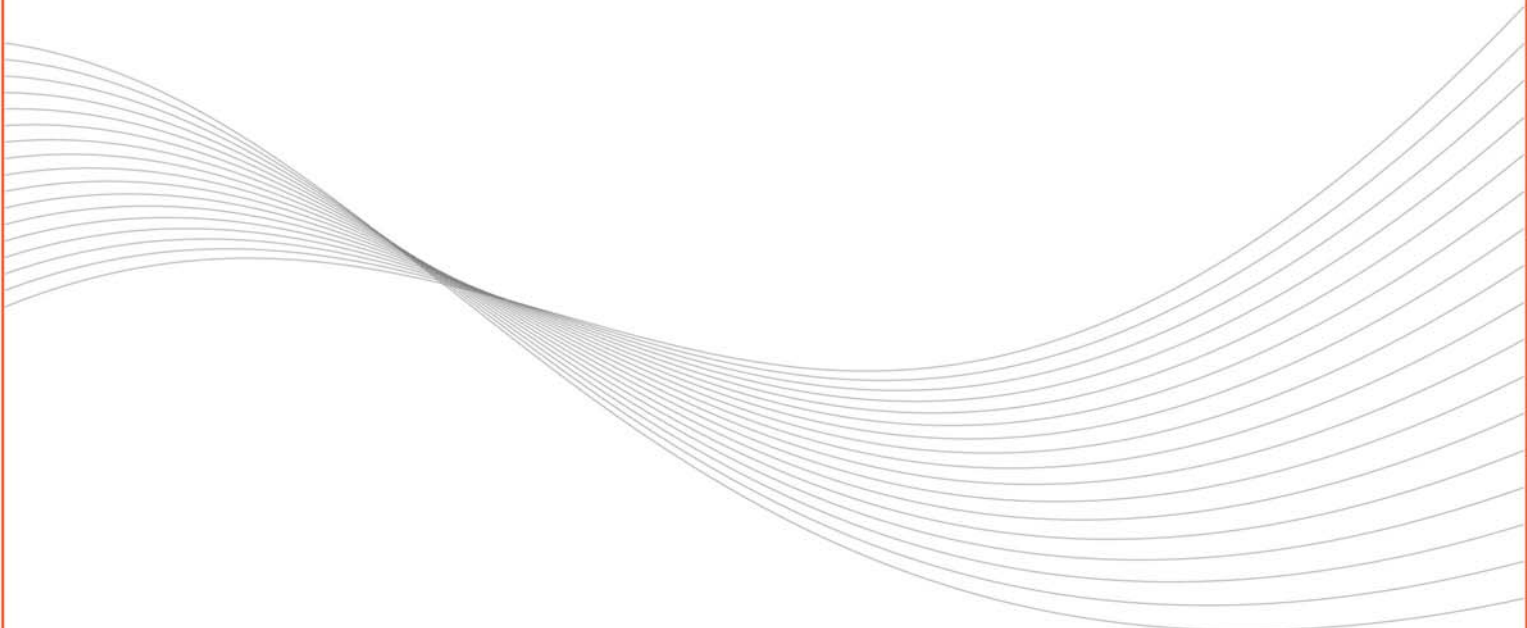




Allscripts Stimulus Series

Frequently Asked Questions

Updated August 10, 2010





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The HITECH Act, and the Final Rule for Meaningful Use Incentives

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Basics of the Bill

I've seen lots of numbers out there about the health IT parts of the Stimulus - \$19 billion, \$30 billion and \$27 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, in the Final Rule on Meaningful Use Incentives released on July 13, 2010, the Center for Medicare & Medicaid Services (CMS) revised the estimated spend on incentive payments to between \$14 billion and \$27.6 billion, depending on a variety of factors that can impact adoption levels over the next decade. This does not include the \$2 billion allocated to ONC that is being spent on support and "wrap around" programs, bringing the possible spend up to almost \$30 billion.

How does the \$30 billion (net) that's allocated to Health IT break down in the Stimulus Bill?

There is \$2.1 billion that was made available to the Secretary of Health & Human Services for distribution through the Office of the National Coordinator for Health IT (ONC). These funds have been / are being 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 Regional Extension Centers.

There is an additional amount that is predicted to be between \$14 billion and \$27.6 billion that will be applied to longer term utilization incentive bonuses for providers meeting certain criteria – this is the net cost after anticipated savings and savings from Medicare fee reductions are subtracted from the total spend on incentive payments.

How many providers does CMS expect to participate in the program?

Of the 624,000 healthcare organizations that CMS estimates will participate in the incentive program, they estimate that approximately 591,000 (94.71%) will be Eligible Professionals (EPs) – the individuals collecting payments.

What are the different incentive options?

There are two incentive payment programs available to Eligible Professionals (EPs) outlined under the HITECH Act – one through Medicare and another from Medicaid. Providers in an ambulatory

environment can only submit for 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.

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

"Meaningful Use" is defined in three fairly vague ways within the HITECH legislative language:

- 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

Beyond that, a robust proposed set of Rules – one related to the standards products must meet to earn certification, one on the certification process itself, and third on the required provider behavior with their EHR – was released by HHS on July 13, 2010. Components of the Rules are addressed in this document (see *Meaningful Use*).

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

The incentives in the ambulatory space are paid on a per provider basis. Providers within a single organization may choose different routes to the incentives based on different payer mixes or start dates.

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.

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 may be established by the States in 2010 or 2011 based on Stimulus funding from the Federal government, the incentive payments and funding sources identified as "grants" will not be loans or expected to be repaid at any point.

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?

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.

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

There is nothing in the Bill that addresses private payers. However, several major private payers (including United, Aetna, Highmark and WellPoint) have already announced that they will align their Pay for Performance incentive programs with the Meaningful Use requirements, meaning that even practices that do not accept any or significant volumes of government-paid patients will be incited to follow the same models to earn extra revenue for their practices. It is likely that in this area, as in others historically, the insurance companies will continue to follow the lead of the Federal and State governments.



