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Eligible Professionals: Attaining and Sustaining Meaningful Use

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To remain eligible for Medicare or Medicaid incentive payments, eligible professionals (EPs) must navigate the complexities of achieving "meaningful use" of certified electronic health record (EHR) technology and know how to prepare for attestation and a possible audit by the Centers for Medicare & Medicaid Services (CMS). Once attained, sustaining meaningful use requires a long-term commitment to behavior and workflow changes as well as robust monitoring and training programs.

Funding EHR Incentive Programs

In 2011, the federal government began allocating monetary incentives to EPs under the *Health Information Technology for Economic and Clinical Health Act*. This legislation laid the groundwork for the nationwide implementation of the EHR technology as a means of reducing healthcare costs while improving patient care.

Government funding is provided through the Medicare and Medicaid EHR Incentive Programs to EPs who successfully demonstrate the meaningful use of certified EHR technology. An EP is defined as follows:

Eligible Professionals Under the Medicare EHR Incentive Program	Eligible Professionals Under the Medicaid EHR Incentive Program
Doctors of medicine or osteopathy	Physicians (primarily doctors of medicine and doctors of osteopathy)
Doctors of dental surgery or dental medicine	Nurse practitioners
Doctors of podiatry	Certified nurse midwives
Doctors of optometry	Dentists
Chiropractors	Physician assistants who furnish services in federally qualified health centers or rural health clinics that are led by physician assistants

Source: CMS

CMS provides an eHealth Eligibility Assessment Tool to assist EPs in determining if they meet eligibility criteria for the Medicare or Medicaid EHR Incentive Programs, among other eHealth programs.

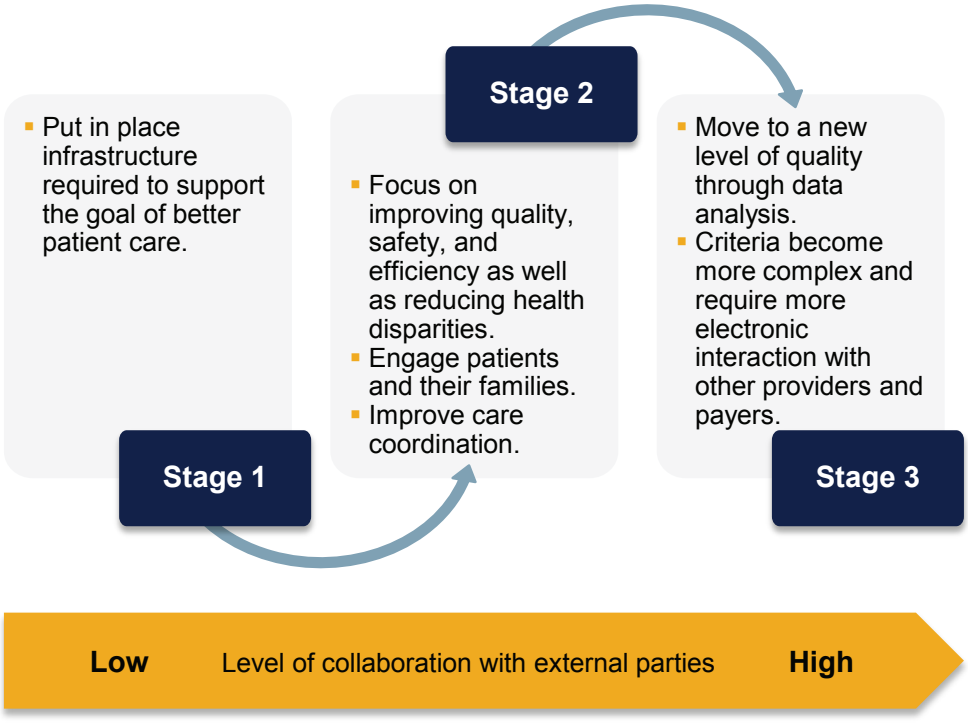
At the inception of the programs, an individual EP could receive up to $44,000 in Medicare EHR incentives over a period of five years and up to $63,750 in Medicaid EHR incentives over six years. These incentives have decreased each year. On March 1, 2013, President Barack Obama issued a sequestration order that reduced Medicare EHR incentive payments to EPs and eligible hospitals by 2 percent, applicable to any payment for a reporting period that ended on or after April 1, 2013. In 2015, sequestration remains in place for these payments. However, Medicaid EHR incentive payments are exempt from sequestration.

