Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW JERSEY MADE INCORRECT MEDICAID ELECTRONIC HEALTH RECORD INCENTIVE PAYMENTS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Brian P. Ritchie
Assistant Inspector General
for Audit Services

August 2016
A-02-14-01009

Office of Inspector General

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EXECUTIVE SUMMARY

New Jersey made incorrect Medicaid electronic health record incentive payments totaling $2.5 million. Incorrect payments included both overpayments and underpayments, for a net overpayment of approximately $2.3 million.

WHY WE DID THIS REVIEW

To improve the quality and value of American health care, the Federal Government promotes the use of certified electronic health record (EHR) technology by health care professionals (professionals) and hospitals (collectively, "providers"). As an incentive for using EHRs, the Federal Government is making payments to providers that attest to the "meaningful use" of EHRs. The Congressional Budget Office estimates that from 2011 through 2019, spending on the Medicare and Medicaid EHR incentive programs will total $30 billion; the Medicaid EHR incentive program will account for more than a third of that amount, or about $12.4 billion.

The Government Accountability Office has identified improper incentive payments as the primary risk to the EHR incentive programs. These programs may be at greater risk of improper payments than other programs because they are new and have complex requirements. Other U.S. Department of Health and Human Services, Office of Inspector General, reports describe the obstacles that the Centers for Medicare & Medicaid Services (CMS) and States face overseeing the Medicare and Medicaid EHR incentive programs. The obstacles leave the programs vulnerable to paying incentive payments to providers that do not fully meet requirements.

The New Jersey Department of Human Services (State agency) made approximately $118 million in Medicaid EHR incentive program payments from February 1, 2012, to September 30, 2013. This review is one in a series of reviews focusing on the Medicaid EHR incentive program for hospitals.

The objective of this review was to determine whether the State agency made Medicaid EHR incentive program payments in accordance with Federal and State 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 Medicare and Medicaid EHR incentive programs to promote the adoption of EHRs. Under the HITECH Act, State Medicaid programs have the option of receiving from the Federal Government 100 percent of their expenditures for incentive payments to certain providers. The State agency administers the Medicaid program and monitors and pays EHR incentive payments.

To receive an incentive payment, eligible providers attest that they meet program requirements by self-reporting data using the CMS National Level Repository (NLR). The NLR is a provider registration and verification system that contains information on providers participating in the Medicaid and Medicare EHR incentive programs. To be eligible for the Medicaid EHR incentive program, providers must meet Medicaid patient-volume requirements. In general,

patient volume is calculated by dividing the provider's total Medicaid patient encounters by the provider's total patient encounters. For hospitals, patient encounters are defined as discharges, not days spent in the hospital (bed-days).

The amount of an incentive payment depends on the type of provider. Hospitals may receive annual incentive payments that are based on a formula that consists of two main components—the overall EHR amount and the Medicaid share. Professionals receive a fixed amount of $21,250 in the first year and $8,500 in subsequent years; the total may not exceed $63,750 over a 6-year period.

HOW WE CONDUCTED THIS REVIEW

From February 1, 2012, through September 30, 2013 (audit period), the State agency paid $118,634,704 for Medicaid EHR incentive payments. We (1) reconciled both professional and hospital incentive payments reported on the State's Form CMS-64, Quarterly Medicaid Assistance Expenditures for the Medical Assistance Program (CMS-64 report), with the NLR and (2) selected for further review all 33 hospitals whose health systems received an incentive payment totaling $1 million or more during our audit period and the five highest-paid professional groups which had a total of 253 professionals. The State agency paid the 33 hospitals $69,789,948 and the 5 professional groups $5,673,750 during our audit period, which is 64 percent of the total paid during our audit period.

WHAT WE FOUND

The State agency did not always pay EHR incentive payments in accordance with Federal and State requirements. The State agency made incorrect EHR incentive payments to 15 hospitals totaling $2,544,870. Specifically, the State agency overpaid 10 hospitals a total of $2,407,541 and underpaid five hospitals a total of $137,329 for a net overpayment of $2,270,213. Because the incentive payment is calculated once and then paid out over 3 years, payments made after September 30, 2013, will also be incorrect. The adjustments to these payments total $514,107. The State agency made incorrect payments to two additional hospitals; however, we confirmed that the State agency adjusted these payments after our audit period. Additionally, the State agency did not report one professional incentive payment to the NLR. The State agency correctly paid the 5 professional groups.

