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EARLY ASSESSMENT FINDS THAT CMS FACES OBSTACLES IN OVERSEEING THE MEDICARE EHR INCENTIVE PROGRAM

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EARLY ASSESSMENT FINDS THAT CMS FACES OBSTACLES IN OVERSEEING THE MEDICARE EHR INCENTIVE PROGRAM, OEI-05-11-00250

WHY WE DID THIS STUDY

This study is an early assessment of CMS's oversight of the Medicare electronic health record (EHR) incentive program, for which CMS estimates it will pay $6.6 billion in incentive payments between 2011 and 2016. Because professionals and hospitals self-report data to demonstrate that they meet program requirements, CMS's efforts to verify these data will help ensure the integrity of Medicare EHR incentive payments.

HOW WE DID THIS STUDY

This study reviewed CMS's oversight of professionals' and hospitals' self-reported meaningful use of certified EHR technology in 2011, the first year of the program. To address our objective, we analyzed self-reported information to ensure it met program requirements. We also reviewed CMS's audit planning documents, regulations, and guidance for the program, and conducted structured interviews with CMS staff regarding CMS's oversight.

WHAT WE FOUND

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 postpayment is also limited. The Office of the National Coordinator for Health Information Technology (ONC) requirements for EHR reports may contribute to CMS's oversight obstacles.

WHAT WE RECOMMEND

We recommend that CMS: (1) obtain and review supporting documentation from selected professionals and hospitals prior to payment to verify the accuracy of their self-reported information and (2) issue guidance with specific examples of documentation that professionals and hospitals should maintain to support their compliance. CMS did not concur with our first recommendation, stating that prepayment reviews would increase the burden on practitioners and hospitals and could delay incentive payments. We continue to recommend that CMS conduct prepayment reviews to improve program oversight. CMS concurred with our second recommendation.

We recommend that ONC: (1) require that certified EHR technology be capable of producing reports for yes/no meaningful use measures where possible and (2) improve the certification process for EHR technology to ensure accurate EHR reports. ONC concurred with both recommendations.

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OBJECTIVE

To conduct an early assessment of the Centers for Medicare & Medicaid Services' (CMS) oversight of the Medicare electronic health record (EHR) incentive program.

BACKGROUND

The Medicare EHR Incentive Program

The American Recovery and Reinvestment Act (ARRA) established EHR incentive programs for both Medicare and Medicaid to promote the use of EHR technology by health care professionals and hospitals.[1] EHR technology refers to computerized recordkeeping systems that store patients' health-related information, including medical histories and procedure notes.

Only certain types of health care professionals and hospitals are eligible to participate in the Medicare EHR incentive program.[2] Eligible health care professionals include physicians, dentists, podiatrists, optometrists, and chiropractors. Eligible hospitals include acute care hospitals and critical access hospitals.

CMS began making Medicare EHR incentive payments in May 2011 and, as of September 2012, had paid about $4 billion to 82,535 professionals and 1,474 hospitals.[3] Per ARRA, CMS will continue to make Medicare EHR incentive payments to professionals and hospitals through 2016. CMS anticipates spending an estimated $6.6 billion in incentive payments between 2011 and 2016.[4] Professionals can receive up to $44,000 each in incentive payments over the duration of the program.[5] Hospital incentive payments for each year of the program begin with a $2 million base amount that is adjusted by a number of hospital-specific factors and gradually decreased over the duration of the program.[6]

[1] ARRA §§ 4101 and 4201, amending Titles XVIII and XIX of the Social Security Act (SSA).

[2] SSA §§ 1848(o)(5)(C) and 1886(n)(6), as added by ARRA §§ 4101 and 4102; 42 CFR § 495.100.

[3] CMS, *Data and Reports Page*. Accessed at www.cms.gov on November 15, 2012.

[4] CMS, *Justification of Estimates for Appropriations Committees, Fiscal Year 2012*. Accessed at www.cms.gov on July 5, 2011.

[5] SSA § 1848(o)(1), as added by ARRA § 4101(a); 42 CFR § 495.102.

[6] SSA § 1886(n)(2), as added by ARRA § 4102(a); 42 CFR § 495.104.

Medicare EHR Incentive Program Requirements

To qualify for Medicare EHR incentive payments, professionals and hospitals must: (1) possess certified EHR technology; and (2) meaningfully use that certified EHR technology, in accordance with requirements defined by CMS, for a 90-day reporting period.[7]

Certified EHR Technology. The Office of the National Coordinator for Health Information Technology (ONC) defined EHR technology certification requirements in Federal regulations.[8] EHR technology must include certain functions in support of meaningful use requirements to receive certification.[9] ONC requires certified EHR technology to be capable of producing reports (EHR reports) on meaningful use by aggregating information from records in the system.

ONC also defined the EHR technology certification process in Federal regulations.[10] According to this process, private entities (certification bodies) certify that EHR technology meets certification requirements using vendor-supplied test data.[11] ONC lists all certified EHR technology in the Certified Health Information Technology Product List (CHPL), an online, publicly accessible database.

Meaningful Use. Professionals and hospitals must also meaningfully use their certified EHR technology to qualify for Medicare EHR incentive payments. To meaningfully use certified EHR technology, professionals and hospitals must use numerous EHR technology functions defined in Federal regulations as meaningful use measures. These measures encompass EHR technology functions meant to improve health care quality and efficiency, such as computerized provider order entry, electronic prescribing (e-prescribing), and exchange of key clinical information.

Each meaningful use measure has a specified criterion. Each criterion involves performing a one-time action (yes/no measure) or performing a certain action for a specified percentage of unique patients, patient visits, or other events (percentage-based measure). For example, one yes/no measure requires professionals to enable drug interaction checks in their

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[7] The 90-day reporting period applies to a professional's or hospital's first year of participation; in subsequent years of participation, professionals and hospitals must meaningfully use a certified EHR for the entire year. SSA §§ 1848(o)(1) and (2), as added by ARRA § 4101(a); SSA §§ 1886(n)(1) and (3), as added by ARRA § 4102(a); 42 CFR § 495.4.

[8] 45 CFR pt. 170, subpart C.

[9] Ibid.

[10] 45 CFR pt. 170, subparts D and E.

