Meaningful Use Program Faces Audits, Scrutiny

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Health information technology systems have supported the administrative functions of healthcare for more than a decade. Historically, these healthcare administrative systems primarily focused on performing fiscal transactions or supporting key ancillary departments. Widespread use of electronic health records (EHRs) to support the capture of clinical documentation, order entry, and clinical documentation improvement system functionality have only recently begun to reach wide implementation in healthcare organizations, moving healthcare providers closer to realizing the full benefits of EHR systems.

The recent Health Information Technology for Economic and Clinical Health (HITECH) Act has provided financial stimulus for the universal adoption of interoperable EHRs. This initiative, specifically the multi-stage "meaningful use" EHR Incentive Program, is the latest in a series of incentives that aim to foster improved outcomes and lower costs in US healthcare. The American Recovery and Reinvestment Act of 2009 (ARRA) seeks to provide monetary incentives to overcome some of the financial barriers that challenge medical practices and hospitals considering whether or not to purchase an EHR.

But the federal government has begun to better monitor just how and why incentives are issued to providers. As part of an OIG investigation into Medicare and Medicaid fraud, the agency recently sent a letter to a number of hospitals who have received EHR incentive payments asking them to complete a survey identifying EHR fraud and abuse vulnerabilities. Only hospitals that received Medicare incentive payments for meeting meaningful use between January 1, 2011 and March 31, 2012 were asked to complete the survey. The survey is just one part of the overall OIG Work Plan for Fiscal Year 2013.

The OIG plans to review Medicare and Medicaid incentive payments made to eligible healthcare professionals and hospitals for implementing EHRs and to review the Centers for Medicare and Medicaid Services' (CMS) precautions designed to prevent erroneous incentive payments.

EHRs Bring Increased Regulation, Scrutiny

Choosing to implement EHR technologies subjugates healthcare providers to increased regulation and scrutiny under the HITECH Act, which governs the functionality and compliance of "certified EHR systems" with the required security safeguards of the HIPAA security rule. Further complicating the current environment is the ongoing paradigm shift caused by the transition from paper to electronic medical records.

Implementing EHRs introduces new forms of potential risk and liability for healthcare providers. Potentially, one of the largest areas of risk and liability resulting from the use of EHRs is in the milieu of health information exchange and meaningful use incentives. Healthcare providers grasping the opportunities afforded by these two dynamic domains of health IT must meet head-on the potential risks associated with privacy and security. The OIG review will include Medicare incentive payment data from 2011 to identify payments made to providers who should not have received incentive payments (i.e., those not meeting selected meaningful use criteria). In addition, the audits will conclude whether incentive payments issued to Medicaid providers to purchase, implement, and operate EHR technology were claimed in agreement with Medicaid requirements. CMS' plans to administer incentive payments for the duration of the program and the actions taken to resolve erroneous incentive payments will also be assessed.

Recent studies reveal that hindrances to achieving success with the EHR are associated with confronting the design and functionality of the physician history and physical (H&P). To address the design and functionality problems of the H&P, medical practices must insist that systems be "operable as well as interoperable." A noteworthy number of EHR systems fail to consider the significance of medical necessity in the functionality of their E/M coding engines. For the sake of expedience, these same EHR systems integrate non-compliant shortcut tools for manipulating various levels of care. Consequently, these systems further obscure the capture of clinical documentation by utilizing documentation shortcut capabilities such as "copy

and paste," "copy and forward," "documentation by exception," and other mechanisms that initiate an increased predilection to create non-specific H&P documentation issues.

A 2007 report by the Department of Health and Human Services (HHS) and the Office of the National Coordinator for Health IT (ONC) revealed that the overall influence of poorly designed and developed defaults, templates, macros, and copying data capture tools and functionality result in non-compliant records that featured "cloned documentation." This sets the stage for potential fraud and abuse.

AHIMA's 2007 "Resolution on Quality Data and Documentation in the EHR" stressed the magnitude of compliance, meaningful documentation, and data integrity of the electronic H&P. The resolution document recognizes that while "EHRs need to yield quality documentation and data in order to support patient care, health information exchange, quality management, compliance and other secondary uses of data…[these] systems may contain design features and functions that can potentially contribute to suboptimal quality of healthcare data and documentation." The paper determines that entities that are either advancing or executing EHRs should ensure that the functionality of their EHR system supports quality care, valid documentation, and data integrity. The document additionally underscores "that HIM professionals collaborate with clinician users of the EHR, including training, to ensure that the best quality data and documentation is maintained for patient care, quality management, compliance, health information exchange, and secondary purposes."

Legislators Call for Action

An October 4, 2012 letter from four US senators to Kathleen Sebelius, secretary of HHS, raised doubts regarding the current management of the stage 2 meaningful use rules. The letter noted changes between the proposed 2009 stage 1 rules and stage 2 rules that resulted in weaker measureable compliance requirements for interoperability and fraud and abuse tracking. For example, proposed stage 1 meaningful use rules set electronic prescribing and medication reconciliation compliance thresholds at 75 percent and 80 percent, while the final stage 2 rules set this threshold at just 50 percent. In addition, failure to achieve stage 1 comprehensive interoperability leaves our healthcare system trapped in information silos. Over four years into the meaningful use rules-and nearly $10 billion spent-and many industry experts feel healthcare is no closer to achieving interoperability.

The senators conclude their letter by urging HHS to:

- Immediately suspend the distribution of incentive payments until HHS promulgates universal interoperable standards. Such a move would also require a commensurate delay of penalties for providers who choose not to integrate health IT into their practice.
- Significantly increase expectations for meaningful users. For example, the current measure requirement for providing a summary transfer in an electronic format when a patient moves to a different care setting is currently only required 10 percent of the time. Further, only requiring radiology and laboratory orders to be electronic 30 percent of the time and medication reconciliation and electronic prescribing to occur just 50 percent of the time would be inadequate.
- Take steps to eliminate the subsidization of business practices that block the exchange of information between providers.

Benefits of Meaningful Use Questioned

Critics of the meaningful use incentive program say that the current drive to quickly introduce electronic records may be resulting in increased Medicare spending with little improvement in patients' health. The OIG's report did not address patient care.

Many stakeholders within the industry say the speed with which systems are being developed and implemented by hospitals and doctors has also led to a lack of consensus concerning how the records should be used and increasing concerns about their overall accuracy.

Although there is little disagreement over the potential benefits of electronic records in reducing duplicative tests and avoiding medical errors, critics increasingly argue that the federal government has not devoted enough time or resources to making certain the money it is investing is being well spent.

Once accomplished, the widespread adoption of EHRs will represent a fundamental change in how providers use, collect, and document clinical information. This paradigm shift will transform not only how medicine is practiced, but also how patients interact with the healthcare system. The promise of interoperable electronic health record systems promotes an environment where complete documentation and timely access to patient information facilitates sound clinical decision making, improved outcomes, and lower costs.

In response to the inspector general's recommendations, Medicare and ONC are working to improve the process of certifying meaningful use-approved EHR systems. In addition, Medicare and ONC have developed plans to audit payments made since the program started in 2011, and plans are under way to issue additional guidance for providers.

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