Allscripts™

Frequently Asked Questions
American Recovery and Reinvestment Act and the HITECH Act

Basics of the Bill

I've seen lots of numbers out there about the health IT parts of the Stimulus - $19 billion, $23 billion, $36 billion and $38 billion. What is correct?

Originally, it was estimated that $19.2 billion in health IT was included in the American Reinvestment & Recovery Act (commonly referred to as the Stimulus). This was based on $2 billion for the Office of the National Coordinator for Health IT (ONCHIT or ONC) and $31 billion for incentives through Medicare and Medicaid; once savings of $12 billion were subtracted out, the net was $19.2 billion.

However, the Congressional Budget Office (CBO) now estimates higher projections for incentive bonus payments made to eligible providers that demonstrate a meaningful use of certified EHR technology at $36.3 billion, as well as greater savings for the government based on improved efficiencies, tax revenue and reduced fee schedule payments due to penalties for non-adoption. When you subtract the anticipated savings of $18.8 billion achieved through efficiencies, the CBO estimates a new net cost of $19.5 billion. The total difference between the two totals may seem small, but the total value of the incentive payments at $36 billion is a very noteworthy number.

How does the $19.5 billion that's allocated to Health IT break down in the Stimulus Bill?

There is $2.1 billion that will be available to the Secretary of Health & Human Services for distribution through the Office of the National Coordinator for Health IT (ONCHIT). These funds will be spent on projects related to standards evaluation and development, infrastructure for health information exchange (HIE), grants to states for the purpose of furthering EHR adoption, improvements in telemedicine delivery, and the establishment of Regional Health IT Resource Centers.

There is an additional almost $18 billion to be applied to longer term utilization incentive bonuses for providers meeting certain criteria – this is the net cost after anticipated savings are subtracted from the total spend of $36 billion on incentive payments.

What are the different incentive options?

There are two incentive payment programs outlined under the HITECH Act – one through Medicare and another from Medicaid. Providers can only submit for payment of an incentive bonus from one of the programs so will need to analyze their organization's public payer mix to determine where they stand to benefit most. Both require that a provider prove "meaningful use" of an EHR product to qualify for the incentives, as well.

How does the bill define adequate EMR utilization? What does "meaningful use" actually mean?

"Meaningful Use" is defined in three ways in the Bill:

- Use of a certified product complete with ePrescribing capability as determined appropriate by the Secretary of HHS
- The EHR technology is connected for the electronic exchange of PHI
- Complies with submission of reports on clinical quality measures

All further details about what type of reporting will need to be submitted, what level of connectivity will be required and the final criteria for standards will be drafted by CMS and approved by the Secretary of Health & Human Services before the utilization incentives begin.

Is this incentive done on a per physician basis or on an office basis?

The incentives in the ambulatory space are paid on a per provider basis.

What are the bonus payments that will be available to physicians under Medicare?

Under Medicare, physicians will be eligible for up to the following amount as soon as they can demonstrate "meaningful use" (beginning in 2011):

	Amount They'll Receive Each Year						
Year they first file	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**TOTAL**
2011	$18,000	$12,000	$8,000	$4,000	$2,000	$0	$44,000
2012	$0	$18,000	$12,000	$8,000	$4,000	$2,000	$44,000
2013	$0	$0	$15,000	$12,000	$8,000	$4,000	$39,000
2014	$0	$0	$0	$15,000	$12,000	$8,000	$35,000
2015 or Later	$0	$0	$0	$0	$0	$0	$0

Two notes:

- Physicians operating in a "provider shortage area" will be eligible for an incremental increase of 10% in their bonus payments.
- Physicians operating entirely in a hospital environment, such as anesthesiologists, pathologists and ED physicians, are ineligible.

How will the physician payment be calculated under Medicare?

The Medicare payments will be calculated by multiplying the submitted allowable charges to Medicare by 75%, up to the capped amount for the year. So a physician aiming to collect the full incentive payment of $18,000 in 2011 will need to submit allowable charges of at least $24,000. Conversely, a physician submitting only $16,000 in allowables would collect $12,000 in 2011, even though the cap is higher.

