Meaningful Use FAQs for Behavioral Health

Netsmart is your Meaningful Use technology partner with all the solutions you need to meet all Stage 1 Meaningful Use criteria so you don’t have to integrate products from multiple vendors. For more information, visit www.ntst.com/meaningfuluse or call 1.800.472.5509.

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. Within each of these categories incentives are designated for Providers or Hospitals.

Are behavioral health providers currently eligible for incentives?
Behavioral 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 MU 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 behavioral health. Organizations must choose to receive either the Medicaid or Medicare incentives (not both), and since most behavioral health 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, they need to be a non-hospital based eligible professional. Providers that work in hospitals that are eligible under the Hospital side of the incentives are not eligible.
What do providers need to do to qualify and what are the incentive amounts?

To qualify as an EP under the Medicaid incentive program, a physician, nurse practitioner, dentist, certified nurse midwife or physician assistant must provide at least 11% of their services in an outpatient setting, at least 30% of their services must be paid in full or part by Medicaid*, and perform at least 50% of their services in a location(s) equipped with certified EHR technology. The 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.

* If the EP is a pediatrician the threshold is 20%.
* If the EP is a physician assistance at a FQHC or RHC the threshold is 30% of needy individuals.

To qualify as an EP under the Medicare incentive program, a physician, dentist, podiatrist, or chiropractor must provide at least 11% of their services in an outpatient setting, bill at least $24,000 in allowed charges to Medicare, and perform at least 50% of their services in a location(s) equipped with certified EHR technology.

The maximum Medicare Provider incentive amount for that same time period is $44,000. The payment is spread over 5 consecutive years: year 1 is $18,000, year 2 is $12,000, year 3 is $8,000, year 4 is $4,000, and year 5 is $2,000.

How are Medicaid “encounters” defined and calculated?

An “encounter” or “office visit” is defined as a billable service rendered on any one day to an individual. When multiple EPs see the same patient each EP does receive credit for the encounter (e.g. a nurse and a doctor may see the patient on the same day). The methodology for estimating patient volume is determined by dividing the EP’s total number of Medicaid patient encounters for any representative continuous 90 day period by all patient encounters over the same period. States are permitted to choose a different method for calculating the volume as long as it is approved by CMS.

An alternative to calculating the Medicaid patient volume for each individual EP is to use the Clinic Volume Proxy method instead. This method is beneficial when some EPs don’t meet the threshold on an individual basis. The proxy method combines encounters for “all providers”, including those who are not EPs (e.g. social workers), then performs the calculation. To use the Clinic Volume Proxy all three of the following conditions must be met:

- The clinic’s Medicaid volume must be an appropriate proxy for the EP.
- There is an auditable data source to support clinic’s patient volume determination.
- All EPs at the clinic for the report year use the same method (i.e. cannot have some EPs use the individual calculation method and others use the Clinic Volume Proxy method).

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% of their patient encounters in any one practice can meet the 50% threshold through a combination of practices.
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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.

