Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

OHIO 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.

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Office of Inspector General

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EXECUTIVE SUMMARY

Ohio made incorrect Medicaid electronic health record incentive payments to hospitals totaling $526,000. Incorrect payments included both overpayments and underpayments, for a net overpayment of $524,000 over two years.

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 eligible health care professionals and eligible hospitals (collectively, "eligible providers"). As an incentive for using EHRs, the Federal Government makes 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 Ohio Department of Medicaid (the State agency) paid approximately $193 million in Medicaid EHR incentive program payments during calendar years (CY) 2011 and 2012.

Our objective 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. The State had provided guidance and technical assistance to the hospitals, which included a documented overview of the Medicaid EHR Incentive Payment calculation, entitled *Hospital Payment Calculation and Data Sources*. The State agency gave instructions for each calculation element including reporting charity charges, i.e. uncompensated care minus bad debt. Eligible 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 January 1, 2011, through December 31, 2012, the State agency paid $193,381,565 for Medicaid EHR incentive payments. We (1) reconciled both eligible professional and eligible hospital incentive payments reported on the State's Form CMS-64, Quarterly Medicaid Assistance Expenditures for the Medical Assistance Program (Form CMS-64), with the NLR (2) selected for further review 15 eligible professionals previously audited by the State agency to determine eligibility and (3) selected for further review 34 hospitals that received an incentive payment totaling $1 million or more. The State agency paid 20 of the 34 hospitals $25,693,307 during CY 2011 and 33 of the 34 hospitals $42,888,540 during CY 2012 for a total of $68,581,847 as of December 31, 2012.

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 10 hospitals totaling $526,332. Specifically, the State agency overpaid 9 hospitals a total of $525,247 and underpaid 1 hospital a total of $1,085, for a net overpayment of $524,162. The State agency made correct EHR incentive payments to the 15 eligible professionals included in our review.

These errors occurred because the State agency did not ensure that the hospitals had removed all bad debt/write-offs from charity care when calculating the incentive payments.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund to the Federal government $524,162 in net overpayments made to the 10 hospitals for CY 2011 and 2012;

- review remaining payment calculations for the hospitals included in our review using final settled cost reports and additional auditable documentation to determine whether payment adjustments are needed, and refund any overpayments identified;

- review the payment calculations for the 100 hospitals not included in our review using final settled cost reports and additional auditable documentation to determine whether payment adjustments are needed, and refund any overpayments identified; and

- modify the *Hospital Payment Calculation and Data Sources* document to properly exclude bad debt/write-offs from the reported charity care.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency acknowledged that some original hospital EHR Incentive Payment calculations may have resulted in underpayments or overpayments. Our sample population was 134 hospitals at the time of our review. The State Agency will include an additional 28 hospitals not included in our audit period. The State Agency will recalculate 162 hospital EHR incentive payments using final settled cost reports and adjust accordingly.

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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 eligible health care professionals and eligible hospitals (collectively, "eligible 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 Ohio Department of Medicaid (the State agency) made approximately $193 million in Medicaid EHR incentive program payments during calendar years (CY) 2011 and 2012.

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 (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 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.

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 attest to the meaningful use of 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 Ohio, the State agency administers the program.

States use the standard Form CMS-64, Quarterly Medicaid Assistance Expenditures for the Medical Assistance Program (Form CMS-64), 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 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.

Eligible Physicians Audits and Pre/Post-Payment Hospital Reviews

Prior to the authorization of payments, the State agency audited a selected sample of eligible physician payments and reviewed hospital pre-payment attestations. Hospitals were required to provide support for data used to determine the various elements in their calculations, including charity care and discharges. The allowable supporting documentation includes sections from their Medicare and Medicaid cost reports and other auditable documentation. According to the Ohio Administrative Code 5160-57-03 Medicaid provider incentive program (MPIP) (C)(4), "An eligible hospital may not alter or modify data elements used to calculate the hospital EHR incentive payment after MPIP has processed an eligible hospitals application for payment and payment has been disbursed for the payment year."

At the time of our review the State agency had not performed any post-payment reviews. The State agency plans to perform post-payment reviews after all EHR incentive payments have been distributed using a risk-based strategy. Included within the strategy are risk factors for identifying hospitals to be selected for audit including an analytic based on the interim and final settled cost reports. Final settled cost reports contain more accurate data but are not completed until several years after the fiscal year ends.

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 incentive payment history files.

Incentive Payment Eligibility Requirements

To receive an incentive payment, eligible professionals attest that they meet program requirements by self-reporting data using the NLR.[4] 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.[5] See Table 1 for program eligibility requirements for providers.

[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 §§ 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)).

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.

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.

[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)).

[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 4-year period with the first payment being 40 percent of the total; the second payment, 30 percent; the third payment, 20 percent; and the remaining payment, 10 percent.

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

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

[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)).

