Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE PAID HUNDREDS OF MILLIONS IN ELECTRONIC HEALTH RECORD INCENTIVE PAYMENTS THAT DID NOT COMPLY WITH FEDERAL REQUIREMENTS

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June 2017
A-05-14-00047

Office of Inspector General

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EXECUTIVE SUMMARY

From May 2011 through June 2014, the Centers for Medicare & Medicaid Services paid an estimated $729 million in Medicare electronic health record incentive payments to eligible professionals who did not comply with Federal requirements. In addition, it paid $2.3 million in inappropriate electronic health record incentive payments to eligible professionals who switched incentive programs.

WHY WE DID THIS REVIEW

As an incentive for using certified electronic health record (EHR) technology, the Federal Government is making payments to eligible professionals (EPs) and hospitals that attest to the "meaningful use" of EHRs. As of June 2014, Medicare had made EHR incentive payments to EPs totaling approximately $6 billion.

The Government Accountability Office has identified improper incentive payments as the primary risk to EHR incentive programs, and a U.S. Department of Health and Human Services, Office of Inspector General, report describes the obstacles that the Centers for Medicare & Medicaid Services (CMS) and States face in overseeing the Medicare and Medicaid EHR incentive programs. The obstacles leave the programs vulnerable to making incentive payments to EPs and hospitals that do not fully meet requirements. We conducted this review to determine whether CMS's oversight of the Medicare EHR incentive program was sufficient and whether EPs nationwide met Medicare incentive payment program requirements and received appropriate incentive payments.

OBJECTIVE

Our objective was to determine whether CMS made Medicare EHR incentive payments to EPs in accordance with Federal requirements.

BACKGROUND

The Health Information Technology for Economic and Clinical Health Act (HITECH Act), enacted as part of the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5, established the Medicare and Medicaid EHR incentive programs to promote the adoption of EHRs and to improve health care quality, safety, and efficiency through the promotion of health information technology and electronic health information exchange.

Provisions in the HITECH Act defined the types of professionals who may be eligible to receive Medicare EHR incentive payments. EPs may be physicians, dentists, podiatrists, optometrists, or chiropractors (Social Security Act § 1861(r)). During 2011, the first year of the EHR incentive program, 141,649 EPs registered to participate in the program. EPs may receive incentive payments for up to 5 years.

To receive an incentive payment, EPs attest that they meet program requirements by self-reporting data through CMS's online system, at which point the data is stored in the National Level Repository (NLR). The NLR is a provider registration and verification system that contains information on providers participating in the Medicare and Medicaid EHR incentive programs. EPs may not receive EHR incentive payments from both the Medicare and Medicaid EHR incentive programs in the same year. If an EP qualifies for EHR incentive payments from both the Medicare and Medicaid programs, the EP must elect to receive payments from only one program.

On April 16, 2015, Congress enacted the Medicare Access and Children's Health Insurance Program [CHIP] Reauthorization Act (MACRA) (P.L. No. 114-10). Among many other changes, MACRA established payment reforms that consolidated several programs into a Merit-Based Incentive Payment System (MIPS), including the Medicare EHR Incentive Program for EPs (now named "Advancing Care Information" under MIPS). On November 4, 2016, CMS issued a final rule implementing the reforms in MACRA (81 Fed. Reg. 77008). The changes under the Advancing Care Information element of MIPS replace the EHR incentive programs and alter the way Medicare EPs receive payments for being meaningful users.

HOW WE CONDUCTED THIS REVIEW

Our review covered EHR incentive payments totaling $6,093,924,710 that Medicare made to 250,470 EPs from May 2011 to June 2014 (audit period). We selected a simple random sample of 100 EPs who received 1 or more payments during the audit period and reviewed support for their attestation(s) to meaningful use measures. In addition, we reviewed all payments made to deceased EPs and to EPs who switched between Medicare and Medicaid programs to determine whether Medicare made inappropriate payments during our audit period.

WHAT WE FOUND

CMS did not always make EHR incentive payments to EPs in accordance with Federal requirements. On the basis of our sample of 100 EPs, we identified 14 EPs with payments totaling $291,222 that did not meet the meaningful use requirements because of insufficient attestation support, inappropriate reported meaningful use periods, or insufficiently used certified EHR technology. On the basis of our sample results, we estimated that CMS inappropriately paid $729,424,395 in incentive payments to EPs who did not meet meaningful use requirements.

These errors occurred because sampled EPs did not maintain support for their attestations. Furthermore, CMS conducted minimal documentation reviews of self-attestations, leaving the EHR program vulnerable to abuse and misuse of Federal funds.

