CPCA
California Primary
Care Association

Health Care Access for All

Frequently Asked Questions: Final Rule Stage 1, Meaningful Use Incentives

August 16, 2011

Technical Assistance

1. **Question: What if the question I ask is not listed in CPCA's FAQ?**

   Answer: CMS has a very extensive list of FAQs at their website: *http://www.cms.gov/EHRIncentivePrograms/95_FAQ.asp#TopOfPage*.

2. **Question: As a FQHC that purchased and implemented the EMR, we anticipate approaching our providers about reassigning their incentive payments to the clinic. Does CPCA have any sample verbiage for that type of conversation?**

   Answer: As part of the Meaningful Use Registration Tool Kit CPCA has a script for clinic/health center CEOs/ Medical Directors to use when talking to their providers about the reassignment of incentives, as well as a template contract that can be used to revise employment contracts.

   To access the Tool Kit please visit the CPCA website: www.cpca.org. Go to the Policy and Advocacy tab on the left side, click on Topics of Interest, then Health Information Technology, then Electronic Health Records. The Tool Kit links will be in the left hand column.

Timeline

3. **Question: When is California going live with Medicaid Meaningful Use registration?**

   Answer: There is no firm date at this point. However, the State plan is that hospitals will be able to begin registering in October, then Groups in November, and individual providers in December.

4. **Question: What if state doesn't get registration in place until January 2012? Will the data they want then still be 2010 data or will it then be 2011?**

   Answer: Providers have until mid- February 2012 to register and attest to Adopt/Implement/Upgrade for Payment Year 1 using eligibility data from 2010. So if the state were to take until January 2012 to get the system live providers, and groups, could still register and use the 2010 data to do so.

Certification

5. **Question: Do all the information technology systems and products we use have to be certified?**

   Answer: No.
   From the CMS Website FAQ #10589
   Currently, the attestation process requires EPs, eligible hospitals, and CAHs to indicate that they agree with the following attestation statements:

   - The information submitted for clinical quality measures (CQMs) was generated as output from an identified certified EHR technology.
   - The information submitted is accurate to the knowledge and belief of the EP or the person submitting on behalf of the EP, eligible hospital, or CAH.
   - The information submitted is accurate and complete for numerators, denominators, exclusions, and measures applicable to the EP, eligible hospital, or CAH.
   - The information submitted includes information on all patients to whom the measure applies.

   CMS considers information to be accurate and complete for CQMs insofar as it is identical to the output that was generated from certified EHR technology. Numerator, denominator, and exclusion information for CQMs must be reported directly from information generated by certified EHR technology. By agreeing to the above statements, the EP, eligible hospital, or CAH is attesting that the information for CQMs entered into the Registration and Attestation System is identical to the information generated from certified EHR technology.

   CMS does not require EPs, eligible hospitals, or CAHs to provide any additional information beyond what is generated from certified EHR technology in order to satisfy the requirement for submitting CQM information.

   Please note that quality performance results for CQMs are not being assessed at this time under the EHR Incentive Programs. Complete and accurate information for the remaining meaningful use core and menu set measures does not necessarily have to be entered directly from information generated by certified EHR technology. By definition, for each meaningful use objective with a percentage-based measure, certified EHR technology must include the capability to electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage for these measures. However, with the exception of CQMs, meaningful use measures do not specify that this capability must be used to calculate the numerators and denominators. *EPs, eligible hospitals, and CAHs can use a separate, uncertified system to calculate numerators and denominators and to generate reports on all measures of the core and menu set meaningful use objectives except CQMs.*

   In order to provide complete and accurate information for certain of these measures, they may also have to include information from paper-based patient records or from records maintained in uncertified EHR technology. By agreeing to the above statements, the EP, eligible hospital, or CAH is attesting to providing all of the information necessary from certified EHR technology,

uncertified EHR technology, and/or paper-based records in order to render complete and accurate information for all meaningful use core and menu set measures except CQMs.

Eligibility

6. **Question: Would Behavioral Medicine Specialists qualify as Eligible Providers for Medicaid Meaningful Use?**

   Answer: Only if they were one of the following types of providers:
   - Physician (MD, DO, Optometrists)
   - Dentist (DDS, DMD)
   - Certified Nurse Midwife
   - Nurse Practitioner
   - PA practicing at a PA-led FQHC or PA-led RHC

7. **Question: I'm confused about reassignment and eligibility. Please explain again.**

   Answer: First, a provider must be eligible to participate in the Medicaid Meaningful Use Incentive Program. Eligibility for providers at clinics and health centers can take a few forms. In all three scenarios listed below the provider must first be an eligible professional (physician, dentist, certified nurse midwife, nurse practitioner, PA at a PA-led FQHC/RHC).

   The first method requires the provider have 30% of her encounters attributable to Medicaid or 30% Needy (assuming the provider practices predominantly at a FQHC/RHC) over a 90 day period in the last calendar year. A provider may choose the location(s) where she wants to attest to encounters. CMS has clarified that at least one of the locations where encounters are being attested to must be a location that has a certified EHR or is adopting/implementing/ upgrading to a certified EHR. *While this method is technically allowed, currently the state has not developed a system that would allow a provider at a clinic to attest to achieving the 30% Medi-Cal and/or needy encounters because clinics and health centers bill by the clinic/health center, not the provider, thus the state has no way of verifying if the data is accurate at the individual provider level. CPCA is aware of this issue and working with the state to resolve this problem.*

   The second way to be eligible is for a provider to use their practice's aggregate encounters as a proxy for her own. In this scenario the group would have to attest to achieving 30% Medi-Cal encounters or 30% Needy (FQHCs and RHCs only) over a 90 day period in the previous calendar year and then all providers who contributed encounters during that period could use the group's aggregate encounter rate as a proxy for her own.

   The third way to be eligible is called prequalification and is similar to group but extends the time frame. Prequalification is a methodology that the state created and CMS has approved. For 1204a licensed clinics, prequalification will involve the state analyzing the encounter data from the OSHPD reports from the year prior to determine if the site achieved 30% Medi-Cal and/or 30% Needy. If the site does achieve the required threshold, the state will notify the site that they are prequalified. It will then be up to the site to determine which providers can be part of the group that will register with the prequalification percentage approved by the state.