<table>
<thead>
<tr>
<th>Facility A</th>
<th>Facility B</th>
<th>Facility C</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 encounters</td>
<td>40 encounters</td>
<td>30 encounters</td>
</tr>
<tr>
<td>Certified EHR</td>
<td>Certified EHR</td>
<td>No Certified EHR</td>
</tr>
<tr>
<td>30% of encounters</td>
<td>40% of encounters</td>
<td>30% of encounters</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Threshold</th>
<th>Based On</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical decision support – 1 rule</td>
<td>Enabled</td>
<td></td>
</tr>
<tr>
<td>Clinical quality measures</td>
<td>Enabled</td>
<td></td>
</tr>
<tr>
<td>Clinical summaries of office visit</td>
<td>50%</td>
<td>office visits</td>
</tr>
<tr>
<td>Computerized provider order entry</td>
<td>30%</td>
<td>clients seen</td>
</tr>
<tr>
<td>Demographics</td>
<td>50%</td>
<td>clients seen</td>
</tr>
<tr>
<td>Drug-drug, drug-allergy, checks</td>
<td>Enabled</td>
<td></td>
</tr>
<tr>
<td>Electronic copy of health information</td>
<td>50%</td>
<td>client requests</td>
</tr>
<tr>
<td>ePrescribing</td>
<td>40%</td>
<td>non-controlled Rxs</td>
</tr>
<tr>
<td>Exchange patient summary record</td>
<td>One test</td>
<td></td>
</tr>
<tr>
<td>Meaningful use measures</td>
<td>Enabled</td>
<td></td>
</tr>
<tr>
<td>Medication allergy list</td>
<td>80%</td>
<td>clients seen</td>
</tr>
<tr>
<td>Medication list</td>
<td>80%</td>
<td>clients seen</td>
</tr>
<tr>
<td>Patient summary - transition of care out</td>
<td>50%</td>
<td>transitions out</td>
</tr>
<tr>
<td>Problem list</td>
<td>80%</td>
<td>clients seen</td>
</tr>
<tr>
<td>Smoking status (age 13+)</td>
<td>50%</td>
<td>clients seen</td>
</tr>
<tr>
<td>Vital signs, BMI, Growth Charts (age 2+)</td>
<td>50%</td>
<td>clients seen</td>
</tr>
<tr>
<td>Hospital Only - Electronic copy of discharge instructions</td>
<td>50%</td>
<td>clients discharged</td>
</tr>
<tr>
<td>Hospital Only - Electronic copy of health info for discharge summary</td>
<td>50%</td>
<td>clients discharged</td>
</tr>
<tr>
<td>Protect health information via risk analysis and remediation</td>
<td>Conduct</td>
<td></td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Menu Set</th>
<th>Measure Threshold</th>
<th>Based On</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>Threshold</td>
<td></td>
</tr>
<tr>
<td>Drug formulary check</td>
<td>Enabled</td>
<td></td>
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<tr>
<td>Immunization reporting</td>
<td>One test</td>
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<tr>
<td>Laboratory test results stored as structured data</td>
<td>40%</td>
<td>lab orders</td>
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<tr>
<td>Medication reconciliation</td>
<td>50%</td>
<td>transitions in</td>
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<tr>
<td>Patient education resources</td>
<td>10%</td>
<td>clients seen</td>
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<tr>
<td>Patient lists</td>
<td>Enabled</td>
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<td>Patient reminder list (ages &lt; 6 and &gt; 64)</td>
<td>20%</td>
<td>active clients</td>
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<tr>
<td>Public health surveillance reporting</td>
<td>One test</td>
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</tr>
<tr>
<td>Timely access</td>
<td>10%</td>
<td>clients seen</td>
</tr>
<tr>
<td>Hospital Only - Advance directives</td>
<td>50%</td>
<td>clients admitted</td>
</tr>
<tr>
<td>Hospital Only - Reportable lab results</td>
<td>One test</td>
<td></td>
</tr>
</tbody>
</table>

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

**How do I determine if professionals working in my inpatient facility are eligible professionals?**

Standalone Psychiatric Hospitals are currently excluded from Hospital incentives. The only hospitals included for Hospital incentives are Acute Care Hospitals (CCN 0001-0879) and Children’s Hospitals (CCN 3300-3399). However, if a psychiatric unit is operating under its parent Hospital’s CCN number, and that CCN number is eligible per the above codes, the psychiatric unit is eligible for the Hospital-based incentives.

If the Hospital is not eligible for the Hospital incentives based on its CCN number, then it may be able to receive Eligible Professional incentives based on the professional’s Point of Service (POS) Billing Codes.

If a professional is billing 10% or more under any code below, they are considered an Eligible Professional and able to receive EP incentives and assign them to their facility.

11) Office  
12) Home  
24) Ambulatory Surgical Center  
25) Birthing Center  
26) Military Treatment Facility  
31) Skilled Nursing Facility  
32) Nursing Facility  
33) Custodial Care Facility  
34) Hospice  
41) Ambulance-Land  
42) Ambulance-Air or Water  
50) Federally Qualified Health Center  
51) Inpatient Psychiatric Facility  
52) Psychiatric Facility Partial Hospitalization  
53) Community Mental Health Center  
54) Intermediate Care Facility/Mentally Retarded  
55) Residential Substance Abuse Treatment Facility  
56) Psychiatric Residential Treatment Center  
61) Comprehensive Inpatient Rehabilitation Facility  
62) Comprehensive Outpatient Rehabilitation Facility  
65) End Stage Renal Disease Treatment Facility  
71) State or Local Public Health Clinic  
72) Rural Health Clinic  
81) Independent Laboratory  
99) Other
If a professional is billing more than 90% using one of the following three Point of Service Billing codes, then they are NOT eligible:

- **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.

