

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CALIFORNIA MADE INCORRECT
MEDICAID ELECTRONIC HEALTH
RECORD INCENTIVE PAYMENTS
TO HOSPITALS**

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EXECUTIVE SUMMARY

California made incorrect Medicaid electronic health record incentive payments to hospitals, resulting in a net overpayment of \$22 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 California Department of Health Care Services (State agency) made approximately \$971 million in Medicaid EHR incentive program payments from October 1, 2011, through December 31, 2014. Of this amount, \$370 million was paid to 15,074 health care professionals, and \$601 million was paid to 263 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 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 December 31, 2014, the State agency made \$600,894,455 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 64 hospitals that each received a first-year incentive payment exceeding \$2 million. The State agency paid the 64 hospitals \$317,444,168, which was 53 percent of the total paid from October 1, 2011, through December 31, 2014. The State agency made additional payments to 37 of the 64 hospitals, totaling \$25,700,188 as of December 31, 2015, 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 requirements. Specifically, from October 1, 2011, through December 31, 2015, the State agency made incorrect Medicaid EHR incentive payments to 61 of the 64 hospitals reviewed, totaling \$23,227,540. These incorrect payments included both overpayments and underpayments, resulting in a net overpayment of \$22,043,234. Because the incentive payment is calculated once and then paid out over 4 years, payments made after December 31, 2015, will also be incorrect. The adjustments to these payments total \$6,318,006.

The State agency made incorrect hospital incentive payments because it did not review supporting documentation from the hospitals to help identify errors in its calculations.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund to the Federal Government \$22,043,234 in net overpayments made to the 61 hospitals,
- adjust the 61 hospitals' remaining incentive payments to account for the incorrect calculations (which will result in cost savings of \$6,318,006 after December 31, 2015),

- review the calculations for the hospitals not included in the 64 we reviewed to determine whether payment adjustments are needed and refund to the Federal Government any overpayments identified, and
- review supporting documentation from all hospitals to help identify any errors in incentive payment calculations.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency disagreed with our first recommendation and agreed with our remaining recommendations. Regarding our first recommendation, the State agency agreed that incorrect Medicaid EHR incentive payments may have been made to hospitals but did not concur with our recommended refund amount. Specifically, the State agency commented that (1) it believes further detailed analysis and validation of hospital data is required to support the overpayments we identified in our review; (2) our review used hospital-generated schedules and internal financial records, which did not include detailed testing against actual payments and adjudicated claim data; and (3) as part of its approved audit strategy, it has committed to conducting audits of all hospitals participating in the EHR incentive program and has prioritized the audits of the 64 hospitals we reviewed. Regarding our second recommendation, the State agency agreed and commented that it will adjust future incentive payments where a recalculation of the total payment is necessary. The State agency agreed with our third and fourth recommendations and provided information on actions that it planned to take to address our recommendations.

After reviewing the State agency's comments, we maintain that our finding and recommendations are valid. We obtained the hospitals' (1) Medicare cost reports used to support incentive payment calculations; (2) attestation agreements certifying that all information in their applications for the EHR incentive program was accurate and complete; and (3) internal financial records, which supported the attested information. We also analyzed the hospital data and applied the relevant Federal requirements to verify that specific data elements were included in or excluded from the incentive payment calculations. We provided the State agency with a summary of the data that each hospital provided to us, including our incentive payment calculations that applied the relevant Federal requirements. We suggest that the State agency work with CMS to resolve any discrepancies that are identified between its postpayment audit calculations and our calculations of the incentive payments.

