

The American Recovery and Reinvestment Act of 2009, Meaningful Use and the Impact on Netsmart's Public Health Clients

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Netsmart Note:

The Health Information Technology for Economic and Clinical Health (HITECH) Act, as part of the American Recovery and Reinvestment Act of 2009 (ARRA), provides significant financial incentives to hospitals and behavioral health professionals who demonstrate meaningful use of certified electronic health records (EHR) technology. Beginning in 2015, the law also imposes penalties (Medicare reimbursement reductions) to those organizations that are not meeting Meaningful Use criteria.

This white paper update includes references to information from the "Final Rule" for Meaningful Use and product certification issued July 13, 2010, by the Centers for Medicare & Medicaid Services (CMS).

Netsmart is your single-source Meaningful Use technology partner, providing all the solutions needed to meet all Stage 1 Meaningful Use criteria, avoiding the need for providers to integrate products from multiple vendors. Netsmart's Insight™ 7.1 electronic health record (EHR) software for public health achieved 100 percent ONC-ATCB ARRA Ambulatory certification in July 2011.

For additional information, visit www.ntst.com/meaningfuluse or call 1.800.472.5509.



Introduction

In February 2009, Congress signed the American Recovery and Reinvestment Act of 2009 (ARRA) into law. ARRA was established to preserve and create jobs, promote economic growth, assist those most impacted by the recession and provide investments needed to increase economic efficiency by spurring technological advances in science and health.

In addition to underwriting a process for computerizing health records to reduce medical errors and health care costs, ARRA includes the Health Information Technology for Economic and Clinical Health (HITECH) Act, which established programs under Medicare and Medicaid to provide incentive payments to providers and organizations for the "meaningful use" of certified electronic health records (EHR) technology. This Act consists of three primary parts:

1. Create standards, specifications and certification criteria for health information technology (HIT) infrastructure interoperability
2. Implement the HIT infrastructure and electronic health records (EHRs) through grants, loans, and incentives for the "Meaningful Use (MU)" of Certified EHRs
3. Encourage the use of HIT infrastructure by improving information privacy and security

The incentives for EHRs defined in #2 are of major importance to our industry. ARRA offers two types of incentives for the "Meaningful Use of Certified EHR Technology" to Eligible Professionals (Providers) and Hospitals, through either Medicare or Medicaid. For Provider incentives, organizations must choose to receive either Medicaid or Medicare incentives. Since organizations typically have a higher percentage of Medicaid consumers, the Medicaid incentives will typically result in higher incentive funding levels. Medicare and Medicaid incentives are also available for hospitals, but are not included in this document since hospital incentives are not applicable to most health departments.

Incentives for Providers

Health Departments are eligible for ARRA Medicaid Provider Incentives based on the number of Eligible Professionals (EPs) in their organization, assuming the organization meets criteria for Meaningful Use of an EHR and the professionals assign their incentives to the organization. The definition of EP includes physicians, dentists, nurse practitioners, certified nurse-midwives and physician assistants practicing in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC). To qualify as an Eligible Professional, they must be non-hospital based, do more than 30% Medicaid encounters over a representative 90-day period and assign their incentives to the organization using an EHR in a "meaningful" way per the Meaningful Use criteria. Fifty percent of the EP's encounters must be at facilities using a certified EHR. The only exception to this rule is that Medicaid EPs practicing predominantly in a FQHC or RHC are not subject to the hospital-based exclusion. In addition, Providers who work in incentive-eligible hospitals are not eligible for incentives under the Provider side.

While most Health Departments do not do a significant amount of Medicare billing, those that do are eligible for incentive payments of up to 75% of their Medicare billings to a maximum amount of \$44,000 per EP that assigns incentives to the Health Department.

Provider Incentive Amounts - Medicaid

The current benefit for Medicaid-Eligible Professionals is \$21,250 for the first year of Meaningful Use and \$8,500 per year for years 2-6 for a total benefit of \$63,750 per EP.

