Information for Providers—With 2013 Update

Applying to the Medi-Cal EHR Incentive Program is a two-step process:

- Step One is to register with CMS at the National Level Registry (NLR) at https://ehrincentives.cms.gov/hitech/login.action.
- Step Two is to register with California's State Level Registry (SLR) at http://medi-cal.ehr.ca.gov/. Providers may begin the enrollment process with the SLR, but the application will not be processed until enrollment has been completed with the NLR.

Incentive Payments

Providers can receive incentive payments from Medi-Cal for 6 years through 2021. These years do not have to be consecutive. The payment for the first year is $21,250 and for subsequent years is $8,500 for a total of $63,750 over the 6 years. Payment for each year is contingent upon fulfilling the requirements for that year only. Failure to meet the requirements for one year does not affect the retention of the payments the provider received for prior years. The last year that providers can begin the program is 2016.

Providers may also be eligible to receive incentive payments from the Medicare EHR Incentive Program, which is administered at the federal level by CMS. Providers cannot participate in both programs simultaneously, but can switch once between programs through 2014. If providers switch programs they cannot receive more than the maximum ($63,750) they would have received exclusively from Medi-Cal.

Participation Requirements

In the first year of participation in the Medi-Cal EHR Incentive Program providers can choose to demonstrate meaningful use (MU), or that they have adopted, implemented, or upgraded certified EHR technology (AIU). For more information about AIU, see "Adoption, Implementation, or Upgrade of Certified EHR Technology" below.

To receive payments in program years 2-6 providers must demonstrate MU and report on a number of "meaningful use" measures to Medi-Cal. For more information about meaningful use visit CMS here.

A list of acceptable certified EHR technology is available here.

Eligible Provider Types

Actively licensed professionals of the following types are eligible:

- Doctor of Medicine
- Doctor of Osteopathy
- Doctor of Dentistry Dental Surgery or Dental Medicine
- Nurse Practitioner
- Certified Nurse Midwife (does not include Licensed Midwife)
- Physician Assistant practicing in a Physician Assistant led federally qualified health center or

rural health center (see further information below).
- Optometrist (beginning in 2013—see further information below)

Hospital-Based Disqualification

Providers cannot be "hospital based." This is defined as furnishing 90% or more of professional services in an inpatient hospital setting or emergency room connected to a hospital in the calendar year preceding the payment year. Services delivered in an outpatient clinic located in a hospital do not count as "hospital-based."

For example, if the provider applies for incentive funding for 2011, the "hospital based" determination would be based on the provider's practice in the 2010 calendar year. DHCS will use place of service codes in its claims data for verification. There are two types of place of service codes in DHCS data:

1) "Original" Place of Service Codes—in this category 21, 23, and B will be counted as hospital-based claims
2) Place of Service Codes—in this category 0 and 1 will be counted as hospital-based claims

If claims data is insufficient to verify the "hospital-based" status of providers, DHCS will consider other sources of documentation, such as attendance records or residency rotation schedules. All alternative forms of documentation will be individually accessed by DHCS.

Beginning in 2013 providers may apply for a waiver of the hospital-based exclusion if they can provide documentation that they personally fund the acquisition and maintenance of hardware and certified EHR software that they use in the hospital setting instead of the hospital's EHR technology. The State Level Registry will not be able to accept applications for this waiver until April 2013 and providers wishing to utilize such a waiver will need to delay their applications until the State Level Registry has this capability.

Practice Volume—30% Medicaid Requirement

- The basic eligibility requirement for the 2011 and 2012 program years is that 30% or more of practice volume must be paid for to some extent by Medicaid (including through Medi-Cal's 1115 waiver) during any 90-day representative period in the preceding calendar year. Beginning in program year 2013 all Medi-Cal covered services that are delivered to Medi-Cal enrolled patients can be counted as Medi-Cal encounters regardless of whether Medi-Cal was ever billed for or paid for the services. The only exception for this is that patients enrolled a few "state only" programs that do not receive federal funding cannot be considered enrolled in Medi-Cal for the purposes of establishing eligibility of providers for the Medi-Cal EHR Incentive Program. For a detailed discussion of this topic see "Understanding Medi-Cal and Other Needy Individual Encounters."
- There is no lower limit on total practice volume to be eligible for the program. A provider can be in practice only one day per week and see only a few patients and still be eligible for the program.
- Encounters are to be attributed to the provider who actually delivered the service, not to the provider who submitted the bill to Medi-Cal. However, unless the provider delivering the service is acknowledged as the "rendering" provider on the Medi-Cal claim, DHCS will have difficulty verifying the encounter volume for the provider delivering the service.