TABLE OF CONTENTS

INTRODUCTION 1

 Why We Did This Review 1

 Objective 1

 Background 2

 Health Information Technology for Economic and Clinical Health Act 2

 Medicaid Program: Administration and Federal Reimbursement 2

 National Level Repository 2

 Incentive Payment Eligibility Requirements 2

 Eligible Hospital Payments 3

 How We Conducted This Review 5

FINDING 5

 Federal Requirements 6

 The State Agency Made Incorrect Hospital Incentive Payments 7

RECOMMENDATIONS 8

STATE AGENCY COMMENTS 8

OFFICE OF INSPECTOR GENERAL RESPONSE 9

APPENDIXES

 A: Related Office of Inspector General Reports 10

 B: Audit Scope and Methodology 11

 C: State Agency Comments 13

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 California Department of Health Care Services (State agency) made approximately \$971 million in Medicaid EHR incentive program payments from October 1, 2011, through December 31, 2014. Of this amount, \$370 million was paid to 15,074 health care professionals, and \$601 million was paid to 263 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 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 California, 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 50 percent, the second payment was 30 percent, the third payment was 10 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-days¹¹ 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 December 31, 2014, the State agency made \$600,894,455 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 64 hospitals that each received a first-year incentive payment exceeding \$2 million. The State agency paid the 64 hospitals \$317,444,168, which was 53 percent of the total paid from October 1, 2011, through December 31, 2014. The State agency made additional payments to 37 of the 64 hospitals, totaling \$25,700,188 as of December 31, 2015, 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 requirements. Specifically, from October 1, 2011, through December 31, 2015, the State agency made incorrect Medicaid EHR incentive payments to 61 of the 64 hospitals reviewed, totaling \$23,227,540. These incorrect payments included both overpayments and underpayments, resulting in a net

overpayment of \$22,043,234.¹³ Because the incentive payment is calculated once and then paid out over 4 years, payments made after December 31, 2015, will also be incorrect. The adjustments to these payments total \$6,318,006.

The State agency made incorrect hospital incentive payments because it did not review supporting documentation from the hospitals to help identify errors in its calculations.

FEDERAL REQUIREMENTS

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

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 or rehabilitation 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)).

Furthermore, CMS guidance states that nursery, rehabilitation, 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

Federal regulations state that providers should retain documentation to support incentive payment calculations for at least 6 years following the date of attestation (42 CFR § 495.40(c) and 77 Fed. Reg. 53968, 54112 (Sept. 4, 2012)).

The Medicaid share amount for a hospital is essentially the percentage of a hospital's inpatient, noncharity-care days that are attributable to Medicaid inpatients (75 Fed. Reg. 44314, 44498 (July 28, 2010)). Also, if a State determines that hospital data on charity care necessary to use in the calculation are not available, the State may use a hospital's uncompensated care data; however, it must include a downward adjustment to eliminate bad debt (42 CFR § 495.310(h)).

Federal regulations state that the numerator of the Medicaid share calculation must exclude Medicaid dual-eligible acute inpatient bed-days (75 Fed. Reg. 44314, 44500 (July 28, 2010)).

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, rehabilitation, and psychiatric days and discharges from CMS FAQs 2991, 3213, and 3261. Available online at <https://questions.cms.gov/>. Accessed on January 28, 2016.

In computing inpatient bed-days, a State may not include estimated acute inpatient bed-days attributable to individuals (1) for whom payment may be made under Medicare Part A or (2) who are enrolled with a Medicare Advantage organization under Medicare Part C. The denominator may include Medicaid dual-eligible acute inpatient bed-days (42 CFR § 495.310(g)(2)(iii)).

THE STATE AGENCY MADE INCORRECT HOSPITAL INCENTIVE PAYMENTS

Of the 64 hospital incentive payment calculations reviewed, 61, or 95 percent, did not comply with Federal regulations or guidance or both. Some calculations had multiple deficiencies. Specifically, the calculations included:

- unpaid Medicaid bed-days in the Medicaid-bed-days-only portion of the Medicaid share (30 hospitals);
- non-acute-care services (23 hospitals);¹⁶
- hospital data not supported by documentation required to be retained (21 hospitals);
- bad debt within charity-care charges (13 hospitals);
- Medicaid dual-eligible acute inpatient bed-days in the numerator (5 hospitals); and
- clerical errors, such as reporting an incorrect charity-care charge because of a keying error (5 hospitals).