Here is an example of the potential total Medicaid incentive dollars over a six-year period for an average Health Department. Each EP generates \$63,750 over six years. The organization in this example has three EPs and may receive \$191,250 in incentive dollars over six years.

Eligible Professional	Quantity	Total Medicaid Incentive over 6 years
Physician	1	\$63,750
Nurse Practitioner	1	\$63,750
Dentist	1	\$63,750
Certified Nurse Midwife	0	\$0
Total	3	\$191,250

In addition to the monetary benefits, the adoption of EHRs can significantly improve quality of care, advance patient safety, increase consumer satisfaction and enhance office efficiency. Health Departments may also experience increased profitability through reduced costs and increased revenue.

Meeting Medicaid Thresholds for Eligibility

Under the Final Rule, an “encounter” is defined as services rendered on any one day to an individual where Medicaid paid for part or all of the service or part of their premiums, copayments or cost-sharing.

The Final Rule confirmed the following Medicaid Patient encounter thresholds for incentive payment eligibility:

- At least 30% for Physicians, Dentists, Certified Nurse Midwives, and Nurse Practitioners
- At least 20% for Pediatricians
- At least 30% attributable to ‘Needy Individuals’ for Physician Assistants when practicing at an FQHC/RHC led by a physician assistant

The methodology for estimating Medicaid patient volume is determined by dividing the EP's total number of Medicaid patient encounters in any representative continuous 90-day period by all patient encounters over the same period.

The Final Rule also allows States to choose other methods for calculating thresholds.

Further clarification was also offered about multiple EPs seeing the same patient or consumer. It may be common for a physician assistant or nurse practitioner to provide care to a patient, then a physician to also see that same patient. The Rule states it is acceptable in circumstances like this to include the same encounter for multiple providers when it is within the scope of practice.

In addition, the Final Rule addresses the situation where encounters and patient volume may be difficult to track at a specific individual professional level. States will allow clinics and group practices to use the practice or clinic Medicaid patient volume and apply it to all EPs in their practice under three conditions:

1. The clinic or group practice's patient volume meets the eligible thresholds above (e.g. 30% of the entire practice is Medicaid);
2. There is an auditable data source to support the clinic's patient volume determination; and The practice and EPs must use one methodology in each year (i.e., clinics cannot have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data).

Eligible Professionals Practicing in Multiple Practices

To be eligible for incentive payments, an EP professional must have 50% or more of their patient encounters during the EHR reporting period at a practice or combination of practices equipped with certified EHR technology. An EP who does not conduct 50% of their patient encounters in any one practice can meet the 50% threshold through a combination of practices equipped with certified EHR technology. If they do not, then they are not eligible for payments. If they are eligible to receive payments, the professional can reassign their incentive payments to an employer or an entity with which they have a valid employment agreement. *An EP cannot reassign the incentive payment to more than one employer.*

In this example, the professional is eligible because they have 70% of their encounters at facilities that use a certified EHR. This professional can assign their incentive to one practice.

Facility A	Facility B	Facility C
30 encounters	40 encounters	30 encounters
Certified EHR	Certified EHR	No Certified EHR
30% of encounters	40% of encounters	30% of encounters

How Meaningful Measures are Calculated for Professionals Practicing in Multiple Practices

Once a professional is eligible, they then have to use the Certified EHR in a Meaningful way (e.g. meeting the Stage 1 criteria). For professionals that practice at multiple locations (as in the example above) with some of those locations not using a certified EHR, then the measurements to determine Meaningful Use are based only on the encounters from the locations using a certified EHR (Facilities A and B). The encounters from Facility C are not used in the calculation.

Potential Penalties for Non-Compliance

If an organization does not meet the Meaningful Use criteria, they will not only miss out on the Medicaid incentives, but some experts believe they will also be subject to Medicare penalties (as applicable) for failure to meet Meaningful Use. Penalties are imposed by reductions in Medicare fee schedules. Medicare reductions for non-Meaningful Use users are Medicare reductions – 99% in 2015, 97% in 2017 and 95% each subsequent year.

