Medicare’s Electronic Health Records Incentive Program—Overview

American Recovery and Reinvestment Act

- Goal » To promote use of EHR technology by health care professionals and hospitals.
- Payments began in May 2011 and will continue through 2016
- CMS estimates it has paid out $7.4 billion through February 2013
Qualifying for Incentives

- Possess certified EHR technology and
- Meaningfully use that certified EHR technology
  - computerized provider order entry
  - e-prescribing
  - exchange of key clinical information

Meaningful Use Measures

- Stage 1
  - Professionals:
    - 15 core objectives + 5 of 10 menu objectives
    - 20 total objectives
  - Hospitals:
    - 14 core objective + 5 of 10 menu objectives
    - 19 total objectives

Meaningful Use Measures

- Yes/No measures
  - Check the box
- Percentage based measures
  - Provide numerical totals for the numerator and denominator of each measure
    - E.g., for e-prescribing measure, EPs must report both the number of prescriptions submitted electronically and the total number of prescriptions.
Stages of Meaningful Use

- Stage 1:
  - Data capturing and sharing
- Stage 2:
  - Advanced clinical processes
- Stage 3:
  - Improved outcomes

Meaningful Use Measures

Required criteria objectives include:

- Use computerized prescriber order entry for medication orders
- Generate and transmit prescriptions electronically
- Maintain an up-to-date problem list of current and active diagnoses
- Maintain an active medication list
- Record smoking status for patients age 13 and older
- Report quality measures to CMS and the states
- Provide clinical summaries for patients for each office visit

Menu objectives include:

- Implementation of drug-formulary checks
- Record of advanced directives for patients age 65 or older (EH and CAH only)
- Incorporate clinical lab test results into certified EHR technology as structured data
- Send reminders to patients per patient preference for preventive/follow-up care (EPs only)
- Use certified EHR technology to identify patient-specific education resources and provide to patient, if appropriate
What’s Ahead

- Starting in 2014, providers participating in the EHR Incentive programs who have met Stage 1 criteria for two or three years will need to meet meaningful use Stage 2 criteria.
- 2015 - Penalties if no meaningful use of EHR-
  - Medicare reimbursement reductions

CMS Audit Initiative

- 5% of Participants to be Audited
  - OIG criticism – lack of CMS oversight
  - CMS to audit Medicare and dually eligible (Medicare and Medicaid) providers
  - States to audit Medicaid providers participating in the Medicaid E.H.R. Incentive Program
CMS Pre-payment Audits

- Pre-payment edits already in place to check
  - eligibility, reporting and payment
- Additional pre-payment audits to focus on attestations submitted during/after January 2013
  - Random
  - Targeting suspicious or anomalous data

Supporting Documentation

- Providers will need to submit supporting documentation for both pre- and post-payment audits
- Documentation must support
  - meaningful use and
  - clinical quality measure data submitted

Supporting Documentation

- Important: save all source material
  - paper and electronic documentation
- for at least six years from attestation
  - or if hospital cost report data, follow current retention process
Supporting Documentation

- Documentation that supports the values entered in the attestation module for clinical quality measures
- Documentation that support payment calculations (hospitals)
- Reports directly from the certified E.H.R. system

Primary documentation should include:
- The numerators and denominators for the measures
- The time period the report covers
- Evidence to support that it was generated for that EP, eligible hospital, CAH
  - Identified by NPI, CCN, provider name, practice name
- Documentation that demonstrates how the data was accumulated and calculated.

Source Documents

- Audit logs
- Screen shots
- Letters received from public health agencies
- Any summary of the data that supports the information entered during attestation
For Example . . . Documentation for Non-percentage Based Objectives

<table>
<thead>
<tr>
<th>Meaningful Use Objective</th>
<th>Audit Validation</th>
<th>Suggested Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug-Drug/Drug-Allergy Interaction Checks and Clinical Decision Support</td>
<td>Functionality is available, enabled, and active in the system for the duration of the EHR reporting period</td>
<td>One or more screenshots from the certified EHR system that are dated during the EHR reporting period selected for attestation</td>
</tr>
</tbody>
</table>

For Example . . . Exclusions

<table>
<thead>
<tr>
<th>Meaningful Use Objective</th>
<th>Audit Validation</th>
<th>Suggested Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusions</td>
<td>Documentation to support each exclusion to a measure claimed by the provider.</td>
<td>Report from the certified EHR system that shows a zero denominator for the measure or otherwise documents that the provider qualifies for the exclusion.</td>
</tr>
</tbody>
</table>

