Don’t Panic! Surviving a Meaningful Use Audit
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DISCLAIMER: The views and opinions expressed in this presentation are those of the author and do not necessarily represent official policy or position of HIMSS.
Learning Objectives

• Describe the types of potential audits that are a part of the EHR Incentive Program

• Analyze the types of information likely to be requested as part of a Meaningful Use Audit

• Determine how a Meaningful Use program could properly prepare and respond to a Meaningful Use Audit
The Journey So Far...
### CMS EHR Incentive Program

<table>
<thead>
<tr>
<th>Own &amp; Implement Certified EHR</th>
<th>Register</th>
<th>Demonstrate Meaningful Use*</th>
<th>Attest**</th>
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</table>
| • Certified by ONC Certified HIT Product List (CHPL) or self-certify | • Medicare, Medicaid, or both | • Core Set Measures  
• Menu Set Measures  
• Clinical Quality  
  • 16- aggregate, calculate, and report numerator, denominator, and exclusions | • Attest to:  
• Core Set  
• Menu Set  
• Submit:  
  • Clinical Quality Measures |

* Stage 1 (2014) Definition, as of CMS May 2014 updates  
** Must be prepared to provide evidence to substantiate audit
What Does It Mean to Attest?

In order to attest, successfully demonstrate meaningful use, and receive an incentive payment under the Medicare EHR Incentive Program, eligible hospitals must indicate that they agree with several attestation statements. The attestation is performed utilizing the CMS online Attestation System. Once the eligible hospital has successfully completed the attestation, they qualify for the payments.

The providers must agree that the information submitted:
- **Is accurate** to the knowledge and belief of the hospital or the person submitting on behalf of the hospital;
- **Is accurate and complete** for numerators, denominators, exclusions, and measures applicable to the hospital;
- **Includes information on all patients** to whom the measure applies; and
- For clinical quality measures (CQMs), was general as output from an identified certified EHR technology.

By agreeing to the above statements, the hospital is attesting to providing all of the information necessary from certified EHR technology, uncertified EHR technology and/or paper-based records in order to render complete and accurate information for all meaningful use core and menu set measures except CQMs. The attestation could be performed by any appropriate officer of the organization, and could be, but is not limited to, the Chief Financial Officer, Corporate Compliance Officer, Chief Medical Officer or Chief Information Officer.
What Does It Mean to Attest to CQM’s?

CMS considers information to be accurate and complete for CQMs to the extent that it is identical to the output that was generated from certified EHR technology. In other words, the hospital is only attesting that the information entered in the attestation model is identical to the output generated by its certified EHR technology. Therefore, the numerator, denominator, and exclusion information for CQMs must be reported directly from information generated by certified EHR technology.

CMS, through Meaningful Use, does not require any data validation. Eligible hospitals are not required to provide any additional information beyond what is generated from certified EHR technology in order to satisfy the requirement for submitting CQM information, even if the reported values include zeros. If a hospital has concerns about the accuracy of its output, the hospital can still attest but should work with its vendor and/or the Office of the National Coordinator for Health Information Technology to improve the accuracy of the individual product and/or the level of accuracy guaranteed by certification.
CMS MU Audit Program

As stated on the CMS Registration and Attestation website, any provider that receives an EHR incentive payment for either the Medicare or Medicaid EHR Incentive Program potentially may be subject to an audit.(1) Details include:

- Congress, for the HITECH Act, specifically authorized submission of information as to meaningful use through attestation. CMS has developed an audit strategy to ameliorate and address the risk of fraud and abuse.(2)

- CMS may request that providers selected for post-payment audits submit documentation, such as patient rosters, EHR screenshots, and reports generated by the EHR system to support data the providers reported to CMS during attestation.

(1) CMS EHR Incentive Program Website, Registration and Attestation page, Audit and Appeals section: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/RegistrationandAttestation.html
3 Types of Audit

**Medicare Audit**
- Focus is on documentation of meeting the MU measures. Conducted by one audit firm - Figliozzi and Company, or other CMS Auditors

**Medicaid Audit**
- Focus is on documentation of eligibility and volume requirements for Medicaid payments as well the MU measures

**OIG audit of a state’s Medicaid EHR program**
- Focus to ensure that states are correctly validating that hospital meets the Medicaid eligibility and volume requirements
Office of Inspector General - HHS

• Mission – “...to protect the integrity of Department of Health & Human Services (HHS) programs as well as the health and welfare of program beneficiaries.”

