Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ARIZONA 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

Arizona made incorrect Medicaid electronic health record incentive payments to hospitals, resulting in a net overpayment of $14.8 million over approximately 4 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 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 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 making incentive payments to providers that do not fully meet requirements.

The Arizona Health Care Cost Containment System (State agency) made approximately $219 million in Medicaid EHR incentive program payments from October 1, 2011, through March 31, 2015. Of this amount, $68 million was paid to 2,920 health care professionals, and $151 million was paid to 70 hospitals. 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 to eligible hospitals 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 hospitals 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, hospitals must meet Medicaid patient-volume requirements. In general, patient volume is calculated by dividing a hospital's total Medicaid patient encounters by 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 October 1, 2011, through March 31, 2015, the State agency made $150,559,419 in Medicaid EHR incentive payments to eligible hospitals. We (1) reviewed and reconciled hospital incentive payments reported on the State agency's Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, with the NLR and (2) selected for further review the 25 hospitals that each received total incentive payments exceeding $2.3 million. The State agency paid the 25 hospitals $101,340,460, which was 67 percent of the total paid from October 1, 2011, through March 31, 2015. The State agency made additional payments to 9 of the 25 hospitals, totaling $6,034,898 as of January 31, 2016, which we also reviewed.

WHAT WE FOUND

Although the State agency made Medicaid EHR incentive program payments to eligible hospitals, it did not always make these payments in accordance with Federal and State requirements. Specifically, from October 1, 2011, through January 31, 2016, the State agency made incorrect Medicaid EHR incentive payments to 24 of the 25 hospitals reviewed, totaling $14,953,577. These incorrect payments included both overpayments and underpayments, resulting in a net overpayment of $14,830,859. Because the incentive payment is calculated once and then paid out over 4 years, payments made after January 31, 2016, will also be incorrect. The adjustments to these payments total $1,674,728.

These errors occurred because hospitals did not always follow Federal and State requirements for calculating their incentive payments. In addition, the State agency did not review supporting documentation provided by the hospitals to help identify errors in their calculations.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund to the Federal Government $14,830,859 in net overpayments made to the 24 hospitals,

- adjust the 24 hospitals' remaining incentive payments to account for the incorrect calculations (which will result in cost savings of $1,674,728 after January 31, 2016),

- review the calculations for the hospitals not included in the 25 we reviewed to determine whether payment adjustments are needed and refund to the Federal Government any overpayments identified,

- educate hospitals to ensure that they follow Federal and State requirements for calculating their incentive payments, and

- review supporting documentation provided by all hospitals to help identify any errors in their incentive payment calculations.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency did not agree with our findings. The State agency commented that it could not reconcile the amounts we reported and that many of the hospitals had submitted to us different cost reporting and supplemental data from what they had provided to the State agency. The State agency said that, as a result, it believes it is limited in being able to resolve or concur with any of our findings until the issue of different cost report data is resolved. The State agency commented that its postpayment audits for the hospitals we selected have identified discrepancies with our incentive payment calculations. The State agency also provided information on actions that it had taken or planned to take to address our recommendations.

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. We provided the State agency with our incentive payment calculations that applied the relevant Federal and State requirements; those calculations were based on data that each hospital provided to us. We also provided the State agency with our calculation of the total incentive payment amount for each hospital. We suggest that the State agency work with the hospitals to resolve any discrepancies between its postpayment audit calculations and our calculations of the incentive payments.

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

The Arizona Health Care Cost Containment System (State agency) made approximately $219 million in Medicaid EHR incentive program payments from October 1, 2011, through March 31, 2015. Of this amount, $68 million was paid to 2,920 health care professionals, and $151 million was paid to 70 hospitals. 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 to eligible hospitals 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] *Electronic Health Records: 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, 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 (§ 4201). The Federal Government reimburses 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 Arizona, the State agency administers the program.

