

Stimulus: The Next Stage

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Agenda

- › Introduction
- › What *You* Need to Do
- › What *Your EHR* Needs to Do
- › How Allscripts Can Help

Welcome to 2010 . . .
THE YEAR OF THE EHR

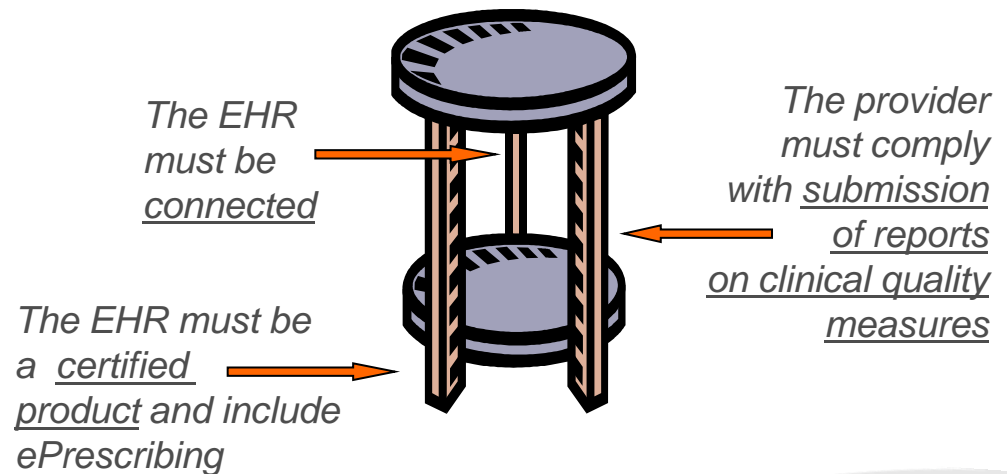
The **BIG** News

354 Days & Counting...

What You Need to Do

But first...a few things *didn't* change

- › This is *still* the greatest opportunity in our industry's history
- › Physicians *still* have to choose one program
- › Medicare is *still* up to \$44,000; Medicaid \$63,750
- › There are *still* penalties for not participating
- › And of course, there's *still* Meaningful Use



“Meaningful” Timing

- › Meaningful Use *Notice of Proposed Rule Making* out on Dec 30, '09
 - 556 pages
 - This document pertains to what you will have to do to earn the incentives
 - Five Ws and the H
 - 60-day comment period ends March 15; will likely be final in the May timeframe

“Meaningful” Timing

- › Standards, Implementation & Certification *Interim Final Rule* out on Dec 30, '09
 - 139 pages, more straight-forward
 - Matches the requirements in the NPRM to product requirements
 - Ultimately more directly related to the work that Allscripts needs to do to ensure our products are ready
 - Will become law February 13, 2010, even in the midst of the 60 day public comment period

“Meaningful” Timing

- › HHS Certification Process *Interim Final Rule* will be out in next two to three weeks
 - Will explain what process Allscripts will need to follow to get our products certified and how certifying bodies will be created
 - Will become law in approximately mid-March, final in May

Long List of Outstanding Questions

- › How often will payments be made?
- › How will I prove I'm meeting the objectives?
- › How long do I have to prove use to earn the incentive?
- › When do I have to be live?
- › How is "hospital-based" going to be defined?
- › How is the 30% threshold for Medicaid going to be calculated?
- › What measures will I have to report as a specialist?
- › How will they get populations to move to EHR that aren't affected by the Stimulus?
- › Will CMS be ready to oversee this program?

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HHS has spoken...

General Program Details

Definitions

- › **EP** – Eligible Professional, meaning the individual provider eligible for the incentives and not hospital-based.
- › **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.
- › **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.
- › **EHR Reporting Period** – The period of time in which a provider says s/he was using an HER
- › **EHR Payment Year** – The year in which a provider participates

Incremental approach to Meaningful Use

- › Three stages of the reporting requirements
 - Stage 1: applied in 2011 and 2012
 - Stage 2: applied in 2013 and 2014
 - Stage 3: applied in 2015

- › All details covered here are for 2011 & 2012, or Stage 1
 - Stage 1 requirements will apply to your first year of use, even if in 2014...
 - ...but your Stage requirements will leap forward to the Stage matching the calendar year after that (i.e. Stage 3 in 2015).