• HHS OIG is the largest inspector general’s office in the Federal Government, with more than 1,700 employees dedicated to combating fraud, waste and abuse. A majority of OIG’s resources goes toward the oversight of Medicare and Medicaid

*Office of Inspector General U.S. Dept. of Health & Human Services Website
Initial review in April 2012; updated November 2012

**Key Findings:** “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 post-payment is also limited. The Office of the National Coordinator for Health Information Technology (ONC) requirements for EHR reports may contribute to CMS’ oversight obstacles.”
Key Recommendations from the OIG Review of the MU Audit Program

• CMS obtain and review supporting documentation prior to payment to verify the accuracy of self-reported information. CMS did not concur with this recommendation

• CMS issue guidance with specific examples of documentation professionals should produce. CMS did concur with this recommendation

• ONC should require CEHRT be capable of producing reports for the yes/no measures where possible. ONC did concur with this recommendation

• ONC should improve the certification process for CEHRT to ensure accuracy of reports. ONC did concur with this recommendation
OIG Work Plan for 2013 – 3 Initiatives

• OIG will identify fraud and abuse vulnerabilities in electronic health records (EHR) systems
  – Surveys sent in October 2012 to EH’s that received Stage 1 money
• OIG plans to review EHR incentive payments
• OIG will audit for security compliance and adequate information technology (IT) security controls are in place to protect sensitive EHR and personal information.
MU Audit Is NOT

• A RAC audit
  – Financial audits of paid claims on behalf of CMS by an approved contractor in order to recover improper payments and identify underpaid claims
  – They are paid a % of recoveries; no recovery = no commission

• Survey of patient care delivery
  – TJC, DNP, Tracer rounds
  – Stroke center accreditation

• HIPAA audit
  – Also referred to as an OCR audit - oversight by the Office of Civil Rights
MU Audit Is

• A “desk audit”
  – Limited scope examination of documentation and records, conducted away from the place of business
  
  – Beginning with attestations submitted during and after January 2013, Medicare providers may also be subject to pre-payment audits which will include random audits, as well as audits that target suspicious or anomalous data.

Based on a desk audit, could a field audit occur?

A limited number of on-site reviews have occurred, however, we do not expect this to become a routine part of the program.
[EHR Incentive Programs] What is the CMS Electronic Health Records (EHR) Meaningful Use Audit Team?

The CMS EHR Meaningful Use Audit Team performs meaningful use audits as part of the Medicare and Medicaid EHR Incentive Programs. If selected for one of these audits, the eligible professional (EP), eligible hospital (EH) or critical access hospital (CAH) will receive a letter with the CMS logo on the letterhead providing instructions on providing supporting documentation and other required information.

Questions can be directed to: MedicareEHRaudit@cms.hhs.gov.

Please visit FAQ 7711 for more information about audits conducted in the EHR Incentive Programs.

Created on 11/20/2013

(FAQ9272)
Consequences

• Providers found NOT to be “meaningful users” will be asked to return the incentive payment

• A false attestation could also be the basis for liability under the Federal False Claims Act or similar state laws
CMS has an appeals process for EPs, EHs, and CAHs that participate in the Medicare EHR Incentive Program. Providers may contact the EHR Information Center through a toll free number, 888-734-6433, between 9 a.m. and 5 p.m. EST, Monday through Friday, for general questions on how to file appeals and the status of any pending appeals. States will implement appeals processes for their Medicaid EHR Incentive Program. Medicaid program participants should contact their state Medicaid agency for more information about these appeals.
Audit Red Flags

• Patient denominator inconsistencies
  – Unique patients on specific measures
  – Comparison of total discharges on cost reports with the number of encounters reported for MU

• Exemptions inconsistent with patient population
  – Exemptions for smoking status from non-pediatric hospitals
  – Public health measures – must check to make sure state is able to accept electronically

• Multiple EHR vendors examined more closely
  – Vendors with a pattern of problems at other sites
  – Ambulatory – certification to calculate CQM’s
Remember

• Protect patient confidentiality and de-identify patient information, per HIPAA requirements

• Provide only the information requested in the audit letter; “less is best”

• Ask questions about the audit if you are not sure how to respond
Retain Attestation Evidence for 6 Years

• Save any electronic or paper documentation that supports your attestation. Retain reports from the certified EHR system to validate all clinical quality measure data entered during attestation, Save the documentation that supports the values you entered in the Attestation Module (CMS portal).