CMS also made EHR incentive payments that were not in accordance with the program-year payment requirements when EPs switched between Medicare and Medicaid incentive programs. Specifically, we identified 471 EHR incentive payments totaling $2,344,680 that CMS made to EPs for the wrong payment year. These errors occurred because CMS did not have edits in place to ensure that EPs who switched from one program to the other were placed in the correct payment year upon switching.

WHAT WE RECOMMEND

We recommend that CMS:

- recover $291,222 in payments made to the sampled EPs who did not meet meaningful use requirements,

- review EP incentive payments to determine which EPs did not meet meaningful use measures for each applicable program year to attempt recovery of the $729,424,395 in estimated inappropriate incentive payments,

- review a random sample of EPs' documentation supporting their self-attestations to identify inappropriate incentive payments that may have been made after the audit period,

- educate EPs on proper documentation requirements,

- recover $2,344,680 in overpayments made to EPs after they switched programs, and

- employ edits within the NLR system to ensure that an EP does not receive payments under both EHR incentive programs for the same program year.

Finally, as CMS implements MACRA, we recommend that any modifications to the EHR meaningful use requirements include stronger program integrity safeguards that allow for more consistent verification of the reporting of required measures so that CMS can ensure that EPs are using EHR technology consistent with CMS's goal of Advancing Care Information under MIPS.

CMS COMMENTS AND OUR RESPONSE

In written and technical comments on our draft report, CMS concurred with our first, fourth, fifth, and sixth recommendations and provided information on actions that it had taken or planned to take to address those recommendations. In addition, CMS partially concurred with our second and third recommendations, stating that it has implemented targeted risk-based audits to strengthen program integrity and will continue to do so in 2017.

After reviewing CMS's comments and having followup discussions with CMS officials, we maintain that the targeted risk-based audits are not capturing errors such as those identified in this report. We therefore continue to recommend that CMS review EP incentive payments to determine which EPs did not meet meaningful use requirements and attempt recovery of the estimated $729,424,395, as well as review a random sample of EPs' documentation supporting their self-attestations to identify inappropriate incentive payments.

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INTRODUCTION

WHY WE DID THIS REVIEW

As an incentive for using certified electronic health record (EHR) technology, the Federal Government is making payments to eligible professionals[1] (EPs) and hospitals that attest to the "meaningful use"[2] of EHRs. As of June 2014, Medicare had made EHR incentive payments to EPs totaling approximately $6 billion.

The Government Accountability Office has identified improper incentive payments as the primary risk to EHR incentive programs. These programs contain complex requirements and may be at greater risk of improper payments than other programs. A U.S. Department of Health and Human Services, Office of Inspector General, report describes the obstacles that the Centers for Medicare & Medicaid Services (CMS) and States face in overseeing the Medicare and Medicaid EHR incentive programs.[3] The obstacles leave the programs vulnerable to making incentive payments to EPs and hospitals that do not fully meet requirements. We conducted this review to determine whether CMS's oversight of the Medicare EHR incentive program was sufficient and whether EPs nationwide met Medicare incentive payment program requirements and received appropriate incentive payments.

OBJECTIVE

Our objective was to determine whether CMS made Medicare EHR incentive payments to EPs in accordance with Federal requirements.

BACKGROUND

Health Information Technology for Economic and Clinical Health Act

On February 17, 2009, the President signed the American Recovery and Reinvestment Act of 2009 (Recovery Act), P.L. No. 111-5. Title XIII of Division A and Title IV of Division B of the Recovery Act are cited together as the Health Information Technology for Economic and Clinical Health Act (HITECH Act). The HITECH Act established EHR incentive programs for both Medicare and Medicaid to promote the adoption of EHRs and to improve health care quality, safety, and efficiency through the promotion of health information technology and electronic health information exchange.

[1] EPs may be doctors of medicine or osteopathy, dental surgery and medicine, podiatry, optometry, or chiropractors (Social Security Act § 1861(r)).

[2] Section 1848(o)(2)(A).

[3] OEI-05-11-00250, *Early Assessment Finds That CMS Faces Obstacles in Overseeing the Medicare EHR Incentive Program*.

Incentive Payment Eligibility Requirements

The Medicare EHR Incentive Program provides for incentive payments to EPs who are meaningful users of certified EHR technology. To receive an incentive payment, EPs attest that they meet program requirements by self-reporting data through the National Level Repository (NLR). The NLR is a CMS web-based provider registration and verification system that contains information on providers participating in the Medicare and Medicaid EHR incentive programs. The NLR database checks for duplicate payments, maintains incentive payment history files, and stores all EP attestations of meaningful use.[4]

EPs may be qualified to receive EHR incentive payments from both Medicare and Medicaid incentive programs (42 CFR § 495.10(e)(2) and (5))[5]; however, EPs may not receive an incentive payment from both programs in the same year. If an EP qualifies for EHR incentive payments from both the Medicare and Medicaid programs, the EP must elect to receive payments from only one program. After an EP qualifies for an EHR incentive payment under one program, the EP may switch between the Medicare and Medicaid programs one time. Upon switching programs, the EP will be placed in the payment year the EP would have been in had the EP not switched programs.

