DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

SEP 25 2017

The Honorable Charles E. Grassley
Chairman
Committee on the Judiciary
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Thank you for your recent letter about the Centers for Medicare & Medicaid Services' (CMS) response to recommendations from the U.S. Department of Health and Human Services, Office of the Inspector General's (OIG) June 2017 report entitled "Medicare Paid Hundreds of Millions in Electronic Health Record Incentive Payments That Did Not Comply With Federal Requirements" (A-05-14-00047).

CMS concurs that it is important to prioritize the protection of taxpayer dollars and 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 analysis, 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 health care services provided to Medicare beneficiaries. CMS also screens providers and suppliers upon enrollment to identify providers that may be at risk for committing fraud.

CMS is committed to guarding against fraud, waste, and abuse in the Electronic Health Records (EHR) Incentive Programs and in the Merit-based Incentive Payment System (MIPS), which will affect Medicare payments beginning in 2019. CMS is conducting prepayment and post-payment audits to determine whether professionals are properly receiving incentive payments and complying with program rules. Audits of the EHR Incentive Programs strengthen our program integrity oversight and help reduce improper payments. If a CMS audit identifies potentially fraudulent activity, the findings are referred to our Center for Program Integrity for further investigation.

CMS implemented targeted risk-based audits, which include non-statistical random sampling, to strengthen the program integrity of the EHR Incentive Program and will continue to perform these targeted risked-based audits on the 2016 and 2017 attestations. All Medicare and dually-eligible (Medicare and Medicaid) providers who are participating in the EHR Incentive Programs or MIPS may be subject to an audit by CMS.

Currently, CMS reviews the data attested to by professionals in order to target certain professionals for audit. Our audit selection process includes business rules that review the attestation data to determine the presence of specific items or relationships within the attestation

which we consider high risk results. In addition, CMS randomly selects some professionals for prepayment and post-payment audits. If selected for audit, the professional must submit additional documentation to support their attestation.

With regard to the OIG's findings, CMS recently received the necessary data to validate the suspected $291,222 in overpayments made to the 14 sampled professionals who did not meet the meaningful use requirements. CMS is working with its contractors to recoup these overpayments in accordance with the agency's policies and procedures and expects to recover these overpayments by the end of the calendar year. The OIG has estimated, based on extrapolating the data from these 14 sampled professionals, that CMS inappropriately paid $729,424,395 to professionals who did not meet meaningful use requirements.

As of September 12, 2017, CMS has recovered $2,143,223 of the overpayments made to professionals who switched between Medicare and Medicaid and received incentive payments from both programs in the same year. If a professional qualifies for EHR incentive payments from both the Medicare and Medicaid programs, the professional must elect to receive payments from only one program. Actions to recover the remaining balance of approximately $201,457 will continue in conformance with CMS' debt collection processes, including referral to the Department of the Treasury for further collection action as appropriate.

CMS recognizes the importance of compliance with program requirements and has implemented targeted risk-based audits to strengthen the program integrity of the EHR Incentive Program and continues to perform these targeted risk based audits in 2016 and 2017. CMS focuses its program integrity efforts on those services, items, and providers/suppliers that pose the greatest financial risk to the Medicare Trust Funds and that represent the best investment of resources. CMS uses a priority-setting process to focus medical review activities and other interventions on areas that pose the greatest risk, including EHR incentive payments.

We appreciate your letter regarding our efforts to audit for compliance with the EHR Incentive Programs and to ensure the protection of taxpayer dollars. I will also provide a copy of this response to Chairman Orrin G. Hatch, the co-signer of your letter.

Sincerely,

Seema Verma