[11] Ibid.

certified EHR technology.[12] One percentage-based measure requires professionals to submit more than 40 percent of all prescriptions electronically.[13]

Professionals and hospitals must meet criteria for a specified number of meaningful use measures for CMS to deem them meaningful users. CMS established 25 measures for professionals—15 mandatory measures (core measures) and 10 additional measures (menu measures). From the 10 menu measures, each professional must select and meet 5. Similarly, CMS established 24 measures for hospitals—14 core measures and 10 menu measures. Like professionals, each hospital must select and meet 5 menu measures. Professionals must meet criteria for 20 measures and hospitals must meet criteria for 19 measures for CMS to deem them meaningful users.[14]

Table 1 illustrates the breakdown of yes/no and percentage-based meaningful use measures, as well as the total number of core and menu measures that CMS established for professionals and hospitals. For a complete list of professional and hospital meaningful use measures, see Appendix A.

Table 1: Number of Meaningful Use Measures by Type

		Percentage-Based	Yes/No	Total
Professionals	Core	10	5	**15**
	Menu	6	4	**10**
Hospitals	Core	9	5	**14**
	Menu	5	5	**10**
Total		**30**	**19**	**49**

Source: Office of Inspector General (OIG) analysis of Federal regulations, 2011.

Demonstrating Meaningful Use of Certified EHR Technology.
Professionals and hospitals must demonstrate meaningful use of certified EHR technology for each year that they wish to receive an incentive payment. As such, professionals and hospitals who received incentive payments for 2011 will have to demonstrate meaningful use of certified EHR technology anew in subsequent years to receive additional incentive payments.

[12] 42 CFR § 495.6(d)(2).

[13] 42 CFR § 495.6(d)(4).

[14] Many measures for professionals involve objectives and EHR capabilities similar to measures for hospitals, although the precise measure definitions differ.

Professionals and hospitals demonstrate meaningful use of certified EHR technology through online self-reporting in the National Level Repository (NLR). The NLR is a CMS database that stores professionals' and hospitals' information relevant to the EHR incentive program.

Professionals and hospitals submit self-reported information for meaningful use measures to the NLR. For yes/no measures, professionals and hospitals indicate that they have met the measure criteria by checking a box. For percentage-based measures, professionals and hospitals provide numerical totals for the numerator and denominator of each measure. For example, to fulfill the e-prescribing measure, professionals must report both the number of prescriptions submitted electronically and the total number of prescriptions.

Professionals and hospitals also report their certified EHR technology to the NLR using an EHR certification code. They obtain an EHR certification code that corresponds to their certified EHR technology from the CHPL database.

CMS's Oversight of the Medicare EHR Incentive Program

To oversee the Medicare EHR incentive program, CMS has authority to review professionals' and hospitals' demonstrations of meaningful use.[15] CMS's reviews consist of prepayment validation in the NLR and postpayment audits.

Prepayment Oversight. CMS conducts prepayment validation of professionals' and hospitals' self-reported meaningful use information to ensure that it meets program requirements. To do so, the NLR runs prepayment system edits to validate that self-reported information meets measure criteria. For example, for each percentage-based measure, the NLR divides the self-reported numerator by the self-reported denominator and determines whether the result meets the relevant percentage threshold. The NLR also automatically checks professionals' and hospitals' self-reported EHR certification codes against ONC's CHPL database to confirm that they are valid. CMS does not approve incentive payments for professionals and hospitals whose self-reported information fails prepayment validation.

Postpayment Oversight. To verify that professionals' and hospitals' self-reported meaningful use information is accurate, CMS plans to audit selected professionals and hospitals after payment. It plans to conduct a risk assessment using data analyses to select audit targets (e.g., check that self-reported denominators are consistent across certain meaningful use

[15] 42 CFR § 495.8(c).

measures). At the time of our review, CMS had not yet completed any postpayment audits.

Professionals and hospitals selected for audit will first undergo a desk audit, during which they will provide documentation supporting their self-reported information to CMS. If CMS is unable to verify the accuracy of that information, it will proceed with an onsite audit. Professionals and hospitals must retain documentation supporting their self-reported meaningful use information for 6 years.[16]

Per its policy, CMS will recover incentive payments when audits find noncompliance.[17] Federal regulations state that professionals and hospitals must meet all relevant meaningful use requirements to receive incentive payments.[18] Partially meeting meaningful use requirements does not qualify professionals and hospitals to receive incentive payments.

Related Work

This is the second of two OIG studies on CMS's and States' oversight of the Medicare and Medicaid EHR incentive programs, respectively. The first study in this series reviewed 13 States' oversight of their Medicaid EHR incentive programs.[19] OIG found that all 13 States planned to verify compliance with at least half of eligibility requirements prior to making EHR incentive payments. OIG also found that data availability limits both the number of eligibility requirements that States plan to verify prior to payment and the completeness of those verifications.

OIG is also conducting a series of audits of Medicare and Medicaid EHR incentive payments. These audits will verify the accuracy of professionals' and hospitals' self-reported meaningful use information, as well as eligibility and payment amounts.

METHODOLOGY

Scope

We conducted an early assessment of CMS's oversight of professionals' and hospitals' self-reported meaningful use information for 2011, the first year of the Medicare EHR incentive program. The goal of this assessment was to identify any potential vulnerabilities in CMS's initial oversight design for the program.

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[16] Ibid.

[17] CMS, *Attestation Overview*. Accessed at www.cms.gov on May 9, 2012.

[18] 42 CFR pt. 495, subpart B.

[19] OIG, *Early Review of States' Planned Medicaid Electronic Health Record Incentive Program Oversight*, OEI-05-10-00080, July 2011.

For our assessment, we reviewed Federal regulations in effect at the time of our data collection. CMS and ONC have recently issued updated regulations for meaningful use and certified EHR technology, respectively. Both CMS and ONC plan to issue additional regulatory updates in future years of the program.

We reviewed CMS's current and planned activities to verify the accuracy of professionals' and hospitals' self-reported meaningful use information. We also analyzed self-reported meaningful use information for professionals and hospitals that CMS approved to receive incentive payments.

We reviewed the components of ONC's certification process and requirements for EHR technology that affect CMS's oversight activities for the Medicare EHR incentive program. Because this study focuses on CMS oversight, we did not conduct a complete review of ONC's certification process and requirements for EHR technology.