• Save all documentation that supports volumes and eligibility calculations payment calculations as well.

• The primary documentation that will be requested in all reviews is the source document(s) the provider used when completing the attestation. This document should provide a summary of the data that supports the information entered during attestation. Ideally, this would be a report from the certified EHR system.
MU MEDICARE EH AUDIT EXAMPLE
Dear Eligible Hospital,

The Centers for Medicare and Medicaid Services (CMS) has contracted with Figliozzi & Company, CPAs P.C.1 to conduct meaningful use audits of certified Electronic Health Record (EHR) technology as required in Section 13411 of the Health Information Technology for Economic and Clinical Health Act (HITECH Act), as included in Title XIII, Division A, Health Information Technology and in Title IV of Division B, Medicare and Medicaid Health Information Technology of the American Recovery and Reinvestment Act of 2009. The HITECH Act provides the Secretary, or any person or organization designed by the Secretary, the right to audit and inspect any books and records of any organization receiving an incentive payment.
You Have Been...

Selected by the CMS for an audit of your facility’s meaningful use of certified EHR technology for the attestation period. Attached to this letter is an information request list. Be aware that this list may not be all-inclusive and that we may request additional information necessary to complete the audit.
What Did the Auditors Request?

- Initial request (desk audit) for:
  - Proof of possession of a certified EHR
  - Documentation of method chosen to report ED visits, all ED or ED Observation
  - Core/Menu measures – the report that used in your attestation, with some way to identify it came from the CEHRT *
  - Screen shots to substantiate Y/N measures functionality, additional report to substantiate functionality was enabled during the entire reporting period

* NOTE – Per CMS FAQ 141, Eligible Professionals and Eligible Hospitals may use a separate, non-certified system to calculate numerators and denominators and to generate reports on the measures of the Core and Menu Set meaningful use objectives
Additional Information

• Second request
  – Unclear as to whether report of measure calculations came from CEHRT; asked for additional documentation*
  – Validation the CDS rule had been active during the entire reporting period
  – A copy of the security risk assessment, including details of the remediation plans for any identified deficiencies

NOTE – Per CMS FAQ 141, Eligible Professionals and Eligible Hospitals may use a separate, non-certified system to calculate numerators and denominators and to generate reports on the measures of the Core and Menu Set meaningful use objectives.
We have completed our meaningful use audit of the certified Electronic Health Record (EHR) technology of your hospital in accordance with Section 13411 of the Health Information Technology for Economic and Clinical Health Act (HITECH Act), as included in Title XIII, Division A, Health Information Technology and in Title IV of Division B, Medicare and Medicaid Health Information Technology of the American Recovery and Reinvestment Act of 2009. The HITECH Act provides the Secretary, or any person or organization designated by the Secretary, the right to audit and inspect any books and records of any organization receiving an incentive payment.

We performed a desk review on your facility’s meaningful use attestation for the Program Year 2011 and Payment Year 1. Based on our desk review of the supporting documentation furnished by the facility, we have determined that your hospital has met the meaningful use criteria.

This audit does not preclude your hospital from future audits in this payment year or in subsequent years. Thank you for your assistance and cooperation.
More Recent Medicare Audit Requests

Changes from 2013:

• For the Core Measure set, no documentation on the Y/N measures was requested except for the Security Risk Audit
  – Unclear if intentional or an oversight that will be corrected with an additional request for documentation
  – Additional details of the security risk audit were requested with regards to implementation plans and completion dates to address deficiencies
• For the Menu set measures, documentation for Y/N measures WAS requested for the measures to which the EH attested
• No information regarding the Clinical Quality Measures was requested in this first round
• Hospitals were given 4 weeks to respond, data to be uploaded to the auditor’s portal as before
FFY 2014 - More and More Audits?

