

Frequently Asked Questions: RECs and LECs

Please note: Cal-REC is continually evolving as an organization; responses may change over time. Updates will be provided as they become available.

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Definitions

- **REC** – Regional Extension Center
- **Cal-REC** – California-Regional Extension Center (Cal-REC) is a not-for-profit joint venture between California Primary Care Association (CPCA), California Medical Association (CMA) and California Association of Public Hospitals (CAPH). Cal-REC will consist of a governing board that will include representatives from statewide provider organizations, local HIT service providers; a fiscal agent, state administrators, and others key stakeholders. The California Safety Net Coalition (CSNC), an affiliation of over 19 California safety net organizations, will serve as an advisory board to ensure all sectors of the healthcare safety net are represented. Cal-REC will partner with the Public Health Institute (PHI) which has over 40 years experience managing large federal grants to assist with grant management.
- **LEC** – Local Extension Center (see next section for description)
- **Service Provider** –People working on the ground providing assistance with HIT to providers, “feet on the streets” who will work directly with the public hospitals, clinics and individual small practice doctors on HER implementation and technical assistance. More information to follow.
Priority Primary Care Providers (PPCP) – Primary-care providers in individual and small group practices (fewer than 10 physicians and/or other health care professionals with prescriptive privileges) primarily focused on primary care; and physicians, physician assistants, or nurse practitioners who provide primary care services in public and critical access hospitals, community health centers, rural health clinics, and in other settings that predominantly serve uninsured, underinsured, and medically underserved populations. Also referred to as simply: Provider.

- EMR-Electronic Medical Record
- EHR-Electronic Health Record

Background

What is a LEC?

The concept of the Local Extension Center is unique to California. Due to the sheer number of providers and the vast geographic area it became clear that California needed a “hub and spoke” model in order to be successful in the execution of this grant. Cal-REC will work to identify organizations within regions that are willing to take on the responsibility of coordinating technical service providers to help clinics, hospitals and practices achieve meaningful use. Additionally:

- Cal-REC encourages potential LEC applicants to think about how they can serve, or partner with multiple types of providers (small practices, clinics and public hospitals), such that one LEC can serve more than one constituent
- LECs will be responsible for either a geographic location—and all of the providers within that region—or a given provider type
- LECs can also provide services to providers within their constituent base, or can offer services to other LECs. Providing services is not a requirement of becoming a LEC, because LECs can sub-contract with other service providers to achieve grant objectives

Will there be fees to use the REC/LEC?

The funds being distributed through this grant are not sufficient to provide all of the services necessary to implement EMRs and get providers to meaningful use. Estimates indicate that it will cost a typical primary care provider between \$40,000-\$60,000 to achieve meaningful use. Individual clinics, doctors’ offices and hospitals will be expected to pay for many of these services (see [Funding](#) for more information).

What kind of services will the LECs be responsible for managing?

In the Cal-REC model, LECs can provide services directly, or another service provider can be contracted to provide those services. In the Cal-REC model LECs are required by the Office of the National Coordinator to be a the vehicle for providing the following services:

- EHR interfaces: to enable providers’ participation in a Health Information Exchange (HIE) by connecting EHR systems with Labs, Radiology, Pharmacies, etc.
- Technical Assistance: to assist in the implementation and project management of EHR systems; services to support progress towards Meaningful Use; and Process & Workflow Redesign.
- Education and Outreach: to develop the health IT workforce, and continued medical education(CME) of providers
- Participation in the National Learning Consortium
- Connector services: from non-standard EHR configurations to the Cal-REC Analytics Tool, and from EPM to EHR systems
- Vendor selection: for providers opting to undergo a full practice evaluation and specialized selection from all EHR vendors
- Create Learning Communities where PPCPs can learn from other PPCPs in their region who are going through this difficult process

What responsibilities do LECs have as being part of a Regional Extension Center?

LECs have a variety of responsibilities in order to further the REC’s goals and obligations. If a LEC uses Service Provider sub-contractors, the LEC will be responsible for gathering the information from that service provider in order to report back to the REC:

1. Quarterly milestone reporting: each LEC will be responsible for reporting the number of providers who meet each milestone to the REC on a quarterly basis. Cal-REC will then report these numbers to the ONC for grant disbursement. LECs may be obligated to utilize ONC software to track and report these milestones.

2. Quarterly cash flow reporting: LEC expenses and income will be reported quarterly, such that Cal-REC can aggregate LEC costs and report them as the REC's cost burden to reflect the 90/10 (grant funding/REC contribution) cost ratio in years 1 and 2 and a 10/90 cost ratio in years 3 and 4.
3. Knowledge transfer: LECs will be responsible for contributing to Cal-REC's knowledge base regarding best practices to get Providers to Meaningful Use. Cal-REC will utilize information gleaned from Local Extension Center experiences for participation in national forums, such as the ONC's National Consortium.
4. Workforce development: Whenever possible, LECs should utilize local businesses and organizations to stimulate workforce development. Cal-REC is responsible for engaging local resources and developing local economies to achieve the grant's goals.
5. Continuous collaboration: LECs must be in continuous contact with Cal-REC's so that the organization can scale to reach the grant's lofty goals.

