



Contract Providers Transition Team (CPTT) Meeting Agenda

September 20, 2011
10:00 a.m. – noon

- ✓ **Welcome**
- ✓ **Announcements**
- ✓ **Los Angeles Network for Enhanced Services (LANES)**
Presentation by Robert Greenless, Ph.D.
- ✓ **Meaningful Use - Menu Set Measures**
Presentation by Gordon Bunch
- ✓ **PATS Decommission and e-Prescribing**
Presentation by Gordon Bunch
- ✓ **IBHIS and HIPAA 5010 Updates**
Presentation by Jay Patel
- ✓ **CPTNP Unit Update**
- ✓ **Open Discussion**

Next Meeting – TBD

"To Enrich Lives Through Effective And Caring Service"

Los Angeles Network for Enhanced Services (LANES)

**Contract Provider Transition Team
Workgroup**

September 20, 2011



What is LANES?

- LANES is a public/private Health Information Exchange (HIE) initiative in which LA County is a participant
- It's purpose is to improve regional health information integration and coordination of care and facilitate electronic exchange of information among public and private providers
- The establishment of LANES is partially funded through a grant from Cal eConnect.



LANES Board Seats

- Local Government Entity
- Public Health Plan
- Community Clinic Group
- Hospital Group
- Independent Organization
- Physician Group
- Commercial Health Plan
- Health Information Exchange
- Health Advocacy Group



The LANES Vision

An integrated, secure and forward-looking information management system that will facilitate the provision of timely, patient-centered and high quality healthcare across the continuum of services, the management of emergency and other situations important to the public's health, and continuous quality improvement of healthcare and public health processes and outcomes.



The LANES Mission

LANES seeks to improve healthcare delivery in Los Angeles County and surrounding areas by ensuring that health information is available when and where it is needed in a safe and secure manner.



LANES Technology Partner

- Western Health Information Network (WHIN) is the technology provider for the LANES HIE infrastructure
- WHIN is a non-profit 501(c)3 corporation
- WHIN has a Federal contract to participate in the National Health Information Network



Health Information Exchange: Defined

- Health Information Exchange (HIE) is the secure, electronic exchange of health information among authorized stakeholders in the healthcare community such as care providers, consumers, and public health agencies
- An essential function of a HIE is the maintenance of an Enterprise Master Person Index (EMPI)



LANES: Enterprise Master Person Index (EMPI)

- An index of clients across all agencies participating in LANES that identifies persons who receive services from one or more participating service providers
- EMPI will contain *ONLY* basic demographics and key identifiers
- Matches and links records across heterogeneous data sources



LANES: Enterprise Master Person Index (EMPI)

- Provides the “Golden” Record for client identification purposes
- Maintains record linkages and updates the “Golden” record when a linked record in a participating system is updated

LANES EMPI

- **EMPI key system functions are to:**
 - **Identify** persons based on defined demographics and key identifiers
 - **Link** identifiers from multiple systems/departments to a specific person record
 - **Refer** users to authoritative sources of information and records using established standards

LANES:

DMH and Contract Provider Participation

- The County had been preparing to purchase an EMPI solution for DHS and DMH; LANES made that effort redundant
- LANES was created at the request of the County Board of Supervisors and DHS and DMH are participating
- Contract Providers, as part of the DMH provider network, will have the option to participate (become members) in the LANES HIE

