



Contract Providers Transition Team (CPTT) Meeting Agenda

January 17, 2012
10:00 a.m. – noon

- ✓ **Welcome***
- ✓ **Announcements***
- ✓ **[IBHIS Update](#) – Jay Patel**
- ✓ **[HIPAA 5010 Updates](#) – Zena Jacobi**
- ✓ **[XML Clinical Document Exchange](#)* – Duane Nguyen**
- ✓ **[e-Prescribing](#) – Abel Rosales**
- ✓ **[Meaningful Use – Clinical Quality Measures](#) - Gordon Bunch**
- ✓ **[CPTNP Unit Update](#)* – Gordon Bunch**
- ✓ **[Other Items](#) – Karen Bollow**
- ✓ **Open Discussion***

Next Meeting – TBD

* No slide presentation. No handouts

“To Enrich Lives Through Effective And Caring Service”

IBHIS and HIPAA 5010

Update

CPTT Workgroup Meeting

January 17, 2012

IBHIS Update

- ▶ Vendor Selected
 - Netsmart Avatar
- ▶ Board approved Netsmart agreement October 18, 2011
 - Eleven Year Agreement Term
- ▶ Vendor Project Team on site (12 Staff)
- ▶ Project Kick-off January 10, 2012

IBHIS Functionality

- ▶ Consumer demographic data
- ▶ Financial and Administrative data
- ▶ Clinical Data Management
- ▶ E-Prescribing
- ▶ Provider Order Entry

IBHIS Functionality

- ▶ Practice Management
- ▶ Outcomes Capture and Reporting
- ▶ Personal Health Record
- ▶ Electronic Data Interchange

Questions



HIPAA 5010 Update

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
- ▶ Enforcement of the federal mandate to use HIPAA version 5010 transactions will begin in April 2012

HIPAA 5010 Schedule

- ▶ DMH anticipates an April 2012 HIPAA 5010 go-live with an IS shutdown in mid – late March
- ▶ DMH will continue to process HIPAA 4010 claims until the IS shutdown in March
- ▶ After the IS comes up in HIPAA 5010 mode, the IS will only accept HIPAA 5010 claims
- ▶ Primarily impacts EDI claims, but there are some screen changes for DDE claims

HIPAA 5010 EDI Testing

- ▶ Preliminary vendor testing begins week of January 23
- ▶ Current EDI provider testing begins in February
 - ALL providers are encouraged to perform EDI 5010 testing prior to sending production claims
- ▶ DMH has discontinued EDI 4010 testing for new EDI providers
- ▶ DMH will begin EDI 5010 testing for new EDI vendors & providers in March or April, 2012

HIPAA 5010 – What's New

- ▶ Rendering Provider NPIs must be unique within a Service Location
- ▶ HIPAA 5010 claims will be denied if the same NPI is associated to a Service Location multiple times (for the same time period)
- ▶ Rendering Provider forms will be rejected if they result in duplicate NPI issues

HIPAA 5010

Sample Duplicate NPI

County of Los Angeles - Department of Mental Health

Rendering Provider Assignment (IS310)

Billing Prov ID: 123
 Billing Prov: 2345 ABC FAMILY SERVICES

Print Date: 01/13/2012
 Printed By: jjacobi

Billing	Billing Prov	Service Location	Phone	Active Dt
Rendering Provider:	141414 SMITH, MARY	Staff Code: 00IC999	Count 3	
111111	1234 ABC FAMILY	1234A ABC FAMILY SERVICES	562-111-2222	07/31/2008
222	2345 ABC FAMILY	2345A ABC FAM SRVS-ADULT	323-333-4444	07/31/2008
333333	3456 ABC FAMILY	3456A ABC FAMILY SERVICES	323-333-4444	07/31/2008
Rendering Provider:	151515 SMITH, MARY	Staff Code: ABC377	Count 3	
222	2345 ABC FAMILY	2345A ABC FAM SRVS-ADULT	323-333-4444	07/31/2008
111111	1234 ABC FAMILY	1234A ABC FAMILY SERVICES	562-111-2222	07/31/2008
333333	3456 ABC FAMILY	3456A ABC FAMILY SERVICES	323-333-4444	07/31/2008