In addition, the incentive payment calculations did not include services that should have been included:

- labor and delivery services (12 hospitals),
- NICU services (10 hospitals), and
- intensive-care services (8 hospitals).

The State agency followed CMS's guidance on cost-report data elements suggested for use when calculating hospital incentive payments but did not follow more specific Federal regulations and guidance. CMS's cost-report guidance tells providers where to find certain data elements on the cost report but does not include which items Federal regulations state should be removed from these data elements.¹⁷ According to State agency officials, the State agency advised hospitals to remove items from these data elements but did not review the hospitals' supporting documentation to help identify these types of errors in the calculations.

¹⁶ These services consisted of nursery, rehabilitation, and psychiatric services.

¹⁷ CMS guidance for cost-report data elements from CMS FAQ 3471. Available online at <https://questions.cms.gov/>. Accessed on January 28, 2016.

As a result, for the 61 hospitals, the State agency made incorrect incentive payments totaling \$23,227,540. Specifically, the State agency overpaid 53 hospitals a total of \$22,635,387 and underpaid 8 hospitals a total of \$592,153, for a net overpayment of \$22,043,234. Because the incentive payment is calculated once and then paid out over 4 years, payments after December 31, 2015, will also be incorrect. The adjustments to these payments total \$6,318,006.¹⁸

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government \$22,043,234 in net overpayments made to the 61 hospitals,
- adjust the 61 hospitals' remaining incentive payments to account for the incorrect calculations (which will result in cost savings of \$6,318,006 after December 31, 2015),
- review the calculations for the hospitals not included in the 64 we reviewed to determine whether payment adjustments are needed and refund to the Federal Government any overpayments identified, and
- review supporting documentation from all hospitals to help identify any errors in incentive payment calculations.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency disagreed with our first recommendation and agreed with our remaining recommendations.

Regarding our first recommendation, the State agency agreed that incorrect Medicaid EHR incentive payments may have been made to hospitals but did not concur with our recommended refund amount:

- The State agency commented that it believes further detailed analysis and validation of hospital data is required to support the overpayments we identified. The State agency also commented that it has implemented robust pre- and postpayment review and audit procedures, which are effective in confirming the accuracy of incentive payment calculations in accordance with Federal regulations.
- The State agency commented that our review used hospital-generated schedules and internal financial records, which did not include detailed testing against actual payments and adjudicated claim data. The State agency commented that, therefore, it is unable to

¹⁸ The adjusted amount is the total net overpayment for 48 of 61 hospitals that did not receive their second-, third- and/or fourth-year payments.

rely on our audit findings because they cannot be supported in administrative appeals available to providers with identified overpayments.

- The State agency commented that as part of its approved audit strategy, it has committed to conducting audits of all hospitals participating in the EHR incentive program and has prioritized the audits of the 64 hospitals we reviewed. The State agency said that any identified overpayments will be offset against future incentive payments to the hospitals. The State agency also commented that if any identified overpayments exceed future incentive payments, it will refund to the Federal Government the remaining overpayment amount.

Regarding our second recommendation, the State agency agreed and commented that it will adjust future incentive payments where a recalculation of the total payment is necessary. The State agency agreed with our third and fourth recommendations and provided information on actions that it 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 finding and recommendations are valid:

- We obtained the hospitals' (1) Medicare cost reports used to support incentive payment calculations; (2) attestation agreements certifying that all information in their applications for the EHR incentive program was accurate and complete; and (3) internal financial records, which supported the attested information.
- We analyzed the hospital data and applied the relevant Federal requirements to verify that specific data elements were included in or excluded from the incentive payment calculations, such as excluding unpaid Medicaid bed-days and including labor and delivery services.