Meaningful Use Criteria Stages

Meaningful Use has been divided into three stages that represent a graduated approach to arriving at the ultimate goal:

- Stage 1 begins in 2011 and focuses on the use of EHRs and capturing health information in a structured format.
- Stage 2 begins in 2013 and encourages the use of health information technology for continuous quality improvement at the point of care and the exchange of information in the most structured format possible.
- *Stage 3 promotes further improvements in quality, safety and efficiency that lead to improved health outcomes.

**An implementation date for Stage 3 has not yet been established.*

The earlier an organization begins to meet the stages of Meaningful Use, the sooner their ability to receive funding. In the Final Rule, CMS removed language discussing the level of criteria that will need to be met by 2015. It is possible that a provider that waits to start may have to achieve a later stage faster to receive funding, making it more advantageous to begin earlier.

Stages of Meaningful Use Criteria by Year

First payment year	Payment Year				
	2011	2012	2013	2014	2015+
2011	Stage 1	Stage 1	Stage 2	Stage 2	TBD
2012		Stage 1	Stage 1	Stage 2	TBD
2013			Stage 1	Stage 1	TBD
2014				Stage 1	TBD

The Final Rule from CMS and ONC made changes to the criteria that Eligible Providers (EPs) and Hospitals must meet to receive incentive funding. A summary of the changes include:

- Introduced the concept of Core and Menu criteria.* Of the nearly two dozen criteria originally introduced, the Final Rule makes approximately 15 of those criteria mandatory (the Core set). In addition, Providers may choose five to be deferred until Stage 2 from the optional criteria (the Menu set); however, at least one optional measure must be selected from the Public Health Measures from the Meaningful Use measures (see table below). Some MU objectives are not applicable to every provider’s clinical practice, thus they would not have any eligible patients or actions for the measurements. It is important to note that these exclusions do not count against the five deferred measures. In the next rulemaking for Stage 2, the Centers for Medicaid and Medicare Services intends to propose that every objective in the Menu set in Stage 1 become required. *(Note: In order for a provider to qualify for ARRA incentives, the provider must own the software required for all criteria, even software that meets Menu Set criteria the provider might opt to defer until Stage 2. The software does not have to be implemented or used, but it must be adopted)*
- Removed criteria.* The requirement for submitting claims electronically and eligibility checking was removed (although language suggests they will be added back in Stage 2). Some MU objectives are not applicable to every provider’s clinical practice, thus they would not have any eligible patients or actions for the measurements. It is important to note that these exclusions do not count against the 5 deferred measures
- Added criteria.* A requirement for Hospitals to record advanced directives was added to the Menu set. Also, a requirement that both EPs and Hospitals provide patient-specific education resources was added to the Menu set.

- *Changed measurements.* Several percentage thresholds for measuring the criteria were lowered.

The table below shows the Core Set and Menu Set Meaningful Use measures and notes any changes from the previous rule:

Core Set

Criteria	Meaningful Use Measure	Change Interim to Final Rule
Computer Physician Order Entry	30% of unique patients with at least one medication entered using CPOE	Change from 80% EPs, 10% Hospitals, and now Meds only
Drug-Drug, Drug-Allergy	Functionality enabled	
e-Prescribing	EP Only - 40% of permissible prescriptions	Change from 75%
Record Demographics	50% of unique patients have demographics recorded	Change from 80%
Maintain Active Medication List	80% of unique patients have one entry	
Maintain Active Medication Allergy List	80% of unique patients have one entry	
Up to Date Problem List of Current/Active Diagnosis	80% of unique patients have one entry	
Record and Chart Changes in Vital Signs	50% of unique patients (age 2+) have Height, Weight, BP, BMI, Growth	Change from 80%
Record Smoking Status	50% of unique patients (age 13+) have status recorded	Change from 80%
Implement One Clinical Decision Rule	Implement one clinical decision support rule	Change from 5 rules
Clinical Quality Measures Reporting	NOTE: See section below for overview of Clinical Quality Measures	

