Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

DELAWARE MADE INCORRECT MEDICAID ELECTRONIC HEALTH RECORD INCENTIVE PAYMENTS TO HOSPITALS

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

Stephen Virbitsky
Regional Inspector General
for Audit Services

September 2015
A-03-14-00402

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

Delaware made incorrect Medicaid electronic health record incentive payments to one hospital totaling $175,000.

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 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 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 making incentive payments to providers that do not fully meet requirements.

The Delaware Department of Health and Social Services (the State agency) made approximately $27 million in Medicaid EHR incentive program payments to providers during calendar years 2011 through 2013. Of this amount, the State agency paid a total of $14 million to health care professionals and $13 million to hospitals. This review is one in a series of reports focusing only 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 makes 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. The National Level Repository 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.

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. The total incentive payment calculation consists of two main components: the overall EHR amount and the Medicaid share.

HOW WE CONDUCTED THIS REVIEW

From January 1, 2011, through December 31, 2013, the State agency paid $13,028,950 to seven eligible hospitals in Delaware for Medicaid EHR incentive payments. We (1) reconciled hospital incentive payments reported by the State on Form CMS-64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program) with the National Level Repository and (2) identified for further review the four hospitals that each received total incentive payments exceeding $1 million. The State agency paid the four hospitals a total of $10,588,386, which represents approximately 81 percent of the total amount paid to all hospitals in Delaware during calendar years 2011 through 2013.

WHAT WE FOUND

The State agency made EHR incentive payments to three hospitals in accordance with Federal and State requirements. However, the State agency paid one hospital $2,017,584 when it should have paid $1,842,849, resulting in a total overpayment of $174,735. This error occurred because the hospital understated the noncharity care charges in its Medicaid share percentage calculation and the State agency did not validate the EHR incentive payment amount requested.

RECOMMENDATION

We recommend that the State agency recover the overpayment and refund the $174,735 in EHR incentive payments.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendation and described corrective action it had taken or planned to take to address it.

TABLE OF CONTENTS

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 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 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 making incentive payments to providers that do not fully meet requirements.

The Delaware Department of Health and Social Services (the State agency) made approximately $27 million in Medicaid EHR incentive program payments to providers during calendar years 2011 through 2013. Of this amount, the State agency paid approximately $14 million to professionals and $13 million to hospitals. This review is one in a series of reports focusing only on the Medicaid EHR incentive program for hospitals. See Appendix A for a list of reports related to payments made for 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.

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 (the 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

[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 Show 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.

Clinical Health Act (HITECH Act). The HITECH Act established EHR Incentive Programs for both Medicare and Medicaid to promote the adoption of EHRs.

Under section 4201 of the HITECH Act, 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 Delaware, the State agency administers the program.

States use the standard Form CMS-64[4] 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 Form CMS-64 and its attachments must represent actual expenditures and be supported by documentation. States claim EHR incentive payments on lines 24E and 24F on the Form CMS-64.

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.[5] To be eligible for the Medicaid EHR Incentive Program, 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.[6]

[4] Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program.

[5] Eligible hospitals may be acute-care hospitals or children's hospitals (42 CFR §§ 495.304(a)(2) and (3); acute-care hospitals include critical access hospitals or cancer hospitals (75 Fed. Reg. 44314, 44484 (July 28, 2010)).

[6] Generally stated, 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)).

The program eligibility requirements for hospitals are as follows:

- The hospital is a permissible provider type that is licensed to practice in the State.
- The hospital participates in the State Medicaid program.
- The hospital is not excluded, sanctioned, or otherwise deemed ineligible to receive payments from the State or Federal Government.
- The hospital has an average length of stay of 25 days or less.[7]
- The hospital has adopted, implemented, upgraded, or meaningfully used certified EHR technology.[8]
- The hospital meets Medicaid patient volume requirements.[9]

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.[10] 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.[11] 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 1 on the following page provides three examples of the overall EHR amount calculation.

[7] 42 CFR § 495.302, definition of "acute care hospital." Children's hospitals do not have to meet the average length of stay requirement.