Meaningful Use Attestation of Core and Menu Measures

Federal regulations (42 CFR § 495.4) define an EP's meaningful use "EHR reporting period" as one of the following: any continuous 90-day period within a calendar year for the first payment year or the entire calendar year for the second, third, fourth, fifth, or sixth payment year. EPs are required to self-attest to being a "meaningful EHR user" by inputting required data into the NLR database that is obtained through numerous EHR technology functions.

Federal regulations (42 CFR § 495.8) have established meaningful use core and menu measures meant to improve health care quality and efficiency. Each meaningful use measure has specified criteria that involve (1) performing a one-time action (yes/no measure) or (2) performing a certain action for a specified percentage of unique patients, patient visits, or other events. EPs must meet applicable core and menu measures at the time of attestation. See the complete list of core and menu measures applicable to EPs in Appendix A.

Eligible Professionals May Receive Incentive Payments for Up to 5 Years

EPs who qualify for the Medicare incentive program and demonstrate meaningful use can begin receiving incentive payments in any calendar year between 2011 and 2014. EPs may receive

[4] The NLR database interacts with other CMS systems to perform validation checks during an EP's registration, attestation, and payment process. Some of these validation checks include National Provider Identification (NPI) status validation; Death Master File validation; hospital-based validation; and provider enrollment, chain, and ownership system enrollment validation.

[5] All CFR citations are to regulations effective during the audit period of May 1, 2011, through June 30, 2014. On October 16, 2015, CMS renumbered or redesignated several provisions in 42 CFR part 495 in 80 Fed. Reg. 62762.

EHR incentive payments for up to 5 years, depending on the year in which the EP initially became a meaningful user of certified EHR technology.

EPs who successfully demonstrate meaningful use and receive an EHR incentive payment for the first or second year of the incentive program (2011 or 2012) may qualify to receive payments for the full 5 years. However, EPs who first successfully demonstrated meaningful use for 2013 may receive incentive payments for only 4 years and will receive less than the maximum possible incentive payment. Likewise, EPs who started demonstrating meaningful use in 2014 may receive incentive payments for only 3 years and will also receive less than the maximum possible incentive payment. An EP who first successfully demonstrated meaningful use of certified EHR technology for 2015 would not qualify for any EHR incentive payments. In addition, starting in 2015, an EP who does not successfully demonstrate meaningful use of certified EHR technology is subject to reduced physician fee schedule payments.

Incentive Payment – Annual Limits

EPs who successfully demonstrate meaningful use of certified EHR technology during the relevant EHR reporting period may be eligible for an incentive payment, subject to an annual limit, equal to 75 percent of the EP's Medicare-allowed charges submitted not later than 2 months after the end of the calendar year.

However, on March 1, 2013, as a result of an order required by law under the Budget Control Act of 2011, incentive payments made through the EHR Incentive Program were subject to the mandatory reductions in Federal spending known as sequestration. Under these mandatory reductions, Medicare reduced by 2 percent the EHR incentive payments made to EPs and eligible hospitals. This 2-percent reduction was applied to any Medicare EHR incentive payment for a EHR reporting period that ended on or after April 1, 2013.

Table 1 illustrates the maximum incentive payments an EP could receive by year and the total incentive payments possible if an EP successfully demonstrated meaningful use and qualified for an incentive payment each year. As shown, the total amount of the incentive payment an EP could receive was dependent in part on the first year that the EP successfully demonstrated meaningful use.

Table 1: Medicare EHR Incentive Payment Schedule for Eligible Professionals

	First Payment Received in 2011	First Payment Received in 2012	First Payment Received in 2013	First Payment Received in 2014
Payment amount in 2011	$18,000			
Payment amount in 2012	12,000	$18,000		
Payment amount in 2013*	7,840	11,760	$14,700	
Payment amount in 2014	3,920	7,840	11,760	$11,760
Payment amount in 2015	1,960	3,920	7,840	7,840
Payment amount in 2016		1,960	3,920	3,920
Total Incentive	**$43,720**	**$43,480**	**$38,220**	**$23,520**

*As required by law, sequestration began on March 1, 2013. Under the mandatory reductions, Medicare EHR incentive payments made to EPs and eligible hospitals were reduced by 2 percent. This 2-percent reduction has been applied to any Medicare EHR incentive payment for a EHR reporting period that ended on or after April 1, 2013. This reduction did not apply to Medicaid EHR incentive payments.

