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Five Things Hospitals Can Do Now to Protect Themselves From EHR Incentive Payment Pitfalls



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A June 2017 audit by the Department of Health and Human Services Office of Inspector General (HHS-OIG) reported that the Centers for Medicare & Medicaid Services (CMS) inappropriately paid as much as 12% of incentive payments to promote the adoption of the "meaningful use" of electronic health records (EHRs). In its audit, OIG estimated that CMS issued as much as $729 million in inappropriate EHR incentive payments to "eligible professionals," (EPs) including physicians, dentists, and other practitioners.

Although OIG's June audit did not examine payments to hospitals, the report provides an early indication that hospitals' receipt of incentive payments for the adoption and meaningful use of EHRs, which comprised a significant portion of the $36 billion in Medicare and Medicaid EHR incentive program payments from 2011 to 2016 under the 2009 Health Information Technology and Clinical Health (HITECH) Act, may likely become a focus of OIG's attention in the near future.

Meaningful use audits are not new in the EHR incentive payment landscape. But with OIG applying heightened scrutiny to such payments, we provide some background and offer five suggestions for what hospitals can do now to ensure that their EHR is compliant with the meaningful use requirements associated with EHR incentive payments. Those suggestions are detailed below but the critical compliance steps are to:

- Review supporting documentation regarding EHR incentive payments;

- Review the periods for which "meaningful use" was reported; and
- Review whether the certified EHR technology was used sufficiently.

Background

OIG's June audit is not the first time that OIG has urged CMS to probe EHR incentive program payments for evidence of inappropriate payments or fraud. As early as November 2012, OIG warned that CMS would "face obstacles" in overseeing the Medicare EHR incentive program because CMS lacked strong safeguards for the program. OIG followed up in December 2013 with a report warning that hospitals had not implemented all the recommended safeguards in their EHR technology.

In January 2014, OIG recommended that CMS probe EHR audit logs to detect fraudulent cloning, or copying, of patient records, as well as over-documentation in individual patient records. At the time, OIG observed that only 44% of the hospitals it studied had EHRs that met the standards for acceptable audit logs under the "meaningful use" requirement for EHR incentive payments. In fact, a 2014 OIG audit found that Louisiana had made $4.4 million in incorrect EHR incentive payments to thirteen hospitals—and that fully 80% of the hospitals it analyzed in the state had failed to comply with EHR regulations.

In February 2014, the U.S. Attorney's Office for the Eastern District of Texas, in conjunction with the OIG's Dallas regional office, announced the indictment of the former CFO of a Texas regional hospital center for claiming wrongful EHR payments. OIG's 2015 Work Plan included reviewing EHR incentive payments and assessing CMS's plans for oversight. In FY2016, OIG released reports and corrective actions on several Medicaid EHR incentive program overpayments, including from the Virginia, California, and Arizona state agencies. OIG again included monitoring Medicare EHR payments in the November 2016 update to its 2017 Work Plan, from which OIG's June audit presumably resulted.

Whistleblower cases under the federal False Claims Act (FCA) involving improper EHR payments have also begun to be made public. In late May, the Department of Justice announced a $155 million settlement to an FCA suit brought by a whistleblower who was formerly an employee of the New York City health care information division alleging that eClinicalWorks, one of the nation's largest vendors of EHR software, misrepresented its software's capabilities and paid kickbacks to certain customers to promote its product. Both eClinicalWorks and its CEO, Chief Medical Officer, and COO as individuals were jointly and severally liable for paying the settlement amount.

Although an official with OIG later confirmed that CMS was not planning to pursue FCA claims against eClinicalWorks' clients, the case illustrated the potential risks associated with false claims. False Claims Act litigation, of course, brings with it the prospect of treble damages, attorney's fees, and the cloud of prolonged litigation, as well as the daunting prospect that a parallel criminal investigation could lead to exclusion, suspension, or debarment from reimbursement from federal programs. Since 2009, FCA cases have netted the government nearly $4 billion per year on average, with over $31.3 billion in fines during that time—the vast majority coming from healthcare-related cases.