- Practice volume can be calculated as either "encounters," "panel patients" or a combination of both. Providers can use either of two formulas in establishing their practice volume:

  Formula 1:
  Total Medi-Cal Encounters
  Total All Patient Encounters

Formula 2:

$$\frac{\text{Total Patients Assigned to a Medi-Cal Panel + Total Medi-Cal Encounters}}{\text{Total Patients Assigned to a Panel + Total Patient Encounters}}$$

- Multiple encounters with the same patient on the same day by the same provider can only be counted once.
- Patients assigned to a panel should only be counted in the numerator or denominator of Formula 2 if the patient has been seen at least once in the 12 months preceding the start of the 90-day representative period. Beginning in 2013 the look back period for this has been extended to 24 months.
- Providers practicing predominantly in an FQHC, FQHC look-alike, RHC, or Indian Tribal Clinic can add "Other Needy Individual" encounters to the numerator of Formula 1 and "Other Needy Individual" encounters and panel patients to the numerator of Formula 2 to attain the 30% patient volume. "Practice predominantly" is defined as having 50% or more of total encounters delivered in the FQHC/RHC during a 6-month period in the prior calendar year. Beginning in 2013 this 6-month period can also occur in the 12 months prior to the date of attestation in the State Level Registry (SLR). The 6-month period must be continuous but does not have to include the 90-day representative period used by the provider or clinic to qualify for the program.
- DHCS has developed a "Provider Workbook" that can be used by providers to calculate their patient volumes prior to entering the SLR.
- Providers who are applying individually (not with a group or clinic) and are not prequalified (see below) need to provide supporting documentation for the patient volume information they enter when enrolling through the SLR. DHCS will attempt to verify reported volumes against Medi-Cal claims and encounter records but for some providers may need to review the supporting documentation uploaded by providers. Providers are required to retain any supporting documentation for 7 years after payment.

Prequalification

- DHCS has been able to use claims and encounter data to "prequalify" high volume Medi-Cal providers for 2011 and 2012. An initial list of prequalified providers for 2013 will be established in April 2013.
- A description of the methodology used for this process is described in the State Medicaid Health Information Technology Plan posted on the DHCS website here.
- Prequalified providers do not need to enter patient volume information or upload supporting documentation when they enroll for the program in the SLR.

Qualifying with a Clinic or Group

- Federal regulations allow providers in clinics or groups with an overall 30% or greater Medicaid volume to qualify for the program regardless of their personal Medicaid volumes.
- DHCS has designed a portal in the State Level Registry for clinics and groups to input their patient volumes and identify all of their providers who saw Medi-Cal patients (or other needy patients in the case of FQHCs and RHCs) during the prior calendar year. When providers enter the SLR they may find that they have been identified as being eligible for the program because of clinic or group membership. Such providers will not need to enter their own patient volumes and can still personally receive the incentive payments. They may reassign their payments to the clinic or group (see "Reassignment" below), but according to federal regulations, any such reassignment must be voluntary. Providers identified by a group or clinic can also choose to qualify based on their personal patient volumes, but if they choose to do so using patient volumes from the clinic or group they will prevent other group or clinic members who have not already attested from using the group or clinic patient volumes to qualify for the current payment year.

Special Information for Pediatricians

- Pediatricians can qualify for the program if they have a 20% or greater Medicaid patient volume. If they qualify at 20% Medicaid patient volume but less than 30% Medicaid patient volume they will be eligible for a payment that is 66.6% of the payment for those attaining a 30% or greater Medicaid patient volume for that year.
- DHCS has defined "pediatrician" for this purpose to be a physician who is either board-certified or board-eligible with the American Board of Pediatrics or the American Osteopathic Board of Pediatrics.
- Pediatricians wishing to take advantage of this special reduced threshold are required to upload a copy of their board certification or proof of board eligibility when enrolling for the program through the SLR.
- Pediatricians who do qualify with at least 30% Medi-Cal patient volume should not designate themselves as pediatricians and should not upload documentation of board eligibility or board certification. These physicians will receive the full incentive payments.