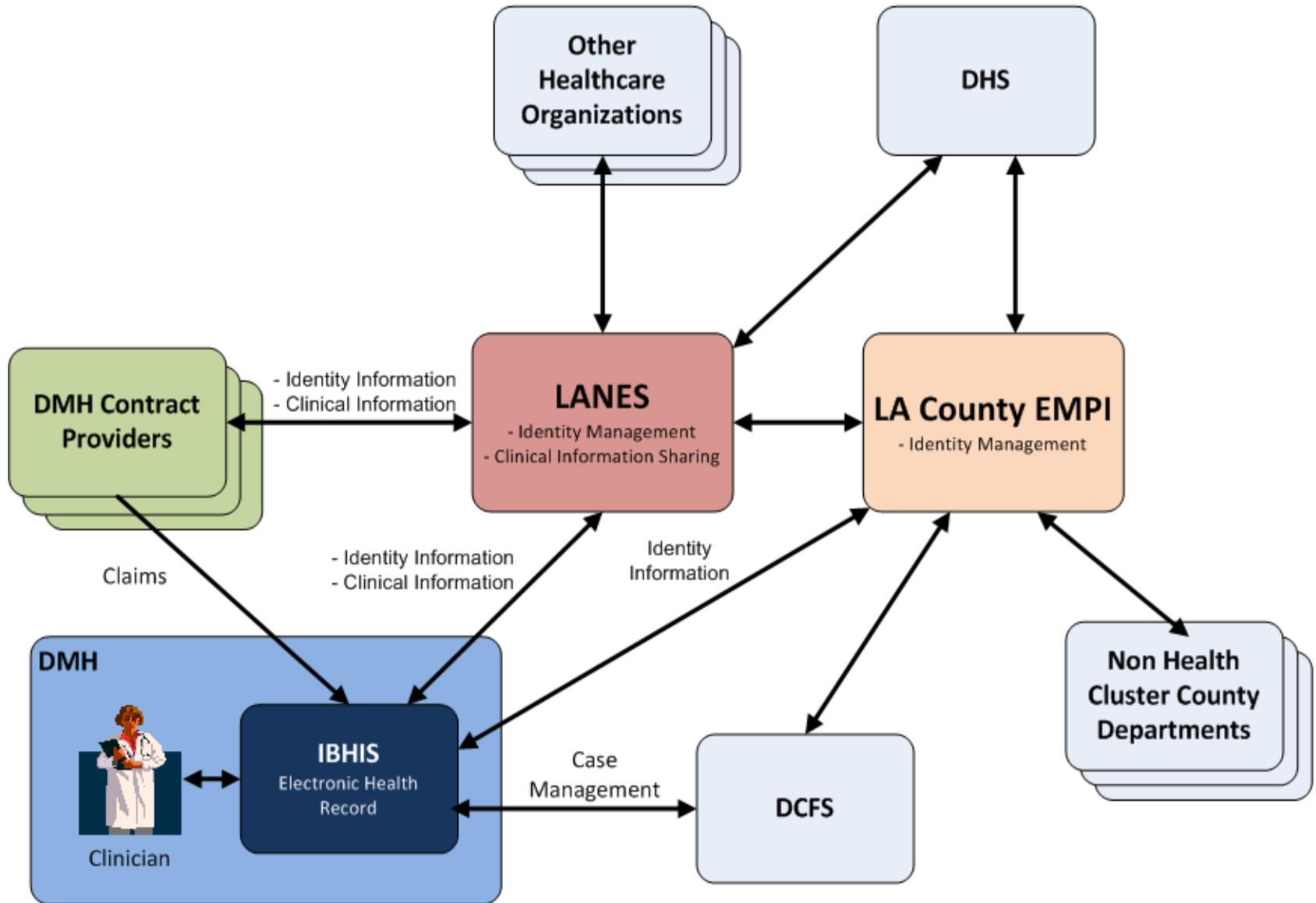


LANES: A Change of Direction Consistent with Meaningful Use

- To achieve meaningful use of health information technology and receive ARRA stimulus funds, you must participate in an HIE to coordinate care electronically and collaborate with other members of your patients' care team



LOS ANGELES COUNTY DMH IBHIS/LANES/EMPI FUTURE VISION



FUTURE VISION: KEY POINTS FOR CONTRACT PROVIDERS

- Contract Provider claims transactions will still be submitted directly to DMH
- Client identity, most clinical, and some administrative information exchanges between Contract Providers and DMH may be conducted via LANES (And this is expected to evolve over time.)