**Is there legislation in process that will allow community mental health centers and substance abuse treatment provider organizations to receive Medicaid incentives as an “Organization” and not just through Eligible Professionals?**

Corrective legislation ([www.ntst.com/legislation](http://www.ntst.com/legislation)) was introduced in the 112th Congress in March 2011 by Senator Sheldon Whitehouse (D-RI) to extend eligibility for Medicaid and Medicare incentive funds for the Meaningful Use of Electronic Health Records (EHRs) to behavioral health, mental health, and substance abuse treatment professionals and facilities not previously included as eligible for funds under ARRA.

Netsmart, along with industry groups such as the National Association for Community Behavioral Healthcare, the National Association of Psychiatric Health Systems and the National Association of Counties, are working collaboratively to secure additional sponsors in the House and Senate for this new legislation.

The proposed bill, S. 539, expands federal health information technology payments to previously ineligible community behavioral health providers and organizations by expanding federal incentive payments for the adoption of health information to behavioral and mental health professionals, psychiatric hospitals, mental health treatment facilities, and substance abuse treatment facilities. By expanding HIT incentive payments to behavioral health providers, this legislation will provide much needed funding for community behavioral health organizations as they seek to implement electronic health records and improve care quality.

The proposed legislation clarifies the definition of “health care provider” to include behavioral and mental health professionals, substance abuse professionals, psychiatric hospitals, behavioral and mental health clinics, and substance abuse treatment facilities. It also expands the Medicaid/Medicare incentives through the following:

- Expand the types of professionals that are eligible for Medicaid and Medicare Eligible Professional incentives for the “meaningful use” of EHRs to include licensed psychologists and clinical social workers. Currently, behavioral healthcare provider organizations can qualify for Medicare and Medicaid incentive funds only through the current definition of eligible professionals, which includes physicians and nurse practitioners that are affiliated with their facilities. The typical behavioral health organization has a limited number of these professionals compared to psychologists and other clinical social workers.
- Expand Medicare Hospital meaningful use incentive funding eligibility to include inpatient psychiatric hospitals.
• Expand Medicaid Hospital meaningful use incentive funding eligibility to include mental health treatment facilities, psychiatric hospitals and substance abuse treatment facilities.

If the corrective legislation does pass, the expanded list of eligible professionals (to include licensed psychologists, clinical social workers, etc.) can receive incentives as currently defined (e.g. $63,750 for Medicaid and $44,000 for Medicare). The dollar amount of incentives will need to be determined if an organization applies for the Hospital incentives, but it is likely to be a similar structure to what hospitals can receive now:

\[
\left( \frac{\$2M + \$200 \times \text{Total No of Discharges}}{\text{Total No of Discharges}} \right) \times \left( \frac{\% \text{ of Medicaid Business}}{\% \text{ of Medicaid Business}} \right) \times \left( \frac{\text{Year Factor}}{\text{Year Factor}} \right) \times \left( \frac{\text{Charity Care Factor}}{\text{Charity Care Factor}} \right)
\]

If an organization waits until 2014 to start, the incentives are reduced.

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 EPs 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 need a human readable report of the stats (any 90-day period). For the year 2015, 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).

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:
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- Stage 1 begins in 2011 and focuses on the use of EHRs and capturing health information in a structured format.
- Stage 2 begins in 2014 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.

An eligible provider participates in each Meaningful Use Stage for at least two years:
- 2 years in Stage 1 (3 years if began in 2011)
- 2 years in Stage 2
- 2+ years in Stage 3

**Do providers have to fully implement a certified EHR to be eligible for incentive funds?**
No. In the first year of participation, eligible providers can adopt (acquire, install), 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 and when should I start preparing?**
Most provider organizations 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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