We did not review the appropriateness of the meaningful use measures as defined by CMS in Federal regulations. We also did not review CMS's activities to verify that professionals and hospitals were among the types eligible for the Medicare EHR incentive program. Further, we did not review the accuracy of CMS's calculated incentive payment amounts for professionals or hospitals. Finally, we did not audit professionals' or hospitals' self-reported meaningful use information to verify its accuracy.

Data Collection and Analysis

To address the study's objective, we analyzed professionals' and hospitals' self-reported meaningful use information, CMS's audit planning documents, and Federal regulations and guidance for the Medicare EHR incentive program. We also conducted structured interviews with CMS staff about current and planned oversight.

Professionals' and Hospitals' Self-Reported Meaningful Use Information. We collected professionals' and hospitals' self-reported information from the NLR from the program's inception in May 2011 through December 2011. We requested all registration, meaningful use, and payment information from this period. This included self-reported meaningful use information for 26,653 professionals and 668 hospitals that CMS approved for about $1.7 billion in incentive payments. Professionals and hospitals that CMS approved for payments included those that had received incentive payments as well as those waiting to receive their payments.

We also collected certified EHR technology information from ONC's CHPL database. We obtained a list of all valid EHR certification codes that were present in the CHPL database as of December 2011.

We determined whether professionals' and hospitals' self-reported meaningful use information met meaningful use measure criteria. Specifically, we checked that self-reported numerators and denominators met the required thresholds for percentage-based measures, that professionals and hospitals selected "yes" for yes/no measures, and that they reported the correct number of core and menu measures. We also compared professionals' and hospitals' self-reported EHR certification codes to the list of valid EHR certification codes from the CHPL database.

We also replicated part of CMS's risk analysis of professionals' and hospitals' self-reported meaningful use information. We compared denominator values across selected percentage-based measures that should have the same denominator to detect mismatches. We selected measures for comparison based on CMS's audit planning documents.

CMS's Audit Plan, Staff Interviews, and Guidance to Professionals and Hospitals. We collected planning documents outlining CMS's audit strategy for the Medicare EHR incentive program in December 2011, and obtained updates to these documents in April 2012. The documents included a comprehensive overview of CMS's planned audit strategy and details on CMS's audit plan for each meaningful use measure.

In December 2011, we also conducted structured interviews with CMS staff about CMS's prepayment and postpayment oversight. We interviewed staff responsible for implementation and oversight of the Medicare EHR incentive program, including staff from the Office of E-Health Standards and Services, the Office of Financial Management, the Office of Information Systems, and the Office of Clinical Standards and Quality.

We analyzed the information from CMS's audit planning documents and interviews to identify any limitations to CMS's prepayment and postpayment oversight. First, we reviewed CMS's audit planning documents to determine what data sources CMS had identified to verify the accuracy of professionals' and hospitals' self-reported meaningful use information. We then analyzed the interview results to determine what current and planned prepayment and postpayment verification activities CMS conducts using those data sources.

We also reviewed Federal regulations for the Medicare EHR incentive program, a list of frequently asked questions (FAQ) on the Medicare EHR

incentive program, and other information on the CMS Web site to determine what audit guidance CMS provided.

Limitations

This report is an early assessment of CMS's oversight as it existed at the time of our data collection. We did not review completed audits conducted by CMS because, at the time of our data collection, CMS had not performed any.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

CMS does not verify the accuracy of professionals' or hospitals' self-reported meaningful use information prior to payment

CMS determines that professionals and hospitals are meaningful users of certified EHR technology, and therefore qualify for incentive payments, based solely on self-reported information. CMS does not verify that self-reported information is accurate prior to payment. Although CMS is not required to verify the accuracy of this information prior to payment, doing so would strengthen its oversight of the anticipated $6.6 billion in incentive payments. Verifying self-reported information prior to payment could also reduce the need to identify and recover erroneous payments after they are made.

CMS's prepayment validation functions correctly but does not verify the accuracy of self-reported information

CMS's prepayment validation of professionals' and hospitals' self-reported meaningful use information functions correctly. We found that all self-reported information met meaningful use criteria for professionals and hospitals approved for payment as of December 2011. In addition, all professionals and hospitals reported valid EHR certification codes and the correct number of core and menu measures.

Although CMS's prepayment validation functions correctly, it does not verify that self-reported information is accurate. The validation checks that self-reported numerators and denominators calculate to required percentage thresholds and that all relevant yes/no measures were checked "yes." However, it does not verify that numerators and denominators entered for percentage-based measures reflect the actual number of patients for a given measure or that professionals and hospitals possess certified EHR technology.

Sufficient data are not available to verify self-reported information through automated system edits

CMS staff reported that CMS considered using automated NLR system edits to verify professionals' and hospitals' self-reported meaningful use information prior to payment, but found that sufficient data were not available to do so. Automated system edits in the NLR could compare self-reported meaningful use information to other data sources as a means of verification.

CMS did not identify any data sources it could use to verify any of the 49 meaningful use measures. According to CMS staff, existing internal and external data sources are not comprehensive enough for verification and, in some cases, are not easily accessible. Further, no data sources exist for many of the meaningful use measures. Table 2 provides detail on CMS's assessment of data sources for verification. For a measure-specific breakdown of the categories in Table 2, see Appendix B.

Table 2: CMS's Assessment of Data Sources To Verify the Accuracy of Self-Reported Meaningful Use Information

Assessment	Number of Meaningful Use Measures
Internal CMS data sources are accessible but not comprehensive enough for verification (e.g., Medicare claims data).	25
External data sources are not accessible for verification (e.g., privately held e-prescribing data, State public health agency data).	6
No data source exists (i.e., data for measure are not currently collected by any entity).	19
Internal CMS data sources and external data sources exist but are not comprehensive or accessible for verification, respectively.	(1)
Total	**49**

Source: OIG analysis of CMS documents and interview data, 2012.

CMS has identified internal data sources for 25 meaningful use measures but does not use the data to verify the accuracy of self-reported information because they do not match measure definitions. For example, CMS cannot verify self-reported denominators using Medicare claims data because these data only cover the portions of the denominators associated with Medicare patients. To verify self-reported denominators, CMS would also need information about the non-Medicare patients.