Providers that contributed to the encounter rate in the last year will be eligible to be in the group.

Reassignment, on the other hand, comes after the provider determines she is eligible. A provider can reassign her incentive payment only to an entity with whom she is employed or whom she has a current contract with that enables the entity to bill on the providers behalf. In order to reassign the contract must be current.

Let's look at a few scenarios to see how the two concepts can work together:

Scenario A: You have a full time provider who worked with you all last year and contributed to the clinic/health center's encounters. The clinic/health center has a 35% Medi-Cal rate. This provider can use the group proxy methodology and be eligible. The provider can also reassign the payment because she is an employed provider with the clinic/health center.

Scenario B: You have a full time provider who worked with you all last year and contributed to the clinic/health center's encounters. The clinic/health center has a 35% Medi-Cal rate. This provider leaves in June and you still haven't registered for the incentive payments yet as a group. This provider cannot reassign to you because your employment contract ended. This provider cannot reassign to anyone because she cannot prove that the encounters she contributed last year were hers.

Scenario C: You have a provider that works part-time with you and part-time in private practice. If the provider contributed to your group's encounter rate last year she may go with your group's encounter rate. If she can meet the eligibility criteria on her own then she may do eligibility on her own using the private practice encounter data only. Whichever way the provider is eligible, she may reassign to the clinic/health center.

Scenario D: You have a provider you hired just this year full time. The provider worked in a private practice last year and saw 30% Medi-Cal patients but the privact practice is not using nor does it intend to use a certified EHR. The provider cannot attest to seeing 30% Medi-Cal patients because the site is not using a certified EHR. This provider cannot reassign because she does not have the necessary encounter rate. This provider will have to wait until next year to participate in meaningful use and can use the encounters done at the clinic/health center to prove eligibility.

Scenario E: You have a provider that practices 40% time at your FQHC. The health center has a 30% Needy rate. Your FQHC decides to do group proxy eligibility with the 30% Needy rate. The provider that practices 40% time at your FQHC cannot participate in the group proxy because she does not practice predominantly, as is required by statute to use the 30% Needy rate. In order to receive the meaningful use incentive payment this provider would have to register on her own using encounter data from other practices. This provider if she could prove eligibility could reassign because she has a current employment contract with your FQHC.

8. **Question: If the clinic/health center bills for a provider's encounters with the organization/sites NPI how does the provider claim any of those encounters if he were to register independently?**

Answer: As it stands, the state is expected to validate all data prior to issuing a meaningful use payment and part of the validation is running the provider's Medi-Cal figures against the California Medicaid Management Information System (MMIS). The provider could not count encounters at the clinic if the clinic bills using the clinic's Medi-Cal number as the MMIS would not be able to associate the provider with those encounter figures.

CMS recently issued guidance that a provider is not required to use encounter data from all of their sites in order to prove eligibility and rather can choose sites. So if the provider worked at other locations he could prove eligibility via encounters done at other practices. The only caveat to this is that at least one of the locations where encounters are being counted must have a certified EHR or be attesting to Adopt/Implement/Upgrade of a certified system.

9. **Question: If an EP changes employers and both employers have certified EHRs, when the eligible professional (EP) enters the new TIN the following year, will she be eligible to receive year 1 incentives with the new company?**

   Answer: Assuming that the first clinic that employed the EP had already received the reassigned incentive payment for year one, the answer is No.

   The incentives, payment years, and stages follow the EP. Each EP can receive no more than $63,750. An EP can make a one-time switch before CY 2015 between the Medicare and Medicaid programs. If an EP participates in payment year 1 and 2 with clinic A, but then goes to work for clinic B, that EP is in payment year 3. There is no restarting the payment years or the stages once payment is received.

10. **Question: When eligible professionals work at more than one clinical site of practice, are they required to use data from all sites of practice to support their demonstration of meaningful use and the minimum patient volume thresholds for the Medicaid EHR Incentive Program?**

    Answer: *From CMS Website FAQs 10416* CMS considers these two separate, but related issues. Meaningful use: Any eligible professional demonstrating meaningful use must have at least 50% of their patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with certified EHR technology capable of meeting all of the meaningful use objectives. Therefore, States should collect information on meaningful users' practice locations in order to validate this requirement in an audit.

    Patient volume: Eligible professionals may choose one (or more) clinical sites of practice in order to calculate their patient volume. This calculation does not need to be across all of an eligible professional's sites of practice. However, at least one of the locations where the eligible professional is adopting or meaningfully using certified EHR technology should be included in the patient volume. In other words, if an eligible professional practices in two locations, one with certified EHR technology and one without, the eligible professional should include the patient volume at least at the site that includes the certified EHR technology. When making an individual patient volume calculation (i.e., not using the group/clinic proxy option), a professional may calculate across all practice sites, or just at the one site.

11. **Question: Does the purchase of the EHR need to occur within a particular time period?**

    Answer: No. There is no look back period for the first payment year. If a clinic/health center bought an EHR in 2010 that was certified but didn't apply for the incentives until 2011, the clinic (with EPs reassigning) could apply with Adopt, even if they were implementing at that time. If the clinic or health center purchased an EHR in 2008 they would need to apply with Upgrade because the 2008 version was not yet certified under the meaningful use program.

12. **Question: As a FQHC, we have many volunteer providers that may not have a Medicaid number, since we bill as a clinic. I heard that providers will need their own Medi-Cal numbers. Do I need to help my providers secure Medi-Cal numbers?**

    Answer: No. California will not require an individual provider Medi-Cal number for the meaningful use program. Providers must have a NPI and license number, however.

