DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

APR 24 2019

The Honorable Charles E. Grassley
United States Senate
Washington, DC 20510

Dear Senator Grassley:

Thank you for your recent letter regarding the Centers for Medicare & Medicaid Services' (CMS) Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs,[1] as well as the agency's response to recommendations in a June 2017 report by the U.S. Department of Health and Human Services' (HHS) Office of the Inspector General (OIG).[2] We share your commitment to protecting taxpayer dollars and look forward to continuing to work with you on this effort.

CMS continuously strives to responsibly operate its programs, while protecting taxpayer dollars from fraud, waste, and abuse. In addition to audits of the EHR Incentive Program described below, CMS utilizes a wide range of program integrity activities to comprehensively address fraud, waste, and abuse. These activities include many different approaches to program integrity, such as data analytics, investigations and audits, and recovery actions. CMS works to identify and correct improper Medicare payments through the efficient detection and collection of overpayments made on claims for healthcare services provided to Medicare beneficiaries.

CMS focuses its program integrity efforts on those services, items, and providers and suppliers that pose the greatest financial risk to the Medicare Trust Funds and represent the best investment of resources. We set priorities using a risk-based approach to focus medical review activities and other interventions on areas that pose the greatest risk. To examine the integrity of the EHR Incentive Program for eligible professionals, CMS implemented thousands of targeted risk-based audits, as well as random sampling.

First, CMS built prepayment edit checks into the EHR Incentive Programs' systems to detect inaccuracies in eligibility, reporting, and payment. For example, prepayment edits were in place to run against Medicare provider/supplier enrollment records to validate whether the supplier's National Provider Identifier (NPI) was active and whether the specialty identified in the CMS enrollment record for that supplier was a specialty that was eligible to receive EHR incentive payments.

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[1] Beginning with the calendar year 2019 EHR reporting period, the Medicare and Medicaid EHR Incentive Programs for eligible hospitals and critical access hospitals are renamed as the Medicare and Medicaid Promoting Interoperability Programs for eligible hospitals and CAHs. The Medicare EHR Incentive Program for eligible professionals was rolled into the Merit-based Incentive Payment System as part of the Quality Payment Program enacted in the Medicare Access and CHIP Reauthorization Act of 2015 (Pub. L. 114-10) and is currently called the Promoting Interoperability performance category.

[2] "Medicare Paid Hundreds of Millions in Electronic Health Record Incentive Payments That Did Not Comply with Federal Requirements" (A-05-14-00047). Available at https://oig.hhs.gov/oas/reports/region5/51400047.asp.

Second, professionals were selected both randomly and because of anomalous data submissions for prepayment audits. For those suppliers selected for pre-payment audits, CMS and its contractor requested supporting documentation to validate submitted attestation data before releasing payment.

Third, CMS conducted post-payment audits. We reviewed data to target certain professionals for audit by establishing rules that reviewed the attestation data to determine the presence of specific items or relationships within the attestation that we consider high-risk for an overpayment. This audit strategy included identifying variations in data submissions and identifying data sources useful for validation. Professionals selected for post-payment audits were required to submit supporting documentation to validate their submitted attestation data. Because these audits did not result in the determination of potential fraud, they did not lead to referrals to the CMS Center for Program Integrity.

When post-payment audits resulted in the determination of an overpayment, the necessary actions were taken to recover those payments. CMS followed our standard process to recoup improper payments from professionals identified by the OIG, as well as through our targeted risk-based audit strategy. Once we identified improper payments, demand letters were generated and mailed to the professionals notifying them of the overpayment amount, the reason the payment was determined to be an overpayment, and their appeals rights.

With regard to the OIG's findings in its June 2017 report, CMS's contractor conducted a further review of the 14 sampled professionals who the OIG found to not meet the EHR Incentive Program's requirements; we identified an additional $1,961 in overpayments associated with non-compliance with documentation requirements, thereby increasing to $293,183, the total amount of overpayment demands sent to those 14 professionals. Of this amount, $109,120 was appealed by the professionals and overturned on appeal. CMS's contractor received appeals from eight of these professionals, who supplied documentation to dispute the conclusions that the relevant measure criteria were not met. The contractor then made a recommendation to CMS to deny or approve each appeal, and CMS's Center for Clinical Standards and Quality reviewed the recommendations and the documentation and made the final determination that in each instance the professionals met the conditions for payment. After the appeals, the pending overpayment amount for these 14 professionals was $184,063. Of this amount, as of April 11, 2019, CMS has recovered $166,694. Actions to recover the remaining balance of $17,369 are ongoing, including referrals to the Department of the Treasury for further collection action.

With respect to the improper payments identified by the OIG for professionals who switched between the Medicare and Medicaid EHR Incentive Programs within the same year, as of February 6, 2019, CMS has recovered $152,209 of the balance of $201,457 in improper payments. Actions to recover the remaining balance of $49,248 are ongoing, including referrals to the Department of the Treasury for further collection action.

From 2015 to 2018, eligible professionals who did not successfully attest to achieving meaningful EHR use in the Medicare EHR Incentive Program were subjected to a downward adjustment to their Medicare payments for covered professional services. Below are the number

of eligible professionals subject to the payment adjustment and the year the payment adjustment was applied.

Medicare EHR Incentive Program for Eligible Professionals

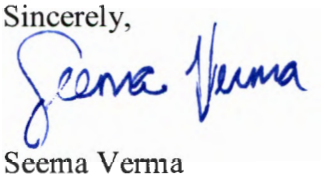
Payment Adjustment Year	Number of Professionals Receiving a Downward Payment Adjustment
2015	257,000
2016	208,500
2017	171,600
2018	180,700

In addition, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) included a sunset date for the payment adjustments associated with certain existing CMS reporting programs for professionals, including the Medicare EHR Incentive Program. Aspects of these programs were incorporated into a single pay-for-performance program for eligible clinicians, the Merit-based Incentive Payment System (MIPS), which is part of the Quality Payment Program. The first performance year of MIPS was 2017, which affects payments in 2019. Under MIPS, eligible clinicians' use of EHRs is assessed through the Promoting Interoperability performance category. Payment adjustments generally are determined based on combined performance across four MIPS performance categories, including the Promoting Interoperability performance category, rather than individual reporting programs such as the Medicare EHR Incentive Program.

We know that audits of our programs strengthen our program integrity efforts and help to reduce improper payments. CMS has an audit strategy in place for eligible clinicians in MIPS and has hired a contractor to begin work in this area. We will be conducting audits and data validation in 2019 with respect to the first year of MIPS. Eligible clinicians were allowed to pick their pace of participation from three flexible options to submit data for the first performance period in MIPS, and the performance threshold was low. Clinicians did not need to submit data in every MIPS performance category in the first year to avoid a downward payment adjustment. These audits will look at data submission of quality measures under MIPS and will also include certain aspects of the Promoting Interoperability performance category, which includes the meaningful use of certified EHR technology.

We look forward to concluding the remaining collection part of this process for the legacy EHR Incentive Programs and focusing on successful implementation of our MIPS audit strategy. We appreciate your focus on this area and are committed to strengthening our efforts to audit for compliance with the requirements of the Medicare programs to ensure the protection of taxpayer dollars.

Sincerely,



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