As a physician, what if I don't demonstrate use of an EHR after the incentives are in place?

A physician who did not demonstrate meaningful use in 2014 will have their Medicare fee schedule reduced beginning in 2015. Reductions will be:

- For 2015, down to 99 percent of the regular fee schedule
- For 2016, down to 98 percent
- For 2017 and each subsequent year, down to 97 percent

If the Secretary finds that less than 75% of eligible healthcare professionals are utilizing EHR beginning in 2018, the Secretary can further reduce the fee schedule to 96% and then 95% in subsequent years but not further.

Are "mid-level" providers covered by the incentive programs?

Under the Medicaid program, nurse practitioners and nurse mid-wives can file for incentive payments. Additionally, Physician Assistants (PAs) are included but only insofar as the PA is practicing in a rural health clinic that is led by that PA or is practicing in a Federally qualified health center that is so led. Medical Assistants and Physical Therapists are not included.

Mid-levels are not included in the Medicare portion of the incentives.

Are groups that do Medicare Advantage also eligible for the stimulus dollars?

Yes, there are provisions of the legislation related to groups accepting Medicare Advantage. Those organizations and their providers are eligible for the incentives as long as the provider delivers a minimum of twenty hours a week of patient care services and the organization furnishes at least 80 percent of the services of the individual professional to clients of their organization.

How do the EHR incentives relate to the ePrescribing and PQRI payments currently available to physicians?

Once a provider starts collecting incentive payments for meaningful use of an EHR (whether in 2011 or beyond), he or she can continue to collect PQRI payments but cannot continue to collect ePrescribing payments.

What are the bonus payments that will be available to physicians under Medicaid?

A healthcare provider is eligible for incentive payments from Medicaid who:

1) is not hospital-based and has at least 30 percent of the professional's patient volume coming from Medicaid patients;
2) who is a pediatrician, who is not hospital-based, and who has at least 20 percent of the patient volume coming from Medicaid patients;
3) practices predominantly in a FQHC or rural health clinic and has at least 30 percent of the professional's patient volume coming from Medicaid patients;
4) is a children's hospital, or an acute-care hospital that is not described in clause (i) and that has at least 10 percent of the hospital's patient volume coming from Medicaid patients.

Incentive payments will be based on a calculation that factors the physician's Medicaid mix in combination with up to $25,000 the first year and $10,000 each subsequent year for five years, all multiplied by 85%. The highest potential for Medicaid payments is $63,750. Additionally, physicians filing under Medicaid must first demonstrate EHR usage by 2015 and will not be eligible for payments after 2021.

Note: Pediatricians, because they have to meet a lower threshold of only 20% Medicaid patients to qualify for the incentives, are only eligible for 66% of the incentive payments described above.

If a physician practice is wholly owned by a hospital, will the physicians receive the incentive payments for meaningful use in 2011, or the hospital as the funding source for the EHR?

This is an area of the law that is slightly ambiguous. Generally, it reads as if this test will be based on the care setting in which a physician furnishes services regardless of the ownership or financial model with a hospital or other provider organization. However, this is an area where further clarification will be sought from the Secretary of HHS.

How can we leverage the recent stimulus bill to make an EHR more affordable for us? How does a rural physician clinic obtain grants for implementing an EHR?

While the majority of the funding in the HITECH Act is reserved for utilization bonuses, part of the $2 billion in discretionary funds to HHS / ONC are to go to grant programs to help organizations offset upfront purchase costs. The details of those grant programs are not yet in place, but it is likely they will prioritize primary care practices, those delivering care in a rural or high Medicaid environment, or those seeking to establish a Medical Home model.

Are the incentives still available if you do not have all medical group offices fully implemented? We have 3 of 30 offices live now.