13. **Question: What if a provider only worked for a few weeks or months in a year, can they still participate and receive meaningful use incentives?**

    Answer: Yes. Eligibility to participate in the Medicaid EHR Meaningful Use Incentives is based on encounters not time. Even if a eligible professional only had 10 encounters all year, and three of them were to Medi-Cal patients, or needy patients, she would be eligible to participate, assuming that the provider could prove this in a 90 day period of time in the previous calendar year. If this same provider were to use group proxy methodology, as long as the eligible provider contributed to the group encounter rate (so at least one Medi-Cal encounter if the group is using 30% Medi-Cal or at least one Needy encounter if the FQHC/RHC is uing 30% Needy) in the time period (90 day or one year if its prequalification) then the provider is eligible and can participate.

    To be a meaningful user though, an eligible professional must conduct 50% or more of her encounters at a practice equipped with certified EHR technology. If the provider cannot reach the 50% threshold at one site, she must aggregate encounters at sites that are equipped with certified EHR technology. The EP must then report on the meaningful use criteria in the time period required (continuous 90 days or a full calendar year).

14. **Question: Does the expense of purchasing or upgrading the EHR have to happen in the year that you are receiving the incentive? Our clinic/health center just purchased an EHR in 2010.**

    Answer: *CMS FAQs 10100:* For AIU, a provider does not have to have installed certified EHR technology. The definition of AIU in 42 CFR 495.302 allows the provider to demonstrate AIU through any of the following: (a) acquiring, purchasing or securing access to certified EHR technology; (b) installing or commencing utilization of certified EHR technology capable of meeting meaningful use requirements; or (c) expanding 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 EHR certification criteria published by the Office of the National Coordinator

of Health Information Technology (ONC). Thus, a signed contract indicating that the provider has adopted or upgraded would be sufficient.

There is no look back period for A/I/U so if the EHR was purchased last year and upgraded this year that would count.

15. **Question: If we have $0 in EHR expenses in 2011 (and all our expenses are in 2010), do we still qualify for the MU funding in 2011?**

    Answer: Yes. There is no look back period. You will need to ensure that the EHR purchased in 2010 is certified however.

16. **Question: Do we need to have new EHR expenses in 2012 to match the funding we request in 2012?**

    Answer: No. There are no longer any matching requirements.

17. **Question: Are there a minimum number of encounters that a provider must hit in order to achieve that $21,250 in the first year? I have heard that FTE and number of work hours don't matter, but is there some other mechanism in place so that someone that works once a month is eligible for less than someone that works every day?**

    Answer: The answer to the first part of the question is no. See question 13 for more information.

    The answer to the second part of the question is No. There are no partial or tiered payments to the eligible providers. The provider must fully satisfy the eligibility criteria and then fully satisfy the meaningful use objectives and criteria to receive the incentive.

18. **Question: Can the dentists in stand-alone dental clinic receive MU funding?**

    Answer: The only way this could happen is if a dentist was using a certified EHR at his practice and could meet the 30% Medicaid threshold. Right now there is not a stand-alone certified Electronic Dental Record to use. There are certified dental modules that can be used in conjunction with a certified EHR that could achieve all the functionalities for meaningful use.

19. **Question: Can you use an EHR contract to do A/I/U with dentists instead of an EDR?**

    Answer: Yes.

20. **Question: Will the facility get funding for the dental clinic independent of the medical clinic if the facility is a comprehensive safety net provider?**

    Answer: Only eligible providers receive the incentive fund, and only an employer will receive the incentive funds if the provider reassigns the payment. It is possible for a physician and a dentist to be eligible for and receive the incentive payment. They could also reassign to the clinic if the clinic were their employer or they were contracting with the clinic.

In the case of this question, the first year will be different because receiving incentive funds can be based on attestation of purchase, installation or upgrade of a system. If a clinic had 10 providers (dentists, physicians, nurse practitioners), and all reassigned, they could all attest to either purchase, installation or upgrade of a certified EHR. The dentist could do this even though ideally the dentist would use an electronic dental record (EDR) not an electronic medical record (EMR).

In the second year, the issue for the dentists becomes using the certified EHR system. Currently, there are no specifications for certifying electronic dental records. This is an unfortunate oversight by the Office of the National Coordinator since dentists are eligible professionals, and yet their products won't be certified. If a dentist could use the certified EHR and achieve the meaningful use requirements the dentist could receive the incentive payments. CPCA has created a resource, with the input of the CPCA EDR Workgroup that reviews stage 1 meaningful use for a dentist if the dentist were to use an EHR instead of an EDR to participate. Please vist the CPCA website for more information: www.cpca.org.

The EDR vendors, like Dentrix, are working with the American Dental Association, to create criteria that would certify EDRs. They expect to have the ONC approve the criteria for stage 2 meaningful use, but it is unknown if this will happen.

CPCA is aware of the issue and is working to ensure dentists at CCHCs can participate in meaningful use. If you have any questions regarding dentists and meaningful use, please contact Andie Martinez Patterson, Assistant Director of Policy, at apatterson@cpca.org.

21. **Question: Does the clinic have the option to implement just an EDR or just an EMR and get funding for that respective piece.**

    Answer: First, incentive payments go to eligible professionals and only to clinics and health centers if the provider reassigns. There are no certified EDRs, so if a clinic adopted an EDR there would be no way of securing the meaningful use incentive payments. The clinic could adopt a certified EHR and then their providers could reassign the incentive payment, dentists included.

22. **Question: Can services to Medicaid patients, whether billed or not, be eligible to be counted as encounters for the purposes of meeting patient volume requirements. This is relevant to CA dentists because the State discontinued Medicaid coverage of adult dental services within the last year, but many dentists still continue to see Medi-Cal-eligible adults for free.**

    Answer: No. The definition of an encounter links to Medicaid payment.

    CMS #10415: The definitions of "encounter" for both needy individual and Medicaid patient volume account for situations where "Medicaid… paid all or part of the individual's premiums, copayments, and cost-sharing." This will include individuals, such as Qualified Medicare Beneficiaries (QMBs), where Medicare may pay for the encounter, but the State Medicaid program is required to pay for the individuals' Medicare Part B premiums. It would also include when Medicaid (or CHIP, as it pertains to needy individual patient volume) paid for the

premiums, cost-sharing, or co-payments for privately provided insurance (including Medicaid managed care programs).

