KNOW THE BASICS OF THE EHR INCENTIVE PROGRAMS

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As we provide technical services to healthcare professionals who would like to become Meaningful Users of electronic health records, we are asked all the time about provider eligibility for the various EHR incentive programs for MU incentives.

Our two organizations know that dentists have been bombarded by information about electronic health records systems (EHRs). EHR incentives and Meaningful Use (MU) are discussed endlessly and frequently the information provided to dentists is both confusing and conflicting. Dentists are just seeking answers to the questions of whether they are eligible for EHR incentives and how they can meet Meaningful Use.

The short answer to whether dentists are eligible for EHR incentives is "It depends." Theoretically, all dentists are eligible for both the Medicare and Medicaid EHR incentive programs since dentists were included in the provider categories established by the federal EHR incentive program statutes. Practically speaking, since Medicare pays for very little dental work, the dentist's eligibility would depend on his/her work through the Medicaid program run by each state individually. What this program is called in each state varies, but you can go to your state's Medicaid website to get information. A list of these websites appears at the end of this article. Medicaid has expanded eligibility categories starting January 1, 2013, so a dentist wondering about eligibility may want to recalculate using the new eligibility criteria.

Year 1 Medicaid Incentives—Adopt/Implement/Upgrade (A/I/U) or 90-Days of Meaningful Use

Medicaid Year 1 EHR incentives are commonly referred to as A/I/U payments. The A/I/U stands for "Adopt/Implement/Upgrade," that is, any of the various ways a provider can obtain a certified system that can be used for the Medicaid incentive program. The whole purpose of the first year of the Medicaid EHR incentive program is to assist providers in paying for the upfront costs of an EHR system. Therefore, Medicaid does not require a provider to already be using the system or to be meeting MU in order to draw down the first year of incentives. It is assumed, though, that the first year payment will be followed by subsequent years' filings showing that a provider is meeting MU. This is the whole intent of the program, to move providers into using electronic systems that have standardized capabilities. This, then, will help to improve and coordinate patient care.

The whole process of filing for EHR incentives is called the attestation process, since a provider attests to the fact that he/she has met the requirements of the program. In subsequent years, a provider would attest to meeting Meaningful Use, but in the first year of Medicaid incentives, the provider is only attesting that he/she is a Medicaid provider, has the required Medicaid patient volume and has either adopted, implemented or upgraded to a certified EHR system.

Payment for Medicaid Year 1 A/I/U is $21,250. It is a true incentive. As long as the provider meets the Medicaid patient volume threshold and has contracted for a certified EHR system, he/she will be eligible to receive the full

incentive regardless of what the total patient volume figure is. The complete Medicaid EHR incentive program payments are $63,750 extended over a 6-year period: $21,250 in Year 1 and $8,500/year in Years 2 – 6.

Starting in 2013, Medicaid will also accept 90-days of Meaningful Use for the first payment year (as an alternative to A/I/U) if the provider is up and running on an EHR, meets the Medicaid patient volume requirements and meets Meaningful Use. In this way, Medicaid is expanding the program to help practitioners to qualify sooner for Meaningful Use payments.

Registration for EHR Incentives

Registration for either the Medicare or the Medicaid incentive program begins with filing at the EHR Incentives.CMS.gov website: https://ehrincentives.cms.gov/hitech/login.action. Once you register at that site, you will receive an e-mail from your state's Medicaid program telling you how to access its portal to finish the Medicaid registration. To file for Medicaid EHR incentives, a dentist must be a Medicaid provider. You will need to enter your Medicaid provider number before you can continue with your Medicaid registration.

The Medicaid EHR Incentive Program is administered individually by each State and territory. The registration process for the program varies from state to state, it is recommended that you check with your State Medicaid Agency for additional details.