Medicare Access and Children's Health Insurance Program Reauthorization Act

On April 16, 2015, Congress enacted the Medicare Access and Children's Health Insurance Program [CHIP] Reauthorization Act (MACRA) (P.L. No. 114-10). Among many other changes, MACRA established payment reforms that consolidated several programs into a Merit-Based Incentive Payment System (MIPS), including the Medicare EHR Incentive Program for EPs (now named "Advancing Care Information" under MIPS). On November 4, 2016, CMS issued a final rule implementing the reforms in MACRA (81 Fed. Reg. 77008). The changes under the Advancing Care Information element of MIPS replace the EHR incentive program and alter the way Medicare EPs receive payment for being meaningful users.

HOW WE CONDUCTED THIS REVIEW

Our review covered Medicare EHR incentive payments made to 250,470 EPs totaling $6,093,924,710 from May 2011 to June 2014 (audit period). We selected a simple random sample of 100 EPs who received 1 or more payments during this period. For each sampled EP, we obtained and reviewed support for the incentive payment(s) and support for the attestation(s) to meaningful use measures applicable to each EP's payment(s) under review. In addition, we reviewed all payments made to EPs who switched between receiving incentive payments from Medicare or Medicaid to the other program and all payments made to EPs who died during the

EHR reporting period to determine whether inappropriate incentive payments were made during our audit period. These payments were not related to our sample.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix B contains the details of our audit scope and methodology, Appendix C contains our statistical sampling methodology, Appendix D contains our sample results and estimates, and Appendix E contains Federal requirements for EHR incentive payments.

FINDINGS

CMS did not always make EHR incentive payments to EPs in accordance with Federal requirements. In our sample of 100 EPs, we identified 14 EPs with payments totaling $291,222 that did not meet the meaningful use requirements because of insufficient attestation support, inappropriate reported meaningful use periods, or insufficiently used certified EHR technology. On the basis of our sample results, we estimated that CMS inappropriately paid $729,424,395 in incentive payments to EPs who did not meet meaningful use requirements.[6]

These errors occurred because sampled EPs did not maintain support for their attestations. Furthermore, CMS conducted minimal documentation reviews of the self-attestations, leaving the EHR program vulnerable to abuse and misuse of Federal funds.

CMS also made EHR incentive payments that were not in accordance with the program-year payment requirements when EPs switched between Medicare and Medicaid incentive programs. Specifically, we identified 471 EHR incentive payments totaling $2,344,680 that CMS made to EPs for the wrong payment year. These errors occurred because CMS did not have edits in place to ensure that EPs who switched from one program to the other were placed in the correct payment year upon switching.

CMS MADE ELECTRONIC HEALTH RECORD INCENTIVE PAYMENTS TO NONCOMPLIANT ELIGIBLE PROFESSIONALS

CMS made EHR incentive payments to some EPs who had not met Federal requirements. Specifically, for 14 of the 100 EPs in our sample, CMS made EHR incentive payments totaling $291,222 to EPs who had not demonstrated meaningful use. On the basis of our sample results, we estimated that CMS inappropriately paid $729,424,395 in incentive payments.

[6] For estimation purposes, we report noncompliant payments at the point estimate. This point estimate reflects an error rate of approximately 12 percent of the total payments made to EPs during our audit period.

Some Eligible Professionals Did Not Maintain or Provide Attestation Support

Generally, to satisfy stage 1 meaningful use, Federal regulations require EPs to meet all core measures and to select 5 of 10 menu measures to satisfy. One core measure requires EPs to "[c]onduct or review a security risk analysis…."[7] Two menu measures that EPs can choose require EPs to "generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach,"[8] and "generate at least one report listing patients of the EP with a specific condition."[9] Finally, to demonstrate meaningful use "[a]ll EPs … must keep documentation supporting their demonstration of meaningful use for 6 years."[10]

Some EPs did not maintain or could not provide adequate support for their meaningful use attestation. Of the 100 EPs in our sample, 12[11] could not provide support for the measures to which they attested:

- 6 EPs could not provide a security risk assessment,
- 4 EPs could not provide support that they had generated at least 1 report listing patients with a specific condition, and
- 3 EPs could not provide required documentation in the form of patient encounter data for the measures to which they self-attested.

The $253,622 in incentive payments to these EPs was inappropriate because the EPs did not maintain or could not provide the documentation to support their attestations to satisfy core and menu measures for stage 1 meaningful use.

An Eligible Professional Reported Inappropriate Meaningful Use Periods

Medicare requires EPs to base their self-attestations of meaningful use on patient encounter data from the appropriate EHR reporting period.[12] In an EP's second program year, the EP is required to attest to a full calendar year's worth of encounter data. One statistically sampled EP based his attestation of meaningful use on 90 days of encounter data instead of a full calendar year, as required,[13] resulting in an inappropriate incentive payment of $11,760.