First, remember that the incentive payments go, for the most part, to the individual physicians delivering the care and are not distributed at the organizational level. However, to earn the payments, the physicians must demonstrate meaningful use, which includes connectivity to other healthcare providers; practices that are not fully operational across the entire enterprise are less likely to have clarified their connectivity strategy and so may present a roadblock to those physicians who are using the EHR. This is among the issues that practices will need to work through in order for their physicians to collect the incentive payments.

PQRI and DOQ have excluded Rural Health Care clinics. Will the new incentives also exclude RHC clinics?

Rural health is a key area of focus in the legislation; many of the formulations of the HITECH Act were so configured specifically to ensure the participation of rural health providers. For example, there is a 10% incremental bonus available to physicians proving meaningful use under the Medicare inventive programs while delivering care in a Health Provider Shortage Area. Additionally, the reporting requirements, while not finalized, are specified to reflect different provider capabilities and will likely not be only code based, as are those in the PQRI program. Instead, the HITECH Act outlines the options of survey and attestation reporting, which could be to the benefit of clinics using 1500 forms.

Do we need to be operating all of 2010 in order to be eligible for 2011 incentive payment?

It is likely the Secretary will determine that funds should be disbursed on a regular and predictable schedule to those demonstrating meaningful use beginning in 2011. For example, if a physician demonstrates use for the first quarter of 2011, a percentage of the utilization incentives will be distributed. We will know the final model once the Secretary outlines the ruling for the timing, frequency and reporting requirements.

How will the EHR Stimulus Funding actually come to the physicians?

The timing and distribution methodology for the incentive payments are not yet finalized.

What are the bonus payments that will be available to hospitals under Medicare?

The calculation used to determine the incentive payments to hospitals efficiently utilizing an EHR is much more complicated than that on the physician side.

Essentially, there is a calculation based on a $2 million base payment plus a figure derived from the discharge volume. *Then,* CMS will additionally determine the hospital's Medicare share in a fraction form by adding inpatient-bed-days for different Medicare patients (Part A and Part C) (equaling the numerator) *over* the product of the total inpatient-bed-days and the total hospital charges divided by the total hospital charges (the denominator). Medicare will then pay incentives based on the year in which the hospital demonstrates meaningful use, decreasing the annual incentive payments with time.

Note: Critical Care Hospitals are not eligible for the incentives described above. Instead, they will be allowed to expense the acquisition cost of health it in a single year for Medicare payment instead of depreciating it over a number of years.

How much of the $19.5B will be allocated for ambulatory solutions vs inpatient clinicals, or critical access hospitals vs PPS hospitals?

The Congressional Budget Office has made some predictions about where they believe the utilization will occur, but there are not specific pools of money allocated to the various care settings or any cap set on incentive spending in any one area.

Does use of an EHR in an Emergency Department qualify me as an Emergency Physician for incentive payments?

Hospital-based physicians are not eligible to individually receive incentive payments based on the fact that their organization was the one to shoulder the cost of purchasing and implementing the EHR. This includes specialties such as ED, pathology, anesthesiology and others.

What happens to hospitals that don't prove meaningful use of an EHR by 2015?

For eligible hospitals not demonstrating meaningful EHR use by 2015, three-quarters of the anticipated percentage increase in the fee schedule shall instead be reduced by 33 1⁄3 percent for fiscal year 2015, 66 2⁄3 percent for fiscal year 2016, and 100 percent for fiscal year 2017 and each subsequent fiscal year. This reduction will be reevaluated each year, and a hospital can return to a normal fee schedule as soon as EHR use is demonstrated.

Are all physicians in the U.S. eligible for incentive bonus payments from Medicare and Medicaid?

While the majority of physicians stand to earn incentive payments if they meet the meaningful use threshold, there are some that will not qualify – those not accepting Medicare, or those that do not have a patient base that is comprised of more than 30% Medicaid patients. Additionally, physicians delivering all care in a hospital, such as anesthesiologists, pathologists or emergency physicians, do not qualify.