Patient Electronic Copy of Health Information	50% of patients that request in 3 business days	Change from 80%, 2 to 3 days
Provide Electronic Copy of Discharge Instructions	Hospital Only - 50% of patients that request are provided with instructions	Change from 80%
Provide Clinical Summaries for Patients for Each Visit	EP – for 50% of all visits within 3 business days	Change from 80%
Exchange of Clinical Information	Performed one EHR test to show exchange	
Protect Health Information	Conduct or review a security risk analysis and implement where necessary	

Menu Set

Criteria	Measurement	Change Interim to Final Rule
Drug- Formulary Checks	Functionality enabled and has access to one internal or external formulary	
Record Advanced Directives	Hospital Only - 50% of unique patients (65+) indicate advanced directive status	NEW
Incorporate Lab Test Results into EHR	40% of clinical lab tests incorporated into EHR as structured data	Change from 50%
Generate Patient Lists by Specific Conditions	Generate at least one report	
Send Reminders to Patient per Patient Preference	EP Only - To 20% of unique patients (age 65+ or <5 years old)	Change from 20% and age change
Patient Electronic Access to Health Information	EP – 10% unique patients have timely access	
Use EHR to Identify and Provide Education Resources	10% of all unique patients are provide patient specific resources	NEW

Medication Reconciliation	50% of relevant encounters, care transitions	Change from 80%
Provide Summary Care Record, Transition Care/Referral	50% of relevant encounters, care transitions	Change from 80%
Submit Electronically to Immunization Registries*	Performed one EHR test to show submission	
Submit Reportable Labs to PH Agencies*	Hospital Only - Performed one EHR test to show submission	
Submit Electronic Syndromic Survey to PH Agencies*	Performed one EHR test to show submission	
Check Insurance Eligibility Electronically	For 80% of unique patients	REMOVED
Electronic Claims Submission	At least 80% of claims electronic	REMOVED

* One of the menu set selections must be one of these three Public Health Measures

Clinical Quality Measures – Quality Reporting

One of the criteria in the Meaningful Use matrix that must be met to receive funding is “Clinical Quality Reporting.” The successful attainment of this criterion for Eligible Professionals includes reporting on the minimum set of clinical quality measures from the following categories:

- Clinical Core Measures
 - Hypertension: Blood Pressure Measurement
 - Preventative Care and Screening Measure Pair - Tobacco Use Assessment and Tobacco Cessation Intervention
 - Adult Weight Screening and Follow-Up
- Clinical Alternate Core Measures
 - Weight Assessment and Counseling for Children and Adolescents
 - Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old
 - Childhood Immunization Status
- Clinical Non-Core Measures

EPs must report on six total measures, which consist of three Core Measures (substituting Alternate Core measures if any of the Core Measures do not apply) and three additional Clinical Non-Core Measures.

In 2011, EPs will only need a human readable report of the stats (any 90-day period). For the year 2012, the goal is for Medicare and Medicaid to receive the statistics via an electronic file (since Medicaid is a state program, the readiness of each state will vary). The expectation is that the certified EHR will automatically report on these measures.

Adopt/Implement/Upgrade

In the first year of participation, eligible providers can adopt (purchase), implement (commence utilization of EHR such as provide training or perform data entry), or upgrade (expand) to a certified EHR capable of meeting meaningful use requirements. Eligible providers are not required to demonstrate Meaningful Use in the first year and no EHR reporting is required. Eligible providers who have already adopted, implemented or upgraded would still receive a first year payment. This is significant because it means that to qualify for MU incentive payments in their first year of participation, a provider can simply adopt (purchase) a Complete ARRA-Certified EHR.

How Will Incentive Eligibility be Tracked?

As the first stage of being eligible for incentives, providers need to register with the Center for Medicare and Medicaid Services (CMS) in January 2011. Providers should first register with CMS in the year they plan to meet Meaningful Use to and start receiving payments, and must re-register in each subsequent year they will receive payments. The Final Rule reaffirmed that Providers must only meet the Meaningful Use (MU) criteria for 90 days for the first year they apply for incentives, and then for full years in subsequent years.