Who is eligible?

› Medicare

1. Doctor of medicine or osteopathy
2. Doctor of dental surgery or medicine
3. Doctor of podiatric medicine
4. Doctor of optometry
5. Chiropractor

› Medicaid

1. Physicians
2. Dentists
3. Certified nurse-midwives
4. Nurse practitioners
5. Physician assistants practicing in an FQHC or RHC that is so led by a physician assistant

When does the program actually start?

- › Medicare: Starts January 1, 2011 for EPs
 - Starts Oct 1, 2010 for hospitals
- › Medicaid: Starts in 2010 for those in the process of implementing, and in 2011 for those already live

When do I have to be live, and for how long?

- › First year of demonstration: Any ***continuous 90-day period within the payment year*** in which you successfully demonstrate Meaningful Use
 - January 1, 2011 to April 1, 2011
 - March 13, 2011 to June 11, 2011
 - September 1, 2001 to November 30, 2011
 - *Unallowable*: November 1, 2011 to January 31, 2012 because it crosses into the next year

- › Second payment year and beyond: The EHR reporting period will mean the entire payment year

Do I have to use an EHR 100% of the time?

- › 50% or more of your patient encounters during the EHR reporting period must be at one or more practices/locations equipped with a certified EHR
- › Allows not only for the minimal levels of down-time expected from an EHR product, but for providers to still participate who work in multiple locations with varying adoption levels

Can I switch between the programs?

- › May switch one time from one program to the other
- › If switching, you will continue in the new program at whichever payment year you would have attained in the first program had you not switched
 - I.e., if two years were completed in Medicaid but you no longer met the 30% threshold of patient volume, you would be allowed to switch to the Medicare program in the third year payment of that program
- › Last year to switch is CY 2014

Medicare Incentive Program

How will my incentive be calculated?

- › Calculated by multiplying your submitted allowable charges to Medicare by 75%, up to the capped amount for the year
 - Part B claims for the Fee for Service program
 - Items in the Medicare Physician's Fee Schedule
 - Only the “professional” components, not the “technical”
 - Only those furnished by the EP

How will my incentive be calculated?

- › 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
- › If your allowable charges are less, you'll still be able to participate – you just won't hit the cap
- › Bonus: Physicians operating in a "health provider shortage area" (HPSA) will be eligible for an incremental increase of 10% in their incentive payments

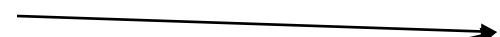

Schedule of payments

		Amount You'll Receive Each Year						
Year you 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	\$12,000	\$8,000	\$4,000	\$24,000	
2015 or Later	\$0	\$0	\$0	\$0	\$0	\$0	\$0	



Medicaid Incentive Program

How is the payment calculated under the Medicaid program?

- › The incentive payments for Medicaid are flat fees intended to cover the “net average allowable” cost of purchasing, implementing and maintaining an EHR
 - First year: $\$25,000 * 85\%$ 
 - Second – sixth years: $\$10,000 * 85\%$ 
- › Average allowable cost for the purchase, including related implementation services and hardware, has been determined by CMS to be **\$54,000**
- › Average allowable cost in subsequent years (costs related to maintenance) has been defined by CMS to be **\$20,610**

What if someone helps pay for my EHR?

- › Outside funds *other than State or local funds*, such as through a Stark program, that are directly attributable to payment for an EHR will be subtracted from the incentive
- › However, the “average allowable costs” from CMS provide some flexibility
 - Can accept as much as **\$29,000** in funding from other sources, and the incentive payment would still cap out at \$21,250 in year one
 - $(\$54,000 - \$29,000 = \$25,000) * .85 = \$21,500$
 - In following years, an eligible professional can receive as much as **\$10,610** in contributing funds, and the maximum incentive payment of \$8,500 would be unaffected
 - $(\$20,610 - \$10,610 = \$10,000) * .85 = \$8,500$

How will the State count whether I've hit the threshold to participate in the Medicaid incentives?