Note that while most providers must demonstrate that 30% of their patients are using Medicaid in order to qualify for that portion of the program, pediatricians need only prove 20%. This is an effort to facilitate the participation of more pediatricians in the program who would not normally accept Medicare and very well might not have a sufficient Medicaid volume to qualify.

If the incentives are for Medicare and Medicaid services, how are the providers incited to adopt if they do not have Medicare or Medicaid patients? Those like pediatricians or a practice with a sports medicine specialty?

If a physician does not meet the Medicaid payer mix threshold and does not accept Medicare, they will be able to apply for grants and/or loans to offset the upfront costs of the purchase of an EHR but will not be eligible for incentives as currently delineated. However, the Secretary of HHS will be assessing utilization levels beginning in 2011, and if he or she believes that there is a need to offer other incentives to prompt adoption among those populations of providers, that will be addressed then.

If I meet the definition of meaningful use now as an EHR user, can I earn incentive payments immediately?

No, all organizations must wait until 2011 to submit for incentive payments. However, you do have an immediate opportunity to earn incentives from CMS for ePrescribing utilization, as well as PQRI bonuses.

Can you please outline how this would work in a private psychiatrist's office? How would they define meaningful use?

Other than the singular Medicaid threshold adjustment for pediatricians, there is no specialty-specific language in the HITECH Act that would mean any criteria changes for any individual type of provider. Therefore, all specialties will need to meet the same criteria: certified EHR product, connectivity to other healthcare professionals, and submission of reports to HHS.

Is this a loan? Will this money have to be paid back if you receive the help for EHR?

With the exception of loan programs which will be established by the States in 2010 based on Stimulus funding from the Federal government, the incentive payments and funding sources identified as "grants" will <u>not</u> be loans or expected to be repaid at any point.

What does the connectivity requirement of the meaningful use definition mean?

CMS, under the guidance of Secretary Sebelius, will be defining this requirement further, but we believe that demonstrating connections and patient data exchange with another provider such as a lab, pharmacy, imaging center, hospital, or other physician will satisfy the requirement. It is possible that as health information exchange initiatives gain traction in more regions across the country that the requirement for connectivity will be adjusted by the Secretary and be interpreted more stringently.

Besides Medicare and Medicaid, how will it work with other large payers?

There is nothing in the Bill that addresses private payers, but it is likely that in this area, as in others historically, the insurance companies will follow the lead of the Federal and State governments.

Are there incentives for providers delivering care in a home care, hospice or other long-term care environment?

There are no incentives in the Stimulus for EHR use in a post-acute setting – the plan is to address this obvious and recognized gap in the larger health reform work that President Obama kicked off in a speech the week of February 23rd. The primary reason for this is that systems for home health, hospice

and nursing homes have not been subjected, to date, to the same certification or standards scrutiny as has taken place in the other care settings, so Congress felt more would be required than could be done by the 2011 incentive timeframe.

Impact on Clients / Product Specific Questions

What does this mean to current Allscripts clients?

The answer depends on the client's current technology utilization patterns.

For those that do not yet use an EHR and meet the criteria for the incentive payments, this program should offer a motivation to adopt so there is sufficient time to implement and learn how to effectively use the software sufficiently enough to comply with the "meaningful use" requirements.

For clients who already use an EHR product, they will be eligible for the utilization incentives assuming they meet the criteria under Medicare or Medicaid and demonstrate meaningful use.

Can I earn incentive payments if I accept Stark funds from the local hospital?

Under the Medicare incentive program, there is no impact on a physician's practice that funded the purchase of their Electronic Health Record with assistance from a hospital or another source. However, under the Medicaid incentives, the statute specifies that if a physician uses external funds to pay for the purchase of an EHR (other than any money that came from the state itself through a grant or loan), it *will* reduce the payment he or she receives in the first year, part of which is intended to cover the purchase of the system and the cost of implementation. The specifics of how the reduction in the payment will be calculated, however, have not yet been released.

If I already use an Allscripts EHR, do you know if I can qualify for a grant once they become available?