Medicaid Patient Volume

Medicaid eligibility for the EHR incentive program requires a dentist to show that for a 90-day period in the past 12 months he/she has maintained a 30% Medicaid patient volume. There are new rules effective in Calendar Year 2013 attestations that should allow more providers to meet the Medicaid patient volume requirements and qualify for Medicaid incentives

Some points to keep in mind in determining your Medicaid patient volume:

- Medicaid patient volume is defined as any patient encounter where Medicaid fee-for-service or Medicaid managed care paid for all or part of the claim (can be either primary or secondary payer). Starting in 2013, providers can also include in the Medicaid patient volume patients that are eligible for Medicaid services whether or not Medicaid paid on the claim. Don't forget Medicaid managed care patients in this calculation!
- If the patient is dually eligible (i.e., both Medicare/Medicaid) he or she can be counted.
- If the same patient receives care more than once in the 90-day period, each visit is counted as a separate Medicaid encounter.
- If the dentist works at a Federally Qualified Health Center (FQHC) or an FQHC-lookalike, then the eligible patient population can expand even further to include 'needy' individuals.

Your information on Medicaid patient volume will need to be uploaded to the Medicaid website using a spreadsheet or report to show how you calculated your patient volume data and what your overall patient volume was during that 90-day period. As previously stated, the program is administered individually by each State and territory and it is recommended that you check with your State Medicaid Agency for additional details.

Certified EHR System

Once you establish your Medicaid eligibility by calculating your 30% Medicaid patient volume, you will need to show that you have legally obligated yourself to purchase or use a federally-certified Electronic Health Record (EHR) system. At the time that you apply for Medicaid incentives, you do not need to be using the system; you do not even need to have the system installed. But you will have to show through a contract or purchase order that you have obligated yourself to acquire such a certified system. If you are unsure whether the system you are using or considering purchasing is certified, you can check on the HealthIT.gov federal website that lists all certified healthcare IT products: http://oncchpl.force.com/ehrcert . Of the almost 3,000 products listed for ambulatory practices, there are few certified systems that are geared specifically for dental practices. If you are planning to use a non-dental product to meet Meaningful Use, you should know how to overlay your dental practice's needs with this more generic EHR product to track all the Meaningful Use measures.

You will need to upload the first few pages of your EHR contract showing the name and version number of the system you are planning on using along with the signed and dated signatory page.

Subsequent Years' Filing

Medicaid, unlike Medicare, does not require a provider to file every year to show MU. It is permissible to skip a year's filing if you have a problem getting your system installed or tracking the MU measures. However, the overall goal of the program is to file for 6 years from 2011 through 2021. The first year is always A/I/U if you are not ready to meet Meaningful Use. The second year would then be 90 days of Meaningful Use, as measured by the federal MU measures. The third and subsequent years require a whole years' tracking of MU, including the submission of Clinical Quality Measures.

Meeting Meaningful Use as a Dentist

Many dentists assume that they cannot meet Meaningful Use since many of the MU measures do not reflect the clinical work done in a dental practice. This is not true. Dentists, like many medical specialties, can interpret the MU measures to track what is or is not done in the normal scope of that specialty's practice. If a certain measure does not apply to a dental practice, then the dentist should take an exclusion for that measure.

Handling Exclusions for Meaningful Use

An example of how to take an exclusion for a MU measure as a dentist would be the MU measures relating to electronic prescriptions, or e-prescribing. One MU measure requires a provider to enter prescription orders into his/her EHR system (i.e., Computerized Prescription Order Entry, or CPOE). Another measure requires the provider to generate and submit these prescriptions electronically. If a dentist does little or no prescribing, then he/she would take an exclusion for this measure. The exclusion does not prevent a provider from meeting MU. The exclusion for these two measures states*: "An Eligible Professional (EP) who writes fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use."*

In this way, dentists can still meet MU even if several of the measures do not apply to them. A complete list of the MU measures to review can be found on the CMS EHR Incentive website: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf .

The following chart summarizes the measures as well as notes on applicability of the measure to different providers:

Meaningful Use Measure Number	Measure	Notes
Core Measure 1 (Required)	CPOE for Medication Orders for >30% of patients with a listed medication	*For dentists who write less than 100 prescriptions during the reporting period, can take an exclusion*
Core Measure 2 (Required)	Drug interaction checks	*No exclusions; must show the functionality is turned on in your EHR system*
Core Measure 3 (Required)	Maintain problem list of current and active diagnoses	*No exclusion. Must show that 80% of patients either have a diagnosis listed as structured data or have an entry showing no known problems*
Core Measure 4 (Required)	Generate and transmit permissible prescriptions electronically for >40% of prescriptions written during the reporting period	*For dentists who write less than 100 prescriptions during the reporting period, can take an exclusion*
Core Measure 5 (Required)	Maintain an active medication list for >80% of patients seen during the reporting period	*No exclusion. Dentists need to list medications or indicate that there are no medications*
Core Measure 6 (Required)	Maintain active medication allergy list for >80% of patients seen during the reporting period	*No exclusion. Dentists need to have a medication allergy list for 80% of the patients seen or indicate that there are no medication allergies*
Core Measure 7 (Required)	Record preferred language, gender, race, ethnicity and date of birth for >50% of patients seen during the reporting period	*No exclusion. If information is captured elsewhere (e.g., practice management system), it is permissible to update the clinical record with this information before or after the visit*
Core Measure 8 (Required)	Record vital signs for >50% of patients seen during the reporting period	*For dentists who believe either height, weight and blood pressure have no relevance to their practice, or for dentists who believe height and weight OR blood pressure separately have no relevance to their practice, can take an exclusion*
Core Measure 9 (Required)	Record smoking status for >50% of patients seen during reporting period of those 13 years or older	*For dentists who don't see patients 13 years or older, can take an exclusion*
Core Measure 10 (Required)	Report Clinical Quality Measures to CMS	*See information below on CQM reporting*
Core Measure 11 (Required)	Implement one clinical decision support rule	*No exclusion*
Core Measure 12 (Required)	Provide an electronic copy of health information within 3 days to >50% of patients who request it during the reporting period	*For dentists who have no patients requesting an electronic copy, can take an exclusion*
Core Measure 13 (Required)	Provide clinical summary for >50% of office visits for patients seen during the reporting period within 3 business days	*For dentists that have no office visits during the reporting period, can take an exclusion*
Core Measure 14 (Required)	Test the capability to exchange key clinical information	*No longer required starting in 2013*
Core Measure 15 (Required)	Conduct or review a security risk analysis using HIPAA guidelines	*No exclusion*
Menu Measures: Report on 5 of the 10 measures that you select for reporting but must include 1 Public Health Reporting Measure (Measure 9 or 10)		
Menu Measure 1	Implement drug-formulary checks	*Must have access to one internal or external drug formulary; for dentists who write less than 100 prescriptions during the reporting period, can take an exclusion*
Menu Measure 2	Incorporate clinical lab test results into the EHR as structured data for >40% of the lab test results for tests ordered during the reporting period	*For dentists who do not order labs with test results reported as either positive/negative or numeric during the reporting period, can take an exclusion; also, lab results do not need to be electronically delivered, can be entered manually into EHR*

Menu Measure 3	Generate at least one list of patients with a specific condition	*No exclusion*
Menu Measure 4	Send appropriate patient reminders to >20% of patients 65 or older or younger than 5 years	*Can use any form of reminder: calls, e-mails, postcards, etc.; can take an exclusion if no patients of the appropriate age*
Menu Measure 5	Provide >10% of patients seen during the reporting period timely electronic access to their records within 4 business days	*For dentists who do not order lab tests or capture information for problem list, med list or medication allergy list, can take an exclusion*
Menu Measure 6	>10% of patients seen during the reporting period are provided patient-specific education resources	*No exclusion*
Menu Measure 7	Medication reconciliation is performed on >50% of patients transitioned into provider's care during the reporting period	*For dentists who do not have any patients who transition into their care during the reporting period, can take an exclusion*
Menu Measure 8	Summary of care records are provided for >50% of patients who are referred or transitioned to another setting or provider	*For dentists who do not transfer or refer patients during the reporting period, can take an exclusion; summary can be a paper record*
Menu Measure 9	Performed at least one test of EHR system's ability to submit electronic data to immunization registry	*Many states are not able to accept electronic immunization records yet; check your state's Department of Health website to determine if you should take an exclusion for this; can also take an exclusion if dentist does no immunizations*
Menu Measure 10	Performed at least one test of EHR system's ability to submit electronic syndromic surveillance data to public health agency	*Many states are not able to accept electronic syndromic surveillance data from individual providers; check on your state's Department of Health website to determine if you should take an exclusion for this; can also take an exclusion if dentist does not collect syndromic surveillance data*

Clinical Quality Measures

In addition to the other Meaningful Use measures, providers need to report on 6 clinical quality measures. For 2013, it is not necessary to electronically report these measures to CMS. Instead, a provider will attest to the fact that the measures are being tracked during the reporting period. The provider will have to enter the numerator and the denominator of those 6 measures that were selected.