The incorrect payment errors occurred because the State agency's program integrity contractor failed to identify certain errors and inconsistently applied this new program's complex requirements. The reporting error occurred due to a technical error.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund to the Federal government $2,270,213 in net overpayments made to the 15 hospitals,

- adjust the 15 hospitals' remaining incentive payments to account for the incorrect calculations (which will result in future cost savings of $514,107),

- review the calculations for the hospitals not included in the 33 we reviewed to determine whether payment adjustments are needed, and refund any overpayments identified and

- work with CMS to ensure that the 1 unreported professional incentive payment is reported to the NLR.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our findings and recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

To improve the quality and value of American health care, the Federal Government promotes the use of certified electronic health record (EHR) technology by health care professionals (professionals) and hospitals (collectively, "providers"). As an incentive for using EHRs, the Federal Government is making payments to providers that attest to the "meaningful use" of EHRs.[1] The Congressional Budget Office estimates that from 2011 through 2019, spending on the Medicare and Medicaid EHR incentive programs will total $30 billion; the Medicaid EHR incentive program will account for more than a third of that amount, or about $12.4 billion.

The Government Accountability Office has identified improper incentive payments as the primary risk to the EHR incentive programs.[2] These programs may be at greater risk of improper payments than other programs because they are new and have complex requirements. Other U.S. Department of Health and Human Services, Office of Inspector General, reports describe the obstacles that the Centers for Medicare & Medicaid Services (CMS) and States face overseeing the Medicare and Medicaid EHR incentive programs.[3] The obstacles leave the programs vulnerable to paying incentive payments to providers that do not fully meet requirements.

The New Jersey Department of Human Services (State agency) made approximately $118 million in Medicaid EHR incentive program payments from February 1, 2012, to September 30, 2013 (audit period). This review is one in a series of reviews focusing on the Medicaid EHR incentive program for hospitals. Appendix A lists previous reviews of the Medicaid EHR incentive program.

OBJECTIVE

Our objective was to determine whether the State agency made Medicaid EHR incentive program payments in accordance with Federal and State requirements.

[1] To meaningfully use certified EHRs, providers must use numerous functions defined in Federal regulations, including functions meant to improve health care quality and efficiency, such as computerized provider order entry, electronic prescribing, and the exchange of key clinical information.

[2] *First Year of CMS's Incentive Programs Shows Opportunities to Improve Processes to Verify Providers Met Requirements* (GAO-12-481), published April 2012.

[3] *Early Review of States' Planned Medicaid Electronic Health Record Incentive Program Oversight* (OEI-05-10-00080), published July 2011 and *Early Assessment Finds That CMS Faces Obstacles in Overseeing the Medicare EHR Incentive Program* (OEI-05-11-00250), published November 2012.

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.

Under the HITECH Act § 4201, State Medicaid programs have the option of receiving from the Federal Government Federal financial participation for expenditures for incentive payments to certain Medicare and Medicaid providers to adopt, implement, upgrade, and meaningfully use certified EHR technology. The Federal Government pays 100 percent of Medicaid incentive payments (42 CFR § 495.320).

Medicaid Program: Administration and Federal Reimbursement

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In New Jersey, the State agency administers the program.

States use the standard Form CMS-64, Quarterly Medicaid Assistance Expenditures for the Medical Assistance Program (CMS-64 report), to report actual Medicaid expenditures for each quarter, and CMS uses it to reimburse States for the Federal share of Medicaid expenditures. The amounts reported on the CMS-64 report and its attachments must represent actual expenditures and be supported by documentation. States claim EHR incentive payments on lines 24E and 24F on the CMS-64 report.

National Level Repository

The National Level Repository (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 is the designated system of records that checks for duplicate payments and maintains the incentive payment history files.