[8] Providers may only adopt, implement, or upgrade the first year they are in the program (42 CFR § 495.314(a)(1)). In subsequent years, providers must demonstrate that during the EHR reporting period it is a meaningful EHR user, as defined in 42 CFR § 495.4.

[9] 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)(l) and (e)(2)).

[10] 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 to distribute incentive payments 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.

[11] The 4-year period is theoretical because the overall EHR amount is not determined annually; 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)).

Table 1: Overall EHR 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 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 Approximately $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

The Medicaid share is calculated as follows:

- The numerator is the sum of the estimated Medicaid inpatient acute-care bed-days[12] for the current year and the estimated number of Medicaid managed care acute inpatient-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, hospitals must attest to the "meaningful use" of EHRs and meet that year's program requirements. A 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.

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

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)).

HOW WE CONDUCTED THIS REVIEW

From January 1, 2011, through December 31, 2013, the State agency paid $13,028,950 to seven eligible hospitals in Delaware for Medicaid EHR incentive payments. We (1) reconciled hospital incentive payments reported by the State on Form CMS-64 with the NLR and (2) identified for further review the four hospitals that each received total incentive payments exceeding $1 million. The State agency paid the four hospitals a total of $10,588,386, which represents approximately 81 percent of the total amount paid to all hospitals in Delaware during calendar years 2011 through 2013.

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.

The appendix contains the details of our audit scope and methodology.

FINDINGS

The State agency made EHR incentive payments to three hospitals in accordance with Federal and State requirements. However, the State agency paid one hospital $2,017,584 when it should have paid $1,842,849, resulting in a total overpayment of $174,735. This error occurred because the hospital understated the noncharity care charges in its Medicaid share percentage calculation and the State agency did not validate the EHR incentive payment amount requested.

THE STATE AGENCY MADE INCORRECT HOSPITAL INCENTIVE PAYMENTS

CMS guidance[13] allow a hospital to use financial data obtained from multiple sources when calculating its requested Medicaid EHR incentive payment. These sources include: the hospital's Medicare cost report, State-specific Medicaid cost reports, State payment and utilization information,[14] and hospital financial statement and accounting records. When data, like charity-care charges, were not available on the Medicare cost report, hospital used comparable information from other sources.

One hospital deducted charity-care charges of $27,475,000 from its total charges to determine the noncharity care portion of the Medicaid Share calculation. The hospital said that it used its Medicare cost report to calculate the Medicaid EHR incentive payment, but the cost report did

[13] Medicaid Hospital Incentive Payments Calculations. Available online at www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/MLN_TipSheet_MedicaidHospitals.pdf. Last accessed May 26, 2015.

[14] This information can be obtained from the State Medicaid Management Information System and other automated claims processing and information retrieval systems.

not identify any amount for charity-care charges. The hospital's financial statements reported only $6,065,253 for charity-care charges and the hospital could not identify any source for the $27,475,000 amount used in its calculation.

Subtracting a larger amount of charity-care charges from the total charges will overstate the Medicaid share in the calculation of the Medicaid EHR incentive payment. Table 2 below shows the hospital's calculation of the Medicaid EHR amount and our calculation based on the corrected amount of charity-care charges.

Table 2. Difference in the Calculation of Medicaid EHR Amount

	Description	State	OIG
A	Total Hospital Charges	$253,274,537	$253,274,537
B	Total Charity-Care Charges	–$27,475,000	–$6,065,253
C=A-B	Total Noncharity Charges	$225,799,537	$247,209,284
D=C/A	Percent Noncharity Charges	89.15%	97.61%
E	Total Inpatient Bed-Days	21,990	21,990
F= D*E	Noncharity Bed-Days (Denominator)	19,605	21,463
G	Medicaid Bed-Days (Numerator)	5,864	5,864
H=G/F	Percent Medicaid Share of EHR Amount	29.91%	27.32%
I	Overall EHR Amount	$6,745,193	$6,745,193
J=H*I	Medicaid EHR Amount[15]	$2,017,584	$1,842,849

Because the hospital understated the noncharity charges, it improperly reduced the noncharity bed-days in its Medicaid share calculation. The State agency did not validate the hospital's calculation. As a result, the State agency paid the hospital $2,017,584 in Medicaid EHR incentive payments when it should have paid only $1,842,849, a difference of $174,735.