States will connect to the EHR Incentive Program website to verify provider eligibility and prevent duplicate payments. States will ask providers for additional information in order to make accurate and timely payments:

- Patient Volume
- Licensure
- Meaningful Use Compliance
- Use of ARRA-certified EHR Technology (*NOTE: Netsmart's Insight™ 2011 electronic health record (EHR) software for public health achieved 100 percent ONC-ATCB ARRA Ambulatory certification in July 2011.*)

For 2011 eligibility, the incentives would be paid in the first quarter of 2012 in a lump sum. In order to show eligibility, an organization would need to do the following:

- Obtain a code from the organization's certified software vendor indicating software certification and include the code in submitted electronic billing files;
- Submit metrics for verification to required entities. These entities may include CMS, states or other organizations;
- Have an officer of the Health Department attest that the organization has met the measurement criteria

Related notes:

- States can determine other methods of tracking that may be imposed.
- Organizations already using an EHR that later becomes ARRA certified are still eligible for incentives.

Netsmart Note:

All providers must:

- **Register via the EHR Incentive Program website**
<http://www.cms.gov/EHRIncentivePrograms>
- **Be enrolled in Medicaid Fee For Service (FFS) or managed care**
- **Have a National Provider Identifier (NPI)**
- **Use certified EHR technology to demonstrate Meaningful Use as outlined in the Final Rule**

Netsmart's Commitment to Help Public Health Clients Meet Meaningful Use Criteria

Netsmart is your single-source Meaningful Use technology partner. Our Insight™ 7.1 public health solution achieved 100 percent ONC-ATCB ARRA Ambulatory Certification in July 2011.

Most health departments will need to undertake major process changes to attain eligibility for incentive funding. It's crucial to evaluate your current situation and create a plan so that your organization can receive maximum benefits under the ARRA. You may need to determine internal process changes, budget and time factors, state criteria and training needs. The first step to take toward meeting Meaningful Use criteria and receiving ARRA incentive funds is to begin using an ARRA-certified EHR and meeting Stage 1 ARRA requirements.

We can provide a roadmap to Meaningful Use for clients, regardless of their current stage of compliance or eligibility. Our goal is to make what can be a complex process as easy and cost-effective as possible, resulting in the ability to obtain additional resources for providing quality care to consumers.

Initial process changes that are necessary to ensure your organization is meeting Stage 1 Criteria include:

- Ensure that each user is trained and consistently using the EHR and that staff and physicians are entering data related to Stage 1 accurately
- Every ordering provider must know how Computer-Based Provider Order Entry (CPOE) works, how to use it and when to use it
- Start e-Prescribing now as Stage 1 requires providers to e-prescribe at least 40% of permissible prescriptions.
- Develop a process for developing, implementing and managing Clinical Decision Support (CDS) rules
- Implement patient health information exchange workflows to ensure you are communicating with patients based on and using your EHR
- Create a provider health information exchange strategy using both informal and formal testing
- Ensure privacy and security compliance to identify and address potential workflow and other weaknesses
- Initiate EHR-based quality performance measurement support to make sure your data is coded and captured accurately so that it can be searched, retrieved, aggregated and compared for reporting.

Netsmart Note:

For more information or to talk one-on-one to a Netsmart representative about your organization's unique needs related to Meaningful Use, visit www.ntst.com or call 1.800.472.5509.

Avatar® 2011, CMHC/MIS 4.2 and Insight™ 7.1 are 2011/2012 compliant and have been certified by the Drummond Group, an ONC-ATCB, in accordance with the applicable certification criteria adopted by the Secretary of Health and Human Services.

Netsmart's TIER® v7.0, is 2011/2012 compliant (CC-1112-29620-1) and has been certified as a Complete EHR by the Certification Commission for Health Information Technology (CCHIT®), an ONC-ATCB, in accordance with the applicable certification criteria adopted by the Secretary of Health and Human Services.

These certifications do not represent an endorsement by the U.S. Department of Health and Human Services or guarantee the receipt of incentive payments.

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Organizations should obtain qualified professional legal and financial opinions on the meaning and impact of the policy on their particular organization prior to making any business plans or decisions.

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