The reductions in incentive payments emphasize the importance of early adoption. EPs must have begun EHR program participation no later than 2014 to receive a Medicare incentive payment. Medicare EPs who are not meaningful users will be subject to a payment adjustment beginning on Jan. 1, 2015. EPs may apply for hardship exceptions to avoid payment adjustments, but exceptions are granted only under specific circumstances that CMS has determined pose a significant barrier to achieving meaningful use.

Achieving Truly Meaningful Use

Achieving meaningful use for EHRs is a three-stage process. With each stage, the EP moves toward improving quality of care, management of disease, sharing of data, and coordination of care delivery. Achievement is determined based on core objectives and menu objectives, some of which require a yes-or-no attestation and others that are measured based on the percentage of patients who meet specified criteria. For specific descriptions of each of the core and menu objectives, see www.cms.gov/EHRIncentivePrograms. In each stage, the threshold for meeting criteria will be raised. Stage one focuses primarily on gathering and recording the necessary patient information, stage two focuses on using the EHRs in a meaningful way, and stage three will focus on using the data to improve outcomes.

Exhibit: Stages of Achieving Meaningful Use for EHRs



Source: CHAN analysis

Managing the Risks and Complexities

Validate EHR System Certification

Providers must use a certified EHR system to achieve meaningful use objectives and measures. The Office of the National Coordinator for Health Information Technology (ONC) has a certification program that provides a defined process to validate that EHR technologies meet the standards and certification criteria adopted by the U.S. Department of Health and Human Services (HHS). EHR systems are tested by accredited testing laboratories, and ONC-authorized entities certify tested EHR products based on the standards and certification criteria. Once the products have been certified, the ONC posts the certified products to its Certified Health IT Product List.

Meet Reporting Requirements

EPs can participate in either the Medicare or Medicaid EHR Incentive Program but not both. The following table summarizes the differences.

Medicare EHR Incentive Program	Medicaid EHR Incentive Program
Program is run by CMS.	Program is run by the applicable state Medicaid agency.
Maximum incentive amount is $44,000 (across five years of program participation).	Maximum incentive amount is $63,750 (across six years of program participation).
Payments are over five consecutive years.	Payments are over six years and do not have to be consecutive.
Payment adjustments will begin in 2015 for providers who are eligible but decide not to participate.	No Medicaid payment adjustments.
Providers must demonstrate meaningful use every year to receive incentive payments.	In the first year providers can receive an incentive payment for adopting, implementing, or upgrading EHR technology. Providers must demonstrate meaningful use in the remaining years to receive incentive payments.

Source: CMS

To receive an EHR incentive payment, providers must show that they are meeting the objectives established by CMS for meaningful use and using their EHRs in ways that can positively affect the care of their patients.

All providers must achieve meaningful use under the stage one criteria before moving to stage two. In stage one, EPs must meet 13 core objectives and satisfy five of 10 menu objectives. In stage two, which began in 2014, EPs must meet 17 core objectives and three of six menu objectives. Some of the objectives have a minimum percentage that providers must meet. All EPs are required to report on CMS clinical quality measures, in addition to the core and menu objectives.

Reporting requirements are more complex in stage two. Nearly all of the stage one core and menu objectives are retained, and the thresholds (percentages) that providers must meet to satisfy the requirements increase. Stage two also broadens the focus of meaningful use to include more rigorous patient engagement, and providers are required to submit their data electronically.