Special Information for Physician Assistants

Physician assistants are eligible for the program if they practice in an FQHC or RHC that is "physician assistant led" at the time of attestation in the State Level Registry. In 2013 DHCS removed the requirement that the clinic also was PA-led 25% of the time in the 12 months preceding attestation.

CMS has defined "physician assistant-led" as:
1. When a PA is the primary provider in a clinic, or
2. When a PA is a clinical or medical director at a clinical site of practice, or
3. When a PA is an owner of an RHC

DHCS has defined "primary provider" for the purposes of number 1 above as when, compared to other providers in the clinic, the:
1. PA is assigned the most patients in the clinic, or
2. PA has the most patient encounters, or
3. PA has the most practice hours

PAs enrolling in the program are required to individually fill out and upload a special form into the SLR attesting that their clinic is PA-led. If an FQHC or RHC has multiple sites and one of them is led by a PA, then PAs in all sites are eligible for the program.

Special Information for Optometrists

DHCS has received approval from CMS to consider optometrists as "physicians" for the purpose of participation in the Medi-Cal EHR Incentive Program beginning in 2013. The State Level Registry must be modified to accept applications from optometrists and may not have this capacity until the second half of 2013. DHCS will issue more specific information on this issue in the future.

Adoption, Implementation, or Upgrade (AIU) of Certified EHR Technology

For the first program year, instead of demonstrating meaningful use, providers have the option to adopt (acquire or install), implement (begin using), or upgrade to (expand an EHR system that is already in use) certified EHR technology.

To fulfill AIU, providers must upload into the SLR documentation of a binding financial or legal commitment for AIU that was signed by December 31st of the payment year.

The documentation of a binding financial or legal commitment can take the form of a contract, license, invoice, or other document. DHCS has decided that documentation can take either of two forms:

1. A copy of the complete, unredacted document
   or
2. Copies of the relevant pages of the document along with completed copies of a Vendor Letter and Provider Letter. Templates for the latter are provided on the SLR.

Providers do not have to provide documentation of actual installation or use. For providers using free web-based EHRs, CMS has determined that a signed copy of the end user license agreement (EULA) is sufficient documentation.

Complete, unredacted copies of the documentation of AIU should be retained by the provider for at least 7 years subsequent to payment.

Reassignment of Payments

Providers are allowed to reassign their EHR incentive payments to an employer or to an entity with which he/she has a contractual arrangement allowing the entity to bill and receive payment for the provider's covered professional services. The employment status or contractual relationship must be currently active. According to federal regulations, this reassignment must be voluntary. Providers make this reassignment when registering at the federal level with CMS for the program by providing the name and tax ID of the employer or contractual entity. Providers cannot partially reassign payments. If a provider reassigns a payment the funds will go directly to the employer or contractual entity, not to the provider. The incentive payments may have tax implications for the recipient of the payments. Providers should consult with a tax advisor or the Internal Revenue Service regarding how to properly report any income on their filings.

Additional Resources Summary List:

National Level Registry (NLR) – https://ehrincentives.cms.gov/hitech/login.action

California State Level Registry (SLR) – http://medi-cal.ehr.ca.gov/

CMS EHR Incentive Program Overview – http://www.cms.gov/EHRIncentivePrograms/

ONC Certified EHR Technology List – http://onc-chpl.force.com/ehrcert

Prequalified Provider List –
http://www.dhcs.ca.gov/provgovpart/Documents/OHIT/Prequalified_Provider_List.pdf

State Medicaid Health Information Technology Plan –
http://www.dhcs.ca.gov/provgovpart/Documents/OHIT/CA%20State%20Medicaid%20HIT%20Plan_v2.0.pdf

Understanding Medi-Cal Encounters –
http://www.dhcs.ca.gov/provgovpart/Documents/OHIT/Understanding_Medi-Cal_Encounters.pdf

Provider Eligibility Workbook –
http://www.dhcs.ca.gov/provgovpart/Documents/OHIT/Provider_Eligibility_Workbook.xls