HHS and ONC will likely first prioritize grant dissemination to organizations that do not have an EHR or to those that use an outdated product that will not meet certification criteria. For those already using an EHR that meets that criteria, the program will instead reward them and offset their purchase costs through the utilization incentives.

Do you have any visibility as to whether HITECH's standards to be adopted before 12/31/09 will be built from scratch, or will be closely based off of CCHIT criteria? What do you anticipate will be the primary variances if they start from the CCHIT certifications?

The primary focus within the legislation is on the need for expanded standards around interoperability and the establishment of clear standards related to privacy. It is widely expected that the currently existing CCHIT criteria will be the base for the go-forward work and that HHS and ONC will simply build on that base to move quickly and efficiently to an expanded set by the end of 2009.

What is Allscripts' position on the standards certification requirement?

Allscripts has been a strong supporter of CCHIT – one of the industry's primary product certification bodies – since its inception, and our CEO, Glen Tullman, is the only vendor representative on the Board of Trustees. We are pleased that Congress appears to be recognizing the good work CCHIT has done through its certification process and that HHS will likely be basing much of their go forward standards on that work to date.

Today, Allscripts has four clinical products that address different market needs and client bases. Each of these solutions has current CCHIT certification, and we intend to ensure that every one of our clients is in a position to participate in the new Stimulus incentives that will become available in 2011.

What are the current CCHIT certifications for the Allscripts EHR solutions?

Each of our Electronic Health Record solutions is currently certified; we will continue to aggressively pursue connectivity, interoperability and CCHIT certifications for our solutions moving forward.

Will Misys EMR meet the certification criteria for meaningful use?

Over 1,800 physician practices use Misys EMR today, and we continue to invest in development, maintenance and support of this solution. With the combination of our current CCHIT certification for Misys EMR (valid until February 2011) and our just released Version 9.1 and the future Version 9.2 (due in early 2010), we are committed to ensuring that all of our clients will able to participate in these, and future, incentives. While the CCHIT requirements for 2009, 2010 and 2011 are not finalized, we will analyze and execute the best approach for each of our clients (across all solutions) as the standards requirements are released by the Department of HHS.

Is there a list of certified EHR companies?

To learn more about companies incorporating CCHIT criteria in their products, visit www.cchit.org.

Do you know what type of reporting will be required to prove EHR utilization to CMS / HHS?

We will not know for some time – even potentially into 2010 – what the requirements will be of physician organizations or hospitals wishing to submit reports to demonstrate meaningful use of an EHR or what those terms will ultimately come to mean. The Bill lists several options for that reporting, including the creation of new CPT or ICD-9 (or ICD-10) codes that indicate use of an EHR, surveys, attestations and other forms. However, Allscripts is committed to ensuring that our products make it as simple as possible for our clients to comply with any directive that comes out of HHS at that point.

I use Document Manager – will that qualify as an EHR under the definition of meaningful use?

Document Manager and our other electronic health record modules are not EHRs and are thus not certified, so they will not qualify on their own or meet the meaningful use definition.

Does Allscripts have an EHR system for solo docs in rural primary care? Can you allow payments for the system to begin in 2011 when incentives start?

Allscripts MyWay is the product appropriate for physician practices with fewer than five providers; if you wish to speak to someone about special Stimulus packages, please call (800) 334-8534.

Will there be an issue for a provider if they purchase a software package, like MyWay, that combines the PM and clinical side being that the Stimulus focuses on, and provides money for, the clinical side?

The incentive utilization payments are not based on any specifics related to your software purchase – PM, clinical, ancillaries, etc. – but on how the EHR product is put to use beginning in 2011. Many people feel strongly that their organization benefits from an integrated PM and EHR system and will purchase along those lines, but ultimately, the Stimulus incentives have no correlation to practice management system status. The entire focus is on Electronic Health Records.

Have you created or will you create a program that extracts PQRI data from Misys EMR?

AllscriptsMisys is not a Qualified Registry, nor can any EHR vendor, at this time, be a qualified registry. Instead, there are 32 registries identified on the CMS web site that can assist with PQRI Reporting. CINA is one example of a vendor that is a Qualified PQRI Registry that is familiar with the Misys EMR product; however, contracting with a Qualified Registry service is between the individual client and the Registry.