FUTURE VISION: KEY CONSIDERATIONS FOR CONTRACT PROVIDERS

- DMH Legal Entity Contract Providers will have the option to join LANES
- Costs associated with participation in the LANES HIE will be at Contractors expense
- Costs of participation for DMH Contract Providers not known at this time



FUTURE VISION: KEY CONSIDERATIONS FOR CONTRACT PROVIDERS

- Data exchange requirements will be determined during IBHIS implementation
- Contract Providers must move forward with Electronic Health Record projects in preparation for:
 - LANES
 - IBHIS
 - E-Prescribing
 - Meaningful Use



FUTURE VISION: KEY CONSIDERATIONS FOR CONTRACT PROVIDERS

- Recommendation: Contract Providers who have not requested MHSA IT funds should submit project proposals soon



LANES Participants

- AltaMed Health Services
- Citrus Valley Health Partners
- Community Clinic Association of LA County
- Community Health Alliance of Pasadena
- Hollywood Presbyterian Medical Center
- Hospital Association of Southern California
- Los Angeles Christian Health Centers
- LAC-DHS
- LAC-DMH
- Providence Health and Services
- QueensCare Family Clinics
- Tarzana Treatment Centers
- The Children's Clinic
- LabCorp
- Quest Diagnostics
- Wellpoint
- LA Care Health Plan



QUESTIONS





Health Information Technology for Economic and Clinical Health Act

HITECH Meaningful Use

- Menu Set Measures-

CPTT Workgroup – September 20, 2011



“To Enrich Lives Through Effective And Caring Service”

What is “Meaningful Use”



MU is a series of goals, objectives and measures that enable significant and measureable improvements through a transformed healthcare delivery system.

Five MU goals – 2011:

- Improve quality, safety and efficiency and reduce healthcare disparities
- Engage patient and families in their health care
- Coordinate care
- Raise the health status of the population
- Maintain privacy and security of systems and data

What is “Meaningful Use”



The HITECH Act specifies three main components of meaningful use:

- The use of a certified EHR in a meaningful manner
- The use of certified EHR technology for electronic exchange of health information to improve quality of care
- The use of certified EHR technology to submit clinical quality and other measures

Payment Schedule: Medicare

Year Paid	MU of EHR starting in year:			
	2011	2012	2013	2014
2011	\$18,000			
2012	\$12,000	\$18,000		
2013	\$8,000	\$12,000	\$15,000	
2014	\$4,000	\$8,000	\$12,000	\$12,000
2015	\$2,000	\$4,000	\$8,000	\$8,000
2016		\$2,000	\$4,000	\$4,000
Total	\$44,000	\$44,000	\$39,000	\$24,000



Payment Schedule: Medi-Cal

Year Paid	MU of EHR starting in year:					
	2011	2012	2013	2014	2015	2016
2011	\$21,250					
2012	\$8,500	\$21,250				
2013	\$8,500	\$8,500	\$21,250			
2014	\$8,500	\$8,500	\$8,500	\$21,250		
2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	
2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
2017		\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
2018			\$8,500	\$8,500	\$8,500	\$8,500
2019				\$8,500	\$8,500	\$8,500
2020					\$8,500	\$8,500
2021						\$8,500
Total	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750





Medi-Cal Registration

State Registry/Attestation Launch Dates:

- October 3, 2011 Eligible Hospital Registration
- November 15, 2011 Eligible Group Registration
- December 15, 2011 Eligible Professional Registration

State is finalizing their definition of a “Group”. Will likely include large health systems and medical practices. Centers for Medicare & Medicaid Services (CMS) must approve the definition submitted by State.

Launch Dates may affect the timing of payments. The total amount of payments will not be affected.