How can we leverage the 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, there are funds that have been made available through the Health Resource Services Administration (HRSA) to community health centers, rural health clinics and the like. Visit www.hrsa.gov for more information.

The Medicare Incentive Program

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):

Year they first file	Amount They'll Receive Each Year						
	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	\$12,000	\$8,000	\$4,000	\$24,000
2015 or Later	\$0	\$0	\$0	\$0	\$0	\$0	\$0

Note:

- Physicians operating in a state-identified health provider shortage area (HPSA) will be eligible for an incremental increase of 10% in their bonus payments.

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 \$16,000 in allowables would still be able to collect \$12,000 in 2011, even though they are not able to hit the cap for that year.

What "allowable charges" will count towards the incentive calculation?

This is going to be based on what Medicare pays under the Physician Fee Schedule in the Part B program. Only those services rendered by a qualified EP will count, and only "professional components", not those classified as "technical components" by Medicare. This is the list of what is included in the Medicare Part B Physician Fee Schedule:

- Physicians' services
- Services and supplies (including drugs and biologicals which are not usually self-administered by the patient) furnished as an incident to a physician's professional service
- Outpatient physical therapy services and outpatient occupational therapy services
- Antigens
- Prostate cancer screening tests
- Colorectal cancer screening tests
- Diabetes outpatient self-management training services
- An initial preventive physical examination
- Diagnostic X-ray tests and other diagnostic tests, but not including clinical diagnostic lab tests
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians
- Screening mammography
- Screening pap smear and screening pelvic exam; and
- Bone mass measurement

The Medicaid Incentive Program

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

Incentive payments to participating EPs will be up to \$25,000 the first year and \$10,000 each subsequent year for five years, all multiplied by 85%. The highest potential for all cumulative Medicaid payments is \$63,750.

How will a State, with jurisdiction over the Medicaid incentive program, determine whether a provider meets the 30% threshold (or 20% for a pediatrician)?

The EP must have a minimum of 30% of all patient encounters attributable to Medicaid over any continuous 90-day period *within the most recent calendar year* prior to reporting.

- This threshold is calculated using as the numerator the individual EP's total number of Medicaid patient encounters in any representative continuous 90-day period in the preceding calendar year and the denominator is all patient encounters for the same individual professional or hospital over the same 90-day period.
 - Will apply a plain meaning test
 - Cannot count a short-term temporary Medicaid outreach program as the representative period
 - Required to annually re-attest to patient volume thresholds to continue to qualify for Medicaid incentive payments
 - States may propose acceptable alternatives that synchronize with existing data sources, which could decrease State data burdens – requires CMS approval
- Individuals enrolled in Medicaid managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), or prepaid ambulatory health plans (PAHPs) can be included in the Medicaid calculation
- An encounter can be counted as a Medicaid encounter in the context of this program as long as all or part of the visit is paid for through Medicaid. This thus includes patients for whom Medicaid is a secondary insurance.

How will the providers working in a FQHC or RHC be assessed?

Medicaid EPs practicing predominantly in an FQHC or RHC must have a minimum of 30 percent patient volume attributable to "needy individuals" over any continuous 90-day period within the most recent calendar year prior to reporting. "Needy individuals" are defined as:

- (1) They are receiving medical assistance from Medicaid or the Children's Health Insurance Program (CHIP);
- (2) They are furnished uncompensated care by the provider; or
- (3) They are furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.
- (4) Bad debt is consistent with this definition.

Additionally, Medicaid EPs practicing predominantly in an FQHC or RHC are not subject to the hospital-based exclusion. "Practices predominantly" means working at an FQHC or an RHC when the clinical location for over 50 percent of his or her total patient encounters over a period of 6 months.

What is the timing of the Medicaid program?

Payments can begin in 2011 for those adopting, implementing, or upgrading certified EHR technology for 90 contiguous days even to providers who are not yet ready to prove Meaningful Use of that EHR. The State – through its State Medicaid Health IT Plan (SMHP), which will oversee the entire program – has to file an indication of readiness to capture the required electronic information about the provider, however, for transmission to CMS and thus the avoidance of duplicate payments, before payments can begin.

- Staffing, maintenance, and training – including efforts to reengineer provider workflow, establishing data exchange agreement with other providers, and expanding functionality to include things like clinical decision support and CPOE, would count towards efforts to adopt, implement and upgrade.

In the event that a Medicaid provider earns the first year's incentive for the implementation / upgrade process and not for Meaningful Use, the 90-day proof period would apply in *both* the first and second payment years.

For those who've already adopted and are ready to prove Meaningful Use, the program will begin in 2011, as in the Medicare program.

Physicians filing under Medicaid must first demonstrate EHR usage by 2015 in order to participate in the program and will not be eligible for payments after 2021.

I heard Medicaid will start paying HITECH incentives in 2010 – can you explain?

While there was something in the NPRM about states being able to pay providers who proved they were upgrading or installing an EHR in 2010, that early payment opportunity was removed by CMS in the Final Rule because states indicated it was putting too much pressure on them to push their plans for program management through faster than was wise.

How will a provider enroll in the Medicaid program?

Medicaid EPs will enroll in the program through the single provider election repository (a national portal) being developed by CMS through a third party. By collecting information in a single data repository, the States and CMS will be able to verify that there is no duplication of payment to a provider taking place.

What about providers caring for significant volumes of Medicaid patients in multiple states?

Medicaid EPs who practice in multiple states will be required to choose only one state from which to receive Medicaid incentive payments but can change that state choice annually when they reattest to their ability to meet the threshold.

Are the Medicare and Medicaid program requirements the same, as it relates to Meaningful Use?

CMS has created a common definition of Meaningful Use that would serve as the definition for providers participating in the Medicare FFS and MA EHR incentive program, and the minimum standard for EPs and eligible hospitals participating in the Medicaid EHR incentive program. The states *are* allowed to make four metrics that are optional under the Medicare program required under Medicaid, but additional changes are not allowed.

