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Meaningful Use and the Costs of Noncompliance

By Christopher Thompson July 2017

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It is something of an understatement to note that the U.S. healthcare legal landscape is currently experiencing a degree of transition and uncertainty. There is no shortage of changes to discuss, debate, and, perhaps, grow apprehensive about. One development that has been the radar of many physicians for several years now--and brought into new relief by more recent changes such as the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)--is the Meaningful Use concept introduced by the Health Information Technology for Economic and Clinical Health (HITECH) Act.

"Meaningful Use" relates to physicians' use of certified electronic health records (EHR) technology in the interest of interoperability and efficient electronic exchange of health information. The Centers for Medicare & Medicaid Services (CMS) offers an incentive program which offers incentive payments to eligible professionals and eligible hospitals who join and comply. Participation involves making "Meaningful Use Attestations" regarding compliance. Both compliance and noncompliance with Meaningful Use goals can represent a significant cost to physicians: compliance, as bringing a practice's technological infrastructure up to the appropriate standards does not come cheaply; noncompliance, as those who choose not participate in CMS's incentive program face reductions in their Medicare and Medicaid payments. These reductions equal a 3% decrease in 2017.

It appears that noncompliance with Meaningful Use standards carries more of a bite than some observers may have thought. In June of 2017, the Office of the Inspector General (OIG) released a report that Medicare made hundreds of millions of dollars' worth of incentive payments to Meaningful Use attesters who failed to meet the necessary requirements. The OIG estimated a total of approximately $730 million dollars in inappropriate payments--more than ten percent of the total payments. CMS's blunder largely resulted from its failure to conduct adequate documentation review, thus rendering the self-attestations of professionals prone to abuse. Note, too, that CMS is not the only authority to make inappropriate EHR incentive payments: the OIG faulted Texas in August 2015 for making such wrongful payments in an amount over $15 million through its Medicaid program.

This does not, of course, amount to a windfall for the physicians who received the wrongful payments. The OIG's recommendation to CMS includes directing CMS to recover the wrongful payments it has identified (a small sample of the total), and to seek to identify, and then recover, the rest of the inappropriately directed federal funds. As is characteristically the case, government overpayments cannot be retained by the recipient. Thus, the takeaway from CMS's improper Meaningful Use largesse should not be an observation that the government has, up till now, not been adequately reviewing Meaningful Use documentation. Instead, it should be that one can, of course, expect such mistakes to be corrected when discovered and that it is even more important to get Meaningful Use compliance correct now. What has been done in the past by a physician may not actually have sufficed. Additionally, part of OIG's recommendation to CMS was to educate eligible clinicians on proper Meaningful Use documentation requirements. Physicians should look for and take advantage of such education.

This need to double down on one's Meaningful Use efforts comes at a time when the reimbursement system is shifting to MACRA. The Medicare EHR Incentive Program is no longer a standalone program--it has been combined through MACRA with the Physician Quality Reporting System and the Physician Value-

based Payment Modifier into a single program, the Merit-based Incentive Payment System (MIPS) under the Quality Payment Program (QPP). Although hospital and Medicaid Meaningful Use programs are unaffected by MACRA, clinicians will make their Medicare Meaningful Use attestations through the QPP. This program still focuses on the use of Certified EHR Technology to support interoperability and healthcare quality objectives. The meaningful use measures are calculated and compensated somewhat differently under MIPS; one significant change is that a hybrid scoring system has replaced the previous all-or-nothing approach.

Although the manner of reporting Meaningful Use has changed somewhat, it has not become either less important or markedly simpler. Getting up to speed on the technological, administrative, and reporting features of establishing Meaningful Use now--when there is some clemency as far as timing goes worked into the transition period--is certainly advisable. The need to establish the goals of interoperability, efficiency, and care coordination that Meaningful Use seeks to advance is a need that is unlikely to diminish. The fact that CMS is now beginning to seek hundreds of millions of dollars in wrongful incentive payments only highlights that Meaningful Use compliance is an issue worth following in the always changing healthcare landscape.

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