Stages of Meaningful Use by Year

	PAYMENT YEAR				
First Payment Year	2011	2012	2013	2014	2015+
2011	STAGE 1	STAGE 1	STAGE 2	STAGE 2	TBD
2012		STAGE 1	STAGE 1	STAGE 2	TBD
2013			STAGE 1	STAGE 1	TBD
2014				STAGE 1	TBD

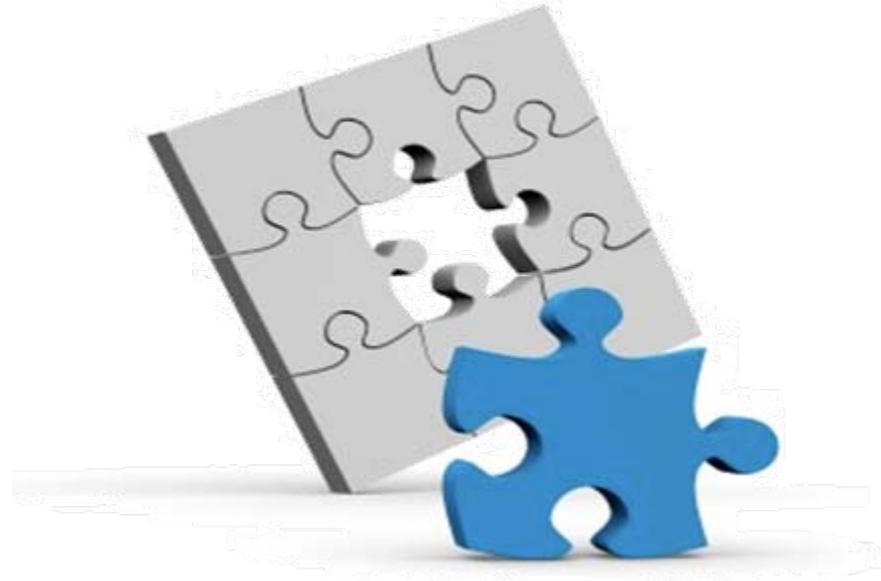


Stage 2 may be delayed until 2014

Meaningful Use Criteria

Ambulatory

Menu Set Measures



Menu Measure 1



Objective: Implement drug-formulary checks

Stage 1 Use Measure: The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.

*Exclusion: Any EP who writes fewer than 100 prescriptions during the EHR reporting period

Menu Measure 2



Objective: Incorporate clinical lab test results into EHR as structured data.

Stage 1 Use Measure: More than 40% of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.*

***Exclusion:** *Any EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.*

Menu Measure 3



Objective: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.

Stage 1 Use Measure: Generate at least one report listing patients of the EP with a specific condition.

Menu Measure 4



Objective: Send reminders to patients per patient preference for preventive/follow-up care.

Stage 1 Use Measure: More than 20% of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.*

***Exclusion:** *An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.*

Menu Measure 5



Objective: Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP.

Stage 1 Use Measure: At least 10% of all unique patients seen by the EP are provided timely (available to the patient within 4 business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information.*

***Exclusion:** *Any EP that neither orders nor creates any of the information listed at 45 CFR 170.304(g) during the EHR reporting period.*

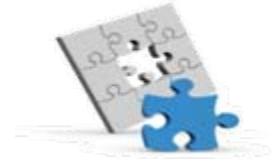
Menu Measure 6



Objective: Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.

Stage 1 Use Measure: More than 10% of all unique patients seen by the EP are provided patient-specific education resources

Menu Measure 7



Objective: The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

Stage 1 Use Measure: The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP.*

***Exclusion:** *An EP who was not the recipient of any transitions of care during the EHR reporting period.*

Menu Measure 8



Objective: The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide a summary care record for each transition of care or referral.

Stage 1 Use Measure: The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.*

***Exclusion:** *An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.*

Menu Measure 9

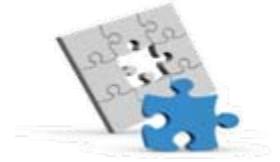


Objective: Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.