- › 30% of all your patient encounters must be attributable to Medicaid over any continuous 90-day period *within the most recent calendar year*
 - Will apply a plain meaning test
 - Cannot count a short-term temporary Medicaid outreach program
 - Required to annually re-attest to patient volume thresholds

- › Pediatricians can qualify with 20%
 - Incentive also decreased by 33%

I'm a provider working in a FQHC / RHC – how will I be assessed?

- › Must “practice predominantly” (more than 50% of the time) in an FQHC or RHC
- › Must have a minimum of 30% patient volume attributable to “needy individuals” over any continuous 90-day period within the most recent calendar year
- › Needy individuals:
 - Receive medical assistance from Medicaid or the CHIP
 - Receive care by the provider for which they are uncompensated
 - Receive services furnished at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay
- › Bad debt is consistent with this definition

How does the timing work under Medicaid?

- › Payments can begin in 2010 if you hit the threshold and prove you are adopting, implementing or upgrading certified EHR technology
 - Your State has to file an indication of readiness to capture the required electronic information before 2010 payments can begin
- › Staffing, maintenance and training counts:
 - Efforts to reengineer provider workflow
 - Establishing data exchange agreement with other providers
 - Expanding functionality to include things like clinical decision support and CPOE
- › Must demonstrate actual installation prior to the incentive, rather than “efforts” to install, to qualify in 2010

What is the timing of the Medicaid program (cont)?

- › The 90-day proof period would apply in *both* the 1st and 2nd payments years (that is, 2010 and 2011) in States approved for early implementation
- › If you've already adopted and are ready to prove Meaningful Use, the program will begin in 2011
- › If you intend to file under Medicaid, you must first demonstrate EHR usage by 2015 and will not be eligible for payments after 2021

What if I care for Medicaid patients from several states?

- › If you practice in multiple states or Medicaid patients from several states come to your office, you will be required to choose only one state from which to receive Medicaid incentive payments
- › You can change that state choice annually when you re-attest to your ability to meet the threshold

Payment Mechanisms

How will they track individual behavior?

- › Tracking will be done at the unique National Provider Identifier (NPI) level
- › You will have to give the following information to be paid accurately and quickly:
 - Name, NPI, business address and business phone
 - Taxpayer Identification Number (TIN) to which you want the incentive payment made
 - Whether you elect to participate in the Medicare EHR incentive programs or the Medicaid EHR incentive program
- › There will be a single program data repository to track participation in both Medicare & Medicaid

How will I be paid?

- › A single, consolidated, annual incentive payment
 - For the Medicare program, it will be paid via CMS
 - For the Medicaid program, payment will come from either the State Medicaid agency or their designated intermediary (i.e., a Medicaid HMO)

When will I be paid?

- › On a rolling basis, as soon as you:
 - Demonstrate Meaningful Use for the applicable reporting period
 - 90 days for the first year or the calendar year for subsequent years
 - Reach the threshold for maximum payment

Can I reassign incentive payments?

- › Can reassign to your employer or an entity with which you have a valid employment agreement
 - Reassignment to only one entity will be allowed
 - Nothing precludes reassignment of only the allowable charges for your professional services to the employer/entity but not the incentive payment, or vice versa
 - Dependent on the details of the contract

Proving Meaningful Use of an Electronic Health Record

What does “Proving Meaningful Use” mean?

