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Navigating Meaningful Use and the EHR Incentive Programs

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Executive Summary

The American Recovery and Reinvestment Act of 2009 (ARRA) (P.L. 111-5) established the concept of the "meaningful use" (MU) of electronic health records (EHRs). Specifically, Division B, Title IV of ARRA (the Health Information Technology for Economic and Clinical Health (HITECH) Act) created Medicare and Medicaid provider incentive programs to encourage the adoption and meaningful use of certified EHR technology by providers. ARRA gave the HHS Secretary discretion in determining measures of meaningful use, but stated that meaningful use should include the electronic prescribing of medications, provide for the electronic exchange of health care information, and involve the reporting of clinical quality measures (CQMs).

HHS developed the Medicare and Medicaid EHR incentive programs, which target two groups of providers: (1) eligible professionals (EPs) and (2) eligible hospitals and critical access hospitals (CAHs). Under the Medicare incentive program, EPs include doctors of medicine, osteopathy, dental surgery, dental medicine, podiatry, and optometry, as well as chiropractors. In addition to doctors of medicine and osteopathy, the Medicaid EP incentive program includes nurse practitioners, certified nurse midwives, dentists, and physician assistants who furnish services in a federally qualified health center (FQHC) or a rural health clinic (RHC) that is led by a physician assistant. Eligible hospitals under the Medicare incentive program include subsection (d) (basic acute care) hospitals in the 50 states and the District of Columbia that are paid under the inpatient prospective payment system (IPPS); CAHs; and Medicare Advantage hospitals. Hospitals eligible for the Medicaid incentive program comprise acute care hospitals, including CAHs and cancer hospitals, with at least a 10 percent Medicaid patient volume, and children's hospitals, with no Medicaid patient volume requirement.

This paper will provide a summary of the EHR incentive programs' goals and requirements, including a discussion of the various program stages and provider incentives and penalties, as well as a history of the program. It will then discuss provider concerns, including compliance with the programs' timelines, as well as government concerns, such as interoperability. Finally, it will note potential developments that providers could be faced with in the not-so-distant future.

Stages

HHS divided the EHR incentive programs into three stages. According to the Office of the National Coordinator for Health Information Technology (ONC), each stage is intended to advance a different goal in the meaningful use process—Stage 1 is intended to cover data capture and sharing, Stage 2

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involves advance clinical processes, and Stage 3 should result in improved outcomes. This has evolved to mean that Stage 1 involved the adoption of EHR technology and Stage 2 will focus on the exchange of data between providers. Stage 3 may also focus on interoperability, among other improvements.

On July 28, 2010, the ONC and CMS published the Stage 1 Final Rules. The ONC Stage 1 Final Rule, which detailed the criteria for EHR technology (75 FR 44590), became effective August 27, 2010. The CMS Stage 1 Final Rule, which established criteria that providers must meet to receive incentives under Stage 1 (75 FR 44314), became effective September 27, 2010. Two years later, on September 4, 2012, the ONC and CMS published the Stage 2 Final Rules (77 FR 54163 and 77 FR 53968, respectively). The ONC Stage 2 Final Rule included specifications for updated 2014 Edition health record technology that differed from the previous criteria and became effective October 4, 2012. The CMS Stage 2 rule, which established the criteria that providers must meet in order to receive incentives under Stage 2, was effective November 5, 2012, although the definition of "meaningful user" was effective the date of publication. The agencies have not yet published Stage 3 Final Rules. However, they did announce a revised timeline on December 6, 2013 (see below).

Incentives and Penalties

Providers participating in the Medicare incentive program can receive incentive payments for each year of participation, up to five years. EPs may receive up to a total of $44,000. However, EPs enrolled in the program who fail to demonstrate meaningful use will be required to pay penalties, or "payment adjustments," beginning in 2015. Penalties increase by 1 percent each year. In the first year, penalized EPs would only receive 99 percent of the Medicare physician fee schedule amount; if, by 2018, less than 75 percent of EPs have become meaningful users, the adjustment will change by 1 percent each year to a maximum of 5 percent, meaning that penalized EPs would receive only 95 percent of the Physician Fee Schedule (PFS) amount. EPs participating in the Medicaid incentive program can receive incentive payments for up to six years

