Group/Clinic

Medi-Cal Promoting Interoperability Program

Frequently Asked Questions

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1. **What is a considered a "group/clinic" under the Medi-Cal Promoting Interoperability (PI) Program, formerly the Medi-Cal EHR Incentive Program?**

   The Department of Health Care Services (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 are considered clinics for the purposes of the Medi-Cal PI Program. These clinics are also referred to as 1204a clinics.

   - Groups – a group of providers that operates as a unified financial entity and has overarching oversight of clinical qualify can be considered a group for the purposes of the Medi-Cal PI Program. The group must have a single taxpayer identification number (TIN) or federal employer identification number (FEIN), but subgroups of providers can have separate national provider identifiers (NPIs).

   - 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.

For more information, please refer to Understanding Groups and Clinics.

2. **Can groups/clinics with a different TIN/FEIN but operating as a single entity apply as a single group in the SLR?**

   No. As defined in Understanding Groups and Clinics , groups must have a single TIN or (FEIN), operate as a unified financial entity, and have overarching oversight of clinical quality.

3. **How do groups/clinics apply?**

   To apply, the group/clinic representative must create a "group representative" account in the State Level Registry (SLR) using the group's NPI and TIN. The registration process requires entry of the group's aggregate Medi-Cal volumes. In addition, each of the providers in the group that contributed to those volumes must be listed as group members. The Group/Clinic Rep SLR Quick Start Guide offers a step-by-step look at the SLR enrollment process for groups.

   It is important to note that, in order for providers to utilize group volumes, the group must list the provider as a group member and submit the group application *first*. Providers will not be able to apply under their group until the group lists them as a member and completes the application process.

4. **Can the group determine which providers' encounters will be used toward the group volumes?**

   No, groups must abide by the "all in" methodology when calculating group volumes: the encounters of ***all*** providers in the group, not just those eligible for incentive payments (i.e. encounters from dieticians, pharmacists, and other ineligible provider types must be included in the volumes as well), during the representative period must be included. If the encounters of any provider are excluded, the group cannot establish eligibility as a whole.

5. **Which providers are groups required to list as group members?**

   Groups are required to add to their group (during Step 3 of the SLR enrollment process) all providers who:

   1) Contributed to group encounters during the representative period, and
   2) Are one of the eligible provider types (physician, nurse practitioner, certified nurse midwife, dentist, physician assistant, and optometrist).

   There has been a misconception that if an eligible provider is not planning to apply to the program or is not *currently* with the group that they should not be added to the group. This is not the case. All eligible providers that contributed to group volumes during the representative period must be listed as group members.

   Groups should not add providers as members of their groups who contributed to group encounters but who are ***not*** one of the eligible provider types (e.g. pharmacists, dieticians). However, groups can upload a letter into the SLR listing the names and NPIs of these non-eligible providers. This may be useful if the group is requested to provide supporting documentation for its patient volumes in a subsequent audit.

Updated – 10/29/15

6. **Which providers may groups list as group members?**
   In addition to the providers that must be listed as group members addressed in question 5 above, groups may list eligible professionals who had at least one Medicaid encounter with the group within the same calendar year as the representative period or within the twelve months preceding attestation In the case of FQHCs, RHCs, and IHCs, professionals may also be listed who practiced predominantly with a clinic during a continuous 6 month period in the 12 months preceding the date of attestation.
   New – 10/29/15

7. **When I attempt to add a provider to my group, I get a "provider not found" error. How do I proceed?**
   The SLR will recognize the provider only after they register with CMS' Registration and Attestation Site (note: it may take the SLR up to 3 days to receive the information from CMS).

   You will receive the "provider not found" error for group members who have not completed registration with CMS. Have the provider complete their registration with CMS, and then try adding the provider again. For providers who do not intend to register, you will be required to upload a letter into the SLR listing these group members that you were unable to "add" to your group.

   It is important to note that if the group does not "add" the provider as a member, the provider will not be able to utilize the group's volumes during the EP registration process.

8. **If a provider chooses to utilize group volumes, will the group automatically receive the provider's incentive payment?**
   No. Incentive payments will be issued either to the provider or to the payee that the provider designates during the CMS registration process. Providers may voluntarily reassign their full incentive payment to their employer or to an entity with which they have a contractual arrangement allowing the employer or entity to bill and receive payment for the EP's covered professional services. 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.

9. **If a provider opts to utilize their group volumes, will they be required to enter any data in the SLR?**
   If a provider chooses to participate with a group (which they indicate in Step 1 of the SLR registration process), they will still be required to register and submit an attestation form to the state, however the provider will automatically inherit the group's volumes and will not be required to enter any eligibility data in Step 2.

10. **Are groups able to aggregate meaningful use (MU) data amongst all of the group members?**
    No, meaningful use data must be reported separately for each provider.

11. What does it mean for a clinic to be prequalified and how can I find out if my group/clinic is prequalified? What can I do if my group/clinic is not prequalified?

Every year, the Department of Health Care Services reviews data from the Office of Statewide Health Planning & Development (OSHPD) to qualify certain clinics based on their Medi-Cal and other needy individual encounter volumes. This qualification status allows the clinic to submit their registration for the EHR Incentive Program without having to calculate and provide encounter data for their providers. It does not suggest those clinics not on the list are ineligible for the program. It is simply a method OHIT has employed to facilitate clinics with current OSHPD data to simplify their application process and speed OHIT's review. The process is called 'prequalification' and may allow your clinic to expedite its application.

For the 2018 program year, the list of prequalified clinics is available on the Medi-Cal EHR Incentive Program website. Please note, the end of this list also includes clinics that have been prequalified but for which no NPI has been documented. These clinics should submit their OSHPD ID number and associated clinic NPI to ClinicPrequal@dhcs.ca.gov. The NPI used by the clinic to bill Medi-Cal is preferred. Once verified, the list of 2018 Prequalified Clinics will be updated. The list is updated once per month, at the end of the month. You will not be able to utilize your clinic's prequalification in the SLR until the list has been updated.

If your group/clinic is not on this list, it may be because your data was not: submitted to OSHPD; submitted by OSHPD's deadline; for a full year of data; or your clinic was found to have a Medicaid or Medicaid plus other needy individual encounter volume below 30%. Your clinic can still submit its group registration for the EHR incentive program to the SLR, but your clinic will need to calculate and provide encounter data for your clinic for a 90-day representative period in the previous year. Although a clinic may not qualify for the Medi-Cal PI Program using an entire year's data, it may qualify based on data from a 90-day representative period.