Stage 1 Use Measure: Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow-up submission if the test is successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically.*

***Exclusion:** *An EP who administers no immunizations during the HER reporting period or where no immunization registry has the capacity to receive the information electronically.*

Menu Measure 10



Objective: Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.

Stage 1 Use Measure: Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information has the capacity to receive the information electronically.*

***Exclusion:** *An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically.*



Menu Set Measures Removed

Two Menu Set Measures in the Interim Rule were removed in the Final Rule

- Check Insurance Eligibility Electronically*
- Submit Claims Electronically*

* Expect these measures to be required in Stage 2

Menu Set Measures: Attestation



The EP must attest to 5 of 10 Menu Set Measures

- The EP must choose at least one Public Health (PH) Measure
 - If both PH Measures can be met, two can be chosen
 - If one PH Measure can be met, choose the one that can be met
 - If the EP meets exclusion criteria for both, choose one and claim the exclusion
- Then select four additional measures relevant to the EP's scope of practice
- If four relevant additional measures cannot be identified, choose those that are relevant and then choose measures with exclusions until a total of four additional measures have been chosen

Public Health Reporting



- California Department of Public Health is currently unable to accept direct test messages for immunization, reportable lab results, and syndromic surveillance
- Local Health Departments that are able to accept test messages as of 9/8/11:
 - Immunization Reporting - Alpine, Amador, Calaveras, Mariposa, Merced, San Diego, San Joaquin, Stanislaus, Tuolumne
 - Lab Results Reporting – San Diego
 - Syndromic Surveillance Reporting – Alameda, San Diego, Stanislaus, Tulare

See “Useful Links” for website addresses to obtain updates for each reporting type

Fully Certified Products – Stage 1

Vendor	Product	Version
Anasazi	Anasazi Complete EHR	1.0
Askesis	PsychConsult Provider	7.1.0
ClaimTrak	ClaimTrak	9
Defran	Evolv-CS	8.4
ECHO	Clinician's Desktop	8.12
Emdeon	Emdeon Clinician	7.4
Netsmart	Avatar	2011
Netsmart	CMHC/MIS	4.2
Sequest	TIER	7
UniCare	Pro-Filer	2011
Welligent	Welligent	7.5





Modular Certified Products – Stage 1

Vendor	Product	Version
Anasazi	Anasazi Central	3.0.171.0
Askesis	Psych Consult Provider	7.0.1





Useful Links

"To Enrich Lives Through Effective And Caring Service"

USEFUL LINKS



- CMS Meaningful Use Website:

<http://www.cms.gov/EHRIncentivePrograms/>

- CMS EHR Incentive Program ListServ:

http://www.cms.gov/EHRIncentivePrograms/65_CMS_EHR_Listserv.asp

- CMS Meaningful Use Measures:

<http://www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf>

- Medi-Cal Incentive Program:

<http://www.medi-cal.ehr.ca.gov/>

USEFUL LINKS



- HITEC-LA:
<http://www.hitecla.org/>
- COREC (Orange County):
<http://www.caloptima.org/>
- Certified EHR Software:
<http://onc-chpl.force.com/ehrcert>
- Senate Bill S539 Text:
<http://www.opencongress.org/bill/112-s539/text>