HIPAA 5010 – What's New

- ▶ DMH will be notifying contract providers that have duplicate NPIs within a Service Location
 - Instructions will be provided on how to remove the duplicates
 - Follow up with DMH in the timeline allotted

HIPAA 5010 – What's New

- ▶ State has implemented a new 5010 requirement for Remaining Liability
 - Applies to claims with Medicare or Other Health Care Insurance
 - The IS will calculate on DDE claims
 - Providers must include on EDI claims
 - The DMH Companion Guides were updated in December, 2012 with this new requirement
 - Make sure your vendor is aware of this new requirement

HIPAA 5010 Update

- ▶ More information will be available at the next Provider Support meeting February 8
- ▶ IS Outpatient 5010 Training is being scheduled for the 1st week in March
- ▶ IS Inpatient 5010 Training will be on March 15
- ▶ DMH will provide more information as it is available via IS Alerts and RMD Bulletins
- ▶ All providers should subscribe to IS Alerts RMD Bulletins to ensure efficient communication

Questions





XML

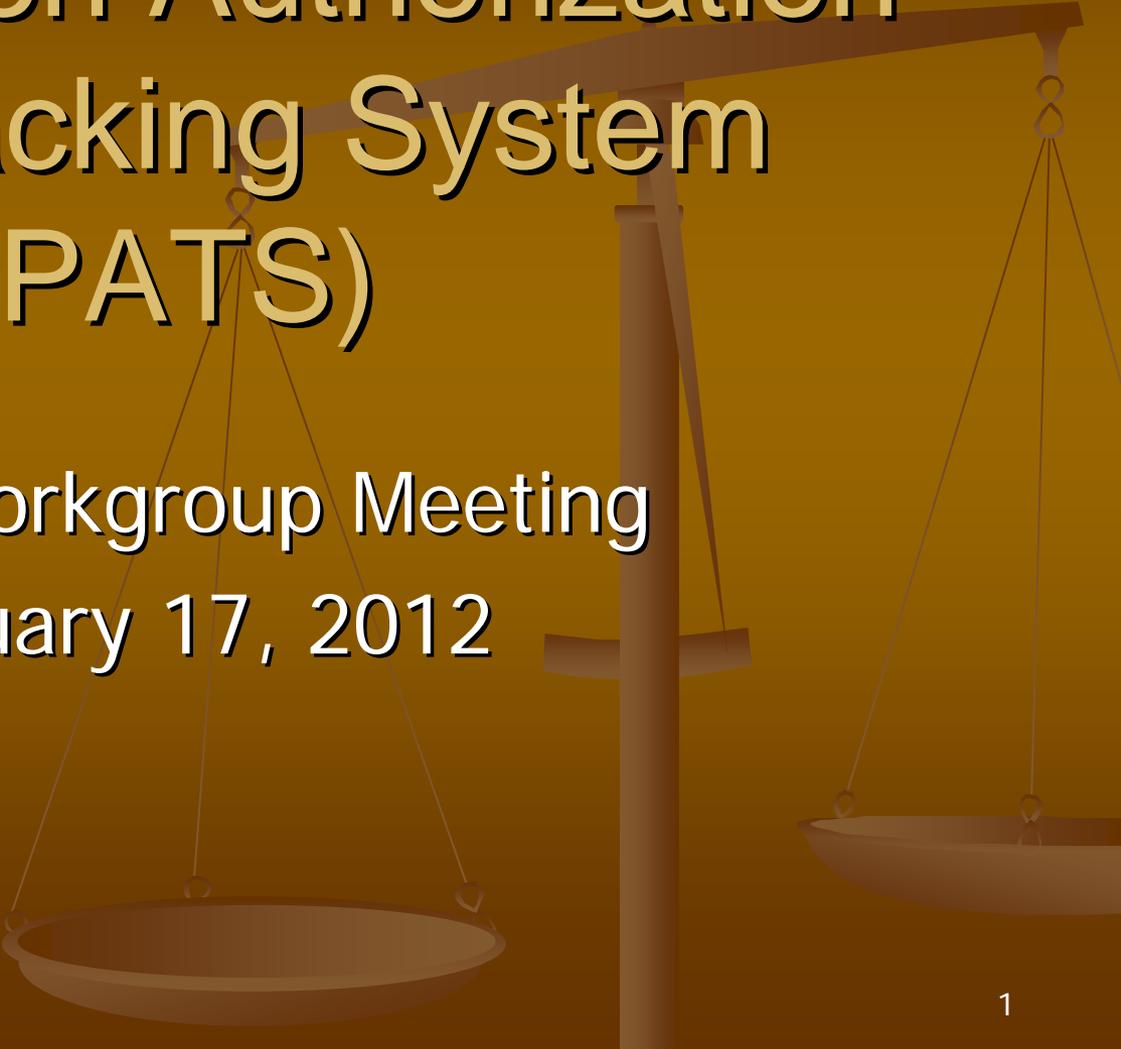
Clinical Document Exchange

For information, please contact:

Duane Nguyen, Data Architect

DuNguyen@DMH.LACounty.GOV

Decommission of the Prescription Authorization and Tracking System (PATS)