Track Registration and Attestation

Registration for the Medicare and Medicaid EHR Incentive Programs is performed at the practitioner level. CMS allows an EP to designate a third party to register and attest on his or her behalf. To do so, those working on behalf of an EP must have an Identity and Access Management System Web user account (user ID and password) and be associated with the EP's National Provider Identifier.

Beginning in 2014, EPs participating in the Medicare EHR Incentive Program can submit their attestation with other participating members of their medical group or hospital system. However, incentive payments are made to individual providers. EPs can choose to designate a practice or organization to receive the incentive funds on their behalf.

Turnover in physician employment poses a challenge to organizations. To estimate incentive payments or payment adjustments, organizations need to understand where the EP is in the meaningful use timeline (for instance, stage one, year one; stage one, year two). For example, CHAN Healthcare encountered a situation in which an EP was audited for an attestation related to a period in which the EP was employed by the client's competitor. The audit was performed after the attestation, and the EP subsequently began employment with the client. Although the audit scope covered the prior attestation period, any payment adjustments would be made to future reimbursements under the physician fee-for-service schedule, thus affecting the client.

CMS publishes a listing of EPs who are recipients of Medicare EHR Incentive Program payments. Updated quarterly, this list can be used by organizations to determine an EP's meaningful use timeline.

Organizations should consider using a tracking mechanism. One CHAN Healthcare client developed an "EP Meaningful Use Tracker" to manage the registrations, attestations, and incentives received for all EPs employed by the organization. This enables management to identify incentives and payment adjustments missed due to lack of registration or lack of attestation. By updating this tool frequently and monitoring the data periodically, management stays proactive in mitigating these risks.

The success or failure of an organization's EHR meaningful use initiative will dramatically affect profitability and sustainability.

Understand the Criteria

Despite the hundreds of articles and seminars about meaningful use, there remains a lack of clarity about the requirements. In a survey by PricewaterhouseCoopers, 92 percent of chief information officers said they were most concerned with the meaningful use reporting requirements and the clarity of the criteria.

The requirements to meet the CMS objectives are open to different interpretations, as CHAN Healthcare noted in a recent audit. Two facilities from the same health system using different certified EHR systems interpreted what constitutes a patient visit differently from one another: At one facility, certain objectives were considered met even if the required criteria occurred outside of the reporting period; at the other facility, the same objectives were considered met only if the required criteria occurred within the reporting period.

The two EHR systems had different interpretations of the requirements, and the CMS guidance on this issue is ambiguous. The requirements clearly state that the denominators must include patients seen in the EHR reporting period; however, the criteria for the numerators is open to interpretation. One example is the recording of vital signs: One facility required that vital signs be taken within the reporting period to be counted in the numerator, while the other facility included the measure as being met as long as the vital signs were in the patient record. These facilities resolved to work with their EHR companies to document the rationale behind these definitions in case of an audit by CMS.

The lack of clarity extends to many other aspects of meaningful use, such as which EPs to include in the denominators and numerators for certain calculations (part-time or inpatient, for example). CMS advises that discretion can be used in some circumstances as long as there is consistency throughout the reporting period. The CMS website offers FAQs on the subject of meaningful use (see the Resources section for links to CMS and related Web pages). If further clarification is required, submit questions directly to CMS.

Balance Priorities

Adopting meaningful use will have a significant impact on an organization's resources and will require significant changes in processes, including clinical operations, information technology, privacy and security, coding, reporting, compliance, patient engagement, and data usage. The success or failure of the EHR meaningful use initiative will have a dramatic impact on profitability and sustainability, so thoughtful planning and wise deliberation are critical.

To successfully implement the initiative, organizations will have to balance priorities, often reprioritizing or delaying other projects. A detailed implementation strategy is critical if deadlines are to be met. The creation of a dedicated project team to undertake strategic planning, tactical and financial planning, implementation planning, program management, progress reviews, compliance monitoring, risk assessment, and grant development is recommended.

