Medi-Cal
Electronic Health Record
INCENTIVE PROGRAM

Understanding Groups and Clinics
(2017 update)

Using Group or Clinic Patient Volumes as a Proxy for Provider Patient Volumes

The federal Final Rule for the Medicaid EHR Incentive Program allows for patient volumes of groups or clinics to be used as a "proxy" for providers in establishing eligibility for the program. A provider in a group or clinic with at least 30% Medicaid patient encounters (or 30% Needy Individual volume for providers practicing predominantly in an FQHC or RHC) would be eligible for the program regardless of whether the provider individually attained the required threshold. This potentially enables more of the providers in the group or clinic to benefit from incentive payments.

The Final Rule specifies some basic rules if the group/clinic option of establishing eligibility is used:

- "All in"—the encounters of all providers in the group or clinic (not just those eligible for incentive payments, i.e. dieticians, pharmacists) during the 90-day representative period must be counted in establishing the Medicaid percentage that will serve as the proxy. If the encounters of any provider are excluded the group or clinic cannot establish eligibility as a whole.
- "All out"—if any provider in the group or clinic chooses to not use group or clinic volumes as a proxy, but decides to use his/her individual patient volumes for care delivered in the group or clinic, then none of the providers can use the group or clinic volumes as a proxy. DHCS, with CMS approval, has designed the State Level Registry (SLR) so that if a provider who has been designated as a group or clinic member chooses this option, in the future all other providers in the group or clinic who have not already attested at the SLR will have to establish their eligibility individually, separate from the group. Providers who have already attested at the SLR with the group will not have their eligibility revoked for that program year.
- A provider can use their patient volumes for care delivered outside of the group or clinic to establish eligibility for incentive payments without affecting the ability of other providers in the group or clinic to use the group or clinic patient volumes as a proxy.
- A provider who had at least one Medicaid encounter with the group/clinic during the prior calendar year or the 12 months prior to attestation can use the group or clinic patient volumes as a proxy to qualify for the program. The provider does not need to

have had encounters with the group/clinic during the 90-day representative period—only during the prior calendar year or 12 months prior to the provider's attestation. A provider without encounters during the 90-day representative period desiring to use his/her own encounters with the group or clinic during a different period in the prior calendar year or 12 months prior to attestation to individually qualify for the program would trigger the "all out" rule, eliminating the ability of all providers in the group or clinic from using the group or clinic patient volumes as a proxy.

- Clinics that have been prequalified by DHCS (see Clinic Prequalification below) can add providers to their group who have had at least one Medi-Cal encounter with the clinic in the prior calendar year or in the 12-month period prior to the provider's attestation using the clinic's eligibility.
- Documentation for a provider's qualifying encounter(s) outside of the group's representative period must be available for audit, and beginning July 25, 2017 must be uploaded into the group's/clinic's and/or provider's SLR accounts prior to or at the time of the provider's attestation. This documentation can be uploaded either to the EP's or the clinic's SLR account. Documentation in support of MU will be considered sufficient for this purpose as long as encounters are designated for specific EPs. For attestations prior to July 25, 2017 lacking documentation of an encounter during the 90-day representative period, OHIT analysts will require submission of a signed letter from the group/clinic administrator stating that the provider had at least one Medi-Cal encounter with the group/clinic during the prior calendar year or the12 months prior to attestation.
- DHCS has identified some providers as "prequalified" for the program based on their individual patient volumes reflected in the Medi-Cal claims and encounter records. If such prequalified providers register on their own with the SLR before the group or clinic registers, this does not automatically trigger the "all out" rule and prevent the group or clinic from registering its providers. Such prequalified providers must be identified in a letter uploaded into the SLR listing their names and NPIs. DHCS staff will subsequently contact these providers to confirm that they are willing to change the basis of their eligibility to qualify based on group/clinic patient volumes. If these providers are unwilling to do this the group/clinic administrator will be notified of the need for all providers in the group/clinic to establish eligibility using individual patient volumes. To minimize this possibility, group/clinic representatives should check with any prequalified provider before establishing the group/clinic in the SLR. DHCS is not able to retrospectively change the eligibility status of a non-prequalified provider who has registered in the SLR before the group/clinic using group/clinic encounters to establish his/her patient volumes. Such a provider would prevent the other providers in the group/clinic from using the group/clinic patient volumes as a proxy.