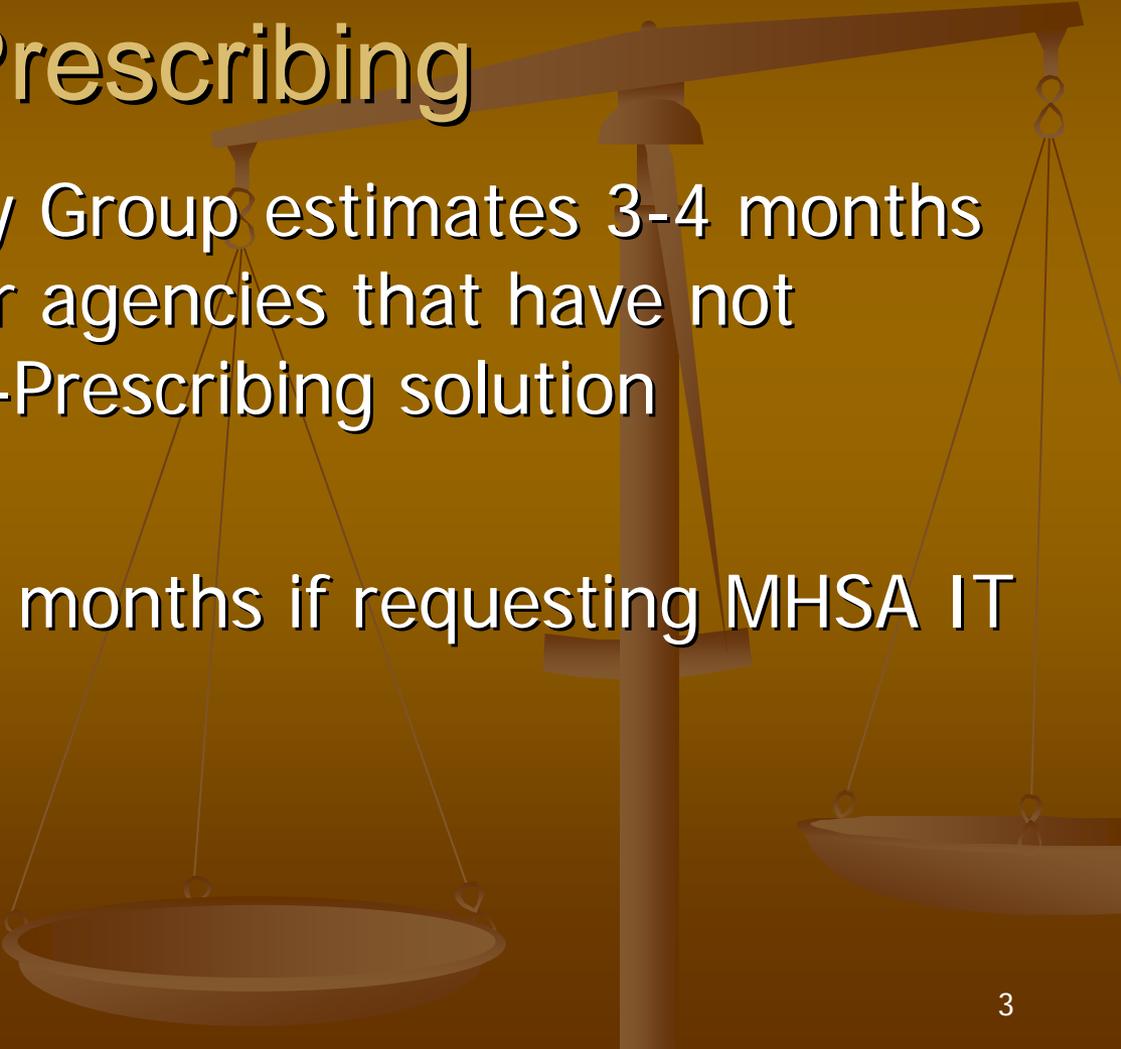


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PATS Decommission

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

Contractor Provider's Implementation of e-Prescribing



- The CPTT Advisory Group estimates 3-4 months implementation for agencies that have not implemented an e-Prescribing solution
- Add additional 3-4 months if requesting MHSA IT funds

Additional Considerations

- If you are currently using an EHR system:
 - Determine whether an e-Prescribing module is included in your purchase; if not, you need to acquire one
 - Determine whether the e-Prescribing module is Surescripts certified

Issues To Be Addressed

- Contractor Provider'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 of DMH clients
 - Send DMH medication history on DMH clients

Health Information Technology for Economic and Clinical Health Act

HITECH Meaningful Use

Medi-Cal Program Update

And

Clinical Quality Measures

CPTT Workgroup – January 17, 2012



“To Enrich Lives Through Effective And Caring Service”



Presentation Outline

- Overview of Meaningful Use Programs
- Meaningful Use Certified EHR Technology
- Medi-Cal Registration
- Clinical Quality Measures
- Useful Links

OVERVIEW: MEANINGFUL USE PROGRAMS



“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



Stages of Meaningful Use by Year

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