- › Providing attestation through a secure mechanism, such as claims-based reporting or an online portal (TBD)
- › Must identify the certified EHR technology in use
- › Describing your performance on all the functional measures associated with Meaningful Use
 - This is not the clinical quality measures you will submit on the care delivered to patients
 - This measures your use of the EHR

Measures of EHR Use

- › CPOE (meds, labs, images & referrals) 80%
- › ePrescribing 75%
- › Drug screening Functionality enabled
- › Active medication list 80%
- › Active medication-allergy list 80%
- › Medication reconciliation 80%
- › Problem list in ICD-9-CM or SNOMED-CT 80%
- › Lab results (numeric) stored as structured data 50%
- › Clinical decision support Five alerts in use

* See Allscripts web site for entire list

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Measures of EHR Use

- › Patient information: electronic copy upon request in 48 hours 80%
- › Patient access to electronic information (i.e. lab results) within 96 hours of availability 10%
- › Clinical summary of each visit to patient 80%
- › Patient reminders (electronic) on request 50%

* See Allscripts web site for entire list

Measures of EHR Use

- › Electronic data exchange with provider not in the same organization 1 test
- › Submission of reportable lab data to PHD 1 test
- › Submission of immunization reports to PHD 1 test
- › Submission of syndromic surveillance to PHD 1 test

* See Allscripts web site for entire list

Clinical Quality Measures

What are Clinical Quality Measures?

- › A report on an aspect of patient care based on administrative or medical record data
- › Allows government and the industry to identify patterns in diagnosis & treatment related to geography, insurance coverage, race, language and other segmentation

Which specialties are covered by the proposed measures?

- › Cardiology
- › Pulmonology
- › Endocrinology
- › Oncology
- › Proceduralist/Surgery
- › Primary Care Physicians
- › Pediatrics
- › Obstetrics and Gynecology
- › Neurology
- › Psychiatry
- › Ophthalmology
- › Podiatry
- › Radiology
- › Gastroenterology
- › Nephrology

** See Allscripts web site for list of specialty-specific measures*

What if my specialty isn't covered?

- › A list will be included in the final rule of any specialties that will be exempt from selecting & reporting on a specialty measures group
- › To claim an exemption, you'll be required to attest, to CMS or the State, to the inapplicability of any of the specialty groups
- › You will still be required to report information on all of the Core measure set

How will I report on the CQM?

- › For 2011: an **attestation methodology** to submit summary clinical quality measurement information
- › For 2012: CMS intends to receive **electronic information** via a web portal, connection to local HIEs and connection to specialty registries
- › In all instances, use certified EHR technology to capture the data elements and calculate the results

Hospital-based Physicians

How will they decide if I'm a Hospital-based physician and thus excluded?

- › What percent of the claims you submitted *the year before the current payment year* were filed using a Place of Service (POS) code indicating a hospital-based status
- › If the percent of claims generated with one of three designed POS codes exceeds 90% – which CMS has said means you deliver “substantially all” care in that setting – you will be deemed hospital-based
 - If those claims don't exceed 90%, your unaffected claims will count as applicable to the incentive program
- › Status will be reassessed annually, using claims data from the year immediately proceeding

Which Place of Service codes are considered?

- › The following POS codes will be used to make the hospital-based determination
 - 21 – Inpatient Hospital – is a facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services
 - 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
 - 23 – Emergency Room, Hospital – is a portion of a hospital where emergency diagnosis and treatment of illness or injury is provided

In Conclusion: Two Routes to \$\$\$

- | | | |
|--|--------|--|
| › \$44,000 | —————> | › \$64,000 |
| › HPSA 10% bonus | | |
| › No minimum # of patients | —————> | › 30% threshold; 20% for peds |
| › No mid-levels | —————> | › NPs, NMWs; PAs only if lead provider in a rural health clinic |
| › Calculation: 75% of submitted allowable charges by doc, up to cap for the year | —————> | › No calculation based on fees – flat payment intended to offset purchase of the EHR and maintenance costs |
| › First year of program is 2011 | —————> | › Can collect in 2010 if State is ready |
| › Penalties for non-compliance | —————> | › No penalties (yet!) |
| › All external funds okay | —————> | › Stark \$\$ or Fed grants may lower the incentive payment |

What Your EHR Needs to Do

What must the EHR do?