Incentive Payment Eligibility Requirements

To receive an incentive payment, eligible providers attest that they meet program requirements by self-reporting data using the NLR.[4] To be eligible for the Medicaid EHR incentive program,

[4] Eligible professionals may be physicians, dentists, certified nurse-midwives, nurse practitioners, or physician assistants practicing in a Federally Qualified Health Center or a Rural Health Clinic that is led by a physician assistant (42 CFR § 495.304(b)). Eligible hospitals may be acute-care hospitals or children's hospitals (42 CFR

providers must meet Medicaid patient-volume requirements (42 CFR § 495.304(c)). In general, patient volume is calculated by dividing the provider's total Medicaid patient encounters by the provider's total patient encounters.[5] See Table 1 for program eligibility requirements for providers.

Table 1: Eligibility Requirements for Professionals and Hospitals

Eligibility Requirements	Professional	Hospital
Provider is a permissible provider type that is licensed to practice in the State.	x	x
Provider participates in the State Medicaid program.	x	x
Provider is not excluded, sanctioned, or otherwise deemed ineligible to receive payments from the State or Federal Government.	x	x
Professional is not hospital-based.[6]	x	
Hospital has an average length of stay of 25 days or less.		x
Provider has adopted, implemented, upgraded, or meaningfully used certified EHR technology.[7]	x	x
Provider meets Medicaid patient-volume requirements.[8]	x	x

Provider Payments

The amount of an incentive payment varies depending on the type of provider.

§§ 495.304(a)(2) and (a)(3)); acute-care hospitals include critical access hospitals or cancer hospitals (75 Fed. Reg. 44314, 44484 (July 28, 2010)).

[5] There are multiple definitions of "encounter." Generally stated, a patient encounter with a professional is any one day for which Medicaid paid for all or part of a service or Medicaid paid the copay, cost-sharing, or premium for the service (42 CFR § 495.306(e)(1)). A hospital encounter is either the total services performed during an inpatient stay or services performed in an emergency department on any one day for which Medicaid paid for all or part of the services or paid the copay, cost-sharing, or premium for the services (42 CFR § 495.306(e)(2)).

[6] Professionals may not have performed 90 percent or more of their services in the prior year in a hospital inpatient or emergency room setting (42 CFR § 495.304(c)).

[7] 42 CFR §§ 495.314(a)(1)(i) or (ii).

[8] Professionals, with the exception of pediatricians, must have a Medicaid patient volume of at least 30 percent; pediatricians must have a Medicaid patient volume of at least 20 percent (42 CFR §§ 495.304(c)(1) and (c)(2)). Hospitals must have a Medicaid patient volume of at least 10 percent, except for children's hospitals, which do not have a patient-volume requirement (42 CFR §§ 495.304(e)(1) and (e)(2)).

Eligible Hospital Payments

Hospital incentive payments are based on a one-time calculation of a total incentive payment, which is distributed by States over a minimum of 3 years and a maximum of 6 years.[9] The total incentive payment calculation consists of two main components—the overall EHR amount and the Medicaid share.

Generally stated, the overall EHR amount is an estimated dollar amount based on a total number of inpatient acute-care discharges over a theoretical 4-year period.[10] The overall EHR amount consists of two components—an initial amount and a transition factor. Once the initial amount is multiplied by the transition factors, all 4 years are totaled to determine the overall EHR amount. Table 2 provides three examples of the overall EHR amount calculation.

Table 2: Overall Electronic Health Record Amount Calculation

Type of Hospital	Hospitals With 1,149 or Fewer Discharges During the Payment Year	Hospitals With 1,150 Through 23,000 Discharges During the Payment Year	Hospitals With More Than 23,000 Discharges During the Payment Year
Base Amount	$2 million	$2 million	$2 million
Plus Discharge-Related Amount (adjusted in years 2 through 4 that are based on the average annual growth rate)	$0.00	$200 multiplied by (*n* - 1,149) where *n* is the number of discharges	$200 multiplied by (23,000 - 1,149)
Equals Total Initial Amount	$2 million	Between $2 million and $6,370,200 depending on the number of discharges	Limited by law to $6,370,200
Multiplied by Transition Factor	Year 1 – 1.00 Year 2 – 0.75 Year 3 – 0.50 Year 4 – 0.25	Year 1 – 1.00 Year 2 – 0.75 Year 3 – 0.50 Year 4 – 0.25	Year 1 – 1.00 Year 2 – 0.75 Year 3 – 0.50 Year 4 – 0.25
Overall EHR Amount	Sum of all 4 years	Sum of all 4 years	Sum of all 4 years