In the Cal-REC model what are the potential roles available to an organization in order to partner with Cal-REC?

In the Cal-REC model, there are four potential roles for those organizations who wish to participate:

1. An organization forms a LEC and also acts as a Service Provider
2. An organization forms a LEC, does not provide services, but subcontracts these services to service providers
3. An organization acts as Service Provider, but is not a LEC
4. An organization is a consumer of Cal-REC offerings and LEC services, but is not a LEC or a service provider

Regardless of the level of involvement, Cal-REC encourages participation at all levels and sees collaboration as essential to achieving the goals of the ARRA grant.

Funding

How does funding for the Regional Extension Center (REC) work?

The Office of the National Coordinator (ONC) plans to distribute funds to the REC on a performance-based model. The only funds that will be distributed upfront are the Core Support dollars. Each REC will receive between \$500,000 and \$750,000 per year for administrative costs, of which 50% will be available for REC startup costs in the first six months. At this time, Cal-REC will be using core support funding for REC startup costs in order to create a series of tools that will be available to PPCPs statewide to help expedite the process of achieving meaningful use.

The bulk of the grant funds will be disbursed to the REC on a quarterly basis as milestones are achieved. Like the REC, LECs will receive their first payment at the end of the quarter in which it signs up providers. The REC is eligible to receive up to \$5,000 per provider as follows:

1. 1/3 will be paid when a clinic, hospital, or private practice signs an agreement to work with the REC.
2. 1/3 will be paid when the clinic "goes live" with an EHR, and produces quality reporting and implements e-prescribing.
3. 1/3 will be paid when the provider achieves meaningful use.

If I have to pay fees, what is the benefit of working with Cal-REC?

Grant funding is intended to enable the REC and LECs to provide discounted services to targeted providers compared to market rates for those same services delivered by vendors not working with the REC. When providers who are further along with EHR implementation and are on the path towards reaching meaningful use, sign an agreement to work with Cal-REC, they allow Cal-REC to receive that much more money from the ONC to assist all providers in the state to achieve meaningful use. It will be Cal-REC and its affiliated LECs, not the providers, who receive the money for each provider signed up based on the following formula: $\# \text{ of providers} \times \$5000 = \$[\text{Providers} \times \$5,000] \text{ worth of services.}$

We believe the ONC created this model because there are a series of services, such as workforce, Learning Communities, group purchasing, vendor selection, coordination of consultants, HIE, consumer advocacy with large for-profit vendors, and overall coordination of community HIT assets, that providers may not be willing to pay for directly, but would greatly help the ONC achieve its extremely ambitious national goal of getting 100,000 PPCPs to meaningful use within four years. We

compare the REC to being part of an association, where there are tangible benefits directly to the member organization as well as benefits to the membership as a whole.

How is the LEC funded?

All funding from ONC goes directly to the REC. The REC will receive funds based on providers meeting certain milestones:

1. Grant Funding

Milestone 1: Technical Assistance Contracts Signed. Cal-REC will receive \$1,666 (1/3 of \$5,000) for each provider who signs up for technical assistance with the REC. This money is to be used for the REC to provide services, mainly through LECS, to providers statewide. This money does not go directly to providers.

Milestone 2: Going Live with EHR (with quality reporting and e-Rx). As providers “go-live” with an EHR system, the REC will receive additional funding (the second third of overall funding - \$1,666.) Again, this money goes directly to the REC who will funnel the funds to the LECS.

Milestone 3: Achieving Meaningful Use. The last payment to the REC will be received when a provider reaches Meaningful Use. At this point providers who have met Meaningful Use will be eligible for Medicare/Medicaid incentive money.

Approximately 80% of REC funds awarded from the ONC will be funneled directly to the LECS to drive down the costs of attaining Meaningful Use. This money cannot be used for purchase of an EHR or for direct payment to providers; rather it is to allow REC/LECS to fulfill the goals/purpose of the REC (see above).

2. Charge for services

LECS can also generate income by acting as service providers to their constituents. LECS will charge providers for services rendered to achieve Meaningful Use (see [Cash Flow Considerations](#) for more information on potential financing options).

How does the REC intend to become self-sustaining by the end of the grant period?

To financially sustain the REC in grant years three and four when the cost burden switches from 90 ONC/10 REC to 10 ONC/90 REC, Cal-REC has developed service offerings which it intends to develop, market and sell. These offerings include: a Standard EHR Configuration, The Cal-REC Analytics Asset Offering: Measurement, Reporting, and Benchmarking, and Best Practices for Process and Workflow Redesign.

Will REC funds cover all the costs for providers getting to Meaningful Use?