Stage 2 has been delayed until 2014



CERTIFIED ELECTRONIC HEALTH RECORD SYSTEMS

BEHAVIORAL HEALTH





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	Avatar CaIPM	2007
Sequest	TIER	7
UniCare	Pro-Filer	2011
Welligent	Welligent	7.5

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MEDI-CAL MEANINGFUL USE INCENTIVE PROGRAM

REGISTRATION





Medi-Cal Registration

State Level Registry (SLR)

Registration and Attestation Launch Dates:

- October 3, 2011 Eligible Hospital Registration
- November 15, 2011 Eligible Clinic/Group Registration*
- January 3, 2012 Eligible Professional Registration

*Groups and Clinics are defined by participating States but must conform to CMS rules regarding Groups/Clinics.



Medi-Cal Registration: Groups & Clinics - Defined



Groups:

A group of providers that operate as a unified financial entity and have overarching oversight of clinical quality can be considered a group for the purposes of the Medi-Cal EHR Incentive Program.

- Must have a single tax identification number (TIN) but subgroups of providers can have separate national provider identifiers (NPI).
- Encounters of all providers under the TIN must be counted to determine group patient volume.



Medi-Cal Registration: Groups & Clinics - Defined



Clinics:

All clinics licensed by the California Department of Public Health (1204a clinics) are considered clinics for the purposes of the Medi-Cal EHR Incentive Program.