[9] No single year may account for more than 50 percent of the total incentive payment, and no 2 years may account for more than 90 percent of the total incentive payment (42 CFR §§ 495.310(f)(3) and (f)(4)). The State agency elected for incentive payments to be made over a 3-year period with the first payment being 50 percent of the total; the second payment, 40 percent; and the remaining payment, 10 percent.

[10] It is a theoretical 4-year period because the overall EHR amount is not determined annually; rather, it is calculated once, on the basis of how much a hospital might be paid over 4 years. An average annual growth rate (calculated by averaging the annual percentage change in discharges over the most recent 3 years) is applied to the first payment year's number of discharges to calculate the estimated total discharges in years 2 through 4 (42 CFR § 495.310(g)).

The Medicaid share is calculated as follows:

- The numerator is the sum of the estimated Medicaid inpatient acute-care bed-days[11] for the current year and the estimated number of Medicaid managed care inpatient acute-care bed-days for the current year (42 CFR § 495.310(g)(2)(i)).

- The denominator is the product of the estimated total number of inpatient acute-care bed-days for the eligible hospital during the current year multiplied by the noncharity percentage. The noncharity percentage is the estimated total amount of the eligible hospital's charges during that period, not including any charges that are attributable to charity care, divided by the estimated total amount of the hospital's charges during that period (42 CFR § 495.310(g)(2)(ii)).

The total incentive payment is the overall EHR amount multiplied by the Medicaid share. The total incentive payment is then distributed over several years. (See footnote 9.) It is possible that a hospital may not receive the entire total incentive payment. Each year, a hospital must re-attest and meet that year's program requirements. The hospital may not qualify for the future years' payments or could elect to end its participation in the EHR incentive program. In addition, the amount may change because of adjustments to supporting numbers used in the calculations.

Hospitals may receive incentive payments from both Medicare and Medicaid within the same year; however, they may not receive a Medicaid incentive payment from more than one State (42 CFR §§ 495.310(e) and (j)).

Eligible Professional Payments

Professionals receive a fixed amount of $21,250 in the first year and $8,500 in subsequent years; the total may not exceed $63,750 over a 6-year period.[12] Incentive payments for pediatricians who meet the 20-percent Medicaid patient-volume threshold but fall short of the 30-percent Medicaid patient-volume threshold are reduced to two-thirds of the incentive payment.[13] Thus, some pediatricians may receive only $14,167 in the first year and $5,667 in subsequent years, for a maximum of $42,500 over a 6-year period.[14]

Professionals may not receive EHR incentive payments from both Medicare and Medicaid in the same year and may not receive a payment from more than one State. After a professional qualifies for an EHR incentive payment and before 2015, the professional may switch one time between programs.

[11] A bed-day is 1 day that one Medicaid beneficiary spends in the hospital.

[12] 42 CFR §§ 495.310(a)(1)(i), (a)(2)(i), and (a)(3).

[13] 42 CFR §§ 495.310(a)(4)(i), (a)(4)(ii), and (b).

[14] 42 CFR § 495.310(a)(4)(iii).

HOW WE CONDUCTED THIS REVIEW

From February 1, 2012, through September 30, 2013, the State agency paid $118,634,704 for Medicaid EHR incentive payments. We (1) reconciled both professional and hospital incentive payments reported on the State's CMS-64 report with the NLR and (2) selected for further review all 33 hospitals whose health systems received an incentive payment totaling $1 million or more during our audit period and the five highest-paid professional groups which had a total of 253 professionals. The State agency paid the 33 hospitals $69,789,948 and the 5 professional groups $5,673,750 during our audit period, which is 64 percent of the total paid during our audit period.

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.

