



Allscripts Stimulus Series

Frequently Asked Questions:

*The Top Baker's Dozen*



## Frequently Asked Questions *The Bakers Dozen*

### **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 will the physician payment be calculated under Medicare, and what "allowable charges" will count?**

The Medicare payments will be calculated by multiplying the submitted allowable charges to Medicare by 75%, up to the capped amount for the year (or will pay less than the cap if so calculated using this method).

"Allowable charges" are 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.

### **How will a State determine whether a provider meets the 30% threshold for participation in the Medicaid incentive program (or 20% for a pediatrician)?**

The Eligible Provider (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.
  - Required to annually re-attest to patient volume thresholds to continue to qualify for Medicaid incentive payments
- Individuals enrolled in Medicaid managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), or prepaid ambulatory health plans (PAHPs) can be included in the 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.

### **What types of providers are eligible for the incentives?**

"Eligible professional" (EP) 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.

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.



***Do all the providers in a practice need to participate at the same time, or through the same program?***

No, one of the beauties of the HITECH legislation is that it allows physicians and other eligible healthcare professionals to participate in the incentive program at the speed they want (providers within a single organization can begin proving and attesting to Meaningful Use at different times) and as best matches their patient mix (one partner with a lot of Medicaid patients may participate under that program while the others choose Medicare).

***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.

- 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.

***When will the EHR Stimulus Funding actually come to the physicians, and in what form?***

A single, consolidated incentive payment 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.

***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?***

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. The five they don't select are considered deferred until Stage 2.



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

In the matrix of EHR Functional Measures (available on the Allscripts web site), 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.

***How will CMS decide if a physician is "hospital-based" within the context of HITECH?***

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 and thus ineligible to collect the HITECH incentives for Eligible Providers.

***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 (posted on [www.Allscripts.com](http://www.Allscripts.com)).

***How is Allscripts going to help me 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.

***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 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.