Medi-Cal Registration: Groups and Clinics

CMS allows for patient volumes of Groups or Clinics to be used as a “proxy” for establishing eligibility for EP(s) in the Group/Clinic.

A provider in the Group/Clinic is eligible for MU incentives if the Group/Clinic Medi-Cal encounters meet threshold even when the individual provider does not meet threshold.



Medi-Cal Registration: Groups and Clinics

Use of group or clinic patient volumes as a proxy to establish eligibility for providers is unrelated to provider voluntary reassignment of incentive payments.

It is important to inform providers of the above as they may elect to use their individual clinic/group patient volumes to establish eligibility if they assume that participating as clinic group member means reassignment of incentives to the group/clinic.



Groups and Clinics: CMS Rules



“All-in” – encounters of **all** providers in the group/clinic (including those not eligible, i.e. psychologists; LCSW, etc.) must be counted in the group/clinic Medi-Cal percentage. No exclusions allowed.

Groups and Clinics: CMS Rules



“**All-out**” – if any provider opts-out of the group by choosing to use individual provider patient volumes for care delivered in the group, then none can use the clinic/group as proxy.

A provider in the Group/Clinic may use individual patient volumes for care delivered outside the group without affecting providers in the group or clinic from using clinic patient volumes as a “proxy”.

Must count providers who use individual patient volumes for care delivered outside the group as “**in**” for purpose of Clinic/Group proxy counts and eligibility and attestation of meaningful use.



Medi-Cal Registration: Medi-Cal Encounters Defined

Encounters may be counted only once for services received from the same provider on the same day.

Encounters must be paid for in part or whole by Medi-Cal or a Medi-Cal demonstration project, including payment in part or whole of an individual's premiums, co-payments, and cost sharing.

Encounters without federal financial participation (not covered by Title 19) may not be counted.

Excluded Medi-Cal aid codes – 2V, 4V, 65, 7M, 7N, 7P, 7R, 71, 73, and 81

Groups and Clinics: Surrogates/Representatives



- California allows for “**Representatives**” to perform the Group/Clinic and individual EP registration function
- CMS allows for “**Surrogates**” who may act on behalf of eligible professionals (EP) for the purpose of registration and attestation

Groups and Clinics: Representatives



- Representatives have a separate Group/Clinic portal in the State Level Registry to enter:
 - Group/Clinic Information
 - TIN, NPI, locations, patient volumes
 - Name and NPI of all EP(s)
 - Certified EHR technology used by Group/Clinic



Eligible Professionals: Representatives



Representatives may complete Steps 1-3 of the Registration process on behalf of the EP

- Step 1 – Provider Information
- Step 2 – Eligibility Information
- Step 3 – Certified EHR Technology Information

Individual EP(s): Attestation



Eligible Professionals must create an account in the State Level Registry and either complete Steps 1 – 5, if not done in advance by a “representative”