Years in Which Incentive Payments Are Available and When Penalties Will Be Assessed in the Medicare and Medicaid Electronic Health Record (EHR) Programs

Notes: Program years are determined and awarded on a fiscal year basis for hospitals and on a calendar year basis for professionals. Professionals may not receive incentive payments under both the Medicare EHR program and the Medicaid EHR program during the same year; they must choose one of the two programs under which they will participate. In contrast, hospitals may qualify for incentive payments under both programs during the same year.

a If Medicaid providers also treat Medicare patients, they are required to meet the Medicare EHR program's requirements from 2015 onward to avoid penalties from the Medicare EHR program.

b In the Medicare and Medicaid EHR programs, professionals include doctors of medicine and dental surgery. In the Medicaid EHR program, professionals also include nurse practitioners, certified nurse-midwives, and certain physician assistants.

Source: GAO-14-207: Health Information Technology for Economic and Clinical Health Act

and $63,750, although all six years need not be consecutive. EPs in the Medicaid incentive program will not receive penalties unless they also treat Medicare patients.

Incentives for hospitals are generally linked to a hospital's annual discharges and Medicare or Medicaid share attributable to the appropriate EHR program, although the incentive for CAHs in the Medicare incentive program is generally based on a CAH's Medicare share and reasonable costs incurred for the purchase of depreciable assets required to administer certified EHR technology. Eligible hospitals that do not meet EHR program requirements will generally receive a reduction in the Medicare Inpatient Prospective Payment System increase by 25 percent annually, with a maximum cumulative reduction of 75 percent.

CMS may grant hardship exemptions to EPs who are unable to comply with EHR requirements on a case-by-case basis pursuant to 42 U.S.C. section 1395w-4(a)(7)(B). Possible reasons include difficulties with internet broadband and natural disaster. There is no sunset date on penalties.

Attestation

Each stage of meaningful use requires providers to meet a particular number of specified core objectives and a specified number of menu objectives, chosen from a wider list, as well as report on clinical quality measures as described below. Providers must then attest to demonstrating meaningful use. Some attestation categories merely require providers to answer yes or no, stating that they have or have not achieved a particular goal, whereas other attestations require providers to make calculations, providing numerators and denominators. Denominators are calculated as either the total number of patients seen or admitted during the EHR reporting period, regardless of whether their records are kept using EHR technology, or the actions or subsets of patients seen or admitted during the EHR reporting period, only if their records are kept using certified EHR technology. Table 3, beginning on page 44376 of the July 28, 2010 Final Rule listed above, identifies the appropriate type of measure, yes/no or numerator/denominator, for each measure.

Stage 1

Providers attesting to Stage 1 meaningful use must meet certain criteria.

EPs must:

- meet 14 core objectives;
- meet five objectives chosen from a list of 10 menu objectives; and
- report on six clinical quality measures, consisting of—
  - three required core measures or three alternative core measures, and
  - three additional quality measures selected from a list of 38 quality measures.

Eligible hospitals and CAHs must:

- meet 13 required core objectives;
- meet five of 10 menu objectives; and
- report on 15 required clinical quality measures.

Each stage of meaningful use requires providers to meet a particular number of specified core objectives and a specified number of menu objectives…

Examples of core objectives required for both groups include the implementation of drug-drug and drug-allergy interaction checks, the recording of demographics for more than 50 percent of all patients seen or admitted, and the use of coordinated physician order entry (CPOE) for more than 30 percent of all patients seen or admitted with at least one medication in their medication list. CQMs for EPs range from adult weight screening and follow-up to asthma pharmacologic therapy. CQMs for eligible hospitals and CAHs are less varied, and include a number of measures involving ischemic stroke and emergency department throughput.

In their first year of Stage 1 meaningful use in the Medicare incentive program, providers must meet requirements for a 90-day period. They must then meet the requirements for the next full year. Providers in the Medicaid incentive program, on the other hand, need only demonstrate that they have adopted, implemented, or upgraded certified EHR technology in their first year of participation and do not need to demonstrate meaningful use of the technology until their second year of participation.

The first providers entered Stage 1 in 2011. The last year that providers may enter Stage 1 of the Medicare incentive

program is 2014. The last year that providers may enter Stage 1 of the Medicaid incentive program is 2016.