If a third-party pays for the encounter (e.g., Workman's Compensation, auto insurance, etc.), the individual is only included in numerator for patient volume when "Medicaid… paid all or part of the individual's premiums, copayments, and cost-sharing." Again, this will include enrollees of Medicaid (or CHIP, as it pertains to needy individual patient volume) when Medicaid paid for the premiums, cost-sharing, or co-payments for privately provided insurance (including Medicaid managed care programs).

Finally, if a fee-for-service Medicaid enrollee has an encounter and Medicaid does not pay for the encounter (e.g., the individual paid out of pocket or because the service is not a Medicaid-covered service), they cannot be included in the numerator for calculating Medicaid patient volume

23. **Question: If a medical professional is not specifically board-certified or board-eligible as a pediatrician but meets the 20% Medicaid patient volume requirement for seeing children 21 and under, could the State allow them to be eligible, in effect, as a pediatrician for the purposes of the Medicaid EHR incentive program?**

    Answer: No. While CMS allows states to define pediatrician for themselves in terms of application of board-certification criteria or seeing predominately children, etc., they have drawn the line at counting non-physicians as pediatricians. In California Board Certification is required for pediatricians.

24. **Question: A health center qualifies using needy category with greater than 30% of their encounters for a 90 day period last year in the “needy” category. Do they require at least one Medi-Cal encounter during the 90 day period?**

    Answer: No. Providers attesting to 30% Needy may meet the threshold without seeing any Medicaid patients. They must see at least one of the patient categories in Needy however, Medicaid, CHIP, sliding fee scale or uninsured.

25. **Question: Does a county indigent encounter count as Needy?**

    Answer: The only way an encounter to a medically indigent person would count in the needy category was if the health center charged the patient a reduced rate on a sliding scale basis based on the individual’s ability to pay.

26. **Question: We have a number of large grants that pay for medical services for our uninsured patients. Do these encounters count as Medi-Cal or Needy?**

    Answer: They would not count as Medi-Cal because Medi-Cal didn’t cover the costs of any of these encounters. And they could count as needy if they were done at a federally qualified health center and the patient was uninsured or the patient was seen under a sliding fee scale.

Prequalification

27. **Question: I've heard that the state will be doing prequalification. What does this mean exactly?**

    Answer: Prequalification is a methodology that the state created as a means to streamline eligibility. For 1204a licensed clinics, prequalification will involve the state analyzing the encounter data from the OSHPD reports from the year prior to determine if the site achieved 30% Medi-Cal and/or 30% Needy (if it's a FQHC or RHC). If the site does achieve the required threshold, the state will notify the site that they are prequalified with either 30% Medi-Cal, 30% Needy, or both. It will then be up to the site to determine which providers can be part of the group that will register with the prequalification percentage approved by the state.

    If a FQHC site is determined to have achieved 30% Medi-Cal and 30% Needy, the site must determine which threshold to use. Only providers that practice predominantly (50% or more of their encounters over a 6 month period in the previous calendar year were at the FQHC) may use the 30% Needy rate. However any provider that provided at least one Medi-Cal encounter during the prequalification time period could use a 30% Medi-Cal rate.

28. **Question: Does this mean we can only pre-qualify clinicians that worked for our organization in the preceding year?**

    Answer: Yes. Only providers that contributed to your clinic or health center's encounter rate could use the prequalification rate.

29. **Question: So does this mean the OSHPD will replace the initial 90 days assessment of the first year of the incentive program.**

    Answer: Yes, if the clinic/health center is prequalified and the clinic/health center chooses to register as a group with the prequalification rate.

    If your site is prequalified it is not required that the site use the prequalified rate. For example, if a FQHC is prequalified at 30% Needy and only 2 of their providers would be able to use the prequalification rate because only 2 practice predominantly, that FQHC could choose not to do prequalification. Instead that FQHC might find a 90 day period in the previous calendar year where they achieved a 30% MEdi-Cal rate as a site and if they use the 30% Medi-Cal rate the other 3 providers at their site, on top of the 2 that practice predominantly, could use the group registration and qualify.

30. **Question: We will receive a letter stating that we are prequalified?**

    Answer: It is the intent of the state to notify the sites that are prequalified with a letter, email or fax. The exact process has not yet been determined.

Group Eligibility/Registration

31. **Question: If an eligible professional (EP) in the Medicaid EHR Incentive Program wants to leverage a clinic or group practice's patient volume as a proxy for the individual EP, how should a clinic or group practice account for EPs practicing with them part-time and/or applying for the incentive through a different location (e.g., where an EP is practicing both inside and outside the clinic/group practice, such as part-time in two clinics)?**

    Answer: *From CMS FAQs 10362:* EPs may use a clinic or group practice's patient volume as a proxy for their own under three conditions:

    a. The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
    b. there is an auditable data source to support the clinic's patient volume determination; and
    c. so long as the practice and EPs decide to use one methodology in each 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 practice must use the entire practice's patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice.

    In order to provide examples of this answer, please refer to Clinics A and B, and assume that these clinics are legally separate entities.

    If Clinic A uses the clinic's patient volume as a proxy for all EPs practicing in Clinic A, this would not preclude the part-time EP from using the patient volume associated with Clinic B and claiming the incentive for the work performed in Clinic B. In other words, such an EP would not be required to use the patient volume of Clinic A simply because Clinic A chose to invoke the option to use the proxy patient volume. However, such EP's Clinic A patient encounters are still counted in Clinic A's overall patient volume calculation. In addition, the EP could not use his or her patient encounters from clinic A in calculating his or her individual patient volume.

    The intent of the flexibility for the proxy volume (requiring all EPs in the group practice or clinic to use the same methodology for the payment year) was to ensure against EPs within the same clinic/group practice measuring patient volume from that same clinic/group practice in different ways. The intent of these conditions was to prevent high Medicaid volume EPs from applying using their individual patient volume, where the lower Medicaid patient volume EPs then use the clinic volume, which would of course be inflated for these lower-volume EPs.