CMS identified external data sources for six measures, but either did not have access to them or chose not to use them to verify self-reported information at the time of our data collection. For one measure, CMS staff reported that the cost of obtaining e-prescribing data from a private company, as well as the logistical difficulty of establishing real-time access, prevented CMS from using that source. For five measures, CMS identified public health data sources, such as State immunization registries, for potential use. CMS staff reported that CMS would attempt

to gain access to these State data sources but, at the time of our data collection, did not yet have access.

For 19 meaningful use measures, CMS did not identify any data sources it could use to verify the accuracy of self-reported information. CMS staff noted that these measures involve information that is not currently collected by any entity.

CMS does not collect supporting documentation to verify self-reported information prior to payment

CMS does not direct professionals or hospitals to submit supporting documentation to substantiate their self-reported meaningful use information prior to payment. While collecting this documentation for all professionals and hospitals may not be feasible, CMS could feasibly conduct risk analyses to select a subset of professionals and hospitals from which to request supporting documentation. CMS could then review this documentation to verify those professionals' and hospitals' self-reported meaningful use information where possible. Conducting such prepayment reviews would be consistent with CMS's stated objective of moving from a "pay and chase" model to a prevention-oriented approach focused on high-risk providers.[20]

Per OIG analysis, if prior to payment CMS had applied one of the risk analyses it proposes to use to select postpayment audit targets, it would have identified 14 percent of professionals (3,825 professionals) and 17 percent of hospitals (111 hospitals) for potential prepayment review. These professionals and hospitals reported different denominator values across selected meaningful use measures that should have the same denominator.

CMS's planned postpayment audits may not conclusively verify the accuracy of professionals' and hospitals' self-reported meaningful use information

In the event of an audit, CMS plans to rely on a combination of EHR reports and supporting documentation to verify that self-reported information is accurate. CMS staff reported that they plan to use EHR reports to verify the accuracy of self-reported information where possible, and obtain supporting documentation from professionals and hospitals as necessary to verify measures not covered by those reports.

[20] CMS, *Statement by Dr. Peter Budetti, JD, on Fighting Fraud and Waste in Medicare and Medicaid.* Accessed at www.hhs.gov on July 18, 2012.

To determine compliance conclusively, CMS's audits must verify that professionals' and hospitals' self-reported meaningful use information is accurate. As such, the EHR reports and other supporting documentation that CMS plans to rely on must be both sufficient (i.e., cover all aspects of each meaningful use measure) and accurate.

Reports from certified EHR technology are not sufficient for CMS to verify self-reported information and may not always be accurate

In the event of an audit, CMS plans to use EHR reports to verify professionals' and hospitals' self-reported meaningful use information. These reports aggregate information from individual records in the certified EHR technology to support the numbers that professionals and hospitals self-reported to CMS to qualify for incentive payments.

CMS Cannot Verify Self-Reported Information Using Only Reports From Certified EHR Technology. CMS cannot use EHR reports to verify all self-reported meaningful use information because ONC does not require certified EHR technology to be capable of producing reports for all meaningful use measures. ONC requires only that certified EHR technology be capable of producing reports covering professionals' and hospitals' performance on the 30 percentage-based meaningful use measures.[21] ONC does not require certified EHR technology to be capable of producing reports for the 19 yes/no measures.[22]

EHR reports also do not contain information necessary for CMS to verify all percentage-based measures. Specifically, the denominators for many percentage-based measures include both patients who have records in the certified EHR technology and patients who do not (i.e., those who have paper records only).[23] Because EHR reports contain information only on patients with records in the certified EHR technology, CMS cannot use them to verify denominators for percentage-based measures that include all patients. For a list of meaningful use measures that require all patients in the denominator, see Appendix A.

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[21] 45 CFR § 170.302(n).

[22] Ibid.

[23] Federal regulations require that denominators for 11 of the 30 percentage-based measures include all patients. For the remaining 19 percentage-based measures, professionals and hospitals may choose to include all patients or only those with records in the certified EHR technology for the denominator. 42 CFR § 495.6 (c)(1)(2).

Reports From Certified EHR Technology May Produce Inaccurate Information. One EHR technology vendor acknowledged that two of its certified products could produce inaccurate EHR reports for three percentage-based meaningful use measures.[24] According to ONC staff, the certification process did not identify these potential inaccuracies because the vendor-supplied test data did not account for the manner in which some professionals use the products. Similar problems may exist with EHR reports in other certified EHR technology.

The vendor is working to correct the problem and has notified CMS, professionals, and hospitals. As of December 2011, 1,079 professionals using the affected products (or 4 percent of all professionals receiving payment) had been approved for or received Medicare EHR incentive payments.

Inaccurate EHR reports may also lead to inaccurate audit determinations. All 30 percentage-based meaningful use measures could potentially be affected by this problem.

CMS may not be able to obtain sufficient supporting documentation to verify self-reported information during audits

Although Federal law and regulations require professionals and hospitals to keep documentation supporting their demonstrations of meaningful use, supplementary guidance from CMS does not provide additional detail on the specific types of supporting documentation it expects. By law, professionals and hospitals must retain documentation sufficient to support all claims to Medicare, including claims for EHR incentive payments.[25] Federal regulations also state that professionals and hospitals "must keep documentation supporting their demonstration of meaningful use."[26] CMS has issued additional guidance—including information posted on its Web site and EHR incentive program FAQs—that provides some further detail regarding documentation requirements.[27, 28] However, none of this guidance details the types of supporting documentation that CMS plans to rely on for audits.

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[24] GE Healthcare, *February letter to customers*. Accessed at www.gehealthcare.com on February 13, 2012.

[25] SSA § 1833(e).

[26] 42 CFR § 495.8(c).

[27] CMS, *Attestation Overview*. Accessed at www.cms.gov on May 9, 2012.

[28] CMS, *FAQs February 2012*. Accessed at www.cms.gov on May 9, 2012.

According to CMS staff, professionals and hospitals should keep detailed supporting documentation to substantiate their self-reported meaningful use information. CMS staff indicated that CMS auditors will use supporting documentation to verify self-reported meaningful use information for measures not covered by required EHR reports (i.e., the 19 yes/no measures and denominator values for percentage-based measures with all-patient denominators). CMS staff reported, for example, that they expect professionals and hospitals to maintain the following:

- screen shots showing that required EHR technology functions were enabled on the first day of or at some point during the 90-day reporting period (yes/no measures),
- documents showing that a security risk assessment was conducted (yes/no measures), and
- evidence of the number of patients with paper records for percentage-based measures with all-patient denominators (percentage-based measures).