Stage 2

Those eligible hospitals and CAHs that have completed Stage 1 entered Stage 2 in October 2013 (fiscal year (FY) 2014), whereas EPs that have completed Stage 1 entered Stage 2 in January 2014 (calendar year (CY) 2014). In 2014, all providers, whether they are engaged in Stage 1 or Stage 2, must only demonstrate meaningful use for a three-month EHR reporting period. This is fixed to the CY for EPs and to the FY for eligible hospitals and CAHs in the Medicare incentive program to align with other CMS quality measurement programs, including the Physician Quality Reporting System (PQRS) and Hospital Inpatient Quality Reporting (IQR). This fixed period will allow providers who must upgrade to 2014 certified EHR technology time to do so. Providers must demonstrate meaningful use for the entirety of the subsequent year. Providers entering Stage 2 in other years must demonstrate meaningful use during their first year. Those providers who are only eligible for Medicaid EHR incentives may choose any three-month period.

During Stage 2, EPs enrolled in the Medicare incentive program must:

- meet 17 core *objectives*;
- meet an additional three menu objectives chosen from a list of six; and
- report on 9 of 64 CQMs.

Eligible hospitals and CAHs in the Medicare incentive program must:

- meet 16 core objectives;
- meet three menu objectives, also chosen from a list of six; and
- report on 16 of 29 CQMs.

In addition, all providers must select CQMs from three of six key health care policy domains, including: patient and family engagement, patient safety, care coordination, population and public health, efficient use of healthcare resources, and clinical processes/effectiveness.

Many of the core objectives from Stage 1 remain, but the thresholds have been raised. For example, in Stage 2, EPs and eligible hospitals must record demographics for more than 80 percent of patients seen or admitted, as opposed to the more than 50 percent required in Stage 1. More than 60 percent of medication, 30 percent of laboratory, and 30 percent of laboratory orders must be recorded using CPOE, as opposed to the more than 30 percent of medication requirement in Stage 1. Stage 2 also introduced new objectives, many of which are included as menu objectives, which emphasize the exchange of data between providers to improve patient care. For example, for more than 10 percent of transitions or referrals, EPs and eligible hospitals must provide a summary of care record to the second provider electronically.

Stage 3

Stage 3, which will raise thresholds even further, is scheduled to begin in 2017. No rules related to Stage 3 have been published as of yet, although CMS and the ONC anticipate publishing proposed rules regarding Stage 3 and the 2017 Edition of ONC standards and certification criteria in the Fall of 2014. The ONC's Health IT Policy Committee recently suggested to CMS that Stage 3 include 19 measures that encompass clinical decision support, patient engagement, care coordination, and population health management.

Concerns

The ONC overall is pleased with the progression of the EHR incentive programs. More than 220,000 EPs and 3,000 eligible hospitals achieved Stage 1 meaningful use requirements. Even more qualified for Medicaid incentive payments for the adoption, implementation, or upgrading to certified EHRs. As of May 2013, more than 293,000 EPs—more than half of those achieving Stage 1 requirements—and 3,900 eligible hospitals—nearly 80 percent—received incentive payments. A November 2013 CMS data brief suggested that rapid progress was made, as it reported that 82 percent of EPs had active registrations in the incentive programs and 63 percent had received incentive payments. It should be noted that participants in the Medicaid Incentive Program, as opposed to the Medicare Incentive Program, need only demonstrate that they have adopted, implemented, or upgraded certified EHR technology in their first year of participation in Stage 1 to receive an incentive and do not need to demonstrate meaningful use of the technology until their second year of participation. The CMS data brief also indicated that 93 percent of eligible hospitals were actively registered in the EHR incentive programs and 86 percent had received an incentive payment for either

demonstration of meaningful use or the adoption, implementation, or upgrading of an EHR system.