    CLINIC A (with a fictional EP and provider type)
    " EP #1 (physician): individually had 40% Medicaid encounters (80/200 encounters)
    " EP# 2 (nurse practitioner): individually had 50% Medicaid encounters (50/100 encounters)

- Practitioner at the clinic, but not an EP (registered nurse): individually had 75% Medicaid encounters (150/200)
- Practitioner at the clinic, but not an EP (pharmacist): individually had 80% Medicaid encounters (80/100)
- EP #3 (physician): individually had 10% Medicaid encounters (30/300)
- EP #4 (dentist): individually had 5% Medicaid encounters (5/100)
- EP #5 (dentist): individually had 10% Medicaid encounters (20/200)

In this scenario, there are 1200 encounters in the selected 90-day period for Clinic A. There are 415 encounters attributable to Medicaid, which is 35% of the clinic's volume. This means that 5 of the 7 professionals would meet the Medicaid patient volume criteria under the rules for the EHR Incentive Program. (Two of the professionals are not eligible for the program on their own, but their clinical encounters at Clinic A should be included.)

The purpose of these rules is to prevent duplication of encounters. For example, if the two highest volume Medicaid EPs in this clinic (EPs #1 and #2) were to apply on their own (they have enough Medicaid patients to do that), the clinic's 35% Medicaid patient volume is no longer an appropriate proxy for the low-volume providers (e.g., EPs #4 and #5).

If EP #2 is practicing part-time at both Clinic A, and another clinic, Clinic B, and both Clinics are using the clinic-level proxy option, each such clinic would use the encounters associated with the respective clinics when developing a proxy value for the entire clinic. EP #2 could then apply for an incentive using data from one clinic or the other.

Similarly, if EP #4 is practicing both at Clinic A, and has her own practice, EP # 4 could choose to use the proxy-level Clinic A patient volume data, or the patient volume associated with her individual practice. She could not, however, include the Clinic A patient encounters in determining her individual practice's Medicaid patient volume. In addition, her Clinic A patient encounters would be included in determining such clinic's overall Medicaid patient volume.

32. **Question: Is there a difference between group registration and group eligibility?**

    Answer: Yes. Group registration is a functionality that California is building into the registration process that would allow a third party to register multiple providers at once. Group eligibility refers to using the group or clinic’s encounter threshold as a proxy for all the eligible professionals at the group or clinic.

33. **Question: If we want to do group eligibility with 30% Medi-Cal and one of our providers wants to do meaningful use in the Medicare program does that eliminate our ability to do group registration?**

    Answer: Not necessarily. If the provider wants to do the Medicare program, he would have to prove eligibility with encounters at practices other than the clinic. If the provider tried to use encounters done at the clinic to be eligible for the Medicare program while the rest of the clinic providers wanted to do the Medi-Cal program, the clinic would not be able to use group proxy for their Medi-Cal providers.

34. **Question: If we don't want to wait for prequalification, can't we just walk our providers through registration?**

    Answer: Not at this time. Because California is not yet live with the Medicaid Meaningful Use program providers in California cannot complete registration at the federal level.

    Once the state of California goes live with meaningful use providers can fully register at the federal level and then complete attestation at the state. However, a provider at a clinic/health center cannot use her encounters from the clinic/health center to prove eligibility unless the providers at the clinic/health center do group proxy.

    If the provider can prove eligibility at other locations where her NPI is associated with the encounters and one of those locations has or is attesting to A/I/U of a certified EHR then the provider could register and attest individually.

35. **Question: How many groups or clinics can a provider be a part of? And how does a provider associate him/herself with a group?**

    Answer: A provider can only register with one group but can be part of many groups. A provider is associated with a group once the group assigns him to their respective group in the state attestation process. Only one group can claim a provider, linked by the provider's NPI. There is no requirement for a group to prove the provider wants to be with that group, so it's possible for a provider to sign an agreement to be with your group but have another practice claim him when they register. A provider could remove himself from a group by contacting the state.

36. **Question: If a provider joins a group after the reporting period (90 day window in previous calendar year) – are they eligible for the incentive if they are part of the group now?**

    Answer: Yes she could still be eligible for the incentive but she cannot be part of your group because the provider didn't contribute to your group's encounters in the chosen 90 day period. The provider would have to register individually and attest to the 30% Medi-Cal encounter threshold or 30% needy if she has practiced predominantly at a FQHC or RHC in the last year, and at least one of the locations where the provider is attesting to eligibility would need to have a certified EHR or be attesting to adopting/implementing/upgrading one.

37. **Question: If EP's join the group after the group submits an attestation, can the group resubmit? Or do they submit as EP's?**

    Answer: Only those providers that contributed to the group encounter data in the respective time period (90 days or full calendar year if using prequalification) can be included in the group. If providers join later they cannot be implicated with the group data because they did not contribute to it. For providers that join after the 90 day period chosen by the group, that provider must register individually as an EP and attest to the 30% threshold individually.

    Next year, assuming the new provider stays with the clinic/health center, that provider could register with the group.

38. **Question: What if the clinic uses group data from the last calendar year and providers that contributed to that group data are no longer at the clinic? Can the clinic still use that 90 data time period data and include the providers that did contribute to that data and are still with the clinic?**

    Answer: Yes. The only caveat is that if the providers that left wanted to use encounters they performed at your clinic for their own eligibility it would exclude your providers from using group, however, the state currently does not have a way of verifying encounters providers perform at clinics because the provider's NPI is not associated with the encounters.

39. **Question: What providers exactly can be in the group eligibility for 30% Medi-Cal threshold?**

    Answer: Only those providers that are in the class of eligible professional and who have more than 0% Medi-Cal encounters in the 90 day period chosen by the group or in the year if the clinic or health center is going with prequalification. However, all the encounters of the group are counted, even those from providers that are not eligible professionals.