Cope With Shortages of Skilled Staff

Following a prediction by the ONC of a shortfall of approximately 51,000 health IT workers in the five years from 2010 to 2015, $118 million was allocated to assist educational institutions in establishing health informatics programs and other educational efforts. Programs from 2010 through 2014 trained more than 21,000 students. Many health systems have hired additional staff members and are using consultants and vendors to implement EHR initiatives.[1]

Collaborate With Physicians

EPs need to maximize their efforts by aligning meaningful use with their missions, visions, and business goals. One important issue for physicians is time: Two-thirds of physicians surveyed by the Medical Group Management Association indicated that fulfilling meaningful use requirements slows down workflow.

The addition of an EHR champion in the organization to engage and educate clinical staff on the long-term advantages of an EHR system to clinical workflow can be a vital element of successful implementation. The fundamental role of the EHR champion is to promote the workflow benefits of EHR systems, including improvements to workflow efficiency, enhancement of patient safety, and improvements to delivery of care.

Sustain Meaningful Use

Sustaining EHR meaningful use means changing behavior and workflow patterns to produce demonstrable results on an ongoing basis. Organizations need to adopt robust monitoring and training programs in order to sustain meaningful use. Periodic monitoring of core and applicable menu set objectives must occur to validate that necessary data is completely and accurately captured. The following section provides guidance on how to monitor and audit meaningful use.

Organizations also should establish a formal training and education program that focuses on meaningful use. The program should be updated as new requirements are published, and frequent communication among eligible providers, clinicians, office staff, EHR system administrators, and EHR vendors regarding requirement updates and process flow changes should occur.

In addition, the EHR system should be monitored for any upgrades or modifications that may affect how the meaningful use requirements are reported. These might be changes the EHR vendor makes to meet new certification requirements.

Preparing for Attestation and CMS Audit

Through August 2014, more than 480,000 providers received nearly $6.5 billion in Medicare incentive payments, and $3.3 billion had been paid out for the Medicaid program to more than 190,000 providers. In November 2012, the HHS Office of Inspector General stated, "CMS faces obstacles to overseeing the Medicare EHR incentive program that leave the program vulnerable to paying incentives to professionals and hospitals that do not fully meet the meaningful use requirements. Currently, CMS has not implemented strong prepayment safeguards, and its ability to safeguard incentive payments postpayment is also limited."[2]

To address this concern, CMS engaged a private contractor, Figliozzi and Co., to conduct both prepayment and postpayment audits of recipients of meaningful use incentive payments. A prepayment audit is conducted before an EP receives the incentive payment. A postpayment audit is done after the attesting EP has received the incentive payment. In November 2014, CMS provided the following information, current as of Sept. 16, 2014, about the results of the EP audits.[3]

Prepayment Audits

- 3,820 of the 5,825 selected prepayment audits (66 percent) of EPs had been completed, and more than 2,000 were still in progress.
- 21 percent (802) of the EPs audited so far did not meet the meaningful use attestation requirements.
- About 93 percent of those 802 EPs did not meet "appropriate objectives and associated measures," and 7 percent did not use a certified EHR.

Postpayment Audits

- 4,780 EPs that had received their incentive payments were audited.
- About 23 percent (1,106) of the audited EPs failed the postpayment audit.
- 99 percent of those 1,106 EPs did not meet "appropriate objectives and measures," and 1 percent did not use a certified EHR.
- Barring an appeal, an EP that fails a postpayment audit is required to return to the government the incentive payment it had previously received. The proposed return amount for the EPs failing this audit ranged from $41.92 to $19,800.
- The average proposed return amount, prior to an appeal, was $16,863.

Considering these statistics, EPs should assume they will undergo an audit by Figliozzi and prepare accordingly.

Initial notification will be sent to the main contact listed during the attestation period. The notification will include an audit engagement cover letter, a document request letter, and Web portal instructions for submitting the requested data.

Typically, the first request is for the EP or health system to do the following:

Part I – General Information

- Provide proof that the system uses certified EHR technology, including a copy of the licensing agreement with the vendor or invoices. It is important that licensing agreements identify the vendor, product name, and product version number of the system used during the attestation period. If the version number is not present on the contract, supply a letter from the vendor that verifies the version number used during the attestation period audited.