Reassignment of Incentive Payments to a Group or Clinic

Federal regulations allow providers to reassign their incentive payments to an "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." Providers who decide to use eligibility established through a group or clinic are not obligated under federal regulations to reassign their incentive payments to the group or clinic. It is important that providers and group/clinic representatives understand that use of group or clinic patient

volumes as a proxy to establish eligibility for providers is unrelated to reassignment of incentive payments by providers. Lacking this understanding providers may mistakenly choose not to use the group or clinic volumes to establish eligibility, because they believe that they have no choice but to reassign incentive payments to groups or clinics. In turn, group or clinic administrators may improperly plan budgets because they believe that providers are obligated to reassign payments to the group or clinic. The decision to reassign payments is made by providers at the National Level Registry level before they reach the State Level Registry and decide whether to take advantage of group or clinic eligibility.

In the Preamble to the Final Rule for the EHR Incentive programs, CMS has stated:

> "Any reassignment of payment must be voluntary and we believe the decision as to whether an EP does reassign incentive payments to a specific TIN is an issue which EPs and these other parties should resolve." (Federal Register, Vol. 75, No. 144, July 28, 2010, page 44486)

In compliance with this guidance, DHCS will not make determinations as to whether reassignments are voluntary and will leave that issue for providers and groups/clinics or other employers to resolve.

Definition of Groups and Clinics

DHCS has adopted the following three parameters for defining groups and clinics.

- Clinics—all clinics that are licensed by the California Department of Public Health ("1204a clinics") are considered clinics for the purposes of the Medi-Cal EHR Incentive Program.
- Groups—a group of providers that operates as a unified financial entity and has overarching oversight of clinical quality can be considered a group for the purposes of the Medi-Cal EHR Incentive Program. The group must have a single federal employer identification number (FEIN), but subgroups of providers can have separate national provider identifiers (NPIs). As dictated by federal regulations, the encounters of all providers under the FEIN must be counted in determining the patient encounter volumes for the group for the 90-day representative period. Pediatricians can apply to the program as members of a pediatric group for the purposes of establishing eligibility at the 20-29% Medi-Cal encounter level. However, non-pediatrician providers in the practice, such as nurse practitioners, cannot be members of a pediatric group even though they may bill Medi-Cal under the same FEIN. Because of the "all in—all out" rule if non-pediatrician providers in the practice apply for program eligibility based on their own encounters the pediatric group would have to be disbanded and all pediatricians would have to apply separately based on their own encounters. For this reason, it is recommended that pediatric groups only be used to establish eligibility if there are no other eligible providers in the practice who are not pediatricians.
- Designated Public Hospital (DPH) Systems—these systems often utilize one TIN to bill for the services of a large number of providers and data systems and clinical oversight may be divided into separate regions. For these reasons DHCS will consider

exceptions, on a case by case basis, that all providers under the single TIN must be registered as a single group. DHCS will assess requests from DPH systems to create multiple groups to assure that such requests follow operational and clinical oversight lines of authority and that the encounters of all providers under the TIN are captured in an appropriate group's volumes.

The Role of Group and Clinic Representatives

Group and clinic representatives play an important role in the State Level Registry for the Medi-Cal EHR Incentive Program. Group and clinic representatives have a separate portal in the SLR where they can enter information about the group/clinic, including the name of the group/clinic, TIN, NPI, its locations, the NPI of the eligible providers in the group/clinic, the group/clinic patient volumes, and the certified EHR technology utilized by the group/clinic. The group or clinic representative signs a statement regarding the validity and accuracy of the information entered about the group/clinic.

The Relationship of Group/Clinic Representatives and Eligible Providers

Eligible providers are identified by a group or clinic representative through the group/clinic portal. Providers may be identified as members by more than one group or clinic. When providers enter the provider portal of the SLR they will be notified of any groups or clinics for which they have been identified as members and given the option to choose to qualify with one of them or to qualify individually based on patient encounters elsewhere or on patient encounters in one of the groups or clinics. In the latter case, because of the implications to the relevant group or clinic, they will be requested to contact the SLR Help Desk. DHCS staff will have the ability to grant the provider individual registration and to "freeze" the affected group so that no further providers can use the group/clinic volumes to qualify, although providers who have already qualified with the group/clinic will not be disqualified.