However, concerns remain. A March 2014 report from the Government Accountability Office noted that, within the 36 states that had determined what providers would receive incentives for the 2012 Medicare EHR programs plan year at the time of the GAO analysis, 16 percent of professionals and 10 percent of hospitals participating in 2011 chose not to participate in 2012. An even higher number of Medicaid EHR program participants chose not to continue to participate in 2012: 61 percent of EPs and 36 percent of eligible hospitals. That discrepancy is easily explainable, as Medicaid providers are not required to participate in consecutive years to maximize payments, there are no penalties for nonparticipation, and they are only required to demonstrate adoption of EHR technology, as opposed to meaningful use in their first year of participation. However, a sample of providers from both the Medicaid and Medicare EHR programs who chose not to continue suggested that providers did not know that they were required to continue or did not know the deadline for submission of information; some found it difficult to move from a 90-day reporting period to a one-year reporting period, and others, who had switched EHR vendors, were not ready to participate.

Overall, the GAO found that participants in Stage 1 tended to exceed reporting thresholds, suggesting they would experience success with Stage 2. However, providers found certain optional or less stringent measures involving the exchange of information, which are mandatory or more stringent in Stage 2, challenging. For example, less than 10 percent of hospitals and less than 15 percent of EPs in 2011 and 2012 reported on providing a summary of care document for each transition of care or referral.

The GAO recommended that CMS and the ONC develop a strategy to ensure that clinical quality measures reported via EHRs are reliable and develop performance measures to assess and improve the outcome of EHR programs, including effects on health care quality, efficiency, and patient care, as opposed to simply measuring adoption and meaningful use. While HHS agreed with the importance the goals highlighted by the GAO, it neither agreed nor disagreed with its recommendations. Despite its general satisfaction with progress so far, even the ONC acknowledges the existence of certain obstacles in the way of meaningful use: interoperability of EHR systems and disparities in implementation between urban and rural eligible hospitals and CAHs and small and large EP practices.

Stage 2 Timeline

Providers have repeatedly expressed concerns about their ability to comply with the Stage 2 timeline. A chief concern is the dearth of certified EHR systems. In order to achieve Stage 1 meaningful use and successfully report CQMs, providers that engaged in meaningful use in 2011, 2012, and 2013 had the option of utilizing 2011 certified EHR systems or using technology certified to the 2014 Edition EHR certification criteria that met the base EHR definition. Beginning with FY or CY 2014, depending on the provider type, providers in all stages of meaningful use must utilize 2014 certified EHR technology. Due to the limited number of vendors with certified systems, providers are facing lengthy waiting lists to have systems installed or upgraded. According to both the American Medical Association (AMA) and the American Hospital Association (AHA), as of July 17, 2013, only nine 2014 inpatient EHRs, produced by six vendors, had been certified. As of August 21, 2013, the Medical Group Management Association (MGMA) and its affiliate, the American College of Medical Practice Executives (ACMPE) reported that there were 75 products and 21 EHRs certified to 2014 criteria.

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The National Ambulatory Medical Care Survey (NAMCS) conducted by the Centers for Disease Control and Prevention's National Center for Health Statistics from February through June 2013 suggested that providers' EHR systems left them ill-prepared to demonstrate meaningful use. Data revealed that 69 percent of physicians intended to participate in the Medicare or Medicaid EHR incentive programs

in 2013; however, only 19 percent had EHR systems capable of supporting 14 of the 17 Stage 2 Core Set objectives. Demonstration of meaningful use actually requires meeting all 17 of those objectives. The results also revealed geographic variations in the adoption of EHR systems, with the adoption of basic EHR systems ranging from 21 percent in New Jersey to 83 percent in North Dakota.

Based on attestation data available to the ONC as of July 31, 2013, 66 percent of EPs and 64 percent of eligible hospitals that attested to Stage 1 used primary vendors that had some type of 2014 edition product as of August 2013. However, this does not mean that the providers actually used the certified 2014 EHR system in their attestations.

A study of EHR adoption and meaningful use achievement published in *Medical Care* in February 2014 identified the challenges faced by primary care providers serviced by the ONC's Regional Extension Centers (RECs), which were created to aid small local providers in implementing EHRs. The study identified four primary challenge classifications: practice issues, vendor issues, attestation process issues, and meaningful use measure-specific issues. The study found that challenges varied by both the stage of the adoption process in which providers were engaged and their practice setting. Sites that had not yet implemented EHRs described issues with provider engagement, selecting an EHR system, and administrative practice. Those that had implemented an EHR system described challenges with meaningful use measures, as well as administrative practice and provider engagement issues.