FINDINGS

The State agency did not always pay EHR hospital incentive payments in accordance with Federal and State requirements. The State agency made incorrect EHR incentive payments to 15 of the 33 reviewed hospitals totaling $2,544,870. Specifically, the State agency overpaid 10 hospitals a total of $2,407,541 and underpaid five hospitals a total of $137,329 for a net overpayment of $2,270,213.[15] Because the incentive payment is calculated once and then paid out over 3 years, payments made after September 30, 2013, will also be incorrect. The adjustments to these payments total $514,107.

Additionally, while the State agency correctly paid the 5 reviewed professional groups, the State agency did not report one professional incentive payment to the NLR.

The incorrect payment errors occurred because the State agency's program integrity contractor failed to identify certain errors and inconsistently applied this new program's complex requirements. The reporting error occurred because a transaction code was not recognized by the CMS-64 system and consequently was not reported to the NLR.

THE STATE AGENCY MADE INCORRECT HOSPITAL INCENTIVE PAYMENTS

The overall EHR incentive payment amount for a hospital is based on various discharge-related information (75 Fed. Reg. 44314, 44450 (July 28, 2010)). To calculate incentive payments, a hospital uses the discharge-related amount for the 12-month period ending in the Federal fiscal year before the fiscal year that serves as the hospital's first payment year. For the 1,150th

[15] The State agency made incorrect payments to two additional hospitals; however, we confirmed that the State agency adjusted these payments after our audit period.

through the 23,000th discharge, the discharge-related amount is $200. Any discharge greater than the 23,000th discharge is not included in the calculation (42 CFR § 495.310(g)(1)(i)(B)).

Additionally, Federal regulations restrict discharges and inpatient bed-days to those from the acute-care portion of a hospital and further explain that an eligible hospital, for purposes of the incentive payment provision, does not include a psychiatric or rehabilitation unit of the hospital, which are distinct parts of the hospital (75 Fed. Reg. 44314, 44450 and 44497 (July 28, 2010)).

Furthermore, CMS guidance states that nursery, rehabilitation, psychiatric, and skilled nursing facility (SNF) days and discharges (inpatient nonacute-care services) cannot be included as inpatient acute-care services in the calculation of hospital incentive payments.[16] Finally, the Medicaid share amount for a hospital is essentially the percentage of a hospital's inpatient, noncharity care days that are attributable to Medicaid inpatients (75 Fed. Reg. 44314, 44498 (July 28, 2010)). The final rule states that uncompensated care can be used to determine an appropriate proxy for charity care, but the charges must be adjusted to eliminate bad debts, courtesy allowances, or discounts (75 Fed. Reg. 44456, 44580 (July 28, 2010)).

Of the 33 hospital incentive payment calculations reviewed, 15 did not comply with regulations, guidance, or both. Some calculations had multiple deficiencies. Specifically, the calculations included:

- nursery services (6 hospitals);
- psychiatric services (5 hospitals);
- clerical errors, such as using the wrong line on the cost report (5 hospitals); and
- bad debt and self-payments in the charity care amounts (4 hospitals).

The calculations for six hospitals did not include labor and delivery services, which should have been included.

Prior to our review, the State agency adjusted payments totaling $2.5 million for our selected hospitals based on the work of its program integrity contractor. However, the contractor failed to identify certain errors and inconsistently applied this new program's complex requirements.

As a result of the program integrity contractor's errors, the State agency made incorrect incentive payments to 15 hospitals totaling $2,544,870. Specifically, the State agency overpaid 10 hospitals a total of $2,407,541 and underpaid 5 hospitals a total of $137,329, for a net overpayment of $2,270,213. The State agency made incorrect payments to two additional hospitals; however, we confirmed that the State agency adjusted these payments after our audit period. Because the hospital calculation is computed once and then paid out over 3 years, payments made after September 30, 2013, will also be incorrect. The adjustments to these payments total $514,107.

[16] CMS Frequently Asked Questions: https://questions.cms.gov/ FAQs 2991, 3213, 3261, and 3315; last accessed on April 1, 2016.