[7] 42 CFR § 495.6(d)(15)(i) and (ii).

[8] § 495.6(e)(3)(i).

[9] § 495.6(e)(3)(ii).

[10] § 495.8(c).

[11] The total exceeds 12 because 1 EP had more than 1 deficiency.

[12] § 495.4 Definition of a Meaningful EHR User (1) and (3). See Appendix E for full citation.

[13] § 495.4 Definition of an EHR reporting period (1)(i) and (ii)(A).

An Eligible Professional Made Insufficient Use of Certified Electronic Health Record Technology

Medicare defines meaningful EHR users as EPs who have at least 50 percent of their patient encounters during the EHR reporting period at a location equipped with certified EHR technology.[14] However, one statistically sampled EP had less than 20 percent of his patient encounters at a location that used certified EHR technology and did not meet the 50 percent or more threshold. Therefore, the EP was not entitled to the EHR incentive payments he received totaling $25,840.

CMS MADE INAPPROPRIATE PAYMENTS TO ELIGIBLE PROFESSIONALS WHO CHANGED INCENTIVE PROGRAMS

An EP who qualifies as both a Medicaid EP and Medicare EP, after receiving at least one EHR incentive payment, may switch between the two EHR incentive programs (Medicare or Medicaid) only one time, and only for 1 payment year before 2015.[15] After an EP switches from one program to the other, CMS moves the EP to the other incentive program, and the EP remains in the same program year that the provider would have been in prior to switching. For example, an EP who began receiving Medicaid incentive payments in 2011 and then switched to the Medicare program for 2012 was in his or her second payment year in 2012. However, when EPs switched programs, CMS made payments as though the EP was in his or her first payment year instead of at the lower second payment year amount.

CMS made inappropriate incentive payments totaling $2,344,680 to 471 EPs who switched incentive programs. The EPs received payments as if they were in their first program year under the program to which they switched. These errors occurred because CMS did not have sufficient edits in place to determine which payment year an EP should be in after switching between incentive payment programs.

CMS' CONTROLS WERE NOT ALWAYS EFFECTIVE IN PREVENTING INAPPROPRIATE ELECTRONIC HEALTH RECORD INCENTIVE PAYMENTS TO ELIGIBLE PROFESSIONALS

CMS made EHR incentive payments to noncompliant EPs because sampled EPs did not maintain support for their attestations. Furthermore, CMS limited the documentation reviews that it performed. CMS's minimal oversight of self-attestations left the EHR program vulnerable to abuse and misuse of Federal funds.

In addition, CMS did not have edits in place to ensure that EPs who switched from one program to the other were placed in the correct payment year upon switching.

[14] § 495.4 Definition of a Meaningful EHR User (3). See Appendix E for full citation.

[15] 42 CFR § 495.10(e)(2).

RECOMMENDATIONS

We recommend that CMS:

- recover $291,222 in payments made to the sampled EPs who did not meet meaningful use requirements,

- review EP incentive payments to determine which EPs did not meet meaningful use measures for each applicable program year to attempt recovery of the $729,424,395 in estimated inappropriate incentive payments,

- review a random sample of EPs' documentation supporting their self-attestations to identify inappropriate incentive payments that may have been made after the audit period,

- educate EPs on proper documentation requirements,

- recover $2,344,680 in overpayments made to EPs after they switched programs, and

- employ edits within the NLR system to ensure that an EP does not receive payments under both EHR incentive programs for the same program year.

Finally, we recommend that as CMS implements MACRA, any modifications to the EHR meaningful use requirements include stronger program integrity safeguards that allow for more consistent verification of the reporting of required measures so that CMS can ensure that EPs are using EHR technology consistent with CMS's goal of Advancing Care Information under MIPS.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written and technical comments on our draft report, CMS concurred with our first, fourth, fifth, and sixth recommendations and provided information on actions that it had taken or planned to take to address those recommendations. In addition, CMS partially concurred with our second and third recommendations, stating that it has implemented targeted risk-based audits to strengthen the program integrity and will continue to do so in 2017. CMS's comments are included in their entirety as Appendix F.

After reviewing CMS's comments and having followup discussions with CMS officials, we maintain that the targeted risk-based audits are not capturing errors such as those identified in this report. We therefore continue to recommend that CMS review EP incentive payments to determine which EPs did not meet meaningful use and attempt recovery of the estimated $729,424,395, as well as review a random sample of EPs' documentation supporting their self-attestations to identify inappropriate incentive payments.

OTHER MATTERS

Medicare makes incentive payments to EPs who are legally authorized to practice medicine and have an active NPI number. Federal regulations (45 CFR § 162.408(c)) state that the National Provider System shall deactivate an NPI upon receipt of appropriate information confirming the dissolution of a health care provider that is an organization, the death of a health care provider who is an individual, or other circumstances justifying deactivation. Upon the death of an EP, the NPI should be deactivated within 60 days. Without a valid NPI, a provider is ineligible for the Medicare EHR program.