• With the start of FFY 2014, CHIME reported that almost 6 percent of their members surveyed had received a notice of MU audit in October.

• CHIME staff contacted CMS to ensure agency awareness

• CMS indicated a sensitivity to the timing and to the compliance burden
  – The MU audits are on-going and they are done in rolling waves throughout the year
  – Officials confirmed EHs and EPs can ask the auditors directly for an extension and CMS has communicated to the auditors that this is permissible
MEDICAID AIU AUDIT EXAMPLE
Please be advised that the State of Texas Health and Human Services Commission (HHSC) has contracted the independent CPA firm of Davila, Buschhorn & Associates, P.C., (DBA) to perform an audit to review documentation supporting your attestation for Adopt, Implement, or Upgrade (All) of the Medicaid Electronic Health Record (EHR) Incentive Program.

CMS has set standards that Eligible Professionals (EPs) and Eligible Hospitals (EHs) must meet in order to successfully demonstrate AIU and continue receiving incentive payments under the Medicaid EHR Incentive Program. We are responsible for confirming that EPs and EHs enrolled in the incentive program are using certified EHR technology in this manner as part of our audit and oversight responsibilities.

To facilitate the audit, please complete the attached questionnaire. The questionnaire is based around general information regarding your practice and the adoption, implementation or upgrade to certified electronic health records. In addition to providing responses to the requested information in the questionnaire, please also provide relevant supporting documentation (in either paper or electronic format) used to support your questionnaire responses for the applicable objectives.

Please complete the desk questionnaire within 10 days of receiving it and submit your completed questionnaire, including supporting documentation to:

Davila Buschhorn & Associates, P.C.
Attention: EHR Audit
7207 McNeil Drive
Austin, TX  78729
What Do Medicaid Auditors Ask For?

Example from state of Texas AIU audit

- NPI, CCN, Tax ID
- ONC Certification number of EHR
- Proof of possession of a certified EHR
- What percentage of your services are provided to Medicaid members? Please provide documentation to support your response
- What is the average length of a patient stay? Please provide documentation to support your response
- Please describe the procedures performed, or process followed, for purposes of the Medicaid EHR Incentive Program, to determine patient volume in your practice/hospital
OIG AUDIT EXAMPLE
• The purpose of a OIG audit is to audit the state’s program for payments of Medicaid incentives.
• Therefore, they will ask the hospital to provide the same kinds of information they may have already provided directly to the state previously.
• If an OIG audit found that the state had failed to appropriately establish an EH as a meaningful use, that report would be returned to the state, and the state would take action to recover the incentive payment from the EH
OIG Audit of Medicaid AIU

The U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), is conducting an audit of Florida's Medicaid Incentive Payments for Electronic Health Records. The objective of our audit is to determine whether providers claimed State and Federal reimbursement for Electronic Health Record (EHR) incentive payments in accordance with State and Federal regulations. Our audit period will include payments made during the period January 1, 2011, through April 30, 2012.

OIG performs independent reviews of HHS programs pursuant to the Inspector General Act of 1978 (the Act), 5 U.S.C. App. 3 § 4(a)(1). Section 6(a)(1) of the Act authorizes OIG “to have access to all records, reports, audits, reviews, documents, papers, recommendations, or other material available to [HHS] which relate to programs and operations with respect to which the Inspector General has responsibilities under this Act” (5 U.S.C. App. 3 § 6(a)(1)).

Under the health information privacy regulation that implements the Health Insurance Portability and Accountability Act of 1996, providing the information requested by this letter is a permitted disclosure because it (1) is “required by law” to be produced to OIG as part of your participation in a Government benefits program (45 CFR §§ 164.512(a) and 164.103) and (2) will be used for “health oversight” activities by OIG, which meets the definition of a “health oversight agency” (45 CFR §§ 164.512(d) and 164.501).

To expedite completion of our work, we request that you provide to us by secure carrier the documents listed in the enclosure within 10 days of receiving this letter. During our review, we may need access to additional documents and records. We appreciate your cooperation in this matter and will make every effort to minimize any disruption to the work of your office.
What Does the OIG Ask for?

