

Provider

Medi-Cal Promoting Interoperability Program

Frequently Asked Questions

The Medi-Cal Promoting Interoperability (PI) Program, formerly the Medi-Cal Electronic Health Record (EHR) Incentive Program, provides incentive payments to eligible Medi-Cal providers and hospitals to adopt, implement, and upgrade the use of certified EHR technology. In 2012, the program began providing incentive payments for the “meaningful use” of certified EHR technologies. The frequently asked questions below provide basic information about the program divided into five sections. For specific FAQs, click on a topic below:

Eligibility Requirements

Incentive Payments

Adopt, Implement, and Upgrade (AIU)

Meaningful Use

Program Registration and Enrollment

Eligibility Requirements

What types of providers are eligible for the Medi-Cal EHR Incentive Program?

Eligible providers include:

- Physicians
- Nurse Practitioners
- Certified Nurse-midwives
- Dentists
- Optometrists (beginning in January 2013)
- Physician Assistants working in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is led by a physician assistant

Can any Medi-Cal provider receive EHR incentive program payments?

In order to be eligible for payments providers are required to have 29.5% or more of their patient volume attributable to Medi-Cal patients during a 90-day period in the preceding calendar year. Pediatricians can qualify at the 19.5-29% level but will receive payments reduced by one-third at this Medi-Cal patient volume level. Providers that practice predominantly in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) may count Healthy Families, partial pay, and uninsured patients towards meeting the 30% (or 20%) patient volume requirement. For this purpose, beginning in 2013, practicing predominantly is defined as having at least 50% of the provider’s patient encounters occur at an FQHC or RHC in a 6-month period in the preceding 12 months or the prior calendar year. Because of this new definition, providers who practice predominately in an FQHC or RHC may

use the clinic's encounter volume as a proxy to establish program eligibility without having an encounter with the clinic in the preceding calendar year.

Providers whose practice volume occurs 90% or more in an acute hospital or emergency room setting are not eligible for Medi-Cal EHR Incentive Program payments. However, beginning in 2013, providers will be able to apply for a waiver of this exclusion if they can provide documentation that they fund the acquisition and maintenance of hardware and certified EHR technology that they use in a hospital or emergency room setting instead of the hardware and certified EHR technology provided by the facility.

How is patient volume calculated?

The provider may calculate patient volume for a representative, continuous 90-day period in the preceding calendar year using either of two formulas:

- **Formula 1:**

$$\frac{\text{Total Medi-Cal Encounters}^*}{\text{Total All Patient Encounters}}$$

* Note: Medi-Cal encounters may only be counted once for services received from the same provider on the same day.

Beginning in program year 2013 services that are covered by Medi-Cal and delivered to patients enrolled in Medi-Cal may be counted regardless of whether Medi-Cal is billed for or pays for the service. Medi-Cal encounters may not be counted for patients in the 13 Medi-Cal aid codes that do not include federal financial participation, including OR, OT, 2V, 4V, 53, 65, 7M, 7N, 7P, 7R, 71, 73, 81.

- **Formula 2:**

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

* Note: In order to be counted in either the numerator or denominator, capitated panel patients must have had at least one encounter in the 24 months immediately preceding the 90-day period selected for determining eligibility.

What constitutes a “billable” Medi-Cal service?

A complete list of the CPT codes for billable Medi-Cal services are available on the [Medi-Cal website](#).

What are the “representative” and “MU reporting” periods and how do they differ?

The representative period is used to determine if the provider is eligible for the Medi-Cal EHR Incentive Program.

- It must be a continuous 90-day period in the calendar year prior to the calendar year for which the provider is applying for Medi-Cal EHR incentive funds.
- The Medi-Cal encounters during this 90-day period must constitute 29.5% or more (19.5% or more for pediatricians) of the provider's total encounters in order for the provider to be eligible for Medi-Cal EHR incentive payments for the subsequent calendar year. For example, a provider applying for 2013 calendar year would use a 90-day period from the 2012 calendar year as the representative period.

The MU reporting period is used to determine whether a provider has satisfied meaningful use (MU) of their EHR.

- It must be in the same calendar year as the calendar year for which the provider is applying for incentive payments.
- For the first year of MU participation the reporting period can be any continuous 90-day period within the calendar year for which the provider is applying for funds. For the second and subsequent MU years, the MU reporting period must be the entire calendar year for which the provider is applying for incentive payments (except in the 2014 and 2015 program years when all MU reporting periods are 90 days). For program year 2019, all providers will have a 90-day MU reporting period. (Revised 6-17-2019).
- For the 2019 program year, a 2015 CEHRT must be used during the entire MU reporting period but does not need to be certified until the end of the MU reporting period. (Revised 6-17-2019).