40. **Question: What providers exactly can be in the group eligibility for 30% Needy threshold?**

    Answer: Only those providers that are in the class of eligible professional and who practiced predominantly at a FQHC or RHC for 6 months in the calendar year prior and who contributed to the needy encounters during the chosen 90 day period or in the year if the health center is going with prequalification. However, all the encounters of the group are counted, even those from providers that are not eligible professionals.

41. **Question: What does PA-led mean?**

    Answer: Physician Assistant-led in the final rule on meaningful use means the following:

    a. Physician assistants (PA) who are practicing in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) led by a physician assistant.
        - When a PA is the primary provider in the clinic (for example, when there is a part-time physician and full-time PA, CMS would consider the PA as the primary provider)
        - When a PA is a clinical or medical director at the clinical site of practice
        - When a PA is an owner of a RHC

    CPCA has worked with the state to understand how to apply this policy in California. The last choice, owner of an RHC, is not applicable in California, however the other two are.

    For the PA as the primary provider, this means that there must be a PA that either works more hours, has more encounters, or has more patients assigned to him relative to the other provider at the health center that has the next most hours, encounters or patients assigned.

    The other way to deem a site as PA-led is that the PA is the clinical director of the site. A PA in California, as outlined in state licensing law, cannot be a medical director of a site.

    Once a site is deemed PA-led, then all the other PA's at the site are eligible for the Medi-Cal Meaningful Use Incentive Payments.

42. **Question: Does the PA also have to have more encounters/hours than all other providers- MD and FNP or just all other MD's?**

    Answer: It would be relative to the other providers, not just MDs.

43. **Question: Can a PA be the lead at more than one site?**

    Answer: Yes. There is nothing in the rule prohibiting this.

Registration

44. **In order to receive payments under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, does a provider have to be enrolled in the Provider Enrollment, Chain, and Ownership System (PECOS)?** *From CMS FAQs 10154:* In order to receive Medicare EHR incentive payments, EPs, eligible hospitals, and critical access hospitals must have an enrollment record in PECOS. Medicaid EPs do not have to be in PECOS.

    There are three ways to verify that you have an enrollment record in PECOS:
    1. Check the Ordering Referring Report on the CMS website. If you are on that report, you have a current enrollment record in PECOS. Go to http://www.cms.gov/MedicareProviderSupEnroll, click on "Ordering Referring Report" on the left.
    2. Use Internet-based PECOS to look for your PECOS enrollment record. If no record is displayed, you do not have an enrollment record in PECOS. Go to http://www.cms.gov/MedicareProviderSupEnroll, click on "Internet-based PECOS" on the left.
    3. Contact your designated Medicare enrollment contractor and ask if you have an enrollment record in PECOS. Go to http://www.cms.gov/MedicareProviderSupEnroll, click on "Medicare Fee-For-Service Contact Information" under "Downloads."

    If you are not in PECOS, the best way to submit your application is through internet-based PECOS. For more information go to: http://questions.cms.hhs.gov/app/answers/detail/a_id/10038/kw/pecos/session/L3NpZC9qeG1GdDliaw%3D%3D Indian Health Service (IHS) providers who submit a paper CMS-855 will have their enrollment information entered into PECOS.

45. **Question: My understanding is that we won't get MU funding until providers register with both CMS and State. Is that correct?**

    Answer: Yes. For Medicaid Meaningful Use incentives a provider must register on both the CMS (National Level Registry) and State side (State Level Registry).

46. **Question: Can someone at the clinic other than the provider herself register for the meaningful use incentive payments on behalf of the provider?**

    Answer: Yes. CMS created third party registration, a system that allows a provider to elect a third party to register on her behalf. Third party does not constitute group registration

however. In California there is expected to be a third party registration capability as well as a group registration.

47. **Question: If data is captured using certified electronic health record (EHR) technology, can an eligible professional or eligible hospital use a different system to generate reports used to demonstrate meaningful use for the Medicare and Medicaid EHR Incentive Programs?**

    Answer: *From CMS FAQs 10465:* By definition, certified EHR technology must include the capability to electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage for all percentage-based meaningful use measures (specified in the certification criterion adopted at 45 CFR 170.302(n)). However, the meaningful use measures do not specify that this capability must be used to calculate the numerators and denominators. Eligible professionals and eligible hospitals may use a separate, non-certified system to calculate numerators and denominators and to generate reports on the measures of the core and menu set meaningful use objectives.

    Eligible professionals and eligible hospitals will then enter this information in CMS' web-based Medicare and Medicaid EHR Incentive Program Registration and Attestation System. Eligible professionals and eligible hospitals will fill in numerators and denominators for meaningful use objectives, indicate if they qualify for exclusions to specific objectives, report on clinical quality measures, and legally attest that they have successfully demonstrated meaningful use.

    Please note that eligible professionals and eligible hospitals cannot use a non-certified system to calculate the numerators, denominators, and exclusion information for clinical quality measures. Numerator, denominator, and exclusion information for clinical quality measures must be reported directly from certified EHR technology.

48. **Question: For the first year when do providers need to register by to receive payment in 2011?**

    Answer: The state expects to launch the Medi-Cal Meaningful Use Incentive Program by October. Hosptials would register first and then groups, like clinics, in November. If the site is prequalified the state anticipates being able to issue incentive payments relatively quickly. It is possible that if registration launches when the state anticipates that sites could receive incentive payments in December.

49. **Question: How do I find out if my provider has a NPI number or how do I get a NPI number for a provider?**

    Answer: To look up a NPI number or to apply for one go to the National Plan and Provider Enumeration System (NPPES).
    - To search for a provider's NPI go to https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do
    - If the provider doesn't have n NPI go to https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart

CPCA's Health Center Operations Department has put together a NPI resource on the website at http://www.cpca.org/healthcenterops/membersonly/npi/. Note: You must be a CPCA member to access this resource. If you are a member and do not have a password to the CPCA website, visit http://www.cpca.org/about/membership/membersiteaccess.cfm.