Who's Eligible?

What types of providers are eligible for the Medicare incentives?

"Eligible professional" for the Medicare program, specifically, is defined as, 1) a doctor of medicine or osteopathy, 2) a doctor of dental surgery or medicine, 3) a doctor of podiatric medicine, 4) a doctor of optometry or 5) a chiropractor.

What types of providers are eligible for the Medicaid incentives?

The Medicaid program includes more provider types than the Medicare one. Those allowed to submit for incentives include Physicians, DOs, dentists, certified nurse-midwives, nurse practitioners, and physician assistants practicing in an FQHC or RHC that is so led by a physician assistant.

How is it determined that a FQHC or RHC is "led" by a PA?

Such a leadership requirement can be satisfied in three ways:

1. When a PA is the primary provider in a clinic
 - a. i.e. when there is a part-time physician and full-time PA, the PA would be considered the primary provider
2. When a PA is a clinical or medical director at a clinical site of practice
3. When a PA is an owner of an RHC, regardless of other providers delivering care there

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 substantially all care in a hospital, such as hospitalists, pathologists or emergency physicians, do not qualify. (see "Definition of Hospital-based.")

How can a pediatrician participate in the Medicaid incentives?

Pediatricians are allowed to participate by meeting a lower threshold of only 20% Medicaid patients to qualify for the incentives (or 66% of the regular threshold requirement). If they do this, they will then be eligible for 66% of the incentive payments described above, or a total of \$45,520. However, if a pediatrician actually has a patient volume of 30% Medicaid patients, they can collect the full incentive amount of \$63,750.

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

Under the Medicaid program only, Nurse Practitioners and Nurse Midwives 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 physical therapists eligible for incentives?

No, physical therapists do not qualify as an Eligible Professional under either the Medicare or Medicaid incentive program.

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 and certain specialties that are most often hospital-based and thus excluded, the EP program is not intended to be specialty-specific. Therefore, all specialties will need to meet the same criteria: certified EHR product, connectivity to other



healthcare professionals, and submission of reports to HHS, all within the context of being a defined Eligible Provider as outlined above.

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 any provider who delivers more than 90% of their services in an inpatient or ED setting.

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.

Additionally, it's important to note that amounts paid by Medicare Advantage Organizations (MAOs) are required to be close to the amounts paid under Medicare Fee for Service (FFS), but they very well may not be identical. The HITECH Act requires that MAOs make incentive payments "in a similar manner" as under Medicare FFS, but there is some flexibility to allow for regional reimbursement patterns.

What are the details of the Medicare Advantage incentive program?

- It is only when an EP is employed by a single qualifying MA organization, or is employed by or in partnership with an entity that contracts with a single qualifying MA organization, that an EP can satisfy the criteria to be an MA EP
- CMS will only consider covered professional services provided to enrollees of MA plans offered by qualifying MAOs and will not include in the calculation any services reimbursed by Medicare FFS
- CMS will calculate the payment due the qualifying MA organization for each qualifying MA EP as an amount equal to 75% of the reported annual MA revenue of the qualifying MA EP, up to the maximum amounts specified
- No incentive payment will be made to qualifying MA organizations for the MA EPs until after the final computation of EP incentive payments for that year under the Medicare FFS program to avoid duplication. This means that while those qualifying under Medicare FFS will receive their incentive payment as soon as they demonstrate use and hit the cap for the year, those filing under the Medicare Advantage element will not be paid until Spring of the following calendar year so CMS can be sure the provider has not also been paid under the Medicare FFS program.

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

Absolutely. The key here is that the incentive payments go to the individual physicians delivering the care and are not distributed at the organizational level, which allows providers within the same organization to move at a different pace and thus collect the incentives at a different pace.

One thing to consider, however, is that 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.

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.

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

Under the Medicaid incentives (and only the Medicaid incentives), the HITECH 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. Thus, in the situation in which a practice accepts money from a local hospital through a Stark program, the “average allowable costs” will be adjusted in order to subtract any payment that is made to Medicaid EPs and is directly attributable to payment for certified EHR technology or support services of such technology.

The good news, however, is that because the average allowable cost has been defined well above the payments allowed under the Medicaid program, there is still room for physicians to accept a certain amount of money each year and still collect the maximum Medicaid incentive.

- The average allowable cost has been determined by CMS and ONC to be \$54,000 in the first year; thus, EPs could receive as much as \$29,000 in funding from sources (other than from State or local governments) as contributions to the certified EHR technology, and the incentive payment would still be the maximum net average allowable cost of \$21,250.
- If in the following years an eligible professional can receive as much as \$10,610 in contributing funds from sources other than State or local governments, and the maximum incentive payment of \$8,500 would be unaffected in such subsequent years.

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.

Meaningful Use Details

How are they going to track the behavior of the Eligible Professionals (individual providers)?

Each objective must be satisfied by an individual EP as determined by unique National Provider Identifiers (NPIs), and each provider who proves Meaningful Use will be required to submit one Tax ID Number (TIN) to which CMS should route the payment. This will allow CMS to check for any duplication.

What information is CMS going to require from participating providers?

Three conditions are required:

- (1) knowing which EHR incentive program a provider has selected
- (2) uniquely identifying each provider participating in each incentive program
- (3) ensuring that each State has access to the information on which EPs or hospitals intend to receive incentive payments from another State, or from the Medicare program.

EPs must also pick one TIN through which to receive their payment, even if they practice in multiple locations. They can then reassign dollars to other TINs if they so desire.

To ensure accurate and timely incentive payments, providers will have to provide the following information:

- Name, NPI, business address, and business phone
- Taxpayer Identification Number (TIN) to which the EP or eligible hospital wants the incentive payment made. A provider may provide their Social Security Number in the event that the incentive is not to go to a practice.
- For EPs, whether they elect to participate in the Medicare EHR incentive programs or the Medicaid EHR incentive program.