Part II – Core Set Objectives and Measures

- Provide supporting documentation (either paper or electronic) used in completion of the attestation module responses (for example, a report from the EHR system that relates to the attestation). It is helpful to have the system name shown as part of the supporting documentation.
- Provide proof that a security risk analysis of the certified EHR technology was performed prior to the end of the reporting period. If deficiencies were identified in this analysis, supply the implementation plans and completion dates.

Part III – Menu Set Objectives and Measures

- Provide supporting documentation (either paper or electronic) used in completion of the attestation module responses (for example, a report from the EHR system that relates to the attestation). It is helpful to have the system name shown as part of the supporting documentation.
- Provide supporting documentation for nonmeasurable menu items claimed and documentation proving that measures were obtained.

In February 2013, CMS published a document outlining expectations for supporting documentation for audits, including audits by Figliozzi (see the Resources section). EPs must do several things prior to attestation and during the attestation period to demonstrate meaningful use:

1. **Validate that the EHR system used for attestation is certified.** The ONC stated that EHR technology needs to be able to produce reports that provide information by measure to substantiate the meaningful use requirements. It is imperative that organizations obtain evidence that their EHR technology is certified and meets the requirements. It is recommended that providers obtain certification or assurance letters from their EHR vendors as evidence in the event of a CMS audit. In April 2013, the ONC revoked a certification for an ambulatory EHR system for the first time. On April 25, 2013, Carol Bean, director of the ONC's Office of Certification and Testing, stated in her blog that the office does not stop its auditing and monitoring efforts after a system receives its certification. Monitoring continues to determine if systems are meeting the requirements.

EPs should perform their own due diligence to test the accuracy of meaningful use reports prior to attestation.

2. **Test the certified EHR system prior to the attestation period.** Considerable testing of the certified EHR system should be performed before providers begin their first 90-day attestation period. It is not advisable to rely on the fact that the system was certified. Organizations should create detailed test plans for each measure and menu item that will be used for attestation. Every menu and core item should be tested for accuracy and consistent interpretation. Organizations should understand the intent of each menu and core measure and validate that the system's interpretation is in line with the requirements. The FAQ section of the CMS website provides resources to help EPs interpret these measures. However, even with these resources, organizations may choose to engage their legal counsel to determine the proper interpretations.

   The ONC has funded 62 Regional Extension Centers (RECs) to provide education, outreach, and technical assistance to help EPs select, implement, and "meaningfully use" certified EHR technology. While REC representatives can provide guidance and education, EPs should perform their own due diligence to test the accuracy of meaningful use reports prior to attestation. CHAN Healthcare has identified instances where the work performed by REC representatives did not include detailed testing of the integrity of reports generated from certified EHR technology, resulting in reporting inaccuracies and errors in report logic that had gone undetected.

   The extent of the testing prior to attestation will be dependent on the size of the physician practice and the level of resources available to the EP. In larger physician groups, the testing should be extensive in order to validate that the certified system is counting the patients correctly according to the CMS guidelines. Both "met" and "not met" instances should be tested to gain a full understanding of how the system counts each measure.

   The organization should seek out an appropriate party to aid in this testing, such as an internal audit group, finance department, or compliance department. CHAN Healthcare has provided this type of assistance to healthcare organizations both prior to and during the attestation period.

3. **Test the certified EHR system during the attestation period.** EPs should also consider testing their certified system during the attestation period. In the event of a CMS audit, organizations will need to prove that the numerators and denominators used for attestation are accurate. Testing during the attestation period will further aid organizations in proving their numbers. The degree of testing in this stage should be dependent on the size of the physician practice and the resources available as well as on how much testing was performed prior to the start of the attestation period.

Take Percentage-Based Measures

For stage one, there are 13 core and five menu percentage-based measures. For stage two, there are 17 core and three menu percentage-based measures. When testing the accuracy of the numerators and denominators, different factors have to be considered.