States use the standard Form CMS-64, Quarterly Medicaid Statement of 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 of 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 hospitals attest that they meet program requirements by self-reporting data using the NLR.[4] To be eligible for the Medicaid EHR incentive program, hospitals must meet Medicaid patient-volume requirements (42 CFR § 495.304(e)). In general,

[4] 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)).

patient volume is calculated by dividing a hospital's total Medicaid patient encounters by total patient encounters.[5]

To meet program eligibility requirements, a hospital must:

- be a permissible provider type that is licensed to practice in the State;
- participate in the State Medicaid program;
- not be excluded, sanctioned, or otherwise deemed ineligible to receive payments from the State or Federal Government;
- have an average length of stay of 25 days or less;[6]
- have adopted, implemented, upgraded, or meaningfully used certified EHR technology;[7] and
- meet Medicaid patient-volume requirements.[8]

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.

[5] For hospitals, patient encounters are defined as discharges, not days spent in the hospital. 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] The definition of "acute-care hospital" in 42 CFR § 495.302. Children's hospitals do not have to meet the average-length-of-stay requirement.

[7] A provider may only adopt, implement, or upgrade certified EHR technology in the first year it is in the program (42 CFR § 495.314(a)(1)). In subsequent years, the provider must demonstrate that during the EHR reporting period it was a meaningful EHR user, as defined in 42 CFR § 495.4.

[8] 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. Of the total, the first payment was 40 percent, the second payment was 30 percent, the third payment was 20 percent, and the fourth payment was 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 factor, all 4 years are totaled to determine the overall EHR amount. The table provides examples of the overall EHR amount calculation for three types of hospitals, with differing numbers of discharges during the payment year.

Table: Examples of Overall Electronic Health Record Amount Calculation

EHR Calculation	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 on the basis of 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)).[12]

[10] 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)).

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

[12] For reporting purposes, we refer to the numerator of the Medicaid share as the "Medicaid-bed-days-only portion of the Medicaid share."

- 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 reattest that it met 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)).

HOW WE CONDUCTED THIS REVIEW

From October 1, 2011, through March 31, 2015, the State agency made $150,559,419 in Medicaid EHR incentive payments to eligible hospitals. We (1) reviewed and reconciled hospital incentive payments reported on the State agency's CMS-64 report with the NLR and (2) selected for further review the 25 hospitals that each received total incentive payments exceeding $2.3 million. The State agency paid the 25 hospitals $101,340,460, which was 67 percent of the total paid from October 1, 2011, through March 31, 2015. The State agency made additional payments to 9 of the 25 hospitals, totaling $6,034,898 as of January 31, 2016, which we also reviewed.

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.

FINDING

Although the State agency made Medicaid EHR incentive program payments to eligible hospitals, it did not always make these payments in accordance with Federal and State requirements. Specifically, from October 1, 2011, through January 31, 2016, the State agency made incorrect Medicaid EHR incentive payments to 24 of the 25 hospitals reviewed, totaling $14,953,577. These incorrect payments included both overpayments and underpayments,

resulting in a net overpayment of $14,830,859.[13] Because the incentive payment is calculated once and then paid out over 4 years, payments made after January 31, 2016, will also be incorrect. The adjustments to these payments total $1,674,728.

These errors occurred because hospitals did not always follow Federal and State requirements for calculating their incentive payments. In addition, the State agency did not review supporting documentation provided by the hospitals to help identify errors in their calculations.

FEDERAL AND STATE REQUIREMENTS

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 psychiatric units, which are distinct parts of the hospital (75 Fed. Reg. 44314, 44450, and 44497 (July 28, 2010)). Also, Federal regulations state that bed-days include all inpatient bed-days under the acute-care payment system and exclude nursery bed-days, except for those in intensive-care units of the hospital (neonatal intensive care units (NICUs)) (75 Fed. Reg. 44314, 44453, 44454, 44498, and 44500 (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 (42 CFR § 495.310(g)(1)(i)(B)). Additionally, hospital incentive payments are based on a one-time calculation that includes inpatient acute-care discharges and bed-days (42 CFR § 495.310(g)). Federal regulations consider observation services to be outpatient services (75 Fed. Reg. 44314, 44484 (July 28, 2010)). Therefore, observation services would not be included in the calculation of hospital incentive payments.