There are sometimes reasons that an EHR product might not be functioning, or issues with broadband connectivity. What does this mean for the incentive program?

CMS has indicated that in order to be a meaningful EHR user, an EP must have 50 percent or more of their patient encounters during the EHR reporting period at one or more practices/locations equipped with certified EHR technology. This allows not only for the minimal levels of down-time expected from an EHR product, but additionally, for providers to participate who work in multiple locations with varying adoption levels.

Does a provider need to be using an EHR all of 2010 in order to be eligible for 2011 incentive payment?

How long, and when, do you have to prove Meaningful Use to earn the incentives?

No. The EHR Reporting Period for purposes of the Medicare and Medicaid incentive payments for the first year of demonstration will mean any **continuous 90-day period within the payment year** in which the EP successfully demonstrates Meaningful Use of certified EHR technology. The EHR reporting period therefore could be any continuous period beginning and ending within the relevant payment year.

- For example, for payment year 2011, an EHR reporting period of March 13, 2011 to June 11, 2011 would be just as valid as an EHR reporting period of January 1, 2011 to April 1, 2011.
- An example of an *unallowable* EHR reporting period would be for an EP to begin on November 1, 2011 and finish on January 31, 2012 because it crosses into the next payment year.
- Starting with the second payment year (and any subsequent payment years) for a given EP or eligible hospital, the EHR reporting period will mean the entire payment year.

This 90-day period allowed in the first year would allow an EP until October 1, 2011 to begin meaningful use of their certified EHR technology and receive an incentive for payment year 2011.

What are the implications if I don't get going until 2014? How will measurements of my Meaningful Use be conducted?

Beyond the delay in receiving payment, and the reduction in that payment because the earliest years are the most lucrative, the actual measurement of Meaningful Use will change, as well. There are three stages of the reporting requirements: Stage 1 requirements will be applied in 2011 and 2012; Stage 2 requirements will be applied in 2013 and 2014, and Stage 3 requirements will be applied in 2015.

- In recognition of the fact that physicians and other program participants require time to learn how to use the system and participate in the incentive program, the Stage 1 requirements will *always* be applied to an EP's first year of Meaningful Use, meaning if a provider waits until 2014 to first demonstrate use, s/he would be held to the Stage 1 requirements only.
- The earlier adopters will thus have more time to become proficient in the incremental adjustments as the requirements are ramped up, versus late adopters who will go from the training wheels of Stage 1 immediately to a motorcycle.

Can a provider switch from the Medicare to the Medicaid program, or vice versa?

Recognizing that a provider's payer mix may fluctuate slightly from year to year, an EP is allowed to switch one time from one of the incentive programs to the other. If switching from one program to another, the EP would continue in the new program at whichever payment year he or she would have attained had the EP not chosen to switch (i.e., if two years were completed in Medicaid but a provider no longer met the 30% threshold of patient volume, s/he could switch to the Medicare program and be eligible for the third year payment of that program).

- No EP should receive more than the maximum incentive available to them under Medicaid, which is the higher of the two caps. The last year incentive payment would be reduced if awarding the EP the full amount would exceed the overall maximum available under Medicaid.
- The last year for making an incentive payment program switch would be CY 2014.

How is a provider going to be asked to prove they are, in fact, "meaningfully using" an EHR?

EPs will provide attestation through a secure mechanism, which will be an online portal available in April 2011. That attestation process will require that they identify the certified EHR technology they are utilizing and the results of their performance on all the measures associated with the objectives of meaningful use. (See "Metrics to Prove Meaningful Use".)

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

Payments will be made on a rolling basis, as soon as CMS ascertains that a provider has demonstrated Meaningful Use for the applicable reporting period (that is, 90 days for the first year or a calendar year for subsequent years), and reached the threshold for maximum payment. For those participating under Medicare, this could be as early as May 2011, as CMS has committed to payment 15-46 days after attestation is submitted and maximization of the incentives is achieved.

How will the successful providers be paid?

Eligible professionals will be sent a single, consolidated incentive payment. For those who've earned it through the Medicare program, they will be paid via CMS; for those participating in the Medicaid program, payment will come from either the State Medicaid agency or their designated intermediary (i.e. a Medicaid HMO).

Can a provider ask that all or part of his/her incentive be paid to an employer instead of directly to them?

EPs are allowed to reassign their incentive payment to their employer or an entity which they have a valid employment agreement or contract providing for such reassignment, consistent with all rules governing reassignments.

- Reassignment to only one entity will be allowed, not multiple ones



- Nothing in the statute or existing regulations would prohibit an EP from assigning to the employer/entity only the allowable charges for his or her professional services, with the EP retaining any incentive payment, or vice versa.
- If an EP will reassign his or her incentive payment to an employer/entity with which the EP has a contractual arrangement, the parties will need to review their existing contract to determine whether it currently provides for reassignment of the incentive payment to the employer/entity or needs to be revised.

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

Providers or eligible hospitals may begin their EHR reporting period on any date starting with the first day of the payment year – i.e., Jan 1, 2011 for the 2011 payment year, Jan 1, 2012 for 2012, etc. You cannot prove Meaningful Use before then.

What does the connectivity requirement of the Meaningful Use definition mean?

In the Final Rule on Meaningful Use, CMS and ONC reflected on the current state of the industry, which does not afford most providers an opportunity for extensive connectivity with other local healthcare organizations, and as such, the requirements in the first years for data exchange or “care coordination” are fairly minimal.

Methods of proof will include:

- Transmitting 75% of allowed scripts electronically
- Reception of lab results electronically with 50% recorded in the EHR
- Electronic eligibility checking
- Testing – and only testing – a variety of other “connectivity” functions (data exchange, submission of immunization and syndromic surveillance data to public health departments, etc.).