For the Medicare and Medicaid EHR Incentive Programs, when a patient is only seen by a member of the eligible professional's (EP's) clinical staff during the EHR reporting period and not by the EP themselves, do those patients count in the EP's denominator?

The EP can include or not include those patients in their denominator at their discretion as long as the decision applies universally to all patients for the entire EHR reporting period and the EP is consistent across meaningful use measures. In cases where a member of the EP's clinical staff is eligible for the Medicaid EHR incentive in their own right (NPs and certain physician assistants (PA)), patients seen by NPs or PAs under the EP's supervision can be counted by both the NP or PA and the supervising EP as long as the policy is consistent for the entire EHR reporting period.

Can providers include encounters that occurred before they became licensed toward establishing eligibility for the Medi-Cal Promoting Interoperability Program?

Yes, if the encounters occurred during the appropriate 90-day representative period in the preceding calendar year and were performed in a training role required for licensure. For example, a licensed second year medicine resident can count encounters that were delivered during the previous calendar year when they were an unlicensed intern in training. In order to

apply for the program providers must be currently licensed.

Is there a minimum amount that a provider must spend on implementation, adoption or upgrading of a certified EHR in order to qualify for the Incentive Program?

There is no minimum spending amount that must be demonstrated. The only requirement is a binding legal or financial agreement to adopt, implement or upgrade to certified EHR technology. This can be in the form of a contract, lease or other appropriate documentation.

Is a provider or hospital eligible for the Medi-Cal EHR Incentive Program if they are also participating in the Medicare EHR Incentive Program?

Providers can only participate in one program at a time and can switch between programs once before the 2015 payment year. The Medicare EHR incentive program is administered directly by CMS and has different eligibility requirements and payment schedules. The main difference is that the Medicare program does not provide incentive funds for adopting, implementing, or upgrading an EHR in the first year.

When a provider begins in the Medicare EHR Incentive Program and subsequently switches to the Medi-Cal EHR Incentive Program is the provider eligible for the first year AIU payment?

No. A payment for AIU can only be made in the first year of the Medi-Cal program and providers who switch from Medicare to Medi-Cal are considered to be in the same payment year they would have been in had they started first with the Medi-Cal program. Section 495.10 of the Final Rules states that an EP who switches programs “Is placed in the payment year the EP would have been in had the EP begun in and remained in the program to which he or she has switched.”

What does PA-led mean?

Physician Assistant-led means that one PA must currently lead the clinic. A lead PA is either:

- a. Clinical director, or
- b. Dominant provider with the
 - i. Most patient encounters, or
 - ii. Most assigned patients, or
 - iii. Most practice hours

“Currently” means for the day on which the PA signs the [PA-led attestation form](#). The day of signing must be within the valid attestation period for the program year (i.e. the calendar year and the grace period in the following calendar year). Before 2013, the Department of Health Care Services (DHCS) also required that the clinic be PA-led for 25% of the time in the 12 months prior to attestation, but this requirement has been removed.

Does every PA have to fill out the PA-attestation form and where can it be found?

Yes, every PA at a PA-led FQHC must individually fill out the form, sign, and submit it with their registration. The [PA-led attestation form](#) can be found at [State Level Registry website](#).

If one site is PA-led, does that mean that every PA at the other sites within one FQHC or RHC are eligible for the Medi-Cal EHR Incentive Program?

Yes, if all sites are legally part of the same FQHC or RHC.

If I am audited, what documentation will I need to supply to prove that my clinic is PA-led?

The provider should be able to provide documentation that shows the clinic site was led by a PA for the day on which the attestation was signed by the provider. Time sheets or appointment schedules may be useful for documenting practice hours or number of patients.

If my clinic is PA-led on a certain day, does that day have to be within the 90-day representative period that is selected for eligibility?

No, but the day of signing must be within the valid attestation period for the program year (i.e. the calendar year and the grace period in the following calendar year).

Are licensed midwives eligible to participate in the Medi-Cal Promoting Interoperability Program?