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

> 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)). If the State determines that an eligible provider's data are not available on charity care necessary to calculate the portion of the formula specified in paragraph (g)(2)(ii)(B) of this section, the State may use the provider's data on uncompensated care to determine an appropriate proxy for charity care, but must include a downward adjustment to eliminate bad debt from uncompensated care data. The State must use auditable data sources.

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 amounts could change due to 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.

HOW WE CONDUCTED THIS REVIEW

[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).

From January 1, 2011, through December 31, 2012, the State agency paid $193,381,565 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 (Form CMS-64), with the NLR (2) selected for further review 15 eligible professionals previously audited by the State agency to determine eligibility and (3) selected for further review the 34 hospitals that received an incentive payment totaling $1 million or more. The State agency paid the 20 hospitals $25,693,307 during CY 2011 and 33 of the 34 hospitals $42,888,540 during CY 2012 for a total of $68,581,847 as of December 31, 2012.

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 A contains a listing of previous OIG reports on Medicaid EHR incentive programs. Appendix B contains the details of our audit scope and methodology.

FINDING

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 10 hospitals totaling $526,332. Specifically, the State agency overpaid 9 hospitals a total of $525,247 and underpaid 1 hospital a total of $1,085, for a net overpayment of $524,162. The State agency made correct EHR incentive payments to the 15 eligible professionals included in our review.

These errors occurred because the State agency did not ensure that the hospitals had removed all bad debt/write-offs from charity care when calculating the incentive payments.

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 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. An eligible hospital, for purposes of the incentive payment provision, does not include its psychiatric or rehabilitation units, which are distinct parts of the hospital (75 Fed. Reg. 44314, 44450 and 44497 (July 28, 2010)).

Also, 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.[15]

Furthermore, CMS's Appendix M: EH Payment Calculation Guidance states that data sources should include "hospital internal financial records from the hospital's accounting system for charity care charges detailing the total bad debt expense, including bad debt relating to contractual write-offs." Appendix M also stipulates that "charity care charges should not include bad debt." According to 42 CFR§413.89(b), bad debts are "amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services."

Of the 34 hospital incentive payment calculations reviewed, 10 hospitals, or 29 percent, did not comply with regulations, guidance, or both, related to charity care. The State agency's instructions for charity care (defined as health services for which a hospital demonstrates that the patient is unable to pay) did not clarify the role of bad debt in the charity care calculation element.

In addition, the State agency did not ensure in the instances it sampled that the hospitals had removed all bad debt/write-offs from charity care. The State had provided guidance and technical assistance to the hospitals, which included a documented overview of the Medicaid EHR Incentive Payment calculation, entitled *Hospital Payment Calculation and Data Sources*. The State agency gave instructions for each calculation element including reporting charity charges, i.e. uncompensated care minus bad debt. However, cost report data submitted by the hospitals were not always accurate. In addition, the data had been amended by the hospitals several times when reporting uncompensated care to determine an appropriate estimate for charity care costs.

We contacted hospitals to determine their appropriate estimate for charity care costs. In one example, the hospital's cost report calculated $16 million for charity care but reported $140 million for charity care for the incentive payment calculation. We determined the correct estimate was $78 million for charity care resulting in an initial overpayment of $63,484. [16]

The hospital's Medicaid EHR incentive payments are calculated generally using the same formula as the Medicare payment, with some adjustments (75 Fed. Reg. 44498 (July 28, 2010). Hospitals that used Medicare data in their incentive payment calculation did not substitute Medicaid data because the State agency does not amend the Medicaid cost report data until final settled after approximately a 5 year time period.

During the State agency's pre-payment reviews of the initial attestations made by the hospitals, the State agency lacked the most current cost report amendments to support the hospital attestations. The State agency contacted the hospitals for the current amendments to the cost

[15] CMS Frequently Asked Questions: https://questions.cms.gov/ FAQs 2991, 3213, 3261, and 3315; last accessed on April 1, 2014.

[16] Ohio EHR payments are paid over a 4 year period. The $63,484 overpayment was the initial payment to the hospital. The remaining payments were not included in the scope of this review.

reports when it verified and approved the data for the final payment calculation. However, for the charity care component, not all hospitals selected for our sample had provided the State accurate data at the time of the payment calculation.

As a result, the State agency made incorrect incentive payments totaling $526,332 according to data made available to the State from the hospitals. Specifically, the State agency overpaid 9 hospitals a total of $525,247 and underpaid 1 hospital a total of $1,085, for a net overpayment of $524,162. Because the hospital calculations were computed once and paid out over four years, the remaining payments for the 10 hospitals need to be reviewed and adjusted by the State agency during the post-payment reviews.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal government $524,162 in net overpayments made to the 10 hospitals for CY 2011 and 2012;

- review remaining payment calculations for the hospitals included in our review using final settled cost reports and additional auditable documentation to determine whether payment adjustments are needed, and refund any overpayments identified;

- review the payment calculations for the 100 hospitals not included in our review using final settled cost reports and additional auditable documentation to determine whether payment adjustments are needed, and refund any overpayments identified; and

- modify the *Hospital Payment Calculation and Data Sources* document to properly exclude bad debt/write-offs from the reported charity care.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency acknowledged that some original hospital EHR Incentive Payment calculations may have resulted in underpayments or overpayments. Our sample population was 134 hospitals at the time of our review. The State Agency will include an additional 28 hospitals not included in our audit period. The State Agency will recalculate 162 hospital EHR incentive payments using final settled cost reports and adjust accordingly. The State agency comments are included in their entirety as Appendix C.