CMS Audit Process

- Initial request letter
  - Sent electronically by Figliozzi and Company from a CMS email address
- On-site review (in some cases)
  - Demonstration of the E.H.R. system may be required
- Audit Determination Letter
  - Success in meeting meaningful use or
  - Recoupment of payment
Audit Process

- Appeals
  - For general appeal questions/updates on the status of pending appeals email: https://questions.cms.gov/newrequest.php
  - For info on how to file appeals and the status of pending appeals, call 888-734-6433
- Timeframes
  - Meaningful use – must appeal within 30 days after date of recoupment demand letter
  - Incentive payment calculation – must appeal within 60 days after determination

Audit Process

- Fraud referrals
  - "Several providers" referred for possible fraud investigation
  - Not discovered through audit process, but reported to CMS

Common Problems

- Data security risk assessments – not being performed
- Lack of documentation to support yes/no meaningful use criteria
Responding to Audits

**DO...**
- Collect all source records
- Respond timely

**DON'T!**
- Change records
- Backdate records or –
- Otherwise create, alter or destroy any records.
  - "filling in" an incomplete record can result in criminal charges

---

**Responding to Audits**

**General Guidelines**
- Don’t assume the audit findings are correct.
- Do file appeals when appropriate.

---

**Steps You Can Take To Prevent Negative Outcomes**

- Stay informed of Medicare and Medicaid Regulations
- Perform regular reviews & risk assessments
- Ensure staff are adequately trained
- Know what the hot audit issues are
The Outcome You Want

Potential Legal Liability

The Federal False Claims Act

- Key Provisions for Health Care Providers:
  - Any person who **knowingly** presents or causes to be presented, a false **claim** for payment or approval
  - Any person who **knowingly** makes, uses, or causes to be made or used, a false record or statement material to a false **claim**
  - Any person who **knowingly** conceals or knowingly and improperly avoids or decreases an **obligation** to pay or transmit money or property to the Government
The Federal False Claims Act

What is “Knowingly”?
- Actual knowledge that the information is false;
- Deliberate ignorance of the truth or falsity of the information;
- Reckless disregard of the truth or falsity of the information.

No proof of a specific intent to defraud is required.

Other Key Definitions
- Claim: includes a request for payment presented to the U.S. government or to a contractor if the money or property is to be spent or used on the government’s behalf, and if the government provides any portion of the money requested; or will reimburse such contractor any portion of the money requested.
- Obligation: includes an established duty arising from the retention of any overpayment.

Consequences
- Treble damages
- Per claim penalty of $5,500 to $11,000
- Exclusion from Federal and state health care programs (including Medicare and Medicaid).
Overpayment Reporting Requirement

Health Care Reform 2010
- Section 6402 of the Patient Protection and Affordable Care Act (ACA)
  - Established a new statute (42 U.S.C. 1320a-7k) defining and requiring disclosure/refunding of overpayments.
  - Effective March 2010

Overpayment Reporting Requirement

- Overpayment: Any Medicare and Medicaid funds that a person receives or retains to which the person, after applicable reconciliation, is not entitled under the Medicare or Medicaid laws.
- Person: a provider of services, supplier, Medicaid managed care organization, Medicare Advantage organization or Part D sponsor.
  - does not include a beneficiary.

Overpayment Reporting Requirement

- Overpayments must be reported and returned to the appropriate party (i.e., DHHS, the State, an intermediary, a carrier, or a contractor), at the correct address, and
- Must include a written explanation of the reason for the overpayment.
Timing

- An overpayment must be reported and returned by the later of:
  - 60 days after the date on which the overpayment was identified, or
  - the date any corresponding cost report is due, if applicable.

Potential Liability

- Any overpayment retained after the deadline for reporting/returning is an “obligation” for purposes of the Federal False Claims Act.
  - Treble damages
  - $5,500 - $11,000
  - Exclusion

Criminal Penalties

- The Criminal Health Care Fraud Statute prohibits the knowing and willful execution, or attempted execution, of a scheme or artifice to:
  - defraud any health care benefit program; or
  - obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program;
- in connection with the delivery of or payment for health care benefits, items, or services.
Criminal Penalties

- Penalties for violating the Criminal Health Care Fraud Statute may include:
  - fines
  - imprisonment, or
  - both

---

Stay Informed

- CMS Website
  - Educational Resources
  - FAQ Database
  - Tool kits
  - Tip sheets
  - Listserv