Payments

50. **Question: Assuming that I want to participate in the Medi-Cal incentive program in a consecutive year fashion, what do I need to do each year to receive an incentive payment?**

    Answer:

    - To receive the incentive payment in payment year 1 2011, the EP attests to adopting/implementing/upgrading an EHR.
    - To receive an incentive for payment year 2 2012, the EP would report on meaningful use measures for any continuous 90-day period (starting by January 1, 2012 and no later than October 1, 2012). The EP would then be paid after submission and approval of the data. Depending on when the EP ends the 90-day reporting period, he may be paid in 2013.
    - Then to receive an incentive for payment year 3 2013, the EP would report on meaningful use measures for a full calendar year. The time period for data collection and reporting would begin January 1, 2013 and go until December 31, 2013. The EP would submit the data after December 31, 2013 and be paid sometime in 2014.
    - To receive any of the following payment years, an EP must report on meaningful use measures for a full calendar year.

    Consecutive year participation is not required in the Medicaid Meaningful Use Incentive Program. The provider has between 2011 (or whenever their respective state launches the program) and 2021 to complete Meaningful Use. Currently there are 6 payment years and an anticipated 3 stages.

51. **Question: What if you hire a new provider in 2014, but the clinic and the EPs that reassigned had started meaningful use in 2011? Can the clinic still receive incentives for the provider that it hires in 2014?**

    Answer: The incentives follow the eligible professional (EP). Each year an EP will have to attest to eligibility and then will have to choose to reassign payment but only to an entity with which the EP has a current employment contract and that has a certified EHR. If an EP is employed or contracted with a clinic that has a certified EHR she can choose to reassign to the clinic. The payment she would receive would depend on what payment year it was for her. For example, if the EP had not yet participated in the incentive program (either through Medicare or Medicaid) the first year with the clinic would constitute payment year 1 stage 1, or the $21,250. Presumably, the EP would attest to either adopting/implementing/upgrading. So even if the rest of the clinic was in Stage 2 payment year 4, the newly hired EP would be in Stage 1 payment year one.

52. **Question: If an EP changes employers mid-year and both employers have certified EHRs, who gets the incentive payment?**

Answer: This depends on what payment year the EP is/was participating in. The incentives, payment year, and stages follow the EP, except in the case of the first payment year because there is no reporting time period; if the EP elects adopt/implement/upgrade, once the EP reassigns the money the incentive will go to the clinic/health center, even if the EP leaves during the time period where the state is verifying information.

The answer is different for any payment year where there is a reporting period, 90 days or the full calendar year. Because the incentives follow the EP and meaningful use is tracked by the individual EP's NPI, even if an EP reassigns payment to the clinic, but leaves at some point in the middle of that reporting period, the data for that EP then becomes incomplete and not reportable. A solution could be negotiated between the two EP employers, assuming that the reporting systems in California and at CMS will allow for aggregating. For example, if an EP started with clinic A, but left for clinic B in the 60th day of the 90 day reporting period, and both clinics have certified EHRs and the EP was willing to reassign, the two clinics could negotiate a solution where each would get a portion of that reassigned incentive and would collaborate to submit the meaningful use aggregated data. The only clinic that the EP could reassign to however would be the clinic with which she had a current contract.

53. **Question: If a provider is hired and initially assigned payment to another organization, can this be assigned to the new organization to receive any unpaid incentives?**

    Answer: In order to do this, a provider would have to change the information (PAYEE TIN) in the National Level Registry (NLR) where he first registered. A provider has the opportunity to update the NLR data at any time which will update the data in the State Level Registry (SLR). So while it's possible it would be difficult if the provider had already submitted their signed attestation.

    Part of the agreement that a provider signs includes the payee information, so if the provider wants to change who that PAYEE is, then he would need to contact the state to request that their application be returned to them so he can sign the updated agreement after the change comes through from the NLR. The agreement must display the correct name.

    It will also require that the provider reprint their attestation agreement showing the correct payee, attach it to the system, and resubmit their attestation. This all assumes as well that the incentive has not been issued, because if it has then the provider cannot change which entity receives the incentive payment.

54. **Question: What if a provider refuses to sign over the payment to the health center?**

    Answer: The incentives are directed at eligible professionals and the EP has a choice to reassign. However, for a provider at a clinic/health center to use encounter volumes and attest to A/I/U, she will need to work with the clinic/health center. Encounter volumes at clinics/health centers, at least right now, can only be done via group proxy and prequalification and the clinic/health center will need to provide the EP with the contract for A/I/U in order that the payment be received.

CPCA created a Meaningful Use Registration Tool Kit to assist in this process. To access the Tool Kit please visit the CPCA website: www.cpca.org. Go to the Policy and Advocacy tab on the left side, click on Topics of Interest, then Health Information Technology, then Electronic Health Records. The Tool Kit links will be in the left hand column.

55. **Question: If a provider initially does not reassign can he change that and re-assign if this is done prior to a payment being received?**

    Answer: The provider has the opportunity to update the National Level Registry (NLR) data at any time which will update the data in the State Level Registry (SLR). The timing will have an impact on where the payment is assigned, but the state system (SLR) will support accepting the NLR changes on assignment.

    It becomes more of a challenge if the provider has already submitted their attestation. Part of the agreement that they sign includes the payee information, so if they want to change it, then they will need to contact the state to request that their application be returned to them so they can sign the updated agreement after the change comes through from the NLR. The agreement must display the correct name. Otherwise, they can change any time prior to the payment being issued.

    It will require that the provider reprint their attestation agreement showing the correct payee, attach it to the system, and resubmit their attestation.

56. **Question: Who is responsible for the taxes associated with the incentive payment?**

    Answer: The EP has a choice when registering to use her tax identification number (TIN) or her social security number if she doesn't have a TIN. The EP could also choose to submit the TIN of her employer.

    Taxes will be the responsibility of the entity that's TIN is associated with the EP's registration. For example, if an EP reassigns payment to her clinic employer, the clinic would be the responsible entity.

57. **Question: Does everyone that qualifies get the $21,250 the first year and $8,500 in subsequent years?**

    Answer: Yes. CMS has clarified in a Q/A for state Medicaid Directors that the incentives are not based on the cost of purchasing EHR technology. As long as an EP meets all necessary requirements for qualifying for incentive payments, he may receive the maximum allowed amount regardless of what their EHR technology or implementation costs were.