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

Report Title	Report Number	Date Issued
Delaware Made Incorrect Medicaid Electronic Health Record Incentive Payments	A-03-14-00402	09-30-2015
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, 2012, the State agency paid $193,381,565 for Medicaid EHR incentive payments. We (1) reconciled both professional and hospital incentive payments reported on the State's Form CMS-64 to the NLR and (2) selected for further review the 34 hospitals that received an incentive payment totaling $1 million or more. The State agency paid 20 of the 34 hospitals $25,693,307 during CY 2011 and 33 of the 34 hospitals $42,888,540 during CY 2012 for a total of $68,581,847 as of December 31, 2012.

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 Columbus, Ohio and with hospitals throughout Ohio.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- reviewed 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;
- reviewed the audit guide for the Ohio Medicaid Provider Incentive Program approved by CMS;
- reviewed and reconciled the appropriate lines from the Form CMS-64 to supporting documentation and the NLR;
- reviewed State agency working papers for a sample of 15 from 66 eligible professionals previously reviewed by the State agency;
- selected for further review 34 hospitals that were paid an incentive payment of $1 million or more during CYs 2011 and 2012;
- reviewed the State agency's supporting documentation related to the 34 selected hospitals, which included a technical guidance document entitled *Hospital Payment Calculation and Data Sources*;

- verified that the selected hospitals met eligibility requirements;
- determined whether the selected hospital patient-volume calculations were correct;
- contacted the selected hospitals and verified the supporting documentation;
- reviewed the hospitals' policies and procedures for charity care;
- determined whether the selected hospital incentive-payment calculations were correct and adequately supported; 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

Ohio
Department of Medicaid
John R. Kasich, Governor
John B. McCarthy, Director

June 20, 2016

Sheri L. Fulcher
Region V Inspector General for Audit Services
Office of Inspector General, Office of Audit Services
233 North Michigan Avenue, Suite 1360
Chicago, IL 60601

Dear Ms. Fulcher:

The Ohio Department of Medicaid (ODM) has reviewed the Office of the Inspector General's (OIG) draft report A-05-13-00043 titled, "Ohio Made Incorrect Medicaid Electronic Health Record Incentive Payments." ODM is appreciative of the opportunity to review and comment on the draft report, and we have stated our comments below.

OIG Recommendation 1: Refund to the Federal Government $524,162.00 net overpayments made to the 10 hospitals for CY 2011 and 2012.

ODM Response:

- ODM acknowledges that some of the original hospital EHR Incentive Payment calculations may result in underpayments or overpayments. It is our expectation that these potential underpayments or overpayments will be addressed during a review period once final settled cost report data is available to ODM.
- The original payments are calculated based on interim cost reports and other data reported by a hospital at the time of attestation and pre-payment review. It is ODM's understanding that final cost report data was not available during the OIG's review.
- Because final cost report data was not available during the original payment or during the OIG's review, ODM will review all 162 hospital payment calculations using final settled cost reports and additional auditable documentation. Once the reviews are completed, ODM will recoup or issue additional payments based on the final result.

OIG Recommendation 2: Review remaining payment calculations for the hospitals included in our review using final settled cost reports and additional auditable documentation to determine whether payment adjustments are needed, and refund any overpayments;

ODM Response:

- As noted above, ODM will review all 162 hospital payment calculations using final settled cost reports and additional auditable documentation. Once the reviews are completed, ODM will recoup or issue additional payments.

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OIG Recommendation 3: Review the payment calculations for the 100 hospitals not included in our review using final settled cost reports and additional auditable documentation to determine whether payment adjustments are needed, and refunded any overpayments identified; and

ODM Response:

- As noted above, ODM will review all 162 hospital payment calculations using final settled cost reports and additional auditable documentation. Once the reviews are completed, ODM will recoup or issue additional payments.

OIG Recommendation 4: Modify the Hospital Payment Calculation and Data Sources document to properly exclude bad debt write-offs from the reported charity care.

ODM Response:

- ODM will discontinue issuing the Hospital Payment Calculation and Data Sources document.

Thank you again for the opportunity to review and comment on the draft report. If you have questions about this response or need more information, please contact Angela Houck, Audit Coordinator, at (614) 752-3250 or through e-mail at angela.houck@medicaid.ohio.gov.

Sincerely,

/John B. McCarthy/

John B. McCarthy
Director
Ohio Department of Medicaid