- ✓ Electronically record, store, retrieve, and manage: **Medications; Laboratory; Radiology/imaging; and Provider referrals.**
- ✓ Automatically and electronically generate **alerts** at the point of care for drug-drug and drug-allergy contraindications
- ✓ Enable a user to electronically check if **drugs are in a formulary** or preferred drug list
- ✓ Electronically record, modify, and retrieve a patient's **problem list.**
- ✓ **Electronically** transmit medication orders (**prescriptions**) for patients.
- ✓ Electronically record, modify, and retrieve a patient's **active medication list** as well as medication history.
- ✓ Electronically record, modify, and retrieve a patient's active **medication allergy list** as well as medication allergy history.
- ✓ Electronically record, modify, and retrieve patient **demographic data.**
- ✓ Enable a user to electronically record, modify, and retrieve a patient's **vital signs.**
- ✓ Automatically calculate and display **body mass index (BMI).**
- ✓ Plot and electronically display, upon request, **growth charts** (height, weight, and BMI) for patients 2-20 years old.
- ✓ Electronically record, modify, and retrieve the **smoking status** of a patient.
- ✓ Electronically receive **clinical laboratory test results** in a structured format and display such results in human readable format.
- ✓ Electronically **display** in human readable format any **clinical laboratory tests** that have been received with LOINC® codes.

What must the EHR do?

- ✓ Electronically select, sort, retrieve, and output **a list of patients** and patients' clinical information, based on user-defined demographic data, medication list, and specific conditions.
- ✓ Calculate and electronically display **quality measure results** as specified by CMS or states.
- ✓ **Electronically submit calculated clinical quality measures**
- ✓ Electronically **generate a patient reminder list** for preventive or follow-up care according to patient preferences based on demographic data, specific conditions, and/or medication list.
- ✓ Implement automated, electronic **clinical decision support rules** (in addition to drug-drug and drug-allergy contraindication checking) according to specialty or clinical priorities that use demographic data, specific patient diagnoses, conditions, diagnostic test results and/or patient medication list.
- ✓ Automatically and electronically **generate and indicate real-time, alerts and care suggestions** based upon clinical decision support rules and evidence grade.
- ✓ Automatically and electronically track, record, and generate **reports on the number of alerts** responded to by a user.
- ✓ Electronically record and display patients' **insurance eligibility**, and submit insurance eligibility queries to public or private payers and receive an eligibility response.

What must the EHR do?

- ✓ Electronically **submit claims** to public or private payers
- ✓ Create an **electronic copy of a patient's clinical information**, including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures.
- ✓ **Provide clinical summaries to patients** (in paper or electronic form) for each office visit that include, at a minimum, diagnostic test results, medication list, medication allergy list, procedures, problem list, and immunizations.
- ✓ Electronically **receive a patient summary record**, from other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures and upon receipt of a patient summary.
- ✓ **Transmit a patient summary record** to other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures.
- ✓ Electronically complete **medication reconciliation of two or more medication lists (compare and merge)** into a single medication list that can be electronically displayed in real-time.
- ✓ **Encrypt and decrypt** electronic health information.
- ✓ **Verify** that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information.

I Have an EHR: What Can I Do Now?

Increase use of your EHR for:

- › Orders
- › ePrescribing
- › Clinical Decision Support

How *Allscripts* Can Help

Why Allscripts?

Significant Footprint: 160,000 MDs

All Sizes and Settings: Ambulatory and Acute, Primary Care and Specialty, Small to Large



