DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Office of the National Coordinator
for Health Information Technology
Washington, D.C. 20201

Program Information Notice

DATE: August 17, 2010 DOCUMENT NUMBER: ONC-REC-PIN-002

SUBJECT: Policy for Identifying the Number of Priority Primary Care Providers (PPCP) to be Served by a Regional Extension Center

TO: Health Information Technology Extension Program: Regional Centers Cooperative Agreement Program Grantees

The purpose of this Program Information Notice (PIN) is to clarify the maximum amount that Regional Extension Centers (RECs) may be reimbursed for direct technical assistance services that they provide to priority primary-care providers in their service area.

If you have any questions or require further guidance, please contact the Regional Extension Center Division of the Office of Provider Adoption Support at regional-center-applications@hhs.gov .

Sincerely,

/ David Blumenthal /

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National Coordinator for Health Information Technology
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I. PURPOSE:

The purpose of this Program Information Notice (PIN) is to clarify the Health Information Technology Extension Program: Regional Centers Cooperative Agreement Program Funding Opportunity Announcement and Grant Application Instructions (FOA), and more specifically, clarify the process by which ONC will consider a change in scope of services for a REC and adjust the corresponding two-year provider target.

II. APPLICABILITY

This policy applies to all RECs under the Health Information Technology Extension Program in a cooperative agreement with ONC, to support priority primary care providers in implementing certified EHR technology and attempting to achieve meaningful use.

III. Background

This provider reduction policy is intended to ensure equality and promote fairness across the Regional Extension Centers (RECs), specifically to adjust the scope of services in instances where the funding award was less than the original requested amount. Office of Provider Adoption Support (OPAS) recognizes that where RECs were awarded less money than requested, a corresponding alteration in the scope of services should be considered.

There are two general principles that have various applications for the current RECs:

1. Provider reimbursement rates cannot exceed $5,000 per provider. In instances where the per provider reimbursement rate in the original application was more than $5,000, the awarded amount was reduced without a corresponding reduction on scope of services. In other words, Regional Extension Centers can receive no more than $5,000 per provider in direct assistance, without exception.
2. RECs cannot have a PPCP target that is less than 1,000 priority primary care physicians. In those cases where application of the standard formula would have resulted in a PPCP number below 1,000, the target was set at 1,000 PPCPs.

Of note, RECs may elect to increase their core funding in the first two years from $1,000,000 to $1,500,000. This remains in force and fully acceptable upon approval by the Project Officer. However, for the purposes of determining the target provider number and the per provider reimbursement rate, the standard Core Funding Allowance of $1,000,000 will be used in all cases.

This policy identifies and addresses the four primary scenarios described below:

Scenario 1: There is a discrepancy about how many providers the REC is intended to support. This could occur either because of an inconsistency in the application itself, *or* there is a discrepancy between the application and the formula that was used to calculate the award.

Protocol:

1. ONC Project Officer (PO) will first review the project narrative for numbers of providers to be served (since this is a focal point in the application reviews).
2. The PO will look for the estimate that has the most detail/specificity. For example, numbers that break the targets out by year and milestone[1] should be prioritized over one line responses.
    1. Numbers presented that will render the applicant ineligible (such as, the target does not meet the minimum 1,000 PPCP threshold) will not be considered.
3. In situations where there are two sets of numbers of equal merit, the budget narrative can be used to reconcile the responses.
4. From this, the PO should determine whether the correct number (the target number of Priority Primary Care Providers to assist in reaching meaningful use during the first 2-year budget period) was used in calculating the award.
5. In either case, the PO will consider the various scenarios below to determine if a reduction in the provider number is warranted.

Scenario 2: The applicant's requested budget was reduced upon award and the applicant has requested a corresponding decrease in the scope of services (i.e. PPCP target).
Protocol:

The PO will use the following process to calculate the target number of PPCPs:

1. Calculate the amount of Direct Assistance the program will receive for the first two years. To do this, subtract the Core Funding Allowance[2] from the total grant award; the remainder represents the total amount of Direct Assistance funding over the initial 2-year budget period.
2. Calculate the per provider rate by dividing the total Direct Assistance by the number of providers to be served; the remainder represents the "per provider blended reimbursement rate."
3. Next, identify the variance between the "ONC Maximum Approved Amount[3]" and the "ONC Funded Amount[4]" by subtracting the ONC Funded Amount from the ONC Maximum Approved Amount.
4. Divide the variance from step 3 by the per provider blended reimbursement rate[5]. The remainder is the provider reduction number; this number is the per provider translation of the funding variance.
5. Lastly, subtract the provider reduction number from the original PPCP target to get the new PPCP target number of providers to assist in reaching meaningful use in the first 2-year budget period.