For Stage 1 Meaningful Use, there are a total of 44 clinical quality measures, divided into categories of core (3), alternate core (3) and additional selected quality measures (38). When figuring out which 6 measures to report, a provider must always start with 3 measures from the core or alternate core clinical quality measures, then report on 3 additional measures of the provider's choosing. The core measures are: blood pressure (NQF 0013), tobacco use assessment (NQF 0028) and adult weight screening (NQF 0421). The alternate core measures are: weight assessment/counseling for children (NQF 0024), childhood immunization status (NQF 0038) and flu immunizations for patients 50 years or older (NQF 0041). The remaining 38 measures are from a variety of areas relating both to chronic care management and to preventive care.

Dentists frequently ask how they could meet Meaningful Use when so few of the clinical quality measures relate to a dental practice. Arguably, the only ones in the list of 44 measures that relate to dentists are the two having to do with smoking: NQF 0028 Tobacco Use Assessment and NQF 0027 Medical Assistance for Smoking and Tobacco Use Cessation. The federal regulations acknowledge the fact that not all medical specialties will have clinical quality measures that pertain to their scope of practice. In those instances where there are not 6 clinical quality measures

that relate to the provider's practice, the regulations state that zero, "0", is an acceptable value for reporting quality measures and the provider will still be able to meet Meaningful Use. The certified EHR will be expected to generate the zero values that will be reported.

Beginning in 2014, specific dental CQMs have been added to the list of reportable measures. For reporting in 2013, however, to meet Meaningful Use when there are fewer than 6 CQMs that relate to a dental practice, use the following flowsheet:

- Report on the 3 core clinical quality measures (blood pressure, tobacco use assessment and adult weight screening). *If not all 3 measures apply to the dental scope of practice, then*
- Report on any alternate core clinical quality measures that will bring the total of CQMs to 3 (weight assessment/counseling for children, childhood immunization, flu immunizations for patients over 50*). If the only core CQM that applies to dental practice is tobacco use assessment, the dentist would report the numerator and denominator for that CQM, then report a "0" for all the remaining core and alternate core CQMs.*

  Report on any three additional clinical quality measures of the dentist's choosing. *If there is only 1 additional CQM that applies to dental scope of practice (i.e., medical assistance for smoking and tobacco use cessation), the dentist would report the numerator and denominator for this CQM, then report a "0" for 2 additional CQMs. The dentist would also be required to attest to the fact that all remaining CQMs have "0" in the denominator, which would indicate that no other CQMs fit the dental scope of practice.*

Points to Consider When Deciding Whether to File

- If you are considering applying for Medicaid EHR incentives, the process is straightforward and can be done directly by you and your office staff. It is not complicated and each state's Medicaid program has a help desk for answering incentive questions. If you have questions about eligibility or the Medicaid incentives generally, you can call the number found on your state's Medicaid website.
- Consulting groups that state they can file for your Medicaid incentives frequently cover only the first year Medicaid incentive payment. Some do not continue to work with your practice to assist you in meeting MU in subsequent years. Read the contract before you sign with a consultant so you know what services are being provided!
- Potential liability for taking incentive payments without moving ahead to MU in a reasonable amount of time will rest with you, the provider. You are the Medicaid provider and will be liable if CMS or Medicaid decides that you acted in bad faith in drawing down the incentives while not intending to move ahead to MU.
- For approximately the same amount as the fee charged by some consulting groups whose sole purpose is to assist you in drawing down Medicaid incentives, you may be able to contract with a true EHR consultant that can work with you on workflow issues and help you reach MU.
- Drawing down the first year Medicaid incentive is actually the easiest part of the process. The issue with moving to MU is how to adjust your workflow in the office to allow you to track the MU measures as a dental practice. You need to assess (or retain a third party to assess) your workflow as a provider to see how best to use an electronic system to assist with your clinical needs.
- Finally, you should be looking ahead to being part of a health information exchange (HIE) in your state to allow for the sharing of your patients' records. If you want more information on health information exchange (connectivity to a hospital or other providers is an important part of Meaningful Use in later years) or are interested in connecting to an HIE to exchange your records with other providers, you can

contact your state Department of Health or your state Medicaid agency. They will maintain a list of HIEs in your area.

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