Challenges also varied across settings. For example, solo and small private practices reported difficulty with the Security Risk Analysis (SRA) meaningful use measure, while Federally Qualified Health Centers (FQHCs) were challenged by E-prescribing and rural health clinics struggled to meet immunization reporting requirements, often due to vendor interface or local health department testing issues. The CMS data brief discussed above, however, revealed some similarities in the successful performance of objectives for Stage 1. From 2011 to 2013, for example, greater than 97 percent of EPs and eligible hospitals met the Active Medication List core measure requirement and at least 91.5 percent met the Clinical Lab Test Results requirement, with a higher percentage of eligible hospitals than EPs succeeding.

Furthermore, some providers and vendors believe that the certification requirements are too burdensome and are not necessarily more efficient. John Halamka, Chief Information Officer (CIO) of the CareGroup Health System, and CIO and Dean for Technology at Harvard Medical School, has stated that vendors have been forced to create "software that will never be used by any clinician but was necessary to check the boxes of certification scripts that make no sense in real world workflows." A study of four hospitals commissioned by the American Hospital Association revealed that the hospitals significantly altered their workflow to accommodate data needed to report CQMs, without benefiting patient care. Republican Senators wrote a letter to HHS Secretary Kathleen Sebelius on September 24, 2013, seeking a one-year reporting extension for some providers.

As if in response to these concerns, CMS and the ONC announced on December 6, 2013 that they were extending the Stage 2 timeline through 2016. The agencies pushed back the beginning of Stage 3 from 2016 to 2017; specifically, to FY 2017 for eligible hospitals and to CY 2017 for EPs. According to the announcement, CMS anticipates issuing a Stage 3 Notice of Proposed Rulemaking (NPRM) in Fall 2014 and the ONC anticipates issuing an NPRM of Standards and Certification Criteria at the same time. A final rule would then follow in the first half of 2015. The ONC issued a proposed rule of Standards and Certification Criteria (79 FR 10880) that covers certification criteria for 2015 certified EHR technology that would improve upon the 2014 Edition. However, according to the proposal, participants in the EHR incentive programs would not be required to upgrade to the 2015 Edition and EHR technology developers that already certified their technology to the 2014 Edition would not need to recertify their products. Henceforth, the ONC proposes to issue standards and certification criteria on a more frequent basis of every 12 to 18 months in order to allow it to more effectively respond to stakeholder feedback, correct bugs, enhance the quality of systems, and make smaller changes that are easier to integrate into software development cycles. The ONC maintains that the proposed 2015 criteria would enhance interoperability, allow a wider choice of available software, and allow providers more time to implement regulatory updates in advance of Stage 3.

CMS and the ONC touted the extension as allowing the agencies to use more data gathered from Stage 2, including provider feedback, to shape Stage 3 policy, and allowing providers more time to prepare for Stage 3. However, providers quickly realized that the extension does little to alleviate concerns about meeting Stage 2 reporting deadlines, which have not been postponed.

Russ Branzell, CEO of the College of Healthcare Information Management Executives (CHIME), for example, noted of providers' upcoming obligations, "There is a perfect storm brewing. With ICD-10 compliance coming into view, with HIPAA compliance demanding renewed attention and with all the activities associated with the Affordable Care Act converging in 2014, providers are nearing a breaking point." Thomas A. Leary, Vice President for Government Relations of the Healthcare Information and Management Systems Society (HIMSS), has suggested allowing providers 18 months, instead of one year, in which to attest to meaningful use for one quarter.

Interoperability

Interoperability is the ability of two or more EHR systems to both exchange and use information. While the main goal of Stage 1 was to achieve EHR adoption, Stage 2 will focus on the exchange of information between providers. All providers participating in Stage 2 will be required to send a patient's medical record to the next provider following a transition in care, communicate with patients via secure messaging, and make patients' records electronically available to them. In its September 4, 2012, Final Rule, the ONC defined the common content, format, and structured data required for EHR systems to be certified. Ann Shepard, Vice President and Chief Nursing Informatics Officer and meaningful use clinical executive sponsor for Catholic Health Initiatives (CHI), cautiously reports success with interoperability in a small closed group in one of CHI's larger markets; many CHI hospitals and providers are currently participating in Stage 1.