58. **Question: I have heard that there are "allowable costs" related to the meaningful use incentives and I don't understand what that is in reference to. What are allowable costs?**

    Answer: In the HITECH Act, the statute relating to the Medicaid incentives for the meaningful use of an EHR, there is reference to allowable costs and net allowable costs. CMS discussed these two terms at length in the Notice of Proposed Rule Making (NPRM) issued in January

2010. There were numerous comments back to CMS about these two terms, and the general argument was that if CMS enforced the proving of costs then the incentives would really be reimbursement payments and not incentives, which was not the intent of Congress. CMS has agreed and in a Q/A document to State Medicaid Directors has said the incentives are not based on the cost of purchasing EHR technology. As long as an EP meets all necessary requirements for qualifying for incentive payments, they may receive the maximum allowed amount regardless of what their EHR technology or implementation costs were.

The Medicare and Medicaid Extenders Act of 2010 (Public Law No: 111-309), enacted on December 15, 2010, amended the Health Information Technology for Economic and Clinical Health (HITECH) established by the American Recovery and Reinvestment Act of 2009. The amended section changes the definition and calculation of the "net average allowable cost" for which a provider is responsible.

The new changes allow CMS to estimate the average payment that Medicaid providers will receive from other (non-governmental) sources. Rather than requiring each eligible professional to calculate payments received from outside sources, each will use the average amount established by CMS. After conducting the required studies, CMS has determined the average contribution from outside sources will remain at $29,000.

Under the recent 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.

WHAT DOES THIS MEAN??? That the EP will not have to attest/verify a 15% match. It reduces some work on the front end, however, it diminishes the leverage clinics and health centers have in asking the EP to reassign the payment because now states are assuming the EP met the 15% match.

59. **Question: If our providers reassign the incentives to the FQHC will it impact our PPS rate?**

    Answer: No. CMS indicated in the final rule on meaningful use that because FQHCs are not eligible providers, incentive payments will not be made to FQHCs. It is true, however, that an eligible professional could choose to reassign his/her incentive payment to the FQHC. Incentive payments are payments designed to promote the adoption and meaningful use of certified EHR technology and are not payments for medical assistance provided in the FQHC. In the meaningful use rule program, CMS does not have the authority to provide that these funds be the basis for the State to reduce it's per visit payment to the FQHC.

60. **Question: If our providers take the Medicaid incentive money, will our FQHC still be able to get our PPS rate change through the EHR qualifying event?**

    Answer: Yes. CMS has indicated in the final rule that because the incentive payments are directed at eligible professionals and not the FQHC, the incentive payments will not impact the PPS rate. Therefore, FQHCs in California can use the adoption of the EHR as a qualifying event for a scope change.

61. **Question: Does the implementation of an EHR qualify as a qualifying event for a scope change for my FQHC's PPS rate?**

    Answer: Yes. Health centers should assess if the adoption and implementation of their EHR system can qualify as a triggering event for a scope of service change for an adjustment in their health center's reimbursement rate. Per the statute, triggering events must directly impact the intensity, duration or amount of services provided, or any combination thereof. Following a CPCA case study in 2008 that documented how the implementation of an EHR impacted the services at one health center in a manner sufficient to qualify for an adjustment to the rate, a number of health centers have since successfully used this event to trigger a scope of service change request.

    It would depend on the individual health center's situation to determine if a scope change was something to pursue – and if their EHR implementation was going to qualify as their triggering event. For any specific questions regarding scope changes, please contact Molly Brassil, Deputy Director of Regulatory Affairs, at mbrassil@cpca.org.

62. **Question: Are most providers at CCHCs assigning their incentive payments to their employer because the costs of the EHR are paid by the employer? If they are assigning payment to the CCHC, how is this being set up – i.e is it by individual contract between the CHC organization and provider or by another method?**

    Answer: According to the CPCA HIT Survey completed in October 2010, 66 percent of respondents (75 organizations) indicated that they believe all of their eligible providers will reassign the incentive payment to the organization. Another 14 percent (16 organizations) believe that over half of their providers will do so.

    CPCA has created a Meaningful Use Registration Tool Kit in order to assist with this issue. There is a sample contract agreement related reassignment, as well as a script CEOs can use in approaching their providers. To access the Tool Kit please visit the CPCA website: www.cpca.org. Go to the Policy and Advocacy tab on the left side, click on Topics of Interest, then Health Information Technology, then Electronic Health Records.

63. **Question: Can an organization take some of the incentive payment a provider reassigns to the organization and pay the provider?**

    Answer: Yes. There is no guidance on what must be done with the incentive payments once received and reassigned.

Reporting

64. **Question:** I am an eligible professional (EP) for whom none of the core, alternate core, or additional clinical quality measures adopted for the Medicare and Medicaid Electronic Health Record (EHR) incentive programs apply. Am I exempt from reporting on all clinical quality measures?

Answer: From CMS FAQs: In the event that none of the 44 clinical quality measures applies to an EP's patient population, the EP is still required to report a zero for the denominators for all six of the core and alternate core clinical quality measures. If all of the remaining 44 clinical quality measures included in Table 6 of our final rule do not apply to the EP, then the EP is still required to report on at least three of the additional clinical quality measures of their choosing from Table 6 of the final rule (other than the six core/alternative core measures). If the EP reports zero values for these three additional, menu-set clinical quality measures, then for the remaining menu-set clinical quality measures, the EP will also have to attest that all the other menu-set quality measures calculated by the certified EHR technology have a value of zero in the denominator. In other words, the EP is required is required to try to find at least three measures in the menu set for which the denominator is other than zero. If s/he cannot, then the EP must still choose three menu-set measures on which to report. S/he may report zero denominators for some or all of these measures, but must accompany such "zero denominator" reporting with an attestation that all of the other menu-set measures calculated by the certified EHR technology have a value of zero in the denominator. A zero report in the menu-set is not sufficient without such accompanying attestation.