THE STATE AGENCY DID NOT REPORT ONE INCENTIVE PAYMENT TO THE NATIONAL LEVEL REPOSITORY

States participating in the Medicaid EHR incentive program are responsible for transmitting payment data to CMS's NLR so that CMS can ensure that providers do not receive payments from more than one State (75 Fed. Reg. 44314, 44501 (July 28, 2010)).

The State agency did not report to the NLR a $21,250 incentive payment made to one professional. According to State agency officials, the State agency paid the professional, then recouped the payment, and then, on appeal, reinstated the payment without reporting it to the NLR because a transaction code was not recognized by the CMS-64 system. As a result, the NLR information was not complete, and the provider could have potentially been paid by another State.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal government $2,270,213 in net overpayments made to the 15 hospitals,
- adjust the 15 hospitals' remaining incentive payments to account for the incorrect calculations (which will result in future cost savings of $514,107),
- review the calculations for the hospitals not included in the 33 we reviewed to determine whether payment adjustments are needed, and refund any overpayments identified and
- work with CMS to ensure that the 1 unreported professional incentive payment is reported to the NLR.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our findings and recommendations.

The State agency's comments appear in their entirety as Appendix C.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Arizona Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals	A-09-15-02036	8/4/2016
Delaware Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals	A-03-14-00402	9/30/2015
Oklahoma Made Incorrect Medicaid Electronic Health Record Incentive Payments to Health Care Professionals	A-06-14-00030	9/3/2015
Texas Made Incorrect Medicaid Electronic Health Record Incentive Payments	A-06-13-00047	8/31/2015
Arkansas Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals	A-06-14-00010	6/22/2015
The District of Columbia Made Correct Medicaid Electronic Health Record Incentive Payments to Hospitals	A-03-14-00401	1/15/2015
Massachusetts Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals	A-01-13-00008	11/17/2014
Louisiana Made Incorrect Medicaid Electronic Health Record Incentive Payments	A-06-12-00041	8/26/2014
Florida Made Medicaid Electronic Health Record Payments to Hospitals in Accordance With Federal and State Requirements	A-04-13-06164	8/8/2014
Early Review of States' Planned Medicaid Electronic Health Record Incentive Program Oversight	OEI-05-10-00080	7/15/2011

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

From February 1, 2012, through September 30, 2013, the State agency paid $118,634,704 for Medicaid EHR incentive payments. We (1) reconciled both professional and hospital incentive payments reported on the State's CMS-64 report to the NLR and (2) selected for further review all 33 hospitals whose health systems received an incentive payment totaling $1 million or more during our audit period and the five highest-paid professional groups which had a total of 253 professionals. The State agency paid the 33 hospitals $69,789,948 and the five professional groups $5,673,750 during our audit period, which is 64 percent of the total paid.

We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only those internal controls related to our objective.

We performed our fieldwork at the State agency's office in Trenton, New Jersey, and at hospitals and professional groups throughout New Jersey.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- held discussions with CMS officials to gain an understanding of the Medicaid EHR incentive program;
- held discussions with State agency officials to gain an understanding of State policies and controls as they relate to the Medicaid EHR incentive program;
- selected for review (1) all 33 hospitals whose health systems were paid an incentive payment of $1 million or more from February 1, 2012, to September 30, 2013; and (2) the 5 highest-paid professional groups during the same period which had a total of 253 professionals;
- reviewed and reconciled the appropriate lines from the CMS-64 report to supporting documentation and the NLR;
- visited the selected hospitals and professional groups and verified the supporting documentation;
- verified that the selected hospitals and professionals met eligibility requirements;
- determined whether the selected hospital and professional group patient-volume calculations were correct;

- determined whether the selected hospital and professional group incentive-payment calculations were correct and adequately supported;

- calculated the cost savings from correcting payments made after September 31, 2013; and

- discussed the results of our review and provided our recalculations to State agency officials.