We provided the State agency with a summary of the data that each hospital provided to us, including our incentive payment calculations that applied the relevant Federal requirements. We suggest that the State agency work with CMS to resolve any discrepancies that are identified 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
<i>New Jersey Made Incorrect Medicaid Electronic Health Record Incentive Payments</i>	<u>A-02-14-01009</u>	8/25/2016
<i>Pennsylvania Made Correct Medicaid Electronic Health Record Incentive Payments to Hospitals</i>	<u>A-03-15-00403</u>	8/10/2016
<i>Arizona Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals</i>	<u>A-09-15-02036</u>	8/4/2016
<i>Delaware Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals</i>	<u>A-03-14-00402</u>	9/30/2015
<i>Oklahoma Made Incorrect Medicaid Electronic Health Record Incentive Payments to Health Care Professionals</i>	<u>A-06-14-00030</u>	9/3/2015
<i>Texas Made Incorrect Medicaid Electronic Health Record Incentive Payments</i>	<u>A-06-13-00047</u>	8/31/2015
<i>Arkansas Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals</i>	<u>A-06-14-00010</u>	6/22/2015
<i>The District of Columbia Made Correct Medicaid Electronic Health Record Incentive Payments to Hospitals</i>	<u>A-03-14-00401</u>	1/15/2015
<i>Massachusetts Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals</i>	<u>A-01-13-00008</u>	11/17/2014
<i>Louisiana Made Incorrect Medicaid Electronic Health Record Incentive Payments</i>	<u>A-06-12-00041</u>	8/26/2014
<i>Florida Made Medicaid Electronic Health Record Payments to Hospitals in Accordance With Federal and State Requirements</i>	<u>A-04-13-06164</u>	8/8/2014
<i>Early Review of States' Planned Medicaid Electronic Health Record Incentive Program Oversight</i>	<u>OEI-05-10-00080</u>	7/15/2011

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

From October 1, 2011, through December 31, 2014, the State agency made \$600,894,455 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 64 hospitals that each received a first-year incentive payment exceeding \$2 million. The State agency paid the 64 hospitals \$317,444,168, which was 53 percent of the total paid from October 1, 2011, through December 31, 2014. The State agency made additional payments to 37 of the 64 hospitals, totaling \$25,700,188 as of December 31, 2015, 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.

Our audit work included contacting the State agency in Sacramento, California.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal 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 64 hospitals that each received a first-year incentive payment exceeding \$2 million during the period October 1, 2011, through December 31, 2014, and (2) all payments made to the 64 selected hospitals from January 1 through December 31, 2015;
- 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



State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

August 17, 2016

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

Dear Ms. Ahlstrand

The California Department of Health Care Services (DHCS) has prepared its response to the U.S. Department of Health and Human Services, Office of Inspector General (OIG) draft report entitled, *California Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals (A-09-16-02004)*.

DHCS appreciates the work performed by OIG and the opportunity to respond to the draft report. Please contact Ms. Sarah Hollister, External Audit Manager, at (916) 650-0298 if you have any questions.

Sincerely,

/Jennifer Kent/

Jennifer Kent
Director

Enclosure

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Ms. Lori Ahlstrand
Page 2

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**Department of Health Care Services Response to the OIG draft audit report
entitled, *California Made Incorrect Medicaid Electronic Health Record
Incentive Payments to Hospitals (A-09-16-02004)***

Finding #1: Although the State agency made Medicaid EHR incentive program payments to eligible hospitals, it did not always make these payments in accordance with Federal requirements. Specifically, from October 1, 2011, through December 31, 2015, the State agency made incorrect Medicaid EHR incentive payments to 61 of the 64 hospitals reviewed, totaling \$23,227,540. These incorrect payments included both overpayments and underpayments, resulting in a net overpayment of \$22,043,234.

Finding #2: Because the incentive payment is calculated once and then paid out over 4 years, payments made after December 31, 2015, will also be incorrect. The adjustments to these payments total \$6,318,006.