USEFUL LINKS

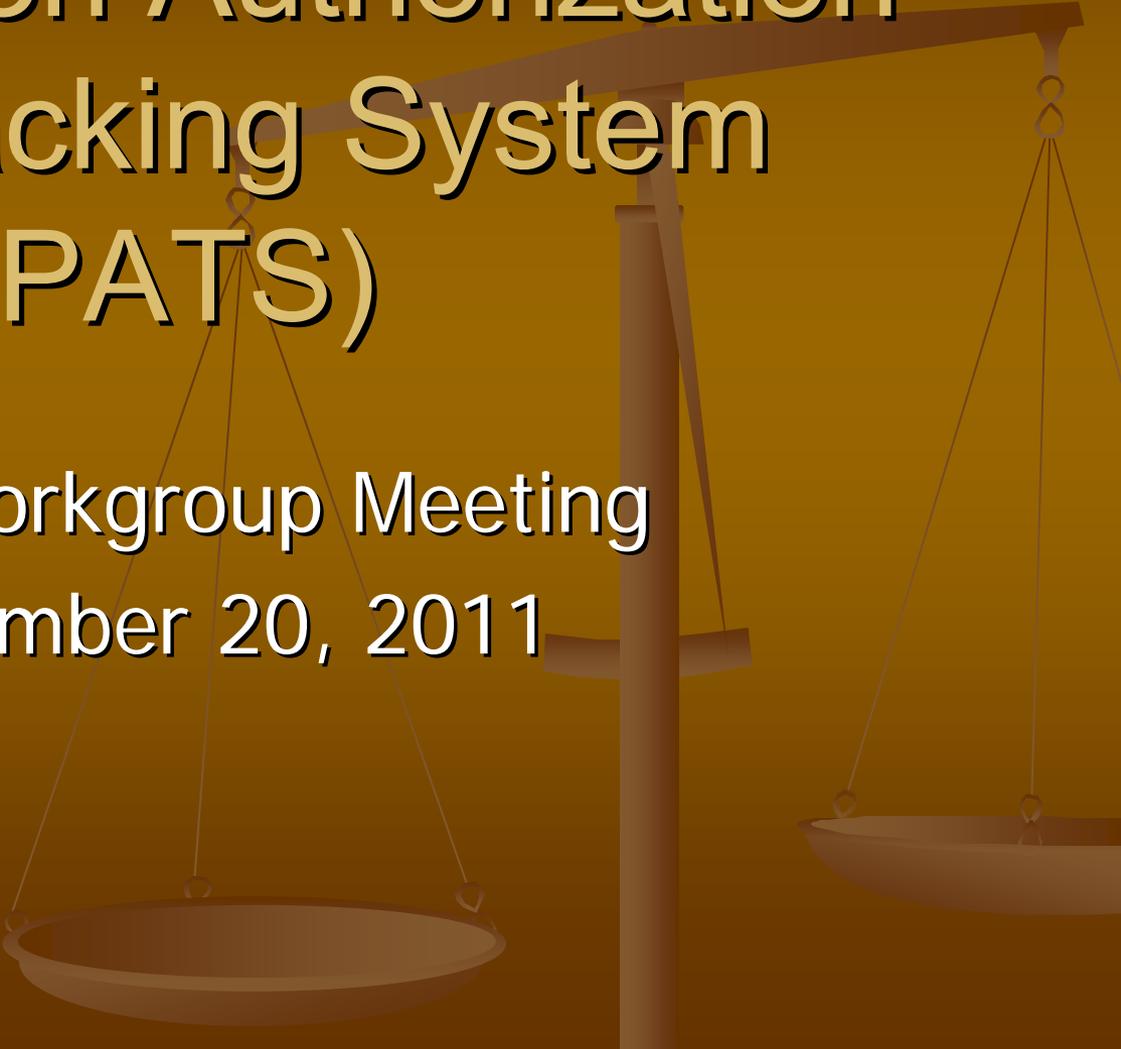


- **Public Health – Immunization Test Message Status**
<http://www.cdph.ca.gov/data/informatics/Documents/CDPH-MngUse-Imm.pdf>
- **Public Health – Lab Results Test Message Status**
<http://www.cdph.ca.gov/data/informatics/Documents/CDPH-MngUse-ELR.pdf>
- **Public Health – Syndromic Surv. Test Msg. Status**
<http://www.cdph.ca.gov/data/informatics/Documents/CDPH-MngUse-SS.pdf>

Questions



Decommission of the Prescription Authorization and Tracking System (PATS)