Providers that elect to qualify with a group/clinic inherit the group's information already entered into the SLR, including the group/clinic's patient volumes and Certified EHR Technology information—thus expediting the provider's application. Providers will be able to modify the Certified EHR Technology information and stipulate the site or sites at which it has been or will be adopted, implemented, or updated.

Clinic Prequalification

DHCS has received approval from CMS to prequalify a large number of 1204a clinics based on data they submitted to the Office of Statewide Health Planning and Development (OSHPD) for 2010. When clinic representatives for these clinics enter the group/clinic portal beginning November 15, 2011 they will not be required to provide patient volume numbers. Beginning in program year 2017, prequalified clinics will be required to upload documentation of at least one Medi-Cal encounter in the prior calendar year or 12 months prior to attestation for each EP in their group/clinic. This documentation can be uploaded either to the EP's or the clinic's SLR account. Documentation in support of MU will be considered sufficient for this purpose, as long as encounters are designated for specific EPs.

Some prequalified clinics may find it advantageous to participate in a larger group to be established by a parent entity, such as a parent corporation. As long as the parent entity is

able to comply with the rules for groups described above, the parent entity can establish a group that would include providers in all clinics under it. By aggregating patient volume information across all clinics, some providers in clinics that did not qualify or only qualified at the 30% Needy Individual level may be able to participate in the program. DHCS is leaving it up to individual clinics and their parent organization to decide the best strategy for establishing eligibility for the Medi-Cal EHR Incentive Program.

Clinics that are not prequalified, or which choose not to take advantage of prequalification, will still be able to enter the group/clinic portal and enter all information about their clinic, but will be required to provide patient volume information and documentation for a 90-day period in the prior calendar year or in the12 months prior to attestation.

Adding Providers to Submitted Groups/Clinics

Group and Clinic representatives are able to add providers to the group/clinic subsequent to the original submission. This may be necessary because some providers have not been recognized by the SLR upon original submission due to not being found in DHCS's provider master file (PMF) or the National Level Registry (NLR). This can be remedied by the provider registering with the NLR, or by applying for participation in the Medi-Cal Fee-For-Service Program and being added to the PMF by DHCS. Also, beginning with program year 2016, DHCS expanded group/clinic membership to include providers with at least one Medi-Cal encounter with the group/clinic during previous calendar year or during the 12 months prior to the provider's attestation. Groups/clinics must have documentation for the qualifying encounter(s) outside of the group's 90-day representative period available for audit, and beginning July 25, 2017 must upload this documentation into the group/clinic SLR account prior to or at the time of the provider's attestation.

In order to add more than 4 providers to a group/clinic, a request to reopen the group in the SLR must be approved by OHIT. For 4 or fewer providers a manual work around process can be used. This two-step process is described below.

1. A letter must be uploaded to the group account stating the EP's name and NPI as well as the group/clinic name and NPI . The letter needs to acknowledge the provider has had at least one Medicaid encounter with the group/clinic in the 12 months prior to attestation or in the previous calendar year. The letter must also specify the number of Medicaid encounters and total encounters of the group/clinic during the representative period or must state that the group/clinic has a pre-qualified status. The letter is to be printed on letterhead and signed by the SLR Group Administrator or official replacement.

2. A letter must be uploaded to the EP's SLR account stating that the provider desires to apply with group. The group name and NPI must be specified in addition to the group/clinic Medicaid and total encounter volumes or prequalified status. This can be the same letter that was uploaded to the group/clinic account if it is also signed by the EP**.** Rather than submitting this letter, the EP may strike through the patient volume encounter numbers on the SLR generated Provider Attestation form (if individual

provider encounters or placeholder encounters such as 100/100 have been used), write in the correct encounters (from the group) or note that the group/clinic is prequalified. The group/clinic name and NPI must be specified and the EP must sign (not initial) near this added hand-written information. This amended Provider Attestation form must be uploaded to the EP's SLR account.

California Department of Health Care Services
Office of Health Information Technology
1501 Capitol Avenue, MS0004
Sacramento, CA 95814
(916) 552-9181

Email:
Medi-Cal.EHR@dhcs.ca.gov
Follow us on Twitter