One difficulty surrounding EHR incentive payments is that under the Affordable Care Act, even inadvertently inaccurate attestations could become the basis for false claims should a hospital fail to repay overpayments within 60 days of their identification.

Steps hospitals can take now

With that background in mind, we offer five steps hospitals can take now to better protect themselves from EHR incentive overpayment-related liability:

1. Review supporting documentation regarding EHR incentive payments.

OIG's June audit report examined whether incentive payment recipients were meeting the program's meaningful use requirements. To receive an incentive payment, the recipient must attest that it meets those requirements, which differ based on the period in question (as currently numbered, 42 C.F.R. § 495.20 for periods before 2015, 42 C.F.R. § 495.22 for periods from 2015 through 2017, and 42 C.F.R. § 495.24 for 2018 onward). Some of the meaningful use criteria are one-time actions (yes/no measures) while others require meeting percentage thresholds. There are separate lists of meaningful use criteria for EPs and hospitals, but the approach to certifying compliance is the same.

The OIG's audit focused on attestations from EPs (not hospitals). OIG reported that 12% of the EPs it audited demonstrated "insufficient attestation support." For example, OIG found that several of the EPs it audited could not provide a security risk assessment, while others could not provide a generated list or provide patient encounter data.

At a minimum, under the meaningful use regulations all participants in the incentive payment program must keep documentation supporting their demonstration of meaningful use for six years. Historical documentation can be notoriously difficult to maintain, but hospitals would be well served to do a sample review of their documentation back to the initial periods in which they participated in the EHR incentive payment program to ensure that they have maintained sufficient documentation to demonstrate the required meaningful use.

2. Review the periods for which "meaningful use" was reported.

OIG's June audit report also identified that certain participants had reported inappropriate periods for meaningful use. In the OIG audit, at least one audited EP had claimed meaningful use for a full year, even though the EP's data supported only 90 days of meaningful use. That will not do.

CMS defines the "EHR reporting period" somewhat differently for hospitals than for EPs. The periods change based both on the year in which the hospital received an incentive payment, as well as the time in the program and stage of development the hospital had demonstrated; significantly, the reporting periods typically extend from 90 days in the first year of participation to a full year in subsequent years. Hospitals need to evaluate the support for their demonstrated use of EHR against this sliding scale. It is not unusual for the degree of sophistication and level of use of EHR technology to change dramatically over the course of several years. A mismatch in use and program requirements could result in noncompliance.

3. Review whether the certified EHR technology was used sufficiently.

OIG's audit also uncovered a glaring inadequacy: at least one audited EP had less than 20% of patient encounters at a facility with certified EHR technology, when the meaningful use regulations require an EP to conduct at least 50% of his or her patient encounters at facilities with such technology. While this particular threshold does not apply to hospitals, other percentage thresholds are applicable, and it would not be surprising to see an OIG audit of a hospital's compliance with its particular percentage thresholds for meaningful use.

4. Consult counsel promptly to determine whether overpayments occurred.

Hospitals should involve counsel early in exploring whether their attestations involving EHR incentive payments potentially resulted in overpayments. Determining potential overpayment liability involves addressing both technical and legal questions with which experienced counsel can prove invaluable, both in working to understand the historical issues and to provide accurate and timely advice. The 60-day repayment trigger under the Affordable Care Act makes early involvement of counsel even more important.

5. Work with counsel to ensure ongoing compliance with EHR requirements.

Issues surrounding the use of electronic health records and other medical technology will only continue to grow as technology's use in federal payment systems becomes more essential. Counsel can assist hospitals in reviewing their compliance systems to ensure that they identify and correct issues early. If a hospital has not undergone a recent compliance system review with counsel, the June OIG report on EHR incentive payments offers a timely reminder to do so.