The deactivation of NPIs of 11 deceased EPs was more than 60 days past the date of death, and 2 deceased EPs are still active in identification and payment systems at the end of the audit period.[16] In addition, CMS made an inappropriate payment of $11,760 to an EP who died during the EHR reporting period and was not entitled to an incentive payment; this EP was not included in our sample.

CMS did not have the proper controls in place to recognize status changes within the National Plan and Provider Enumeration System, which allowed the NLR to distribute an inappropriate incentive payment to a deceased EP. A prior OIG report concluded that inaccurate, incomplete, and inconsistent provider data, coupled with insufficient oversight, place the integrity of the Medicare program at risk and present vulnerabilities in all health care programs.[17]

[16] We provided to CMS the information about these deceased EPs so that it may take action as it deems appropriate.

[17] OEI-07-09-00440, *Improvements Needed to Ensure Provider Enumeration and Medicare Enrollment Data are Accurate, Complete, and Consistent.*

APPENDIX A: MEANINGFUL USE MEASURES FOR ELIGIBLE PROFESSIONALS

This table encompasses all core and menu measures that were applicable to Medicare EPs during the scope of our review.

Core Measures	
Stage 1 Objective	**Stage 1 Measure**
Computerized provider order entry (CPOE)	More than 30% of unique patients with at least one medication in their medication list seen by the EP … have at least one medication entered using CPOE.
Drug interaction checks	The EP … has enabled this functionality for the entire EHR reporting period.
Problem lists	More than 80% of all unique patients seen by the EP … have at least one entry (or an indication that no problems are known for the patient) recorded as structured data.
Electronic prescribing	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.
Active medication lists	More than 80% of all unique patents seen by the EP … have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.
Medication allergy lists	More than 80% of all unique patents seen by the EP … have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.
Demographics	More than 50% of all unique patients seen by the EP … have demographics as recorded structured data.
Vital signs	For more than 50% of all unique patients age 2 and older seen by the EP … height, weight, and blood pressure are recorded as structured data.

Smoking status	More than 50% of all unique patients age 13 and older seen by the EP … have smoking status recorded as structured data.
Ambulatory clinical quality measures	Successfully report to CMS ambulatory clinical quality measures selected by CMS in the manner specified by CMS.
Clinical decision support rule	Implement one clinical decision support rule.
Electronic copy of health information	More than 50% of all unique patients of the EP … who request an electronic copy of their health information are provided it within 3 business days.
Clinical summaries	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days.
Electronic exchange of clinical information	Performed at least one test of the certified EHR technology's capacity to electronically exchange key clinical information.
Protection of electronic health information	Conduct or review a security risk analysis per 45 CFR 164.308(a)(1) and implement updates as necessary and correct identified security deficiencies as part of the EP's … risk management process.
Menu Measures	
Drug formulary checks	EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.
Clinical lab test results	More than 40% of all clinical lab test results ordered by the EP 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.
Patient lists	Generate at least one report that lists patients of the EP with a specific condition.
Patient reminders	More than 20% of all patients age 65 and older or age 5 and younger were sent an appropriate reminder during the EHR reporting period.

Patient electronic access	At least 10% of all unique patients seen by the EP 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 EP's discretion to withhold certain information.
Patient-specific education resources	More than 10% of all unique patients seen by the EP are provided patient-specific education resources.
Medication reconciliation	EP performs medication reconciliation for more than 50% of transitions of care in which the patient transitioned into the care of the EP.
Transition of care summaries	EP who transitions or refers patients to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.
Immunization registries data submission	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful.
Syndromic surveillance data submission	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow up submission if the test is successful.

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 485,499 Medicare EHR incentive payments made to 250,470 EPs from May 1, 2011, through June 30, 2014 (audit period). These incentive payments totaled $6,093,924,710. Medicare EHR incentive payments began in May 2011.

We did not perform an overall assessment of CMS's internal control structure. Rather, we reviewed only the internal controls that pertained to our objectives.