Federal regulations require that unpaid Medicaid bed-days be excluded from the incentive payment calculation (75 Fed. Reg. 44314, 44500 (July 28, 2010)). CMS guidance further clarifies that unpaid Medicaid bed-days must be excluded from the Medicaid-bed-days-only portion of the Medicaid share component of the incentive payment calculation.[14]

CMS and State agency guidance state that nursery, labor and delivery, observation, and psychiatric days and discharges (non-acute-care services) may not be included as inpatient acute-care services in the calculation of hospital incentive payments.[15]

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[13] Several hospitals had multiple deficiencies in their incentive payment calculations, which resulted in both overpayments and underpayments. We reported the net effect of these deficiencies.

[14] CMS Frequently Asked Questions (FAQ), FAQ 7649. Available online at https://questions.cms.gov/. Accessed on March 18, 2016.

[15] CMS guidance for nursery and psychiatric days and discharges from CMS FAQs 2991, 3213, and 3261. Available online at https://questions.cms.gov/. Accessed on January 28, 2016. State agency guidance for nursery, labor and delivery, and observation days and discharges from the *Arizona State Medicaid Health Information Technology Plan*, dated July 18, 2011.

THE STATE AGENCY MADE INCORRECT HOSPITAL INCENTIVE PAYMENTS

Of the 25 hospital incentive payment calculations reviewed, 24, or 96 percent, did not comply with regulations or guidance or both. Some calculations had multiple deficiencies. Specifically, the calculations included:

- non-acute-care services (17 hospitals);[16]
- unpaid Medicaid bed-days in the Medicaid-bed-days-only portion of the Medicaid share (15 hospitals);
- clerical errors, such as reporting the incorrect number of discharges because of a keying error (11 hospitals); and
- data for more than 12 months (3 hospitals).

The incentive payment calculation for one hospital did not include NICU services, which should have been included.

The State agency made incorrect hospital incentive payments because it did not ensure that hospitals followed Federal and State requirements for calculating their incentive payments by:

- excluding (1) non-acute-care services, (2) unpaid Medicaid bed-days in the Medicaid-bed-days-only portion of the Medicaid share, and (3) data for more than 12 months and
- including NICU services.

According to State agency officials, they instructed hospitals on how to calculate Medicaid EHR incentive payments but did not review supporting documentation provided by the hospitals to help identify these types of errors or clerical errors in their calculations.

As a result, for the 24 hospitals, the State agency made incorrect incentive payments totaling $14,953,577. Specifically, the State agency overpaid 22 hospitals a total of $14,892,218 and underpaid 2 hospitals a total of $61,359, for a net overpayment of $14,830,859. Because the incentive payment is calculated once and then paid out over 4 years, payments after January 31, 2016, will also be incorrect. The adjustments to these payments total $1,674,728.[17]

[16] These services consisted of nursery, labor and delivery, observation, and psychiatric services.

[17] The adjusted amount is the total net overpayment for 18 of 24 hospitals that did not receive their third- and/or fourth-year payments.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government $14,830,859 in net overpayments made to the 24 hospitals,
- adjust the 24 hospitals' remaining incentive payments to account for the incorrect calculations (which will result in cost savings of $1,674,728 after January 31, 2016),
- review the calculations for the hospitals not included in the 25 we reviewed to determine whether payment adjustments are needed and refund to the Federal Government any overpayments identified,
- educate hospitals to ensure that they follow Federal and State requirements for calculating their incentive payments, and
- review supporting documentation provided by all hospitals to help identify any errors in their incentive payment calculations.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not agree with our findings. The State agency commented that it could not reconcile the amounts we reported and that many of the hospitals had submitted to us different cost reporting and supplemental data from what they had provided to the State agency. The State agency said that, as a result, it believes it is limited in being able to resolve or concur with any of our findings until the issue of different cost report data is resolved.

The State agency commented that it has begun postpayment audits for the hospitals we selected and has found variances in the incentive payment calculations for all 25 facilities. Specifically, it identified four discrepancies between its postpayment audit calculations and our calculations that it said had the greatest impact on these variances. In addition, the State agency commented that it believes it has followed its CMS-approved payment rules and that it "would welcome the chance to work more closely with [the Office of Inspector General] to resolve the concerns identified above to ensure that the most accurate source of data is being evaluated for payment appropriateness."