No. Federal regulations specify that only certified nurse-midwives are eligible to participate in the program. In California, certified nurse-midwives are licensed by the California Board of Registered Nursing and are required to be registered nurses. Licensed midwives are licensed by the Medical Board of California and are not required to be registered nurses. These are different professional categories with different scopes of practice. Only nurse-midwives licensed by the California Board of Registered Nursing are eligible to participate in the Medi-Cal Promoting Interoperability Program.

Incentive Payments

What are the maximum incentive payments an eligible provider can receive under the Medi-Cal EHR Incentive Program?

The maximum incentive payment for providers is \$63,750 over a period of 6 years. The first year payment is \$21,250 with 5 subsequent payments of \$8,500. Payments to pediatricians qualifying at the 19.5-29% patient volume level are reduced by one third.

Can providers reassign their payments to a clinic or other entity?

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. Partial reassignment of payments is not permitted.

Will the State make determinations as to whether reassignment of an EHR Incentive payment by a provider to an employer is voluntary?

No. 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.

Can I change the assignment of my payment after I have been paid?

No. DHCS issues the payment (and the 1099 form) to the Tax Identification Number (TIN) or Social Security Number (SSN) that the provider designated in CMS's National Level Registry. After a payment has been issued, DHCS does not have a mechanism to recover and reissue a payment to a different TIN or SSN. If a provider receives a payment and then would like to give the funds to an employer without being liable for income taxes, the provider may consult with an accountant as to how this can be accomplished.

Are providers required to use the incentive payments for offsetting the cost of an EHR?

The incentives are not a reimbursement and may be used at the provider's discretion, similar to a bonus payment.

How will I receive my incentive payment?

Incentive payments are issued to the payee National Provider Identifier (NPI)/TIN that is designated when the provider registers with CMS through the [CMS Registration & Attestation Site](#).

If the payee NPI/TIN has a record in the state's Provider Master File (PMF) and currently receives Medi-Cal claim reimbursements, incentive payments will be issued in the same method as the Medi-Cal claim reimbursements (electronic fund transfer (EFT), or paper warrant) sent to the payment address that Medi-Cal has on file.

If the payee NPI/TIN does not have a record in the state's PMF, a record will be created and the payee will receive the incentive payment in the form of a paper warrant. If providers have reassigned payments to a group or clinic, the payments will be received separately by the group or clinic for each provider.

Incentive payments will appear on the Medi-Cal Remittance Advice Detail (RAD) under a single Accounts Receivable (A/R) Transaction code, followed by the total dollar amount of your incentive payment, and a three digit RAD code message of 728 (for payments made prior to 1/21/2013) or 769 (for payments made after 1/21/2013).

Adopt, Implement, and Upgrade (AIU)

What does Adopt, Implement or Upgrade (AIU) mean?

In the first participation year of the Medi-Cal EHR Incentive Program, eligible providers chose to adopt, implement or upgrade to (AIU) a Certified EHR instead of demonstrating meaningful use. CMS defines AIU as:

- Adopt: to acquire and install a certified EHR system
- Implement: to begin using a certified EHR system
- Upgrade: to expand a certified EHR system that is already in use

What is a Certified EHR System?

The Secretary of the Department of Health and Human Services has implementation specifications, and certification criteria for EHR technology. Certified EHR systems have to be tested and certified as such by the Office of the National Coordinator.

A list of certified EHR systems can be found on the [Certified Health IT Product List](#). It includes both complete and modular systems for both ambulatory and inpatient use. If modular systems are used they must be combined so as to provide the full functionality of a complete system.

Can a provider sign a contract for certified EHR technology during the 3 month extension period for attestation and still be eligible for incentive payments for that year?

For the 2016 program year only, professionals may qualify for AIU by signing a contract or other binding document for certified EHR technology during the 3-month extension period ending March 31, 2017. Contracts for prior program years must have been signed during the program year and not during the extension period. (Revised 7-25-16)

Can dentists attest to AIU with a non-dental certified EHR?

Yes, at present there is no requirement that the certified EHR technology must be specialty appropriate.

Meaningful Use

What is meaningful use?

Meaningful use of an EHR is demonstrated by providers reporting on a number of required functional and clinical objectives established by CMS. In 2012, the program began accepting attestations on meaningful use objectives, and providers will be required to submit new attestations in order to continue receiving payments after their AIU year.

If a provider fails to report on meaningful use objectives must the AIU incentive payments be returned?

No. The incentive payments received for each year in the program are separate from each other.

Will the state require hospitals or providers to report on any additional objectives or measures beyond those required by of all states by federal regulations?