For numerators, the measures report each line item as either “met” or “not met.” Testing the accuracy of numerators should include reviewing the patient electronic chart to validate that each element was captured appropriately. For example, for the smoking measure, the chart should contain a date and identify the provider/nurse who checked the smoking status for patients who are older than 13.

Denominators require a different level of scrutiny. It is important to test the denominators for both accuracy and completeness. Some measures require unique patients, and other measures require that all visits be included. Organizations should validate that the denominators are accurate and include the correct patients. For accuracy of the denominators, it is important that all registration and scheduling systems interface with the EHR system. Performing a reconciliation of systems might identify visit types that were not included in the denominator logic (exceptions may occur when patients cancel appointments in the scheduling system). By performing this comparison, CHAN Healthcare audits have identified instances where patient visits were not included in the denominators.

Many of the percentage-based measures are interrelated, sharing a common denominator. For example, in stage one, the Maintain Problem List, Active Medication List, Medication Allergy List, and Record Demographics measures require inclusion of all unique patients seen by the EP during the EHR reporting period. When testing the accuracy of the denominators for these measures, organizations should compare all the measures side by side and expect the same patients to be included in each.

Similarly, the information for the Record Vital Signs and Record Smoking Status measures should coincide with the first group of measures, with the exception of patients that are excluded based on age. Reviewing these measures in aggregate will help verify that the denominators are accurate.

Take Yes-or-No Measures

There are five core and three menu measures in stage one and four core and three menu measures in stage two that are based on yes-or-no responses. According to the Office of Inspector General report, when conducting an audit CMS will look specifically for the following in support of the yes-or-no measures:

- Screen shots showing that required EHR technology functions were enabled for the duration of the reporting period
- Documentation showing that a security risk assessment was conducted
- The Office of Inspector General also states that CMS will have a difficult time obtaining sufficient evidence for the following yes-or-no measures:
  - Drug-drug and drug-allergy interaction checks
  - Clinical decision support rule
  - Drug formulary checks

CMS will accept screen shots or demonstrations as evidence for the yes-or-no measures. It is recommended that organizations provide additional proof that the measures are functioning as intended. For example, for the yes-or-no measure on patient lists, organizations should be able to provide an example of a generated report listing patients of the EP who have a specific condition.

Retain Documentation

EPs should retain electronic documentation that supports the numbers reported to CMS during attestation. Every EP should be able to provide detailed records of the numerators and denominators used for each measure. In addition, EPs should retain documentation support for the work done related to the yes-or-no measures.

Conclusion

An attestation submitted for a meaningful use incentive payment is viewed as a claim by the federal government. Inaccuracies in an attestation can expose organizations to potential liability under the *False Claims Act*. Therefore, great care should be taken before any provider attests for meaningful use payment. If errors are found in attestation, prompt disclosure by the EP is advised. EHR scope and requirements are changing, and it is imperative that providers keep up with the changes and adapt to them. Successful EHR implementation, and sustaining that implementation, depends on careful planning and testing.

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Resources

CMS EHR Incentive Programs website:
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

CMS guidance for supporting documentation for audits:
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHR_SupportingDocumentation_Audits.pdf

CMS meaningful use FAQs:
https://questions.cms.gov/faq.php?id=5005&rtopic=1979

CMS tip sheets:
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Meaningful_Use_Specialists_Tipsheet_1_7_2013.pdf
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[3] CMS provided this information to Steve Spearman, of advisory firm Health Security Solutions, in November 2014, nine months after he filed a *Freedom of Information Act* request. See slide show at "What You Need to Know About Meaningful Use Audits," HealthDataManagement.com, November 2014, http://www.healthdatamanagement.com/gallery/what-you-need-to-know-about-meaningful-use-audits-49183-1.html?utm_medium=email&utm_source=newsletter&ET=healthdatamanagement%3Ae3300959%3A3675750a%3A&st=email

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