CPTT Workgroup Meeting
September 20, 2011

PATS Overview

- A custom-developed software application to perform key functions related to the administration of drugs to the residents of Los Angeles County served by DMH.
- Used by DMH Pharmacy Division, DMH Directly Operated clinics, and Contract Providers
- Contracted pharmacies access prescriptions generated by PATS via an electronic terminal, the VeriFone®

PATS Decommission

- DMH will decommission PATS
- Target is the 1st Quarter of FY 12/13
- To decommission PATS DMH must:
 - Acquire the services of a Pharmacy Benefits Manager (PBM)
 - Implement a Surescripts[®] certified e-Prescribing solution
- DMH Contract Providers who prescribe medications for DMH CGF clients must implement a Surescripts[®] certified e-Prescribing solution prior to DMH implementation

Rationale for using a PBM

- Broaden network of pharmacies for client convenience
- Offer better prices on prescription medications
- Provide drug utilization review
- Adjudicate County General Fund (CGF) medication claims
- Provide access to client medication history
- Manage formulary and eligibility
- Manage process for Treatment Authorization Request (TAR)

Reasons For PATS Decommission

1. PATS is not certified for Meaningful Use
2. This custom mainframe application is written in COBOL; the pool of knowledgeable resources at ISD to support this is greatly diminished
3. Very expensive to maintain, support and enhance
4. Compatible VeriFone[®] hardware is no longer manufactured

Reasons For PATS Decommission (continued)

4. DMH must procure refurbished VeriFone[®] equipment to replace failed units; refurbished equipment is in short supply, difficult to find, unreliable and must be continuously replaced
5. PATS does not provide comprehensive controls and auditing capabilities requested by County Auditor- Controller; these features are available in today's electronic prescribing systems

Impact of PATS Decommission

- DMH recognizes that the decommission of PATS and the requirement for Contract Providers to implement e-Prescribing will impact Contract Providers
- Impact variable depending upon:
 - Whether agency serves County General Fund (CGF) clients
 - Current use of e-Prescribing
 - Readiness to move toward e-Prescribing
- DMH will work with Contractors to assess impact and address concerns

Impact of PATS Decommission

■ Variable Impact

- Contractors who do not serve CGF clients
- Contractors with EHRS currently using e-Prescribing
- Contractors with EHRS and e-Prescribing functionality but not using e-Prescribing
- Contractors who must add e-Prescribing functionality to their EHRS
- Contractors without an EHRS or standalone e-Prescribing solution

CONTRACTOR STATUS

- 58 LE Providers used PATS from 1/1/11 through 8/1/11
- ~50% of the 58 LE Providers are using an EHRS
- ~60% of the 58 LE Providers are either using an EHRS with e-prescribing functionality or have submitted an MHSA project to implement an EHRS system with e-prescribing capability

Contractor Implementation of e-Prescribing

- Research Surescripts® certified e-Prescribing Solutions
- Vendor selection (EHRS or Standalone)
- Purchase and Install
- Testing
- Training
- Implement Solution in advance of DMH

Contractor Implementation of e-Prescribing

- Following execution of the DMH contract with the PBM, DMH will provide a list of pharmacies participating in the PBM network
- Prescriptions for CGF clients must be submitted to pharmacies in the PBM network

Contractor Implementation of e-Prescribing

- The CPTT Advisory Group estimated 3-4 months implementation for agencies that have not implemented an EHR
- Add additional 3-4 months if requesting MHSA IT funds for EHR project

ADDITIONAL CONSIDERATIONS

- If you are currently using an EHRs:
 - Verify that the e-prescribing solution integrated with the system is Surescripts® certified
 - If EHRs is accessed via an Application Service Provider (ASP), determine additional costs to access e-prescribing functionality
 - If EHRs is a Commercial-Off-The-Shelf (COTS) product determine whether e-Prescribing was included in the purchase

ADDITIONAL CONSIDERATIONS

- If you are evaluating EHR products:
 - Assess whether the product has an integrated Surescripts® certified e-prescribing solution
 - Determine whether additional costs for e-prescribing functionality apply
 - Consider HITECH Act Meaningful Use requirements