- A copy of your license and Medicaid Enrollment Number
- The Cost Report worksheet S-3 Part I column 15 line 12 for each of the prior 4 years before your incentive application
- For the year of attestation, the following most recent Cost Report pages:
  - S-3, part 1, col 15, line 12
  - S-3, part 1, col. 5, sum of lines 1, 6-10
  - S-3, part 1, col. 5, line 2 (excluding unpaid days)
  - S-3, part I, col. 6, sum of lines 1, 2, 6-10
  - C. col 8, line 101
  - S-10, line 30
- A Microsoft Excel file containing a list of patient records for the attestation period. Please save on a CD
- Supporting documentation for EHR incentive payment amount received
- Supporting documentation for Adopt, Implementation, and Upgrade (AIU)
- Copy of EHR Technology and Security Plan for Safeguarding Technology and Patient Information
- Certified Health IT Product List (CHPL) EHR certification number
Clarification from the OIG

II. Requested Documents

- **Bullet Item #1** Does the request refer to the hospital license? If not, to which license does this request refer?  
  Response: We are looking for a copy of the hospital business license.

- **Bullet Item #2**—  
  Response— We are looking for the cost report S-3 attestation year plus three prior years.

- **Bullet Item #3**—  
  Response— I believe your cost report dates are correct. What we are asking for is the pages from settled or audited cost reports. We are looking to make sure nothing changed in the data you originally submitted.

- **Bullet Item #4**—  
  Response— You are correct that is the data we need. For each of the records we need:  
    - Patient Name (First and Last)  
    - Patient Account Number  
    - Date of Birth  
    - Dates of Service (From – Thru)  
    - Primary Payor
In Conclusion...
How to Minimize the Impact of An Audit

• Have a defined procedure in place to manage the audit process
  – What to do when letter is received to ensure it is recognized and processed in a timely manner
• Be able to produce documentation quickly
  – Desk audit materials are required within 2 weeks
  – Send via email as PDF or direct PDF upload to their portal
• Be able to prove what you owned
  – All vendors, all versions, all the time
Self Assessment

- Vision
- Culture
- Governance, Roles and Responsibilities
- Design of Evidence Documents
- Storage of Evidence
- Audit Response Plan
Has your organization developed a clear vision of how you will respond to a CMS Audit? Do you see it as:

- A foundation for assuring the CMS MU program has been developed to the full extent of the law and you have solid evidence to support audit, which includes a comprehensive audit readiness plan?

- A means to secure funding for IT initiatives, and placing responsibility with your Compliance Department?
Self Assessment

Vision

Culture

Governance, Roles and Responsibilities

Design of Evidence Documents

Storage of Evidence

Audit Response Plan

• What is the organizational culture? Do you adapt to change easily?
• Do you agree to shared decision making and have a clear outline of roles and responsibilities?
• Do you hold key stakeholders accountable after clearly outlining roles and responsibilities?
Self Assessment

Vision

Culture

Governance, Roles and Responsibilities

Do you have a governance structure in place outlining clear roles and responsibilities for each key component of MU that may be touched by an audit?

- Site dashboard monitoring
- Physician/clinician engagement
- Training
- Attestation
- Audit and compliance trail
- Registration and payment

Design of Evidence Documents

Storage of Evidence

Audit Response Plan
Do you have a solid understanding of the key components that should be included in the Design of Evidence Documents:

- Proof of Ownership of CEHRT for all systems?
- Core and Menu Set percentage measures?
- Core and Menu Set Y/N measures?
- Clinical Quality Measures?
Self Assessment

Have you designed a robust storage system allowing you to:

- Track time/date of evidence creation and ID of person recording the evidence, and sign off?
- Use a storage tool to support complex conditional processes and workflows (tool drives the procedure for collecting information, send reminders)?
- Protect the evidence from alteration after attestation?
- Store all evidence documents for 6 years post attestation?
- All for fast and easy retrieval of documentation, if audited?
Self Assessment

- Vision
- Culture
- Governance, Roles and Responsibilities
- Design of Evidence Documents
- Storage of Evidence
- Audit Response Plan

- Are roles and responsibilities outlined?
- Are you confident that your plan can be quickly executed with maximum results?
- Have you had a “dry run” audit response?
Thank You!
Questions?

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