Experience

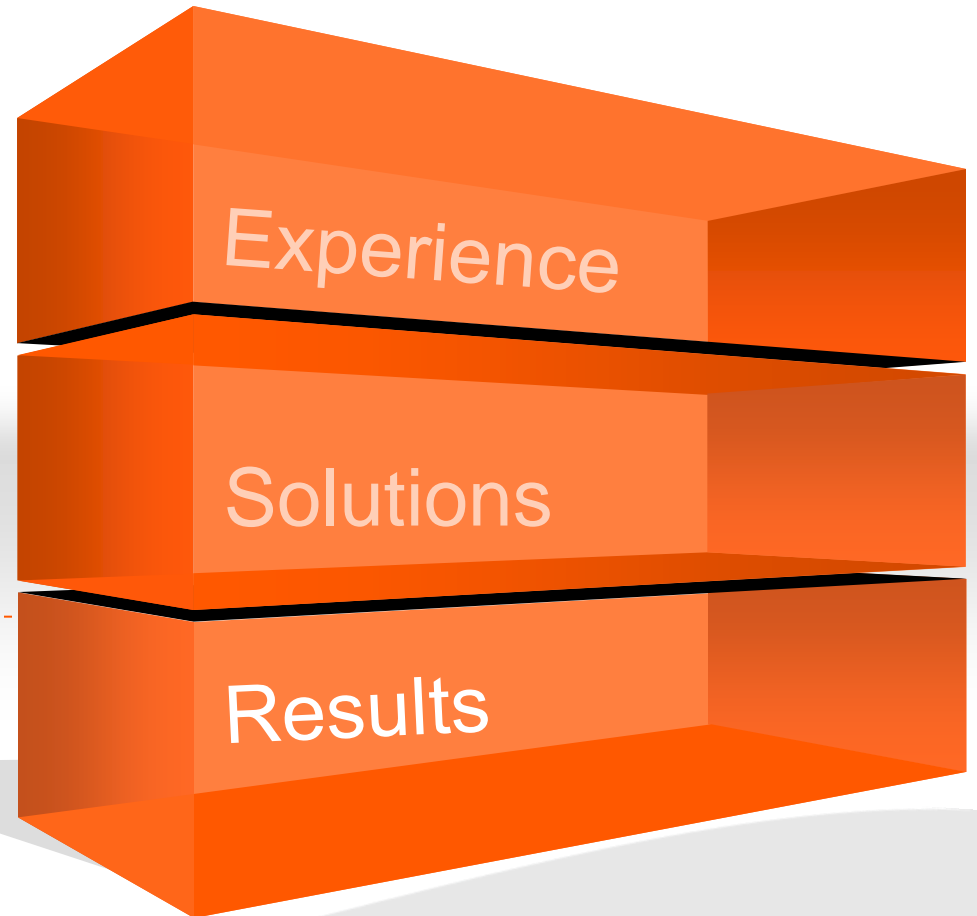
Why Allscripts?



Diversified: Clinical and Business Solutions

All World-Class: Top-Rated Consistently

Why Allscripts?



Real Utilization: Not Just Implementation

Strong ROI: The Solution That Pays You Back

Delivering the Next Step: Connect to Health™

INTRODUCING...

The Allscripts Stimulus Program

Join the 160,000 MDs using Allscripts solutions today.



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2. The Right Guarantee.

Our EHR solutions will meet the criteria for EHR certification. If not, we'll credit you up to 12 months of support. Guaranteed.

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2. The Right Guarantee.

Our EHR solutions will meet the criteria for EHR 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.

I Don't Have an EHR: What Do I Do Now?

- › **Schedule a Demo or an ROI Assessment**
 - EHRNOW@Allscripts.com
 - 1-877-EHRNOW1

- › **Stay connected at www.allscripts.com/TheTimelsNow**
 - Regularly updated FAQs
 - Upcoming Webcasts
 - Live polls
 - Ask a Question
 - Additional Stimulus Education Resources

- › **Event Survey and Question Submission**
 - After our question and answer session, if you have further questions, please put them on your Event Survey and we'll get you an answer.

Questions???

Appendix

Are the Medicaid & Medicare Meaningful Use requirements the same?

- › The Medicare Rule will be the minimum standard for the Medicaid incentive program
- › States may add additional objectives to the definition of Meaningful Use and/or modify how objectives are measured
- › They cannot add requirements that don't further promote the use of EHRs and healthcare quality or that would require additional EHR functionality

What if I take a couple of years to get going?

- › Biggest dollars are in the first year, so will lose those
- › From a programmatic perspective, the Stage 1 requirements will *always* be applied to an EP's first year of Meaningful Use
 - If you waited until 2014 to first demonstrate use, you would be held to the Stage 1 requirements only
 - *However*, your second year of use would jump to Stage 3 requirements because the second year of use would be 2015
- › Earlier adopters will have more time to become proficient before the requirements are ramped up
 - Latest adopters will go from the training wheels of Stage 1 immediately to a motorcycle of Stage 3