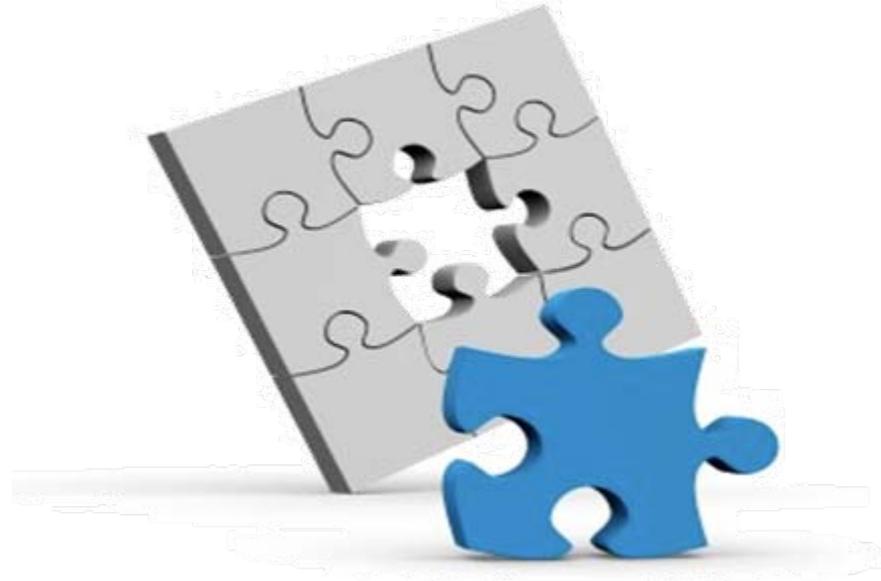
OR

complete only Steps 4 – 5 if a representative registered the provider in advance of attestation.

- Step 4 – Attestation
- Step 5 – Submit

Meaningful Use Criteria

CLINICAL QUALITY MEASURES





Clinical Quality Measures (CQM)

- Calculated CQM(s) must be reported to State or CMS directly from the certified EHR technology
- EP(s) must report on three Core CQM(s) or Alternate Core and three Additional CQM(s)
- If one or more Core CQM(s) is outside your scope of practice, you must report an equal number of Alternate Core CQM(s)



Clinical Quality Measures (CQM)

- If the denominator value for all three Core CQM(s) is zero the EP must report a zero denominator for each and then report on three Alternate Core CQM(s)
- If the denominator value for all three Alternate Core CQM(s) is zero, the EP must report on three Additional CQM(s)
- You will report a minimum of 6 CQM(s) or a maximum of 9 CQM(s)

Clinical Quality Measures

Core	<u>3(0)</u>	2 (1)	1 (2)	0 (3)	0 (3)	0 (3)	0 (3)
Alt. Core	0	1	2	3 (0)	2 (1)	1 (2)	0 (3)
Add'l	3	3	3	3	3	3	3
Total	6	7	8	9	9	9	9

Numbers in parentheses represent counts of zero denominator reports

Clinical Quality Measures: Core and Alternate Core

1	Core	Hypertension: Blood Pressure Measures
2	Core	Preventive Care & Screening Measure Pair
3	Core	Adult Weight Screening & Follow-up
1	Alt.	Weight Asmnt. & Couns. Child & Adult
2	Alt.	Prev. Care and Screening - Influenza
3	Alt.	Childhood Immunization Status

All MU Certified EHR Systems should be capable of reporting all Core and Alternate Measures



Core CQM 1 – Hypertension Blood Pressure Measurement

- Percentage of Patient Visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least two (2) office visits with blood pressure recorded.

Numerator _____ Denominator _____



Core CQM 2 – Preventive Care and Screening Measure Pair

- Tobacco Use Assessment - Percentage of Patient Visits for patients aged 18 years and older who have been seen for at least two (2) office visits who were queried about tobacco use one or more times within 24 months

Numerator _____ Denominator _____

- Tobacco Cessation Intervention - Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 (two) office visits who received cessation intervention

Numerator _____ Denominator _____



Core CQM 3 – Adult Weight Screening and Follow-up

- Percentage of patients aged 18 years and older with a calculated BMI in the past 6 (six) months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.

- Population Criteria 1

Numerator _____

Denominator _____

- Population Criteria 2

Numerator _____

Denominator _____



Alternate CQM 1 – Weight Assessment Counseling for Children and Adolescents

- Percentage of patients 2 to 17 years of age who had an outpatient visit with a Primary Care physician or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year.
- Population Criteria 1 [Age ≥ 2 - ≤ 16]
 Numerator _____ Denominator _____
 Numerator _____ Denominator _____
 Numerator _____ Denominator _____
- Population Criteria 2 [Age ≥ 2 – ≤ 10]*
- Population Criteria 3 [Age ≥ 11 - ≤ 16]*

*Provide 3 Numerators and Denominators as in Population 1



Alternate CQM 2 – Preventive Care and Screening – Influenza Immunization

- Percentage of patients age 50 years and older who received an influenza immunization during the flu season (September – February).