The State agency provided information on actions that it had taken or planned to take to address our recommendations.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. We provided the State agency with our incentive payment calculations that applied the relevant Federal and State requirements; those calculations were based on data that each hospital provided to us. We summarized the relevant data from the hospitals and showed how we determined our calculations, such as excluding non-acute-care services.

We also provided the State agency with our calculation of the total incentive payment amount for each hospital. To calculate those amounts, we used a payment calculation worksheet that the State agency provided to us and that was also used by the 25 hospitals to calculate their total incentive payment amounts. In addition, we provided the State agency with the contact information for the hospital officials from which we obtained supporting documentation. We suggest that the State agency work with the hospitals to resolve any discrepancies between its postpayment audit calculations and our calculations of the incentive payments.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
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 October 1, 2011, through March 31, 2015, the State agency made $150,559,419 in Medicaid EHR incentive payments to eligible hospitals. We (1) reviewed and reconciled hospital incentive payments reported on the State agency's CMS-64 report with the NLR and (2) selected for further review the 25 hospitals that each received total incentive payments exceeding $2.3 million. The State agency paid the 25 hospitals $101,340,460, which was 67 percent of the total paid from October 1, 2011, through March 31, 2015. The State agency made additional payments to 9 of the 25 hospitals, totaling $6,034,898 as of January 31, 2016, which we also reviewed.

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 conducted audit work from July 2015 to March 2016, which included contacting the State agency in Phoenix, Arizona.

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 related to the Medicaid EHR incentive program;
- reviewed and reconciled the appropriate lines from the CMS-64 report with supporting documentation and the NLR;
- selected for further review (1) the 25 hospitals that each received total incentive payments exceeding $2.3 million from October 1, 2011, through March 31, 2015, and (2) all payments made to the 25 selected hospitals from April 1, 2015, through January 31, 2016;
- reviewed and verified the selected hospitals' supporting documentation;
- verified that the selected hospitals met eligibility requirements;
- determined whether the selected hospital patient-volume calculations were correct;

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

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

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

AHCCCS
Arizona Health Care Cost Containment System

Douglas A. Ducey, Governor
Thomas J. Betlach, Director

June 15, 2016

Ms. Lori Ahlstrand
Regional Inspector General for Audit Service
Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

Reference Report Number A-09-15-02036

Dear Ms. Ahlstrand:

The Arizona Health Care Cost Containment System (AHCCCS) has reviewed the U.S. Department of Health and Human Services, Office of Inspector General (OIG) draft report entitled *Arizona Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals*. AHCCCS has significant concerns about the inconsistent calculation methodologies and data sources that were used to create findings for this report. Our responses to OIG's finding and to each of the identified recommendations are stated below.

OIG Finding:

The State agency made incorrect hospital incentive payments.

Of the 25 hospital incentive payment calculations reviewed, 24, or 96 percent, did not comply with regulations or guidance or both. Some calculations had multiple deficiencies. Specifically, the calculations included:

- nonacute-care services (17 hospitals);
- unpaid Medicaid bed-days in the Medicaid-bed-days-only portion of the Medicaid share (15 hospitals);
- clerical errors, such as reporting the incorrect number of discharges because of a keying error (11 hospitals); and
- data for more than 12 months (3 hospitals).

The incentive payment calculation for one hospital did not include NICU services, which should have been included.

AHCCCS Response to OIG Finding:

AHCCCS does not agree with the findings outlined in the OIG report. We cannot reconcile the OIG amounts, based on the data that has been supplied to us. The hospitals reviewed by OIG were paid based on cost report data provided to AHCCCS during the prepayment review process.

Through discussions with OIG, it was identified that many of the hospitals submitted different cost reporting and supplemental data to OIG versus what had been provided to AHCCCS. Not having the same data has limited our ability to compare or recreate OIG findings. While AHCCCS did request additional detailed reports from OIG to better understand their calculations and payment determinations, the information was not made available to us. AHCCCS believes it is limited in being able to resolve or concur with any of the OIG findings until the issue of different cost report data is resolved.