Supporting Documentation That CMS Obtains Will Not Be Sufficient for CMS To Verify Self-Reported Information for Six Measures. Even if professionals and hospitals retain the types of supporting documentation that CMS staff expect, it will not be sufficient to verify self-reported meaningful use information for six measures. These six yes/no measures (three for professionals and three for hospitals) require that professionals and hospitals enable certain EHR technology functions for the entire 90-day reporting period. Specifically, they require professionals and hospitals to implement:

- drug-drug and drug-allergy interaction checks,
- one clinical decision support rule, and
- drug formulary checks.

Per CMS's audit plan, CMS will accept screen shots or in-person demonstrations as supporting evidence to verify the accuracy of self-reported meaningful use information. However, screen shots or demonstrations will only verify that professionals and hospitals enabled the required EHR technology functions at a specific time—not that they enabled them for the entire 90-day reporting period.

These six meaningful use measures may be particularly vulnerable to noncompliance. They require use of clinical decision support tools, which physicians often view as onerous or unnecessary. Several studies show

that physicians frequently develop "alert fatigue" with clinical decision support tools, especially with medication alerts.[29, 30] As a result, professionals and hospitals may disable clinical decision support tools for all or part of their 90-day reporting period.

[29] T. Isaac, et al., "Overrides of Medication Alerts in Ambulatory Care," *Archives of Internal Medicine*. 2009; 169(3):305–311. Accessed at www.archinte.ama-assn.org on March 6, 2012.

[30] H. Van der Sijs, et al.,"Overriding Drug Safety Alerts in CPOE," *Journal of American Medical Information Association*. 2006; 13:138–147. Accessed at www.jama.org on March 6, 2012.

CONCLUSION AND RECOMMENDATIONS

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. Absent changes to the definition of meaningful use, CMS should consider ways to strengthen its program oversight to protect the $4 billion in Medicare EHR incentive payments that it has paid, as well as billions of dollars in future incentive payments.

Currently, CMS has not implemented strong prepayment safeguards. CMS does not verify the accuracy of professionals' and hospitals' self-reported information prior to payment because data necessary for verifications are not readily available. CMS also does not direct high-risk professionals and hospitals to submit supporting documentation for prepayment review.

CMS's ability to safeguard incentive payments postpayment is also limited. CMS's planned postpayment audits may not conclusively verify the accuracy of professionals' and hospitals' self-reported information because supporting documentation may not be available. ONC's requirements for EHR reports may affect the availability of supporting documentation. If CMS cannot conclusively verify the accuracy of a professional's or hospital's self-reported information during a postpayment audit, it will be unable to determine whether the professional or hospital was a meaningful user and thereby qualified for the disbursed incentive payment.

The following recommendations to CMS and ONC will help strengthen oversight of the Medicare EHR incentive program. Our recommendations to CMS focus on immediate changes that CMS can make to improve safeguards, and our recommendations to ONC focus on changes to enhance EHR reports in support of CMS's oversight activities.

We recommend that:

CMS Obtain and Review Supporting Documentation From Selected Professionals and Hospitals Prior to Payment To Verify the Accuracy of Their Self-Reported Information

CMS should direct selected high-risk professionals and hospitals to submit documentation supporting their self-reported meaningful use information for prepayment review. To identify high-risk professionals and hospitals, CMS could use some of the risk analyses it plans to use to select postpayment audit targets. CMS could then collect supporting

documentation and conduct desk or onsite reviews, similar to its planned postpayment audit process, prior to making payments.

CMS Issue Guidance That Details the Types of Documentation It Expects Professionals and Hospitals To Maintain To Support Their Compliance

CMS should bolster its current guidance by detailing the types of supporting documentation it expects professionals and hospitals to maintain for specific meaningful use measures. To do this, CMS could issue an FAQ, conduct provider education, or issue other forms of guidance. This guidance could explain, for example, that CMS expects professionals and hospitals to keep documentation such as screen shots and proof that a security risk assessment was performed.

ONC Require Certified EHR Technology To Be Capable of Producing Reports for Yes/No Meaningful Use Measures, Where Possible

ONC could do this by updating its current regulations on the standards and functions required of certified EHR technology, or by including such a requirement in planned future regulations for the program. OIG acknowledges that producing reports may not be possible for some measures that include information not contained in the certified EHR technology (e.g., that a security risk assessment was conducted).

EHR reports for yes/no measures could help professionals and hospitals prove compliance in the event of an audit and simplify CMS's oversight. In particular, these reports could help CMS conclusively verify that professionals and hospitals had the relevant EHR technology functions enabled for the entire 90-day reporting period.

ONC Improve the Certification Process for EHR Technology To Ensure Accurate EHR Reports

ONC should ensure that certification bodies comprehensively test EHR reports for accuracy as part of the certification process. For example, ONC could require certification bodies to use standardized test data for EHR reports instead of relying on vendor-supplied test data. While recreating every manner of using EHR technology for testing purposes is not be possible, more comprehensive testing may increase the reliability of EHR reports for CMS's postpayment audits.

AGENCIES' COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

We made four recommendations—two to CMS and two to ONC. CMS did not concur with our first recommendation, but did concur with our second recommendation. ONC concurred with both our third and fourth recommendations.

CMS did not concur with our first recommendation that it obtain and review supporting documentation from selected professionals and hospitals prior to payment to verify the accuracy of their self-reported information. CMS stated that the Medicare EHR incentive program is an attestation-based program, and that prepayment reviews would impose an increased up-front burden on practitioners and hospitals. CMS further stated that conducting prepayment reviews would be difficult for practitioners and hospitals beyond their first year of participation, due to timing constraints, and could delay incentive payments.