The Allscripts Stimulus Set will be instrumental in helping our clients who are not already connected to local HIE organizations. It will collect reports on Meaningful Use-required data from each physician’s EHR, where they’ve signed up for it, and will also transmit the data for the providers to satisfy those measures that require data exchange.

As health information exchange initiatives gain traction in more regions across the country and we reach Phases 2 and 3 of the incentive program, the requirement for connectivity will be adjusted by the Secretary and be interpreted more stringently.

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

The PQRI program is scheduled to end on December 31st, 2012, and providers will be allowed to collect both PQRI and HITECH incentive payments. In fact, the reporting requirements were aligned as much as possible between the two programs in the Final Rule, and they are required to be merged entirely beginning in January 2012.

The rules related to HITECH and MIPAA (ePrescribing) incentive collection are different from Medicare to Medicaid.

- Under Medicare, once a provider starts collecting incentive payments for meaningful use of an EHR (whether in 2011 or beyond), he or she cannot continue to collect ePrescribing incentive payments.
- Under Medicaid, a provider can collect both the HITECH incentives *and* the MIPAA ePrescribing incentives.



Additionally, there is nothing that precludes you from accepting the HITECH incentives and others from payers or programs such as Bridges to Excellence or those from private payers. In fact, many private companies such as Aetna, United, Wellpoint and Highmark are already aligning their Pay for Performance requirements to the final Meaningful Use measures.

Metrics to Prove Meaningful Use

Has HHS given any indication of where the reporting requirements are likely to go in the future, such as in Stage 2 (2013)?

The following health IT functionality measures are intended to be built up and made more stringent for Stage 2 meaningful use criteria:

- “CPOE use” will include not only the percentage of orders entered directly by providers through CPOEs but also the electronic transmission of those orders
- “Incorporate clinical lab-test results into EHR as structured data” will be expanded to include the full array of diagnostic test data used for the treatment and diagnosis of disease, where feasible, including blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests
- Measures that currently allow the provision and exchange of unstructured data (for example, the provision of clinical care summaries on paper) will require the provision and exchange of electronic and structured data, where feasible
- Measures that currently require the performance of a capability test (for example, capability to provide electronic syndromic surveillance data to public health agencies) will be revised to require the actual submission of that data

What are the measures I need to report on in order to qualify as a Meaningful User of Electronic Health Records, and what threshold would I need to meet?

To be considered a Meaningful User of electronic health records, a provider will have to satisfy 15 Core (or required of everyone) metrics and five of 10 Menu Set (or optional) metrics. The five that are not selected by the provider are considered deferred to Stage II of their participation in the program.

What are the Core metrics that everyone has to submit against?

<u>Objective</u>	<u>Measure</u>	<u>Exclusions</u>
Use computerized provider order entry for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	Subject to paragraph [c] of this section, more than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.
Implement drug-drug and drug-allergy interaction checks. (formulary removed)	The EP has enabled this functionality for the entire EHR reporting period.	
Maintain an up-to-date problem list of current and active diagnoses.	More than 80% of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.	
Generate and transmit permissible prescriptions electronically (eRx).	Subject to paragraph [c] of this section, more than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.
Maintain active medication list	More than 80% of all unique patient's seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	
Maintain active medication allergy list	More than 80% of all unique patient's seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	
Record all of the following demographics: Preferred language, Gender, Race, Ethnicity, Date of Birth (Insurance Type removed)	More than 50% of all unique patients seen by the EP have demographics recorded as structured data.	
Record and chart changes in vital signs: height; weight; blood pressure; calculate and display: BMI; plot and display growth charts for children 2-20 years, including BMI	Subject to paragraph [c] of this section, more than 50% of all unique patients age 2 and over seen by the EP, height, weight and blood pressure are recorded as structured data.	Any EP who either sees no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice.
Record smoking status for patients 13 years old or older	Subject to paragraph [c] of this section, more than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.	Any EP who sees no patient 13 years or older.
Report ambulatory clinical quality measures to CMS or, in the case of Medicaid EPs, the States.	Subject to paragraph [c] of this section, successfully report to CMS (or, in the case of Medicaid EPs, the States) ambulatory clinical quality measures selected by CMS in the manner specified by CMS (or in the case of Medicaid EPs, the States).	

CORE SET (cont.)

Implement one clinical decision support rule	Implement one clinical decision support rule	
Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, medication allergies) upon request.	Subject to paragraph [c] of this section, more than 50% of all patients who request an electronic copy of their health information are provided it within 3 business days.	Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.
Provide clinical summaries for patient for each office visit	Subject to paragraph [c] of this section, clinical summaries provided to patients for more than 50% of all office visits within 3 business days.	Any EP who has no office visits during the EHR reporting period
Capability to exchange key clinical information (for example, problem list, medication list, allergies, and diagnostic test results) among providers of care and patient authorized entities electronically	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information	
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.	

What is the difference between the Core Set and the Menu Set in how they're applied to this program?

There are 25 total objectives and measures that are part of the Eligible Provider incentive program. 15 of those metrics – the Core Set – are required of everyone who participates and span the various elements of the program that are important to realizing the returns on the program, such as improved care coordination, benchmarking for care best practices and increased patient engagement.

The Menu Set is comprised of ten total metrics, but a provider only has to report on five of them in Stage 1. This allows participating providers to choose the measures that best reflect their practice's demographics, their workflow and where they're going to get the greatest value from learning more about their own clinical delivery.



What are the Menu Set metrics that a provider can choose from in selecting the five additional metrics they will report against?