As an example, AHCCCS has begun post-payment audits for the hospitals selected by OIG and has found variances in the payment calculations for all 25 facilities. It appears the following discrepancies have the greatest impact on these identified variances:

• AHCCCS is calculating different amounts of paid Medicaid days for the Medicaid days component of the Medicaid share than the amounts calculated by OIG. AHCCCS also removes CHIP (Title XXI) days from the Medicaid days, whereas OIG did not.

• AHCCCS is calculating different amounts of low level nursery discharges and days for the growth rate and Medicaid share than the amounts calculated by OIG. It appears that OIG included nursery days and discharges for certain hospitals that do not have level 4 NICUs. This is not consistent with AHCCCS policies.

• AHCCCS is calculating different amounts of labor and delivery discharges and days for the growth rate and Medicaid share than the amounts calculated by OIG and

• AHCCCS required and received detailed reports from each hospital in an excel format, which allowed the data to be analyzed. OIG appeared to only have validated hospital reports in PDF formats. Not having the same data sets in the same format has limited our ability to compare, recreate, or validate OIG findings.

AHCCCS believes it has followed its approved payment rules. AHCCCS payment rules were contained in the state's 2011 State Medicaid Health IT Plan (SMHP) which was approved by the Centers for Medicare & Medicaid Services (CMS). In addition, AHCCCS began to conduct post-payment reviews of all hospital payments with assistance from their consultant as of August 2015. AHCCCS planned to review all hospital payment calculations in detail during post-payment audits to ensure accurate eligible hospital payments and believes that any necessary payment adjustments would have been determined through that process.

AHCCCS's internal auditors and contracted consultants are currently auditing the payment calculations for the 25 hospitals selected by OIG. AHCCCS would welcome the chance to work more closely with OIG to resolve the concerns identified above to ensure that the most accurate source of data is being evaluated for payment appropriateness.

OIG Recommendations Related to Finding:

1. Refund to the Federal Government $14,830,859 in net overpayments made to the 24 hospitals.
2. Adjust the 24 hospitals' remaining incentive payments to account for the incorrect calculations (which will result in future cost savings of $1,674,728).
3. Review the calculations for the hospitals not included in the 25 we reviewed to determine whether payment adjustments are needed and refund to the Federal Government any overpayments identified.
4. Educate hospitals to ensure that they follow Federal and State requirements for calculating their incentive payments.
5. Review supporting documentation provided by the hospitals to help identify any errors in their incentive payment calculations.

AHCCCS Responses to Recommendations:

Response to recommendation 1: AHCCCS's internal auditors and contracted consultants have begun auditing the payment calculations for the 25 hospitals selected by OIG and have been unable to reconcile completely with OIG's calculations. AHCCCS's audit team will continue to work with the hospitals in an attempt to reconcile with OIG's calculations in order to rectify any variances. Once these audits have been completed, AHCCCS will develop a plan for issuing recoupments from the providers and refunding net overpayments to the federal government as appropriate.

Response to recommendation 2: Once the audits referenced in "Response to recommendation 1" above have been completed, AHCCCS will adjust any future payments owed to the hospitals accordingly.

Response to recommendation 3: AHCCCS will conduct audits of the payment calculations for all eligible hospitals not included in the 25 reviewed by OIG to determine whether payment adjustments are required. As part of these audits, AHCCCS will obtain and review detail supporting documentation provided by the hospitals to help identify any mispayments. If any mispayments are identified and recoupments from the hospitals or adjustments are made to the hospitals future payments, any resulting overpayments will be refunded to the Federal Government.

Response to recommendation 4: AHCCCS has updated the Eligible Hospital Payment Worksheet regarding unpaid Medicaid days in the Medicaid Share, and nonacute-care exclusions from the eligible hospital payment calculation. In addition, hospitals that received overpayments will be educated on the aggregate payment calculation and the reasons for the identified overpayments.

Response to recommendation 5: Once the audits referenced in "Response to recommendation 3" above have been completed, AHCCCS will make recoupments from the hospitals and/or adjust any future payments owed to the hospitals accordingly.

If you have questions about our response or need additional information, please feel free to call me at (602) 417-4420 or email me at Lorie.Mayer@azahcccs.gov

Sincerely,

Lorie Mayer

Lorie Mayer
AHCCCS Health IT Coordinator