No. DHCS will only require reporting on the same objectives and measures as specified by the federal Final Rule for the EHR Incentive Programs, which are the same objectives and measures required by the Medicare EHR Incentive Program.

Can medical assistants use an EHR for the purposes of computerized provider order entry (CPOE)?

The Final Rule for Stage 2, published September 5, 2012, stated that for the purposes of CPOE, the definition of “licensed healthcare professionals” who can enter data into an EHR has been expanded to include “credentialed medical assistants.” The criteria for credentialing is not defined except that credentialing “would have to be obtained from an organization other than the employing organization.”

The State of California does not license, certify, or register medical assistants. According to the Medical Board of California, a medical assistant may be considered to be “qualified” if they are certified by a [medical assistant certifying organization](#). Also, according to the California Code of Regulations, Title 16 of the Professional and Vocational Regulations, Section 1366.3(a)(1), medical assistant training may be administered in either of two settings: (1) under a licensed physician, registered nurse, licensed vocational nurse, PA, or a qualified medical assistant; or (2) via a secondary, postsecondary or adult education program, in a community college program or postsecondary institution accredited by a recognized accreditation agency.

In 2013, DHCS decided for the purposes of assisting with CPOE in the Promoting Interoperability Program, a medical assistant to be credentialed if: 1) the medical assistant is certified as defined by the Medical Board of California or 2) the medical assistant has completed a secondary, postsecondary, adult, community college or institutional program as described in option 2 of the California Code of Regulations, Title 16 of the Professional and Vocational Regulations, Section 1366.3(a).

On October 15, 2015, CMS published the 2015-2017 Modification Final Rule which stated: “We maintain our position that medical staff must have at least a certain level of medical training in order to execute the CDS for a CPOE order entry. We defer to the provider to determine the proper credentialing, training, and duties of the medical staff entering orders as long as they fit within the guidelines we have proscribed.” In compliance with this directive, DHCS leaves it up to the providers to determine whether medical assistants and other staff meet the requirements for CPOE.

If a provider switches from Medicare to Medicaid are they considered to be in year one of MU reporting to Medicaid?

No. Providers that have reported MU measures to the Medicare EHR incentive program continue into the next year of MU reporting with Medicaid. Such providers are not eligible to attest to AIU with Medicaid. For example, a provider who has completed one year of MU reporting to Medicare would be considered in their second year of MU reporting with Medicaid. For this reason they would need to use the entire calendar year as the MU reporting period (except in the 2014 program year when all MU reporting periods will be 90 days).

If a provider must use a 365 day reporting period, when can they submit their MU attestation?

Providers using a year-long MU reporting period must apply to the Medi-Cal EHR Incentive program during the 3 month “tail period” in January 1 to March 31 of the next calendar year. For example, such providers using a year-long MU reporting period to apply for 2013 program year incentive payments must submit their application during the period of January 1, 2014 to March 31, 2014.

If a provider did not actively practice (due to maternity leave or other reason) during part of the 90-day representative period and/or MU reporting period, can they still be considered eligible for the program?

Yes. The provider must be an active Medi-Cal provider during the entire 90-day representative period and MU reporting period, and must have delivered at least one encounter for a billable service to a Medi-Cal-enrolled patient. This encounter does not need to actually have been billed to or paid by Medi-Cal. In order to demonstrate “active” Medi-Cal provider status the provider must be in an “active” status in the Medi-Cal Provider Master File or have an active contract to serve Medi-Cal patients through a managed care health plan. (Revised 3-1-16)

Can a provider use a MU reporting period for the CQMs that is different from that used for the core and menu objectives?

Yes, providers under the 90-day reporting period requirement can have a CQM reporting period that is different from the core and menu reporting period as long as the period used is within the same calendar year and at least 90 days long. If doing this, the provider or group should upload a letter into the SLR documenting the beginning and ending dates for the CQM reporting

period (any document upload button available in the SLR can be used for this purpose).

The Medicare EHR Incentive Program is requiring the electronic submission of CQMs in 2014. Will the Medi- Cal EHR Incentive Program also require this in 2014 and beyond?

No. DHCS does not have the ability to electronically receive CQM data from EHRs. For this reason, DHCS will continue to require submission of CQM data into the State Level Registry by attestation⁴. Any future plans to require electronic submission of CQM data from EHRs will be announced on the State Level Registry home page.

