- bimonthly, send Andie an email if you want to be on list to receive (amartinez@cpcpa.org)
- HIT Policy Page- <http://www.cpcpa.org/govaffairs/caissues/HealthInformationTechnology.cfm>

Centers for Medicare and Medicaid Services

- Website on EHR Incentives- <http://www.cms.gov/ehrincentiveprograms/>

Office of the National Coordinator

- Website on HITECH-
http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov_home/1204

California's Office of Health Information Technology

- Website about Medi-Cal EHR Incentives-
<http://www.dhcs.ca.gov/Pages/DHCSOHIT.aspx>

CalHIPSO

- www.calhipso.org

Questions?

Health Care Access for All

Andie Martinez, MPP
Assistant Director of Policy
California Primary Care Association
amartinez@cPCA.org
916-440-8170