Recommendation 1: DHCS should refund the Federal Government \$22,043,234 in net overpayments made to the 64 hospitals.

DHCS Response: DHCS disagrees with the recommendation.

DHCS agrees that incorrect Medicaid EHR incentive payments may have been made to eligible hospitals, but does not concur with the recommendation to refund the Federal Government \$22,043,234 in net overpayments made to 64 hospitals.

DHCS was advised by CMS that over/underpayments could be addressed through adjustments of future incentive payments to Eligible Hospitals (EH). In addition, DHCS believes further detailed analysis and validation of data reported by EHs is required in order to support overpayments identified by the OIG.

DHCS has implemented robust pre and post payment review and audit procedures which are effective in validating EH eligibility, and confirming the accuracy of incentive payment calculations in accordance with Federal regulations. The pre-payment validation and post payment audits are conducted in accordance with the State Medicaid Health Information Technology Plan (SMHP) and DHCS's audit strategy, both approved by the Centers for Medicare and Medicaid Services (CMS).

Prepayment validation of the EHs eligibility and payment calculations includes a comprehensive analysis of auditable data submitted by EHs at the time of attestation. However, this validation does not include the level of review conducted as part of

the post payment audit procedures, as doing so would result in an unacceptable delay in issuing incentive payments.

The detailed review conducted by the OIG in its audit of the EHs is appreciated and DHCS acknowledges the audits were performed in accordance with generally accepted government auditing standards; however, there was a level of reliance on hospital generated schedules and internal financial records which did not include detailed testing against actual payments/adjudicated claims data. Historical experience from administrative appeal hearings requires DHCS to use actual payments/adjudicated claims data from the claims payment reports. Therefore, DHCS is unable to rely on these audit findings, as they cannot be supported in administrative appeals available to providers with identified overpayments.

As part of the approved audit strategy, DHCS has committed to conducting audits of 100% of the EHs participating in the Medi-Cal EHR incentive program. Post payment audits by DHCS audit staff include a review of EH audited cost reports and detailed testing against adjudicated claims.

DHCS has prioritized auditing of the 64 EHs reviewed by OIG, and is committed to having the audits completed within the current state fiscal year. Any identified overpayments will be offset against the EHs future recalculated incentive payments. In the instance overpayments exceed future payments, DHCS will refund to the Federal government, the remaining overpayment amount.

Recommendation 2: **Adjust the 61 hospitals' remaining incentive payments to account for the incorrect calculations (which will result in cost savings of \$6,318,006 after December 31, 2015).**

DHCS Response: DHCS agrees with the recommendation.

DHCS will adjust EH future payments where a recalculation of the total payment is necessary. Recalculations will be determined at the time DHCS completes the initial post payment audits, over the current and subsequent state fiscal year.

Recommendation 3: **DHCS should review the calculations for the hospitals not included in the 64 OIG reviewed to determine whether payment adjustments are needed and refund to the Federal Government any overpayments identified.**

DHCS Response: DHCS agrees with the recommendation.

DHCS agrees that all hospitals not included in the 64 OIG reviews should be audited as had previously been identified in the DHCS audit plan and strategy. Based on the audit reviews, DHCS will

determine if payment adjustments are necessary and will apply the adjustments as offsets against the EHs future recalculated incentive payments as noted above.

DHCS plans to commence reviews of some additional EHs in the current fiscal year and anticipates completing audits of the remaining EHs in the 2017/18 state fiscal year.

Recommendation 4: **DHCS should review the supporting documentation from all hospitals to help identify any errors in incentive payment calculations.**

DHCS Response: DHCS agrees with the recommendation.

As indicated in recommendation 1 above, DHCS will conduct a comprehensive post payment audit on 100% of participating hospitals as has previously been approved by CMS in the SMHP and DHCS's audit strategy.