We continue to recommend that CMS conduct prepayment reviews of selected professionals and hospitals. While we recognize that doing so would impose an increased burden on the professionals and hospitals selected by CMS, that burden would be justified by the reduced likelihood of making improper incentive payments to high-risk professionals and hospitals. We note that the timing constraints CMS raised do not apply to all practitioners and hospitals, and therefore do not justify forgoing prepayment reviews altogether. We further note that our recommendation leaves the decision of how to select high-risk professionals and hospitals to CMS's discretion; as such, CMS can select a methodology that appropriately accounts for the logistical and timing constraints it faces.

CMS concurred with our second recommendation that it issue guidance detailing the types of documentation it expects professionals and hospitals to maintain to support their compliance. CMS indicated that it is currently developing an FAQ document, to be posted online, that will bolster existing guidance to professionals and hospitals. We note that as detailed in our recommendation, the guidance that CMS provides should include examples of the types of documentation professionals and hospitals should retain for specific meaningful use measures.

ONC concurred with our third recommendation that it require certified EHR technology to be capable of producing reports for yes/no meaningful use measures, where possible. ONC stated that it will request recommendations on the scope and feasibility of such a requirement from its two Federal advisory committees. While we support ONC's decision to seek input from its advisory committees, we reiterate that requiring

certified EHR technology to be capable of producing EHR reports for yes/no meaningful use measures would improve CMS's ability to oversee the Medicare EHR incentive program. As such, we continue to recommend that ONC require certified EHR technology to be capable of producing reports for all meaningful use measures, where possible, in its future rulemaking.

ONC also concurred with our fourth recommendation that it improve the certification process for EHR technology to ensure accurate EHR reports. ONC stated that its most recent rulemaking includes more rigorous testing requirements for certified EHR technology, and that it will continue to work with stakeholders to develop more comprehensive test procedures and reduce its reliance on vendor-supplied test data.

CMS provided one technical comment, which we have incorporated into the report.

For the full text of CMS and ONC comments, see Appendix C.

APPENDIX A

Meaningful Use Measures for Professionals and Hospitals

Table A-1: Professional Meaningful Use Measures

Measure	Criterion Type	Measure Criterion	All-Patient Denominator Required
Core Measures			
1. Computerized provider order entry (CPOE)	Percentage-based	More than 30 percent of all unique patients with at least one medication in their medication lists have at least one medication order entered using CPOE.	No
2. Drug interaction checks	Yes/no	The professional enables drug-drug and drug-allergy check functionality for the entire reporting period.	N/A
3. Problem lists	Percentage-based	More than 80 percent of all unique patients have at least one entry (or an indication that no problems are known for the patient) recorded as structured data.	Yes
4. Electronic prescribing	Percentage-based	More than 40 percent of all permissible prescriptions written by the professional are transmitted electronically using certified electronic health record (EHR) technology.	No
5. Active medication lists	Percentage-based	More than 80 percent of all unique patients have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	Yes
6. Medication allergy lists	Percentage-based	More than 80 percent of all unique patients have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	Yes
7. Demographics	Percentage-based	More than 50 percent of all unique patients have demographics recorded as structured data.	Yes
8. Vital signs	Percentage-based	More than 50 percent of all unique patients age 2 and over have height, weight, and blood pressure recorded as structured data.	No

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Table A-1: Professional Meaningful Use Measures (Continued)

Measure	Criterion Type	Measure Criterion	All-Patient Denominator Required
Core Measures (continued)			
9. Smoking status	Percentage-based	More than 50 percent of all unique patients 13 years old or older have smoking status recorded as structured data.	No
10. Ambulatory clinical quality measures (CQM)	Yes/no	The professional successfully reports ambulatory CQMs selected by the Centers for Medicare & Medicaid Services (CMS) in the manner specified by CMS.	N/A
11. Clinical decision support rule	Yes/no	The professional implements one clinical decision support rule.	N/A
12. Electronic copy of health information	Percentage-based	More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days.	No
13. Clinical summaries	Percentage-based	Clinical summaries are provided to patients for more than 50 percent of all office visits within 3 days.	No
14. Electronic exchange of clinical information	Yes/no	The professional performs at least one test of certified EHR technology's capacity to electronically exchange key clinical information.	N/A
15. Protection of electronic health information	Yes/no	The professional conducts or reviews a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), implements security updates as necessary, and corrects identified security deficiencies as part of its risk management process.	N/A
Menu Measures			
1. Drug formulary checks	Yes/no	The professional enables drug-formulary check functionality and has access to at least one internal or external formulary for the entire EHR reporting period.	N/A
2. Clinical lab test results	Percentage-based	More than 40 percent of all clinical lab test results ordered by the professional during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.	No

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Table A-1: Professional Meaningful Use Measures (Continued)

Measure	Criterion Type	Measure Criterion	All-Patient Denominator Required
Menu Measures (continued)			
3. Patient lists	Yes/no	The professional generates at least one report listing patients with a specific condition.	N/A
4. Patient reminders	Percentage-based	More than 20 percent of all patients 65 years old or older or 5 years old or younger are sent an appropriate reminder during the EHR reporting period.	No
5. Patient electronic access	Percentage-based	At least 10 percent of all unique patients are provided timely (available to the patient within 4 business days of being updated in the certified EHR technology) electronic access to their health information subject to the professional's discretion to withhold certain information.	Yes
6. Patient-specific education resources	Percentage-based	More than 10 percent of all unique patients are provided patient-specific education resources.	Yes
7. Medication reconciliation	Percentage-based	The professional performs medication reconciliation for more than 50 percent of transitions of care.	No
8. Transition of care summaries	Percentage-based	The professional who transitions or refers a patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.	No
9. Immunization registries data submission	Yes/no	The professional performs at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and a follow up submission if the test is successful.	N/A
10. Syndromic surveillance data submission	Yes/no	The professional performs at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and a follow up submission if the test is successful (unless none of the public health agencies to which a professional submits such information has the capacity to receive the information electronically).	N/A

Source: Office of Inspector General (OIG) analysis of Federal regulations, 2011.

