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What is the ARRA legislation?

In February 2009, Congress passed the American Recovery and Reinvestment Act of 2009 (ARRA). A direct response to the economic crisis, the Act had among its goals to:

- Preserve and create jobs and promote economic recovery
- Assist those most impacted by the recession
- Provide investments needed to increase economic efficiency by spurring technological advances in science and health

In addition to underwriting a process to computerize health records with the goal of reducing medical errors and health care costs, ARRA is targeted at infrastructure development and enhancement. Specific to healthcare, ARRA included the Health Information Technology for Economic Clinical Health (HITECH Act). This consists of three parts:

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

How are the incentives structured?

ARRA includes Medicare and Medicaid incentives, and in each of these categories incentives are designated for Providers or Hospitals.

Are public health providers currently eligible for incentives?

Public health providers are currently eligible for Medicare and 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. For Medicaid incentives, EPs include physicians, nurse practitioners, dentists, certified nurse midwives and physician assistants practicing in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC). For Medicare, EPs include doctors of medicine, osteopathy and several others not directly related to public health. Organizations must choose to receive either the Medicaid or Medicare incentives (not both), and since organizations typically have a higher percentage of Medicaid consumers, the Medicaid incentives will typically result in the most incentives.

For a provider to be eligible, he or she must be a non-hospital based eligible professional. Providers who work in hospitals that are eligible under the Hospital side of the incentives are not eligible for Provider incentives.

What do providers need to do to qualify and what are the incentive amounts?

To qualify as an EP, a physician, physician assistant, nurse practitioner, dentist or certified nurse midwife 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 MU criteria. Fifty percent of the EP’s encounters must be at facilities using a certified EHR. The current benefit for Medicaid-eligible professionals is \$21,250 for the first year of MU. In years 2-6, the benefit is \$8,500 per year, for a total benefit of \$63,750 per EP.

The maximum Medicare Provider incentive amount for that same time period is \$44,000.

How are “encounters” defined and calculated?

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 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;
3. 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).

Some of our EPs work in multiple practices. Can they assign their incentives to our organization?

To be eligible for incentive payments, in addition to 30% Medicaid encounters, an EP 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 percent of their patient encounters in any one practice can meet the 50 percent threshold through a combination of practices equipped with certified EHR technology. If they do not meet the 50%, 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) to receive funding. 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.

What do I need to do to meet MU criteria? Did it change with the release of the Final Rule?

The Final Rule 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 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.
- *Removed criteria.* The requirement for submitting claims electronically and eligibility checking was removed (although language suggests they will be added back in Stage 2).
- *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 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

What are the Clinical Measures we need to qualify for Meaningful Use?

One of the criteria in the Meaningful Use matrix that must be met to receive funding is “Clinical Quality 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. Successfully meeting these criteria 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

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 certified EHRs will automatically report on these measures.

What are the “stages” of Meaningful Use?

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

What is the timeframe for registration?

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. Providers can begin registering with 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 and start receiving payments, and must re-register in each subsequent year they will receive payments. As a summary, 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

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 Certified EHR technology

What is the reporting period for EPs participating in incentive programs?

In the Notice of Proposed Rulemaking, the Centers for Medicare & Medicaid Services (CMS) proposes that, for an EP's first payment year, the EHR reporting period for EPs be a continuous 90-day period within a calendar year. In subsequent years, CMS proposes that the EHR reporting period for EPs be the entire calendar year.

When will the CMS begin to pay incentives to eligible professionals and hospitals for using certified EHR technology?

According to information from CMS, while the statute does not define a date for the Medicaid incentives program, CMS expects payments to Medicaid providers for the adoption, implementation or upgrade of

certified EHR technology could begin as early as fall 2010. Given the range of regulatory and planning activities that must precede states being able to make provider incentive payments, as well as the importance of coordinating Medicaid and Medicare payments to prevent duplication, CMS indicates it does not expect that states will be able to make such payments until 2011.

How will the government measure compliance with Meaningful Use criteria to determine funding eligibility?

Organizations will be monitored in several ways: certified vendors will provide their clients with codes that will be placed in bills submitted, organizations will self attest data to the state, and audits will be performed. PQRI reporting will also be involved starting in 2012. Compliance measurement criteria are still being defined.

Can states add additional criteria?

It is our understanding that states will be authorized to add additional criteria for incentive funding.

How and when should I start preparing?

Most health departments will need to undertake major process changes to attain eligibility for incentive funding. Netsmart can provide a roadmap to MU for its 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.

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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