What does the stimulus mean for the current NC HIE project that Allscripts is helping on?

Leigh Burchell, Allscripts' Director of Government & Industry Relations, is on the North Carolina HIE Council and works in that capacity to represent our large client base of physician practices, hospitals and home care agencies in North Carolina. It is very clear that North Carolina, with a leadership position in healthcare IT-related work due to success in the NHIN projects, will be striving to put Stimulus dollars to their best effect through HIE efforts and related EHR adoption across the state.

Additionally, Allscripts is involved in similar Stimulus-related initiatives in a variety of other states; if you know of a project where you believe Allscripts would add value or should be involved due to our industry & product leadership, please contact leigh.burchell@allscripts.com.

General Questions

Can hospitals use Stimulus funding for Stark projects?

There is nothing in the Bill that preempts a hospital from moving forward with a program maximizing the relaxation of the Stark and Anti-Kickback laws. Such hospitals may apply for grants and/or loans that become available as the Secretary of HHS allocates the $2 billion and use that money to further EHR adoption in their larger community. The incentive payments for meaningful use will not benefit the hospital as those payments go directly to the practicing providers, but we anticipate that many hospital executives will decide to proceed in an effort to increase physician loyalty and referral dollars.

What do you think will happen in the industry as a result of this? Consolidation? More companies entering the space to get a piece of the pie?

It is likely that smaller, independent players in our space will be acquired as larger companies – and particularly those without any discernible presence in the ambulatory market in particular – seek to gain a share in the incredible opportunity presented by the HITECH Act.

I have a grant request ready to send to HHS – do you know where I should send it?

At this point, the process for grant submission related to Stimulus funds is undefined so it is premature to submit any type of request. The Secretary of HHS Kathleen Sebelius and David Blumenthal, MD, who heads of the Office of the National Coordinator for Health IT (ONCHIT) will release the plan for allocating the $2 billion by the end of spring / early summer, and at that point, it will be clear where clients can submit requests for grants related to "implementation or planning" as outlined by the law.

Do you know of any tax breaks or incentives (existing or coming in due to the stimulus package)?

A long-standing tax break is the section 179 expense deduction, which was just increased to $250,000; generally, however, we recommend speaking to your accountant or financial advisor about this section of the tax code, as well as any other element that may be advantageous to your organization.

What safeguards will be in place to protect physicians from the concern that the "quality" data collected through these incentives won't be turned around in a way that "dictates" how the art of medicine should be practiced?

Allscripts' source of information on this topic is a separate FAQ document released by the Senate in February 2009. Below is a sample Question & Answer on the topic:

Q: ***Can the government use the results of this research to tell me, or my doctor, what tests and treatments I can or cannot have?***

A: Absolutely not. In fact, the Senate bill specifically prohibits the government from making any coverage decisions based on the reporting or comparative effectiveness research, or even from issuing guidelines that would suggest how to interpret the research results. The sole aim is to disseminate the results of the research to the public, so that patients and their doctors can make the best decisions for their specific situations, together.

As an industry leader, how will Allscripts meet the logistical challenges of selling to and implementing a higher number of systems than ever required before? How will you assure prospects that installation will be done in time to allow physicians to qualify for the incentive payments?

As intended by the Stimulus legislation, Allscripts will hire new sales professionals, implementation experts and client support professionals as our client base expands and requirements in those areas of our business grow.

What does this do to product R&D budgets when new system implementation will be #1 Priority?

As always, Allscripts is committed to investing many millions of dollars in product development each year, and this, in fact, is accelerating our R&D investment schedule. We will continue to expand our product functionality to ensure we not only help our clients meet the meaningful use requirements to earn incentive payments but also to evolve their use of the product to a point of active, robust disease management, the implementation of quality care measures, and the like.

Contact your Henry Schein Sales Consultant for more information.

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