A Bipartisan Policy Center survey of primary care physicians, the majority of whom worked in practice settings of 10 or fewer physicians, revealed that 80 percent of the respondents believed that the electronic exchange of information would improve patient care, but 71 percent viewed interoperability as a barrier to successfully sharing clinical information. Joseph Lynch, an attorney with King & Spalding, represents academic medical centers and their faculty practice plans, large community hospitals, dental schools, and physician practices of all sizes in both urban and rural settings with respect to EHR matters. He expressed concern that the HITECH Act's goal of "facilitating broad implementation of EHRs—has been subordinated to the idea that perfect interoperability must be achieved as quickly as possible." Even former ONC National Coordinator Farzad Mostashari acknowledged the obstacles in testimony at a July 17, 2013, hearing before the Senate Committee on Finance. In order to meet the Stage 2 interoperability requirement, after a transition in care, providers will need to electronically send a summary of a patient's record to the next provider or care setting and communicate with patients through secure messaging via, *e.g.,* encrypted email, and make patients' records available to them electronically. Such health information exchanges (HIEs) are not frequently achieved. Fewer than one in four physicians are notified when their patients visit an emergency room, fewer than half receive information needed to manage care within 48 hours of a hospital discharge, and only 16 percent receive information from specialists regarding changes to patients' medications or care plans. Mostashari noted that the average cancer patient has 32 providers, emphasizing the crucial nature of the exchange of health information.

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On March 7, 2013, the ONC and CMS issued a Request for Information seeking feedback on advancing interoperability and health information exchange (78 FR 14793). More than 200 comments were submitted through April 22, 2013. Based on the responses, HHS created a set of principles for advancing standards and interoperability.

One Stage 2 core goal that EPs and eligible hospitals and CAHs have in common is the requirement

that they conduct one or more successful electronic exchanges of a summary of care document with a recipient that uses EHR technology designed by a different developer or that they conduct one or more successful tests with the CMS-designated test EHR. The ONC, along with the National Institute of Standards and Technology (NIST) conducted a pilot program from September through November 2013 with three EHR systems from three developers. On January 17, 2014, the ONC and CMS announced the selection of McKesson and Meditech as the first Test EHRs. Test EHRs will be registered on the NIST's EHR Randomizer software system, which will randomly match providers with Test EHRs designed by different technology developers.

Geographic and Size Disparities

Rural hospitals, including CAHs, may be at a disadvantage compared to their urban counterparts when it comes to meeting meaningful use requirements. Urban hospitals often have more financial resources, a history of EHR use, information technology (IT) staff, and computer literate staff members. Rural hospitals and CAHs, however, may be lacking in one or more of these areas. As of July 2013, 61 percent of CAHs had attested to Stage 1 meaningful use, and an additional 28 percent planned to attest by the end of 2013; an additional 10 percent planned to attest to MU in 2014. However, the ONC reported that nearly six in 10 hospitals related significant financial challenges to MU, including EHR implementation costs, the availability of grants and loans to support EHR adoption and use, and broadband implementation costs. Thirty percent of hospitals noted workflow changes as a challenge to implementation.

Moving Forward

Despite continued pressure from provider groups, neither CMS nor the ONC seems likely to push back any other deadlines. CMS Secretary Marilyn Tavenner told attendees at the 2014 HIMSS conference that Stage 2 compliance deadlines will not be delayed. However, she indicated that CMS would consider case-by-case "hardship exemptions" for providers who might have legitimate issues, such as late delivery of certified software of software vendors who go out of business. Recent guidance explains that EPs participating in the Medicare EHR Incentive Program in 2014 can apply for a hardship exemption based on "Vendor Issues" if they are unable to implement 2014 certified EHR technology. Applications for EPs newly participating in the program are due by July 1, 2014; applications from returning EPs are due by July 1, 2015. A tip sheet for EPs also details exceptions involving poor infrastructure, new EPs, unforeseen circumstances, lack of patient interaction, and practice at multiple locations.