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: STATE AGENCY COMMENTS

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
P.O. Box 712
Trenton, NJ 08625-0712

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

ELIZABETH CONNOLLY
Acting Commissioner

MEGHAN DAVEY
Director

July 20, 2016

Brenda M. Tierney
Acting Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services
Region II
Jacob K. Javits Federal Building – Room 3900
New York, NY 10278

Report Number A-02-14-01009

Dear Ms. Tierney:

This letter is in response to your correspondence concerning the Department of Health and Human Services, Office of the Inspector General's (OIG), draft report entitled *New Jersey Made Incorrect Medicaid Electronic Health Record Incentive Payments.*

Attached please find the Division of Medical Assistance and Health Services' (DMAHS) response to the report which includes comments as well as the status of actions taken or planned in accordance with the report recommendations.

If you have any questions, please do not hesitate to contact me or Richard H. Hurd at 609-588-2550.

Sincerely,

Meghan Davey
Director

c. Elizabeth Connolly
Richard H. Hurd
Stuart Dubin
Herminio Navia
Barbara Cooper
Chris Bailey
Chris Czvornyek

New Jersey Is An Equal Opportunity Employer

New Jersey Department Human Services
Division of Medical Assistance & Health Services
Response to OIG Draft Audit of Medicaid Electronic Health Record (EHR) Incentive Payments
Report Number A-02-14-01009

Background:

As authorized by the American Recovery and Reinvestment Act of 2009, the New Jersey Division of Medical Assistance and Health Services (DMAHS), with approval from the Centers for Medicare and Medicaid Services (CMS), implemented the Medicaid Electronic Health Records (EHR) Incentive Program. CMS reviewed and approved DMAHS' design and proposed technology solution for accepting incentive payment attestations, reviewing and calculating the hospital incentive payment amounts as well as the strategy for conducting post-payment inspections. Eligible hospitals began receiving EHR incentive payments in February 2012, in accordance with the CMS approved methodology. To validate the Program's alignment with these approvals, CMS conducted an onsite review in July 2013 to assess, among other aspects, the pre- and post-payment verification processes. At that time, CMS reported that the "state's Medicaid EHR Incentive Program meets Federal requirements".

All Hospital EHR incentive payments were made and post-payment audits were conducted in accordance with guidance, endorsements and approvals from CMS. The post-payment audit process, including use of an independent certified public accounting (CPA) firm to conduct the audits, was determined the most effective method to verify cost report and other information supporting EHR incentive payments.

DMAHS's responses to each of the recommendations are as follows:

Recommendation:

- "Refund to the Federal government $2,270,213 in net overpayments made to the 15 hospitals."

Response:

DMAHS notes CMS released clarifying guidance with respect to certain services that were contained in payment calculations only after hospital payments and post-payments were completed. DMAHS' contracted auditors traced all the components of the attested data used in the incentive payment calculation to the appropriate lines on the signed Medicare Cost Reports. Where possible, they also traced the data to audited financial statements. The process of compiling this information was discussed with the hospital's representative and certain analytical procedures were applied to the data. The audits of the hospital attestation and payments occurred in fiscal years 2012 and 2013. The cost reports produced for the OIG audits also were impacted as a result of amendments and/or Medicare audit changes. The production of these reports may also be influenced by hospitals in health systems that undergo mergers and acquisitions causing additional report discrepancies.

As stated in the draft report, OIG has "confirmed that the State agency has adjusted payments to hospitals'. DMAHS will notify the affected hospitals, make payment recovery or supplemental adjustments and refund the $2,270,213 in net overpayments to the federal government.

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Recommendation:

- "Adjust the 15 hospitals' remaining incentive payments to account for the incorrect calculations (which will result in future cost savings of $514,107)."

Response:

DMAHS concurs with the OIG findings that future payment calculations should be adjusted. DMAHS will make the necessary payment adjustments in the attestation application and will notify the affected hospitals to realize the future cost savings of $514,107.

Recommendation:

- "Review the calculations for the hospitals not included in the 33 we reviewed to determine whether payment adjustments are needed, and refund any overpayments identified."

Response:

In accordance with the methodology identified in the response to the first recommendation, DMAHS has begun recalculating payments made to the remaining hospitals.

Recommendation:

- "Work with CMS to ensure that the 1 unreported professional incentive payment is reported to the NLR."

Response:

DMAHS concurs with this OIG recommendation. The information for the eligible professional already has been reported and updated in the NLR.

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