Issues To Be Addressed

- Contractor's ability to:
 - View and select DMH Formulary
 - View and select pharmacies in the DMH network
 - Verify the eligibility of CGF clients
 - View medication history

LINKS

- Surescripts - www.surescripts.com



IBHIS and HIPAA 5010

Update

CPTT Workgroup Meeting

September 20, 2011



IBHIS Update

- ▶ IBHIS Vendor Contract Negotiated
- ▶ Board hearing of IBHIS Vendor agreement targeted for late October
- ▶ Upon filing with the Board, the vendor identity and project schedule will be available to the public

What is HIPAA 5010?

- ▶ Federal legislation that mandates the format of administrative electronic transactions between health care providers and payers
- ▶ Covered transactions include claims, remittance advice and eligibility
- ▶ The current version is 4010
- ▶ The federal mandate is to convert the administrative transactions to 5010 by January 1, 2012

HIPAA 5010 Update

- ▶ DMH anticipates a best-case HIPAA 5010 go-live in February 2012 and a worst-case HIPAA 5010 go-live in March 2012
- ▶ Due to the timeline to generate, validate and upload claims to the state, DMH anticipates that the 1st set of HIPAA 5010 claims will be uploaded to the state in March 2012 (best case) or April 2012 (worst case)
- ▶ No EDI claims will be accepted from January 1, 2012 through the HIPAA 5010 go-live in February or March 2012

HIPAA 5010 Update: Submission of 4010 Claims

- ▶ Providers are contractually required to submit claims within 30 days of the Date of Service
 - All Claims for services through September 2011 should be entered into the IS by the end of October 2011
- ▶ Claims representing January – April 2011 dates of service must be submitted to DMH with a regular good cause late code by the end of October 2011 to insure they don't time-out at the state

HIPAA 5010 Update: Submission of 4010 Claims

- ▶ Continue to submit claims via DDE or EDI during November – December 2011
- ▶ DDE claims can be entered into the IS while DMH works to upgrade to HIPAA 5010
- ▶ DMH is working with the State to determine which late code to use for claims after the go live date when applicable

HIPAA 5010 Update

- ▶ DMH is investigating options for paying providers due to the 5010 delays
 - DDE providers will be paid as normal based on the claims entered into the IS
 - EDI providers monthly payment options may consider average value of claims submitted during a prior 3-month period and will not exceed 1/12 of the Legal Entity Contract MCA
 - ▶ The payment formula will be communicated to the providers once it is finalized

HIPAA 5010 Update

- ▶ Current EDI providers can begin 5010 testing in late January or February, 2012
- ▶ DMH is discontinuing EDI 4010 testing for new EDI providers
- ▶ DMH will begin EDI 5010 testing for new EDI providers in March or April, 2012

HIPAA 5010 Update: Submission of 5010 Claims

- ▶ From January 1 - February or March, 2012 only DDE claims can be submitted
- ▶ Options for EDI capable Providers:
 - Submit all claims during the period via DDE
 - Submit priority claims and hold all other claims until DMH is ready to accept 5010 claims
 - No DDE and hold all claims during the period

HIPAA 5010 Update

Post Go-Live

Best Case

- ▶ DDE claims submitted through January 2012 will be transmitted to the state in March 2012
- ▶ HIPAA 5010 EDI claims submitted in February 2012 will be transmitted to the state in April 2012

Worst Case

- ▶ DDE claims submitted through February 2012 will be transmitted to the state in April 2012
- ▶ HIPAA 5010 EDI claims submitted in March 2012 will be transmitted to the state in May 2012

HIPAA 5010 Update

- ▶ More information will be available at the next Provider Support meeting October 12, 2011
- ▶ DMH will provide more information as it is available via IS Alerts
- ▶ All providers should subscribe to IS Alerts to ensure efficient communication