Objective	Measure	Exclusions
Implement drug-formulary checks.	The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.	
Incorporate clinical lab-test results into EHR as structured data.	Subject to paragraph [c] of this section, more than 40% of all clinical lab tests 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.	An EP who orders no lab tests whose results are either in a positive/ negative or numeric format during the EHR reporting period.
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	Subject to paragraph [c] of this section, generate at least one report listing patients of the EP with a specific condition	
Send reminders to patients per patient preference for preventive/ follow up care	Subject to paragraph [c] of this section, more than 20% of all patients 65 years old or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.	An EP who has no patients 65 years old or older or 5 years old or younger with recorded maintained using certified EHR technology.
Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies) within 4 business days of the information being available to the eligible professional	At least 10% of all unique patients seen by the EP are provided timely (available to the patient within 4 business days of the information being updated in the certified EHR technology) electronic access to their health information, subject to the EP's discretion to withhold certain information.	Any EP that neither orders nor creates any of the information listed at 45 CFR 17-.304(g) during the EHR reporting period.
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.	Subject to paragraph [c] of this section, 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	An EP who was not the recipient of any transitions of care during the EHR reporting period.
Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice	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).	An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.

MENU SET (cont.)

Capability to submit electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice	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 or eligible hospital submits such information have the capacity to receive the information electronically)	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.
Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than 10% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources.	
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 summary care record for each transition of care or referral	Subject to paragraph [c] of this section, 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.	An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.

What if some of the metrics – Core or Menu – don't apply to my practice for some reason?

In the matrices above, there are "Exclusions" listed in the right column. These are opportunities for a provider to opt out, through attestation that one of the exclusions applies, from reporting on some of the Core and/or Menu Set metrics. Those that do not have an exclusion listed, however, must be reported on by all providers participating in the HITECH incentives.

In the event that you attest that one of the Exclusion criteria applies to you, it decreases the number of metrics an EP needs to submit against. For example, if one of the 15 Core measures does not fit the demographics or workflow of your practice, you will attest to that fact and then submit only 14; similarly, attesting that a Menu Set metric is not relevant for your practice means that you have to submit on only four. Note that it does not just take one of the Menu Set metrics out of consideration but actually results in the need to submit one less report.

Data exchange would seem to be a requirement that is going to be challenging for physicians in many geographies. What is the Final Rule here?

The challenge here is recognized in the Rule by CMS, and thus, simply testing the exchange of clinical information and the ability to send such information *at least once* prior to the end of the EHR reporting period will satisfy the Stage 1 requirement.

- If multiple EPs are using the same certified EHR technology in a shared physical setting, the testing would only have to occur once for a given certified EHR technology, as CMS does not see any value to running the same test multiple times just because multiple EPs use the same certified EHR technology.
- To be considered an "exchange" in this section alone, the clinical information must be sent between different clinical entities with distinct certified EHR technology and not between organizations that share a certified EHR.



Is a single test of the ability to submit reports the only metric for registries and public health departments?

Within the Final Rule, the submission of reports to registries and public health departments simply has to be tested once by a single physical setting (i.e., multiple EPs in a single location do not need to test repeatedly). However, more stringent requirements may be established for EPs under the Medicaid program in states, as the states have permission from CMS to escalate requirements related to public health department and registry reporting.

Definition of Hospital-based

What is the definition of “hospital-based” under HITECH (and thus how physicians closely affiliated / aligned with a hospital will be allowed to participate)?

While there is extensive language in the Final Meaningful Use Rule on this topic, the determination of whether or not a provider is considered hospital-based (and thus excluded from collecting the EP incentives) will essentially boil down to a few key questions:

1. What place of service (POS) code is listed on the physician’s claim? The use of the following POS codes indicating service in an inpatient hospital setting will be used to make the determination:
 - 21— Inpatient Hospital – is a facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians, to patients admitted for a variety of medical conditions.
 - 23 – Emergency Room, Hospital – is a portion of a hospital where emergency diagnosis and treatment of illness or injury is provided

The financial relationship, ownership model or other issues of “close affiliation” between the hospital and the physician practice are not relevant in making this determination.

How has the definition of “hospital-based” changed?

The initial definition within the Proposed Rule on Meaningful Use, released in December 2009, included the “Outpatient Hospital” place of service, which would have excluded a very large number of physician practices from filing their claims as “allowable charges” under HITECH.

- 22 – Outpatient Hospital – is a portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization

However, since the Proposed Rule was released, Congress acted through passage of an amendment to HITECH to remove the outpatient setting and limit it to inpatient locations. CMS will need to amend the definition of hospital-based in the Final Rule on Meaningful Use as a result, but it is clear that the new definition will, inherently, be inclusive of thousands of additional physicians who previously would have been excluded.

How will they decide if a physician is hospital-based?

The determination will be made by assessing what percent of the services delivered by a physician *the Government fiscal year before the current payment year* were filed using a POS indicating a hospital-based status. If the percent of services delivered exceeds 90% – which CMS has said means the physician is delivering “substantially all” care in that setting – that physician will be deemed hospital-based.

Can my “hospital-based” status be changed over time?

The hospital-based status of each EP will be reassessed each year, using claims data from the Federal Government fiscal year immediately preceding the payment year.

What if I spend some time in the hospital and some time in my practice?

If the percent of your total services delivered in the hospital does not exceed 90%, as described above, then the services you deliver in the outpatient environment, such as those tagged with a POS of 11 or 22, would be eligible for consideration as submitted allowable charges if they are sent to Medicare.

Clinical Quality Measures

HITECH requires that participating providers submit “clinical quality measures” to CMS as part of proving Meaningful Use. What, exactly, does this mean?

A clinical quality measure is a report on an aspect of patient care based on administrative or medical record data. In the context of this program, the goal is to allow CMS, ONC, the Agency for Health Research Quality (AHRQ) and other entities interested in determining delivery best practices to begin to identify patterns in diagnosis & treatment related to geography, insurance coverage, race, language and other segmentation.

How is CMS going to calculate a provider’s success in meeting the set of metrics determined to prove Meaningful Use?

For each of these measures utilizing a percentage and the reporting of clinical quality measures, the EPs will need to submit numerator and denominator information to CMS.

- The calculation will consider all patients, not just those on Medicare or Medicaid.

How does the Rule reflect primary care reporting versus that which is specialty-specific?