METHODOLOGY

To accomplish our audit objective, we:

- reviewed Federal regulations and guidance;
- met with CMS financial and program management officials to gain an understanding of the Medicare EHR incentive program and of their oversight of the program;
- met with CMS and Figliozzi and Company (the contractor), CMS's EHR incentive program audit contractor, to discuss audit strategies and results identified by the contractor, to gain an understanding of the contractor's audit methodology, identify potential risk areas, and eliminate any duplicate efforts;
- extracted from the NLR database EHR incentive payment, registration, and attestation data for EPs, excluding those audited by the contractor;
- identified a sampling frame consisting of 250,470 unique EPs with Medicare EHR incentive payments totaling $6,093,924,710 during the audit period;
- selected a simple random sample of 100 EPs who received incentive payments from May 1, 2011, through June 30, 2014, and:
    - collected and verified supporting documentation related to the EPs' self-attestations and incentive payments received,
    - compared the EPs' attestation documentation to the NLR database and took other steps to determine whether the EPs met Federal attestation and payment requirements, and
    - estimated the amount the Medicare EHR incentive program could have saved if payments to EPs were made in accordance with Federal requirements and calculated the associated improper payment rate;

- identified overpayments made to several EPs who switched between Medicaid and Medicare EHR incentive programs for the program year following the year in which they switched;

- compared EHR incentive payment data to a list of deceased provider NPIs to determine whether CMS made any inappropriate payments during our audit period; and

- discussed the results of our audit with CMS.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The population consisted of Medicare EHR incentive payments made to EPs with an NPI during the audit period and not previously audited by the contractor.

SAMPLING FRAME

We obtained a database containing 250,524 EPs with Medicare EHR incentive payments totaling $6,095,240,998. The payment data were provided by CMS from the NLR database as of June 30, 2014. We used the EPs' NPIs as the unique identifier.

From this database, we removed EPs currently under investigation. The resulting sampling frame contained 250,470 unique EPs with incentive payments totaling $6,093,924,710.

SAMPLE UNIT

The sample unit was an EP and all EHR incentive payments made to the EP during the audit period.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 EPs.

SOURCE OF RANDOM NUMBERS

We generated random numbers using Office of Inspector General (OIG), Office of Audit Services (OAS), statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in the sampling frame. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the dollar amount of the improper Medicare EHR incentive payments made to EPs from May 1, 2011, through June 30, 2014.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 2: Overall Sample Details and Results

No. of Eligible Professionals in Frame	Value of Frame	Sample Size	Value of Payments to Sampled Eligible Professionals	No. of Improper Payments to Sampled Eligible Professionals	Value of Improper Payments Made to Sampled Eligible Professionals
250,470	$6,093,924,710	100	$2,524,892	14	$291,222

Table 3: Overall Estimates
(Limits Calculated for a 90-Percent Confidence Interval)

	Estimated Value of Improper Payments
Point estimate	$729,424,395
Lower limit	402,425,322
Upper limit	1,056,423,467

Table 4: Calculation of Overall Improper Payment Rate

Overall improper payment rate	$\frac{\text{Estimated improper Federal dollars}}{\text{Total Federal dollars in frame}}$	$\frac{\$729,424,395}{\$6,093,924,710}$	= 12%

APPENDIX E: FEDERAL REQUIREMENTS FOR ELECTRONIC HEALTH RECORD INCENTIVE PAYMENTS

MEDICARE DEFINITIONS OF A MEANINGFUL EHR USER

Section 1848 (o)(2)(A) of the Social Security Act stipulates that an EP should be treated as a "meaningful EHR user" if:

> each of the following requirements is met: (i) The eligible professional demonstrates that during such period the professional is using certified EHR technology in a meaningful manner, which shall include the use of electronic prescribing, (ii) The eligible professional demonstrates that during such period such certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination, and (iii) The eligible professional submits information for such period on such clinical quality measures and such other measures.

Federal regulations at 42 CFR § 495.4 define a meaningful EHR user as:

> (1) an EP, eligible hospital or critical access hospital (CAH) that, for an EHR reporting period for a payment year, demonstrates in accordance with Sec. 495.8 meaningful use of certified EHR technology by meeting the applicable objectives and associated measures under Sec. 495.6; and... in addition, (3) to be considered a meaningful EHR user, at least 50 percent of an EP's patient encounters during the EHR reporting period during the payment year must occur at a practice/location or practices/locations equipped with certified EHR technology.

EPs are required to attest to core meaningful use measures to be eligible for an EHR incentive payment. One of the core measures requires a risk analysis in accordance with 42 CFR § 495.6(d)(15).

> (i) Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities. (ii) Conduct or review a security risk analysis in accordance with the requirements under 45 CFR § 164.308(a) (1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.

In addition, EPs must choose applicable menu measures to which to attest to meet meaningful use requirements. One of the menu measures that EPs may attest to includes the generation of a patient list by specific condition. 42 CFR § 495.6(e)(3)(i) and (ii) require EPs to "generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach" and "generate at least one report listing patients of the EP with a specific condition."

Federal regulations at 42 CFR §§ 495.8(c)(1) and (2) state, "CMS may review an EP, eligible hospital or CAH's demonstration of meaningful use." "All EPs, eligible hospitals, and CAHs must keep documentation supporting their demonstration of meaningful use for 6 years."