Numerator _____ Denominator _____

Exclusion _____*

*Includes immunization not done for contraindication, or patient declined, or not done for patient reason, medical reason, or system reason



Alternate CQM 3 – Childhood Immunization Status

- Percentage of children 2 years of age who had four diphtheria tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); two H influenza Type B (HiB); three hepatitis B (Hep B); one chickenpox (VZB); four pneumococcal conjugate (PCV); two Hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.

Numerator _____ Denominator _____*

*Provide 12 Numerators and Denominators



Additional CQM(s)

- CMS has identified 38 Additional CQM(s)
- For Stage 1 MU Certification, EHR systems are required to demonstrate capability to electronically report a minimum of 3 Additional CQM(s)
- To determine which Additional CQM(s) are reported by vendor product, see CMS website – vendor product search

<http://onc-chpl.force.com/ehrcert>

Clinical Quality Measures: Additional Set

1	Diabetes: Hemoglobin A1c Poor Control
2	Diabetes: Low Density Lipoprotein (LDL) Management and Control
3	Diabetes: Blood Pressure Management
4	Heart Failure (HF): ACE or ARB therapy for Left Ventricular Systolic Dysfunction (LVSD)
5	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction
6	Pneumonia Vaccination Status for Older Adults
7	Breast Cancer Screening
8	Colorectal Cancer Screening
9	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
10	Heart Failure (HF): Beta Blocker Therapy for Left Ventricular Systolic Dysfunction
11	Anti-depressant medication management: (a) Effective Acute Phase Tx, (b) Effective Continuation Phase Tx
12	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
13	Diabetic Retinopathy: Documentation of presence or absence of Macular Edema and Level of Severity of Retinopathy
14	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
15	Asthma Pharmacologic Therapy
16	Asthma Assessment
17	Appropriate Testing for Children with Pharyngitis
18	Oncology Breast Cancer: Hormonal Tx for Stage IC-IIIC Estrogen Receptor/Progesterone Rec. Positive Breast Cancer
19	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low risk Prostate Cancer Patients

Clinical Quality Measures: Additional Set

20	Smoking and Tobacco Use Cessation, Medical Assistance: Advice; Discuss Tobacco Use Cessation Medications; Discuss Cessation Strategies
21	Diabetes: Eye Exam
22	Diabetes: Urine Screening
23	Diabetes: Foot Exam
24	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol
25	Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation
26	Ischemic Vascular Disease IVD: Blood Pressure Management
27	Ischemic Vascular Disease IVD: Use of Aspirin or Another Antithrombotic
28	Initiation and Engagement of Alcohol & Other Drug Dependence Treatment: a) Initiation, b) Engagement
29	Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)
30	Prenatal Care: Anti-D Immune Globulin
31	Controlling High Blood Pressure
32	Cervical Cancer Screening
33	Chlamydia Screening for Women
34	Use of Appropriate Medications for Asthma
35	Low Back Pain: Use of Imaging Studies
36	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
37	Diabetes: Hemoglobin A1c Control (<8.0%)
38	Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients



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





CPTNP Unit Update

For information, please contact:

Gordon Bunch, MA

GBunch@DMH.LACounty.GOV

Other Items

- E-Signature Agreement
 - Review and sign if using e-signatures (Att B)
 - Include task in Project Plan to submit form
 - Sample forms available on CPTP Website
- California Senate Bill 850
 - “Confidentiality of Medical Information Act”
 - Signed into law and effective January 1, 2012
 - Review with vendor to ensure compliance

Other Items

- Contract Language – Data Migration
 - Include language to ensure data can be migrated in event of agency merger, vendor change, agency shutdown or vendor availability
 - Include language to ensure periodic data backup
 - Identify as a potential risk and include process to address the risk

Questions