Is a provider required to apply for an exclusion from reporting on an objective if the provider meets the criteria for an exclusion?

No. Providers do not have to apply for an exclusion for an objective just because they are eligible for it. In some circumstances, it may be to the provider's advantage not to apply for an exclusion. For example, applying for exclusions for both Stage 1 public health menu objectives then requires that the provider meet or exclude all non-public health objectives in order to satisfy the menu objectives. The Stage 1 public health objectives can be met by providers even if they lack actual data because the objectives allow providers to submit fictional patient data on immunizations or syndromic surveillance to a registry. Also, if one provider in a physical setting using a single EHR submits test data, all providers in the setting are deemed to have performed such a test. The test can be performed at any time during the program year or the application tail period prior to attestation in the State Level Registry.

Program Registration and Enrollment

How do providers register for the program?

This consists of two steps:

1. Step one: register with [CMS's national level registry \(NLR\)](#).
2. Step two: register with [California's state level registry \(SLR\)](#).

Providers may begin the enrollment process with the SLR, but the application will not be processed until enrollment has been completed with the NLR.

What information will providers need to enter into the SLR for enrollment?

A workbook is available on the [SLR website](#) to assist providers in preparing for enrollment. It is recommended that the workbooks be examined before beginning the enrollment and registration process.

If providers want to participate, must they begin participation by a certain date?

Yes, providers cannot begin participating after program year 2016.

Do providers need to participate every year for the Medi-Cal Promoting Interoperability Program?

No. Providers are not required to participate in consecutive years. Providers who skip years of participation will resume the progression of Meaningful Use (MU) where they left off. All providers are required to meet two years of Stage 1 in their first two years of MU and then proceed to Stage 2, regardless of not participating in consecutive years. (Note: there is an exception to that general rule for providers who demonstrated MU in 2011. These providers need not move to Stage 2 until 2014.)

When does the Medi-Cal Promoting interoperability Program end?

The program is currently scheduled to end in 2021. Providers are no longer able to participate in the program after receiving six yearly payments

Is an electronic/digital signature acceptable on the attestation forms for the Medi-Cal Promoting Interoperability Program? No. Because of the amount of money involved and the need to know that the provider is fully aware of any reassignment of these funds, DHCS requires physical signatures on all attestation forms uploaded to the State Level Registry.

Will Medi-Cal perform audits on providers that participate in the Medi-Cal Promoting Interoperability Program?

Yes. All applications undergo a pre-payment review to validate eligibility requirements have been met before payment is issued. Post-payment audits will also be completed for some

providers during the course of the Medi-Cal Promoting Interoperability Program. DHCS will perform audits on Medi-Cal providers and hospitals participating only in the Medi-Cal Promoting Interoperability Program. Providers and hospitals participating in the Medicare EHR Incentive Program will be audited by CMS and its contractors (this includes dually eligible hospitals that participate in both Medicaid and Medicare incentive programs).

If, based on an audit, a provider is found to have not been eligible for an EHR incentive payment, the payment will be recouped.

What does a provider need to do to prepare for an audit?

All providers attesting to receive an EHR incentive payment through the Medi-Cal Promoting Interoperability Program should retain all relevant supporting documentation (in either paper or electronic format) used in the completion of the attestation process. Documentation should be retained for seven years post-attestation.

An audit may include a review of any of the documentation needed to support the information that was entered in the attestation. To ensure you are prepared for a potential audit, save the electronic or paper documentation that supports all data in your attestation. Upon audit, the documentation will be used to validate that the provider accurately attested and has met all eligibility requirements, as well as to verify that the incentive payment was accurate.

Documentation should be retained that supports all data in your attestation, for example:

- ✓ Patient encounter volumes.
- ✓ Documentation showing a legal and/or financial binding commitment to adopt, implement, or upgrade (AIU) to a certified EHR (required if the first year incentive payment is issued for AIU).
- ✓ Meaningful Use data and reports, including values entered for Clinical Quality Measures (CQMs). The provider should be able to provide documentation to support each measure to which he or she attested, including any exclusions claimed by the provider. To support the attestation, providers are highly encouraged to upload this documentation to the State Level Registry during the application process, although this is currently not required.
- ✓ Hospitals should also maintain documentation that supports their payment calculations.

Note: The level of the audit review may depend on a number of factors, and it is not possible to include an all-inclusive list of supporting documents. Providers are urged to keep records of any and all documentation that supports the data in their attestation.