The measures are no longer focused on a certain specialty or even organized by specialty. Instead, for the Stage 1 EHR reporting periods, CMS outlined a requirement that each EP submit information on two measure groups – a Core set of measures reported by all, and a subset of clinical measures that will be chosen by the provider.

What if the measures in the Core Set don’t apply to me?

There is another set of measures called Alternate Core that can be submitted instead.

How many clinical quality measurements do I need to submit?

In total, EPs will need to submit six clinical quality measures – three from the Core or Alternate Core set, and three chosen from a longer list of 38 additional measures.

What are the measures in the core set of rules that all providers must report on, regardless of specialty?

1. Adult weight screening and follow-up
2. Blood pressure monitoring & management
3. Tobacco use assessment and cessation counseling

And the Alternate Core in the event that any or all of the above do not apply to the patient base:

1. Influenza immunization for patients over 50
2. Weight assessment and counseling for children and adolescents
3. Childhood immunization status

How will a provider submit the clinical quality measures to CMS?

In 2011, CMS has said that EPs should use an attestation methodology to submit summary information to CMS. Practices would, however, have to use certified EHR technology to capture the data elements and calculate the results for the applicable clinical quality measures.

In 2012, Medicare EPs would be required to report the required clinical quality measures information electronically using certified EHR technology via one of three methods.

- Require the EP to log into a CMS-designated portal. Once the EP has logged into the portal, they would be required to submit, through an upload process, data payload based on specified structures and accompanying templates produced as output from their certified EHR technology.

- Permit Medicare EPs and eligible hospitals to submit the required clinical quality measures data using certified EHR technology through Health Information Exchange (HIE)/Health Information Organization (HIO). This alternative data submission method would be dependent on the Secretary's ability to collect data through a HIE/HIO network.
- Accept submission through registries dependent upon the development of the necessary capacity and infrastructure to do so using certified EHRs.

Technical requirements for all will be out no later than 7/1/11.

Is there a concern about misreporting of data related to clinical quality measures? How will CMS know it's real data and that it's been created by an Electronic Health Record?

In submitting clinical quality measures, Medicare EPs will be asked to attest to the following:

- The information submitted with respect to clinical quality measures was generated as output of an identified certified electronic health record.
- The information submitted is accurate to the best of the knowledge and belief of the EP.
- The information submitted includes information on all patients to whom the clinical quality measure applies.
- The NPI and TIN of the EP submitting the information, and the specialty group of clinical quality measures that are being submitted.
- The numerators, denominators, and exclusions for each clinical quality measure result reported, providing separate information for each clinical quality measure including the numerators, denominators, and exclusions for all patients irrespective third party payer or lack thereof; for Medicare FFS patients; for Medicare Advantage patients; and for Medicaid patients.
- The beginning and end dates for which the numerators, denominators, and exclusions apply.

What are the actual measures on the list that an EP can choose to report?

Those have been captured in another document because of their length; please check the *Quality Measures by Specialty* document posted on the Allscripts web site.

Where did the clinical quality measures come from?

As much as possible, ONC and CMS included measures endorsed by the NQF, including NQF endorsed measures that have previously been selected for the Physician Quality Reporting Initiative (PQRI) program. In some instances, however, they proposed measures that are not currently NQF endorsed in an effort to include a broader set of clinical quality measures.

Impact on Clients / Product Specific Questions

What does this mean to current Allscripts clients?

While Allscripts has committed to delivering Meaningful Use-compliant products in time for physicians to collect incentives in 2011, the answer really depends on the client's current technology utilization patterns.

1. For those that do not yet use an EHR and meet the criteria for the incentive payments, this program offers a motivation to adopt now so there is sufficient time to implement and learn how to effectively use the software with time to comply with the Meaningful Use requirements.
2. For clients who already use an EHR product, they will be eligible, after upgrading to a Meaningful Use version of our products, for the utilization incentives, assuming they also meet the criteria under Medicare or Medicaid and demonstrate Meaningful Use.

Is there a list of certified EHR companies?

While some companies have achieved Preliminary ARRA certification from CCHIT, there is truly no EHR product that is Meaningful Use certified. As accredited certifiers are named by ONC in August / September of 2010, the active certification process will begin, allowing Allscripts to put each of our go-forward EHR products through.

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.

How will the EHR products from Allscripts help with the required reporting, and staying on track with the HITECH incentives?

Allscripts has developed a robust tracking and reporting mechanism called the Allscripts Stimulus Set, which provides dashboard functionality to allow individual Eligible Physicians to track how they are doing against each of the required EHR functional metrics. Additionally, the Stimulus Set will help facilitate reporting to CMS on the EHR functional metrics and clinical quality measures, as well as the transmission of clinical data to Public Health Departments, registries and other local healthcare providers to satisfy the metrics related to data exchange.

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

Misys EMR has partnered with CINA for PQRI registry reporting. The CINA PQRI reporting tool is a stand alone application that is installed along side Misys EMR for data extraction of specific measure information pulled from the Misys EMR database. CINA captures the required reporting data and submits a summary report to CMS on behalf of the practice. CINA will setup, configure and implement the PQRI registry solution. Clients interested in the PQRI registry reporting option, should contact Allscripts Inside Sales for more information.

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 to benefit local area providers who need assistance moving forward with EHRs. The incentive payments earned by those EPs 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. Additionally, there is no question that some companies simply will not be able to scale to the demands of this program and will choose to close.

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:

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

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 has hired new sales professionals, implementation experts and client support professionals as our client base has expanded and requirements in those areas of our business have grown. We have, additionally, aggressively reviewed and revised our methodologies to identify new approaches and ways through which we can streamline the implementation process and simplify training for our clients to minimize resource requirements on both sides.

Additionally, Allscripts looks forward to working with the Health IT Regional Extension Centers that are in the process of establishing operations across the country, following grants distributed by ONC to ensure that the primary care physicians in each of the affected geographies receive the best guidance possible.



What does this do to product R&D budgets?