Table A-2: Hospital Meaningful Use Measures

Measure	Criterion Type	Measure Criterion	All-Patient Denominator Required
Core Measures			
1. CPOE	Percentage-based	More than 30 percent of all unique patients with at least one medication in their medication lists have at least one medication order entered using CPOE.	No
2. Drug interaction checks	Yes/no	The hospital enables drug-drug and drug-allergy check functionality for the entire EHR reporting period.	N/A
3. Problem lists	Percentage-based	More than 80 percent of all unique patients have at least one entry (or an indication that no problems are known for the patient) recorded as structured data.	Yes
4. Active medication lists	Percentage-based	More than 80 percent of all unique patients have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	Yes
5. Medication allergy lists	Percentage-based	More than 80 percent of all unique patients have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	Yes
6. Demographics	Percentage-based	More than 50 percent of all unique patients have demographics recorded as structured data.	Yes
7. Vital signs	Percentage-based	More than 50 percent of all unique patients age 2 and over have height, weight, and blood pressure recorded as structured data.	No
8. Smoking status	Percentage-based	More than 50 percent of all unique patients 13 years old or older have smoking status recorded as structured data.	No
9. Hospital CQMs	Yes/no	The hospital successfully reports hospital CQMs selected by CMS in the manner specified by CMS.	N/A
10. Clinical decision support rule	Yes/no	The hospital implements one clinical decision support rule.	N/A
11. Electronic copy of health information	Percentage-based	More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days.	No

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Table A-2: Hospital Meaningful Use Measures (Continued)

Measure	Criterion Type	Measure Criterion	All-Patient Denominator Required
Core Measures (continued)			
12. Electronic copy of discharge instructions	Percentage-based	More than 50 percent of all patients who are discharged from a hospital and who request an electronic copy of their discharge instructions are provided it.	No
13. Electronic exchange of clinical information	Yes/no	The hospital performs at least one test of certified EHR technology's capacity to electronically exchange key clinical information.	N/A
14. Protection of electronic health information	Yes/no	The hospital conducts or reviews a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), implements security updates as necessary, and corrects identified security deficiencies as part of its risk management process.	N/A
Menu Measures			
1. Drug formulary checks	Yes/no	The hospital enables drug-formulary check functionality and has access to at least one internal or external formulary for the entire EHR reporting period.	N/A
2. Advance directives	Percentage-based	More than 50 percent of all unique patients 65 years old or older have an indication of an advance directive status recorded as structured data.	No
3. Clinical lab test results	Percentage-based	More than 40 percent of all clinical lab test results ordered by the hospital during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.	No
4. Patient lists	Yes/no	The hospital generates at least one report listing patients of the hospital with a specific condition.	N/A
5. Patient-specific education resources	Percentage-based	More than 10 percent of all unique patients are provided patient-specific education resources.	Yes
6. Medication reconciliation	Percentage-based	The hospital performs medication reconciliation for more than 50 percent of transitions of care.	No

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Table A-2: Hospital Meaningful Use Measures (Continued)

Measure	Criterion Type	Measure Criterion	All-Patient Denominator Required
Menu Measures (continued)			
7. Transition of care summaries	Percentage-based	The hospital that transitions or refers its patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.	No
8. Immunization registries data submission	Yes/no	The hospital performs at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and a follow up submission if the test is successful.	N/A
9. Reportable lab results to public health agencies	Yes/no	The hospital performs at least one test of certified EHR technology's capacity to provide electronic submission of reportable lab results to public health agencies and a follow up submission if the test is successful.	N/A
10. Syndromic surveillance data submission	Yes/no	The hospital performs at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and a follow up submission if the test is successful.	N/A

Source: OIG analysis of Federal regulations, 2011.

APPENDIX B

Centers for Medicare & Medicaid Services' Assessment of Data Sources To Verify the Accuracy of Self-Reported Meaningful Use Information, by Measure

Table B-1: Professional Meaningful Use Measure Data Sources

Measure	Type of Data Source
Core Measures	
1. Computerized provider order entry (CPOE)	Internal data source
2. Drug interaction checks	No data source
3. Problem lists	Internal data source
4. Electronic prescribing (e-prescribing)	Internal data source External data source: privately held e-prescribing data
5. Active medication lists	Internal data source
6. Medication allergy lists	No data source
7. Demographics	Internal data source
8. Vital signs	Internal data source
9. Smoking status	Internal data source
10. Ambulatory clinical quality measures (CQM)	Internal data source
11. Clinical decision support rule	No data source
12. Electronic copy of health information	No data source
13. Clinical summaries	Internal data source

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Table B-1: Professional Meaningful Use Measure Data Sources (Continued)

Measure	Type of Data Source
Core Measures (continued)	
14. Electronic exchange of clinical information	No data source
15. Protection of electronic health information	No data source
Menu Measures	
1. Drug formulary checks	Internal data source
2. Clinical lab test results	Internal data source
3. Patient lists	No data source
4. Patient reminders	No data source
5. Patient electronic access	Internal data source
6. Patient-specific education resources	Internal data source
7. Medication reconciliation	No data source
8. Transition of care summaries	No data source
9. Immunization registries data submission	External data source: public health agency
10. Syndromic surveillance data submission	External data source: public health agency

Source: Office of Inspector General (OIG) analysis of CMS documents and interview data, 2012.

Table B-2: Hospital Meaningful Use Measure Data Sources

Measure	Type of Data Source
Core Measures	
1. CPOE	Internal data source
2. Drug interaction checks	No data source
3. Problem lists	Internal data source
4. Active medication lists	Internal data source
5. Medication allergy lists	Internal data source
6. Demographics	Internal data source
7. Vital signs	Internal data source
8. Smoking status	Internal data source
9. Hospital CQMs	No data source
10. Clinical decision support rule	No data source
11. Electronic copy of health information	No data source
12. Electronic copy of discharge instructions	No data source
13. Electronic exchange of clinical information	No data source
14. Protection of electronic health information	No data source
Menu Measures	
1. Drug formulary checks	No data source
2. Advance directives	Internal data source
3. Clinical lab test results	Internal data source

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Table B-2: Hospital Meaningful Use Measure Data Sources (Continued)

Measure	Type of Data Source
Menu Measures (continued)	
4. Patient lists	No data source
5. Patient-specific education resources	Internal data source
6. Medication reconciliation	Internal data source
7. Transition of care summaries	Internal data source
8. Immunization registries data submission	External data source: public health agency
9. Reportable lab results to public health agencies	External data source: public health agency
10. Syndromic surveillance data submission	External data source: public health agency

Source: OIG analysis of CMS documents and interview data, 2012.