RECOMMENDATION

We recommend that the State agency recover the overpayment and refund the $174,735 in EHR incentive payments.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendation and described corrective action it had taken or planned to take to address it. The State agency's comments are included in their entirety as Appendix D.

[15] The State calculated the Medicaid EHR incentive payment as $2,017,586. We attributed the difference due to rounding.

APPENDIX A: REPORTS RELATED TO PAYMENTS MADE FOR THE MEDICAID ELECTRONIC HEALTH RECORD INCENTIVE PROGRAM

Report Title	Report Number	Date Issued
Texas Made Incorrect Medicaid Electronic Health Record Incentive Payments	A-06-13-00047	08-31-2015
Arkansas Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals	A-06-14-00010	06-22-2015
The District of Columbia Made Correct Medicaid Electronic Health Record Incentive Payments to Hospitals	A-03-14-00401	01-15-2015
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	08-26-2014
Florida Made Medicaid Electronic Health Record Payments to Hospitals in Accordance With Federal and State Requirements	A-04-13-06164	08-08-2014
Early Review of States' Planned Medicaid Electronic Health Record Incentive Program Oversight	OEI-05-10-00080	07-15-2011

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

From January 1, 2011, through December 31, 2013, the State agency paid $13,028,950 to seven eligible hospitals in Delaware for Medicaid EHR incentive payments. We (1) reconciled hospital incentive payments reported by the State on Form CMS-64 with the NLR and (2) identified for further review the four hospitals that each received total incentive payments exceeding $1 million. The State agency paid the four hospitals a total of $10,588,386, that represents 81 percent of the total amount paid to all hospitals in Delaware during calendar years 2011 through 2013.

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 and at four hospitals in Delaware.

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;
- reconciled the incentive payments reported on Form CMS-64 to the NLR;
- reviewed the four hospitals that received incentive payments exceeding $1 million during calendar years 2011 through 2013;
- reviewed the State agency's supporting documentation related to the four hospitals;
- reviewed that hospitals documentation and verified the information submitted to the State agency;
- verified that hospitals met eligibility requirements;
- determined whether hospital incentive-payment calculations were correct; and
- discussed the results of our review and provided our recalculations to State 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

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID & MEDICAL ASSISTANCE

OFFICE OF THE DIRECTOR

July 15, 2015

Report Number: A-03-14-00402

Mr. Stephen Virbitsky
Regional Inspector General
For Audit Services
Office of Audit Services, Region III
Public Ledger Building, Suite 316
150 S. Independence Mall West
Philadelphia, PA 19106

Dear Mr. Virbitsky:

Thank you for the opportunity to review the June 16, 2015 draft report entitled *Delaware Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals.*

The report includes the following finding and recommendation.

> ***FINDING:*** The State agency made EHR incentive payments to three hospitals in accordance with Federal and State requirements. However, the State agency paid one hospital $2,017,584 when it should have paid $1,842,849, resulting in a total overpayment of $174,735. This error occurred because the hospital understated the non-charity care charges in its Medicaid share percentage calculation and the State agency did not validate the EHR incentive payment amount requested.
>
> ***RECOMMENDATION:*** We recommend that the State agency recover the overpayment and refund the State agency $174,735 in EHR incentive payments.

Delaware concurs that Nanticoke Hospital incorrectly reported amounts for charity care and therefore the Medicaid bed days. This resulted in an overpayment of $174,736. On March 5, 2015 we sent Nanticoke an Audit Findings letter and requested a payment to Delaware Medicaid for the overpayment. On April 6, 2015 we received the overpayment and submitted the transaction to CMS through the MAPIR system.

Please let me know if any further information is required.

Sincerely,

[redacted]

Stephen M. Groff
Director
Division of Medicaid and Medical Assistance

cc: Lisa Zimmerman, DMMA Deputy Director
Harry Roberts, DHSS Chief of Administration
Beth Laucius, DMMA Chief of Administration
Linda Murphy, DMMA Chief of Program Integrity
Troy McDaniel, DMMA Chief of Information Systems
Mary Marinari, Medicaid HIT Coordinator