MEDICARE GUIDANCE FOR INCENTIVE PAYMENTS TO ELIGIBLE PROFESSIONALS

Federal administrative requirement (45 CFR § 162.408) states that:

> "the National Provider System (NPS) shall do the following: (a) Assign a single, unique NPI to a health care provider, provided that—(1) The NPS may assign an NPI to a subpart of a health care provider in accordance with paragraph (g); and (2) The Secretary has sufficient information to permit the assignment to be made. (b) Collect and maintain information about each health care provider that has been assigned an NPI and perform tasks necessary to update that information. (c) If appropriate, deactivate an NPI upon receipt of appropriate information concerning the dissolution of the health care provider that is an organization, the death of the health care provider who is an individual, or other circumstances justifying deactivation."

APPENDIX F: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: FEB 16 2017

TO: Daniel R. Levinson
Inspector General

FROM: Patrick H. Conway, MD
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicare Paid Hundreds of Millions in Electronic Health Record Incentive Payments to Noncompliant Eligible Professionals" (A-05-14-00047)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of the Inspector General's (OIG) draft report. CMS strives to provide Medicare beneficiaries with access to high quality health care while protecting taxpayer dollars.

Beginning in 2011, incentive payments became available under the Electronic Health Record (EHR) Incentive Program to encourage eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) to adopt, implement, upgrade and demonstrate meaningful use of certified EHR technology. Since the EHR Incentive Program began, EHR use has increased dramatically. While only 17 percent of physicians used advanced EHR systems in 2008, by 2013, more than 50 percent of EPs had demonstrated meaningful use and received an incentive payment. Between 2011 and 2016, approximately 500,000 eligible professionals participated in the program.

The requirements for each year of the EHR Incentive Program are defined in the Social Security Act and regulations. As OIG mentions, EPs and hospitals need to successfully demonstrate meaningful use of certified EHR technology through attestation to qualify for an incentive payment. To ensure that the incentive payments are made according to program requirements, CMS has conducted routine audits of the attestations, focusing on areas with the highest potential risk to the program. In addition, based on a previous recommendation by the OIG, CMS implemented a prepayment audit process in January 2013 to provide increased oversight of the EHR incentive program.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) incorporates certain aspects of the EHR Incentive Program into the Merit-based Incentive Payment System (MIPS), which will affect Medicare payments beginning in 2019, and the existing payment adjustments for EPs will end in 2018. CMS recognizes the value of data validation and auditing and remains committed to safeguarding program integrity as MACRA is implemented.

OIG Recommendation
The OIG recommends that CMS recover $291,222 in payments made to the sampled EPs who did not meet meaningful use requirements.

CMS Response
CMS concurs with OIG's recommendation. CMS requests that OIG furnish the necessary data to follow up on the status of the payments. Upon receipt of the files from OIG, CMS will work with its contractor to recoup any overpayments in accordance with the agency's policies and procedures.

OIG Recommendation
The OIG recommends that CMS review EP incentive payments to determine which EPs did not meet meaningful use measures for each applicable program year to attempt recovery of the $729,424,395 in estimated inappropriate incentive payments.

CMS Response
CMS partially concurs with OIG's recommendation. CMS has implemented targeted risk-based audits to strengthen the program integrity of the EHR Incentive Program, and continues to perform these targeted risked-based audits in 2016 and 2017.

OIG Recommendation
The OIG recommends that CMS review a random sample of EPs' documentation supporting their self-attestations to identify inappropriate incentive payments that may have been made after the audit period.

CMS Response
CMS partially concurs with OIG's recommendation. CMS has implemented targeted risk-based audits to strengthen the program integrity of the EHR Incentive Program, which include non-statistical random sampling, and continues to perform these targeted risked-based audits in 2016 and 2017.

OIG Recommendation
The OIG recommends that CMS educate EPs on proper documentation requirements.

CMS Response
CMS concurs with OIG's recommendation. CMS has provided educational materials, including a fact sheet, on the EHR Incentive Program documentation requirements. CMS will assess whether further education is needed.

OIG Recommendation
The OIG recommends that CMS recover $2,344,680 million in overpayments made to EPs who switched programs.

CMS Response
CMS concurs with OIG's recommendation. CMS has implemented edits within the National Level Repository (NLR) system to ensure that EPs who switch programs during a payment year receive payment under only one EHR incentive program. CMS looks forward to receiving these referral files and will review them to take the appropriate steps to recoup any overpayments in accordance with the agency's policies and procedures.

OIG Recommendation
The OIG recommends that CMS employ edits within the NLR system to ensure than an EP does not receive the same program year payment under both EHR incentive programs.

CMS Response
CMS concurs with OIG's recommendation. CMS has implemented edits within the NLR system to ensure that EPs who switch programs during a payment year receive payment under only one EHR incentive program.