The SGR Fix

While CMS and the ONC are pushing forward despite protests from providers, Congress may create new issues with the EHR incentive programs. The legislative body was finally poised to provide an alternative to the sustainable growth rate (SGR), the formula which determines the rate at which CMS pays providers under the Physician Fee Schedule (PFS). Congress has voted to postpone physician payment cuts determined by the SGR annually for more than a decade, since increases in health care costs, until recent years, were much higher than the rate of inflation and would have led to a dramatic decrease in payments to physicians. However, in March the House proposed a solution to the physician payment problem that would have combined the meaningful use EHR program with the other quality incentive programs—the Physician Quality Reporting System (PQRS), and the Value-Based Modifier programs—and created one Merit-Based Incentive Payment System (MIPS). Under the MIPS, meaningful use would have been just one area of evaluation. In some instances, physicians participating in alternative payment models would not have been required to participate in the MIPS or meet meaningful use requirements. The House's additional decision to condition the bill upon an agreement to delay until 2019 an unrelated but key provision of the Affordable Care Act (ACA) (P.L. 111-148) imposing penalties on individuals who do not maintain health insurance made coverage Senate support unlikely. In fact, the Senate rejected a similar bill. Instead, Congress has passed another temporary, one-year postponement of the SGR. Industry groups, however continue to support a long-term solution to the SGR problem.

Audits

Nearly $21 billion has now been paid out to EPs in the EHR incentive programs. As with any other federal health program, providers should expect to see audits relating to EHR incentive payments in the

future. In fact, in its FY 2014 Work Plan, the HHS OIG specifically stated that it will review potentially erroneous payments to providers, along with CMS safeguards to prevent such payments. To ensure the security of protected health information, the OIG will also conduct audits of cloud service providers and other downstream service providers to ensure compliance. The OIG will also conduct audits of covered entities to ensure compliance with the HIPAA Privacy Rule and the HITECH Breach Notification Rule.

CMS began conducting post-payment audits of incentive program participants in October 2012. In November 2012, the HHS Office of Inspector General (OIG) issued a report noting that CMS had not instituted strong prepayment safeguards and recommended that the agency conduct prepayment audits of providers. CMS disagreed with the recommendation, noting that such audits could be burdensome to providers and delay payments. However, the agency is now implementing prepayment audits beginning with attestations submitted during and after January 2013.

Various sources report that audits have increased. In April 2013, Robert Anthony, Deputy Director of the CMS Health IT Initiatives Group, indicated that CMS would audit roughly 5 percent of participants by conducting the same amount of pre- and post-payment audits. However, Anthony has since stated that five to 10 percent of EPs engaged in Stage 2, chosen at random or based on risk profiles, can expect to be audited. Unlike those audited in Stage 1, Stage 2 physicians should expect to have payments withheld until the audits are completed. Anthony noted that the main reason some EPs failed Stage 1 audits was their inability to provide documentation to support the attestation numbers in the system, so EPs should take care to maintain easily accessible documentation. EPs also struggle with the security risk analysis they are required to perform to ensure that their electronic protected health information complies with HIPAA Security Rule requirements. Audits will also be used to ensure that EPs are using certified EHR technology.

Conclusion

Stage 2 meaningful use has begun. CMS and the ONC have spoken, and providers in the program must abide by the rules as they exist. The implementation of EHR technology is onerous, and providers who choose to wait and see what will happen will lose valuable time. EPs and eligible hospitals and CAHs should be on the lookout for Stage 3 NPRMs to issue in Fall 2014 and a proposed rule in the first half of 2015. In the meantime, they should keep abreast of updates from CMS and the ONC as providers and agencies alike adapt to the process and prepare for possible audits

The implementation of EHR technology is onerous, and providers who choose to wait and see what will happen will lose valuable time.

Although the meaningful use EHR incentive programs will expire, the EHR technology that providers are working so hard to implement is here to stay in one form or another. Joseph Lynch remains positive about the impact that meaningful use will ultimately have on the health care system. Although all providers will likely face problems with workflow and other transitions, "It's clear that robust EHRs and practice management products are essential to furnishing clinical care efficiently and effectively." He acknowledges that providers are in for a difficult transition. In fact, it could take "5-10 years to work through a broad range of thorny issues concerning the protection, use, storage, disclosure and transfer of electronic health information." Still, he says, "I believe we'll come through that transition period with a much stronger health care system."