APPENDIX C

Agencies' Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

OCT 09 2012

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report – *Early Assessment Finds That CMS Faces Obstacles in Overseeing the Medicare EHR Incentive Program,* OEI-05-11-00250

Thank you for the opportunity to review and comment on the OIG draft report "Early Assessment Finds That CMS Faces Obstacles in Overseeing the Medicare EHR Incentive Program" (OEI-05-11-00250). The Centers for Medicare & Medicaid Services (CMS) appreciates the contributions and valuable input by the OIG. The draft report assessed CMS's oversight of the Medicare Electronic Health Record (EHR) Incentive programs. The information in the report will help inform our administration of the Medicare and Medicaid EHR Incentive Programs.

The CMS continues to work with the Office of National Coordinator for Health Information Technology (ONC) to maximize the success of the Medicare and Medicaid EHR Incentive Programs and the related Health Information Technology for Economic and Clinical Health (HITECH) Act provisions. The draft report contained four recommendations: two for CMS and two for ONC. We are addressing the CMS recommendations in this response.

OIG Recommendation

The CMS obtain and review supporting documentation from selected professionals and hospitals prior to payment to verify the accuracy of their self-reported information.

CMS Response

The CMS does not believe prepayment audit is necessary at this juncture. CMS has implemented a number of prepayment verification edits to ensure that providers are eligible to participate in the Medicare EHR Incentive Program. In addition, CMS validates all of the EHR certification numbers that are provided by providers. The EHR incentive program is an attestation-based program and our systems have been designed to accommodate this process. It would be particularly difficult to implement for providers after their first year of participation because the reporting period is an entire year and all attestations are received in a two-month period during which CMS would have to review supporting documentation. To change this process and implement pre-payment audits could significantly delay payments to providers.

Requesting additional documentation from providers would also impose an increased up-front burden on providers. CMS is currently implementing a batch reporting mechanism that will enable a provider to submit a batch file of the attestation information generated by their EHR for all of a group's individual eligible professionals. We believe that this new functionality will further enhance the accuracy of the data submitted by providers.

OIG Recommendation

The CMS issue guidance that details the types of documentation it expects professionals and hospitals to maintain to support their compliance.

CMS Response

The CMS concurs with this recommendation. CMS established an EHR website in Fiscal Year 2010. To date, we have posted numerous documents and guidance about EHR compliance. We are in the process of developing a Frequently Asked Questions (FAQ) document that we plan to post on the EHR Website within the next 30 days. The FAQ document will bolster the existing guidance and will be used for education and presentations.

Technical Comments

The fourth paragraph of page 1 of the report describes the hospital incentive payments as always including a $2 million base incentive payment. While the payment formula dictated in section 1886(n)(2) of the Social Security Act includes that base amount, the payment made to the hospital is the product of the base amount, a transition factor and other elements. The transition factor starts at 1 for the first payment year and decreases by a ¼ each year and is designed to steadily reduce the incentive payments. Therefore, payment made to an eligible hospital after the first payment year may be less than $2 million.

The CMS appreciates the effort that went into this draft report and we look forward to continuing to work with you in the future.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Office of the National Coordinator
for Health Information Technology
Washington, D.C. 20201

DATE: September 25, 2012

TO: Daniel R. Levinson
Inspector General

FROM: Farzad Mostashari
National Coordinator

SUBJECT: The Office of the National Coordinator for Health Information Technology's Comments to the Office of Inspector General's Draft Report, *Early Assessment Finds That CMS Faces Obstacles in Overseeing the Medicare EHR Incentive Program*, OEI-05-11-00250

Thank you for the opportunity to review and comment on the findings and recommendations in the Office of Inspector General's (OIG) Draft Report, *Early Assessment Finds That CMS Faces Obstacles in Overseeing the Medicare EHR Incentive Program,* OEI-05-11-00250. The draft report includes recommendations for the Office of the National Coordinator for Health Information Technology (ONC) to enhance reports produced by EHRs to strengthen program oversight of the Medicare EHR incentive program. ONC concurs and has already taken steps to address both recommendations. ONC appreciates the OIG's efforts to improve program integrity. We will continue to collaborate with the Centers for Medicare and Medicaid (CMS) to strengthen the Medicare and Medicaid EHR Incentive Programs and the related Health Information Technology for Economic and Clinical Health (HITECH) Act provisions.

OIG Recommendation

ONC Require Certified EHR Technology to Be Capable of Producing Reports for Yes/No Meaningful Use Measures, Where Possible

ONC Response

ONC concurs with this recommendation and appreciates that the OIG recognizes the difficulty with requiring EHR technology to produce a "yes/no" report for some measures that include information not contained in the certified EHR technology (e.g., that a security risk assessment was conducted). As stated in the 2014 Edition Standards and Certification Criteria Final Rule, we will request ONC's two Federal advisory committees, the HIT Policy Committee and HIT Standards Committee, to provide recommendations on the appropriate scope and feasibility of a certification criterion focused on "yes/no" reports for meaningful use measure. Once we get their recommendations, we will determine appropriate certification criterion in future rulemaking.

OIG Recommendation

ONC Improve the Certification Process for EHR Technology to Ensure Accurate EHR Reports

ONC Response

ONC concurs with OIG's recommendation and has already taken steps to address this recommendation. In response to the HITECH Act, ONC rapidly established the Temporary Certification Program to ensure

that EHR technology could be certified in time for Meaningful Use Stage 1. The recent 2014 Edition Standards and Certification Criteria Final Rule established the permanent ONC HIT Certification Program with more rigorous testing requirements to be effective October 4, 2012. We will work with stakeholders this fall on test procedures that will be more comprehensive and will continue to migrate away from the exclusive use of vendor-supplied test data. ONC will continue to improve the accuracy of EHR reports as the testing and certification process becomes more rigorous over time.

CC: Marilyn Tavenner, CMS
Stuart Wright, OIG

ACKNOWLEDGMENTS

This report was prepared under the direction of Ann Maxwell, Regional Inspector General for Evaluation and Inspections in the Chicago regional office, and Tom Komaniecki and Laura Kordish, Deputy Regional Inspectors General.

Kelly Waldhoff served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the Chicago regional office who contributed to the report include Adam Freeman and Brian Jordan; central office staff who contributed include Debra Roush and Tasha Trusty.