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 by increasing our R&D spend from \$72 million last year to \$90 million this one. We are expanding 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. At this time, Allscripts is an active hiring cycle of Development professionals, as well.



Allscripts Stimulus Program

What special programs is Allscripts offering related to the Stimulus?

The Allscripts Stimulus Program is an offer designed to make it easy for you to get started with an EHR today. With 160,000 physicians using Allscripts solutions, we know what it takes to successfully implement and drive utilization of an EHR. And that’s why we know that the time is NOW for physicians to purchase an EHR.

Some practices may still be taking a wait-and-see approach because they don’t know which EHR to select, or they want to wait until the Meaningful Use rules are completely finalized, or they don’t have the upfront dollars to purchase an EHR. The Allscripts Stimulus Program addresses and eliminates all of these concerns with:

1. **The Right EHR.** Our EHR solutions are designed to meet the needs of your practice, regardless of size or specialty.
2. **The Right Guarantee.** Our EHR solutions will meet the criteria for Meaningful Use certification. If not, we’ll credit you up to 12 months of support. Guaranteed.
3. **The Right Price.** Start right away with \$0 for software for the first 6 months. Then pay for your solution with affordable monthly payments over time.

What is the Meaningful Use Guarantee?

Our guarantee is simple: Our EHR solutions will meet the Meaningful Use certification criteria. Period. If not, we’ll credit you up to 12 months of support fees. Guaranteed.

What is Allscripts actually guaranteeing?

Here are the components:

“Our EHR solutions...”	This includes the MyWay EHR, Professional EHR, and Enterprise EHR from Allscripts.
“...will meet the Certification Criteria.”	The government has established specific requirements for all EHR software. We guarantee that our EHR software will meet or exceed those requirements.
“If not, we’ll credit you up to...”	For every month that our software does not meet the criteria, we’ll credit you that month’s support and maintenance fees.
“...12 months of support fees.”	This is applies to all support and maintenance fees. It does not include software license fees, third-party software fees, or implementation fees.

Why won’t Allscripts guarantee that I will get Stimulus dollars?

To receive the Stimulus incentive payments, physicians are required to demonstrate that they are using an EHR. Neither Allscripts nor any vendor can force a provider to use the EHR, therefore, no company can guarantee Meaningful Use, only that their product will meet the requirements.

That said, Allscripts is committed to being a trusted advisor and partner in this process and will be working with all of our clients to make sure they not only have the right version of the right EHR in place, but the right information to capitalize on the Stimulus incentives.



Why are you doing this?

With 160,000 physicians using Allscripts solutions, we know what it takes to successfully implement and drive utilization of an EHR. And practices that want to earn every incentive dollar possible must start now. The Allscripts Stimulus Program is our way of eliminating any barriers that may stand in the way of adopting an EHR.

Why has Allscripts introduced a Meaningful Use Guarantee?

We are committed to ensuring that our solutions meet or exceed the Certification requirements and supporting our clients in their efforts to access the Stimulus incentives. However, until the actual requirements were released, any guarantee would be meaningless, as there would be no clarity as to what that guarantee actually covered.

With the release of the Meaningful Use Rules on December 30, 2009, Allscripts has conducted a review across our portfolio, and we are now able to provide the appropriate level of assurance to our clients that our EHR solutions will meet or exceed the requirements.



Finance Packages

What is Allscripts offering to help me afford an EHR?

Providers stand to earn up to \$64,000 in Stimulus incentives, but we know that some practices may not have the budget to get started today. However, the time is NOW if a group wants to be eligible for every incentive dollar possible.

That's why Allscripts is offering the Allscripts Stimulus Financing program. Providers can get started now with \$0 for software for the first 6 months. Then pay for their EHR solution with affordable monthly payments over time. Plus, at the end of the term, you own your EHR. Period. Not like some vendors where you keep making monthly payments forever. Budget concerns are no longer a reason to delay.

What is the term of the financing?

\$0 in software payments for 6 months, followed by 54 months of affordable monthly payments. Other options are available.

Is this offer subject to any limitations?

All pricing is subject to change based on the most current, competitive interest rates available at the time.

So, how much will an Allscripts EHR cost me?

Allscripts offers an entire family of EHR solutions to meet the needs of practices of any size and specialty. Please contact an Allscripts sales representative today at 1-800-334-8534 to discuss the EHR that best meets your needs. Your Allscripts sales representative can provide the pricing which best meets the needs of your organization. But regardless of Allscripts EHR you select, you can get started for \$0 in software costs for the first six months.

Is this offer applicable to any of Allscripts EHR solutions?

Yes. This offer applies to each the EHR solutions sold by Allscripts.

Does Allscripts offer other financing options that may work better for my practice?

We offer several financing options to make an EHR affordable for your practice. Talk to your Allscripts sales representative to learn more about how you can start now and pay over time.

How can I learn more about The Allscripts Stimulus Program or the Meaningful Use Guarantee?

Please visit <http://www.allscripts.com/thetimeisnow/> for more information.

Glossary / Definitions

Eligible Professional – The individual providers who are eligible to participate in the incentive program; abbreviated as EP.

Clinical decision support – Health information technology functionality that builds upon the foundation of an EHR to provide persons involved in care processes with general and person-specific information, intelligently filtered and organized, at appropriate times, to enhance health and healthcare.

Medication reconciliation – The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency and route, by comparing the medical record to an externally list of medications obtained from a patient, hospital or other provider.

Relevant encounter – Any encounter that the EP or eligible hospital judges performs a medication reconciliation due to new medication or long gaps in time between patient encounters or other reasons determined by the EP or eligible hospital.

Transition of care – The transfer of a patient from one clinical setting (inpatient, outpatient, physician office, home health, rehab, long-term care facility, etc.) to another or from one EP or eligible hospital (as defined by CCN) to another.

Unique Patient – A unique patient means that even if a patient is seen multiple times during the EHR reporting period, they are only counted once.