No. On average, to implement an EHR, it can cost a practice approximately \$40,000 to \$60,000 per provider. Cal-REC will use 20% of the total REC funds to develop offerings that drive down these costs: standardized EHR configurations, an analytics and reporting tool, and Cal-REC Best Practices. The REC offerings will be available for all LECS and Providers. Though utilization of these services is not obligatory for participating providers, Cal-REC believes that these offerings will significantly decrease the costs and effort needed to achieve Meaningful Use. LECS can choose to develop their own offerings but that cost would fall with the LEC. The remaining 80% of funds will be directed to Local Extension Centers to drive down the costs of implementing and utilizing an EHR. Cal-REC will provide assistance to LECS in developing their fee structures, but LECS will have discretion in developing their fee structures and for developing pricing agreements with their service provider subcontractors.

Eligibility

Who can become a LEC?

Unlike a REC, the service area of a LEC is not dependent on geographical regions. Currently, the Cal-REC model is considering having separate LECS for the public hospitals, small provider offices and clinics. However, in some areas the LEC might serve different types of providers. The REC will coordinate the service areas of the LECS to ensure the needs of all Cal-REC providers are met.

The current model also assumes some of the regional consortia and Health Center Controlled Networks will serve as a LEC. A LEC can provide the TA service or can choose to use outside Service Providers.

What are the eligibility criteria for becoming a LEC?

As of 11/9/09, specific criteria for LECs are not available. In general terms, qualified LEC applicants must have strong credentials in the following areas:

- Company financial stability
- EHR adoption experience with PPCPs in regional service area in each of the required LEC services (see Table Five, Service Matrix)
- Experience in assisting PPCPs achieving metrics associated with meaningful use (chronic disease quality reporting, HIE interfaces, e-prescribing, etc)
- EHR product fluency
- References from existing PPCP clients
- Ability and willingness to work collaboratively with local provider organizations

Cash Flow Considerations

What are the potential models for cash flow from the REC to the LEC?

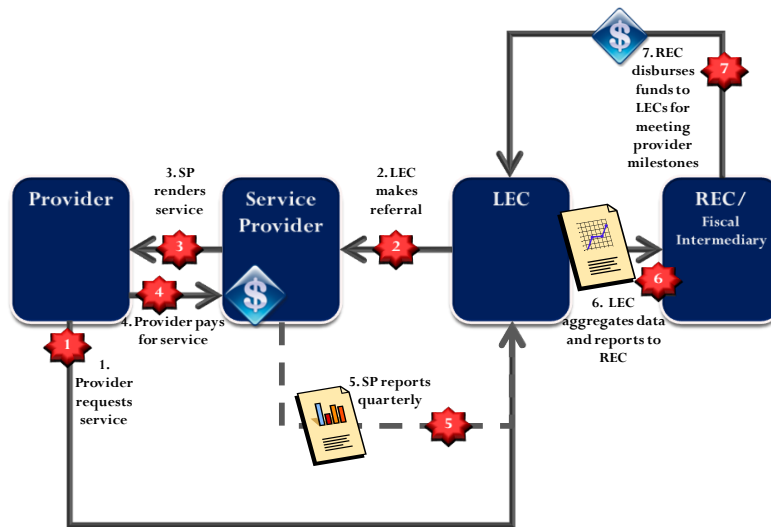
The ONC's performance-based incentive system creates a very complicate cash flow situation for Cal-REC, LECs, service providers, and especially PPCPs. The diagram below outlines a high-level outline of how funds will flow between providers, LECs and Cal-REC. (Please note: this scenario does not include other provider financing options.) To the extent possible, LECs are encouraged to develop subcontracting agreements with service providers that defer payment until REC incentives are met in order to share risk with the entities providing services directly to PPCPs. This will not always be possible. In those situations, there are several cash flow scenarios to be considered:

Scenario 1: Service Provider is sub-contracted to LEC to provide a service and Provider pays Service Provider directly

1. Provider requests service (to achieve Meaningful Use Milestones)
2. LEC provides Service Provider recommendations
3. Service Provider renders service
4. Provider pays for service
5. Service Provider reports quarterly to LEC
6. LEC aggregates data and reports to REC
7. REC disburses portion of funds to LECs for meeting provider milestones

Scenario 2: Service Provider is sub-contracted to LEC to provide a service (or LEC provides services) and LEC provides upfront funding until grant monies are available

1. Provider requests service
2. LEC makes referral
3. Service Provider renders service
4. LEC finances services provided and pays Service Provider
5. Provider reimburses the LEC, according to payment schedule
6. Service Provider reports quarterly to LEC
7. LEC aggregates data and reports to REC
8. REC disburses portion of funds to LECs for meeting provider milestone



Other

If EHR implementation costs exceed what the REC can provide, how will providers pay to get to Meaningful Use?

Cal-REC recognizes that many providers, clinics and public hospitals may not have the capital available to finance a high-quality EHR implementation. For this reason, Cal-REC is strategizing about alternatives to alleviate the upfront cost burden of getting providers to Meaningful Use. Current mitigation efforts include tiered pricing of services and Cal-REC asset offerings. Additionally, Cal-REC is evaluating additional financing strategies.