Netsmart Technologies

Meaningful Use FAQs for Behavioral Health

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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. 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, a physician, nurse practitioner, dentist, certified nurse midwife or physician assistant 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 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?
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, co-payments 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% 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 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 made 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 the Menu Set criteria the provider might opt to defer until Stage 2. The software does not have to be implemented or used for the provider to qualify for first-year MU funds, 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).

- *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	Generate at least one report	

Conditions		
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

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.
- 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.

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) 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:

$$\left(\$2M + \$200 \times \text{Total No of Discharges}\right) \times \left(\text{\% of Medicaid Business} \times \begin{array}{c}\text{Year Factor}\\ \text{Year 1, 100\%}\\ \text{Year 2, 75\%}\\ \text{Year 3, 50\%}\\ \text{Year 4, 25\%}\end{array} \times \text{Charity Care Factor}\right)$$

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 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 began 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 to 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

Can states add additional criteria?
It is our understanding that states will be authorized to add additional criteria for incentive funding, but none have done so yet.

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.

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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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