[1] Definition: ONC's definition of a Milestone refers to the three milestones outlined in the Funding Opportunity Announcement: Provider Sign-up, Go Live, and Meaningful Use. A milestone "payment" is equal to 1/3rd of the "blended per provider reimbursement rate."
[2] Note: for the purposes of establishing an accurate per provider blended reimbursement rate, the calculation must be based on the Core Funding Allowance of $1,000,000, regardless of whether the REC has received approval for a core funding increase to $750,000 per year for the initial 2-year budget period.
[3] Definition: the "ONC Maximum Approved Amount" is the lowest of either 1.) the total federal request for the initial 2-year budget period OR 2.) the outcome of the formula of: $1,000,000 + ($5,000 X PPCP Target- as extracted from the application). The ONC Maximum Approved Amount reflects the fact that ONC cannot fund an award for more than was requested and also establishes a ceiling award amount (through application of the formula).
[4] Definition: the "ONC Funded Amount" is the total federal 2-year share (i.e. "Total Approved Budget") noted in the REC's Notice of Grant Award.
[5] The Per Provider blended reimbursement rate cannot be more than $5,000.

Example Scenario 2:

Applied full funding	$7,584,438
Core Funding Allowance	$1,000,000
Direct Assistance	$6,584,438
Orig. Number of Providers	1,340
Orig. Per Provider rate	$4,914

Max Award	$7,584,438
Approved Amount	$7,256,155
Remainder	$328,283
per provider amount	$4,914
Provider reduction number	67
Orig. Number of providers	1,340
New PPCP target	**1,273**

Scenario 3: The Standard Formula for determining the provider target would have resulted in a provider target that is less than 1,000 priority primary care physicians.

The PO will use the following process to calculate the target number of PPCPs:

1. Calculate the amount of Direct Assistance the program will receive for the first two years. To do this, subtract the Core Funding Allowance[6] from the total grant award; the remainder represents the total amount of Direct Assistance funding over the initial 2-year budget period.
2. Calculate the per provider rate by dividing the total Direct Assistance by the number of providers to be served; the remainder represents the "per provider blended reimbursement rate."
3. Next, identify the variance between the "ONC Maximum Approved Amount[7]" and the "ONC Funded Amount[8]" by subtracting the ONC Funded Amount from the ONC Maximum Approved Amount.
4. Divide the variance from step 3 by the per provider blended reimbursement rate[9]. The remainder is the provider reduction number; this number is the per provider translation of the funding variance.
5. Lastly, subtract the provider reduction number from the original PPCP target to get the new PPCP target number of providers to assist in reaching meaningful use in the first 2-year budget period.
6. If the new PPCP target is less than 1,000, the new target will be 1,000 PPCPs.

[6] Note: for the purposes of establishing an accurate per provider blended reimbursement rate, the calculation must be based on the Core Funding Allowance of $1,000,000, regardless of whether the REC has received approval for a core funding increase to $750,000 per year for the initial 2-year budget period.
[7] Definition: the "ONC Maximum Approved Amount" is the lowest of either 1.) the total federal request for the initial 2-year budget period OR 2.) the outcome of the formula of: $1,000,000 + ($5,000 X PPCP Target- as extracted from the application). The ONC Maximum Approved Amount reflects the fact that ONC can not fund an award for more than was requested and also establishes a ceiling award amount (through application of the formula).
[8] Definition: the "ONC Funded Amount" is the total federal 2-year share (i.e. "Total Approved Budget") noted in the REC's Notice of Grant Award.
[9] The Per Provider blended reimbursement rate cannot be more than $5,000.

Example Scenario 3:

Applied full funding	$5,244,198
Core Funding	$1,000,000
Direct Assistance	$4,244,198
Orig. Number of Providers	1,200
Orig. Per Provider rate	$3,537

Max Award	$5,244,198
Approved Amount	$4,289,613
Remainder	$954,585
per provider amount	$3,537
Provider reduction number	270
Orig. Number of providers	1,200
Prospective PPCP target	930
New PPCP Target	**1000**

Scenario 4: The REC requested ONC Funding that would have resulted in a per provider reimbursement rate in excess of $5,000. In this case, the REC is only eligible for a reduction in scope of services (i.e. target provider number) if the approved amount is less than the Maximum Award.

Protocol:

The PO will use the following process to make this determination:

1. Calculate the amount of Direct Assistance the program will receive for the first two years. To do this, subtract the Core Funding Allowance[10] from the total grant award; the remainder represents the total amount of Direct Assistance funding over the initial 2-year budget period.
2. Calculate the per provider rate by dividing the total Direct Assistance by the number of providers to be served; the remainder represents the "per provider blended reimbursement rate."
3. If this amount is greater than $5,000, the PO will apply the following methodology to determine the Maximum ONC Award;
    a. Core Funding Allowance ($1,000,000) + ($5,000 X PPCP Target- as extracted from the application)

[10] Note: for the purposes of establishing an accurate per provider blended reimbursement rate, the calculation must be based on the Core Funding Allowance of $1,000,000, regardless of whether the REC has received approval for a core funding increase to $750,000 per year for the initial 2-year budget period.

Example Scenario 4:

Applied full funding	$10,438,000
Core Funding Allowance	$1,000,000
Direct Assistance	$9,438,000
Orig. Number of Providers	1,828
Orig. Per Provider rate	$5,163

Max Award	$10,140,000
Approved Amount	$9,738,000
Remainder	$402,000
Per Provider Amount	$5,000
Provider reduction number	80
Orig. Number of providers	1,828
New PPCP Target	1,748