Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MASSACHUSETTS 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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November 2014
A-01-13-00008

Office of Inspector General

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EXECUTIVE SUMMARY

Massachusetts made incorrect Medicaid electronic health record incentive payments to hospitals totaling $3.3 million. Incorrect payments included both overpayments and underpayments, for a net overpayment of $2.1 million.

WHY WE DID THIS REVIEW

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

The Government Accountability Office has identified improper incentive payments as the primary risk to the EHR incentive programs. These programs may be at greater risk of improper payments than other programs because they are new and have complex requirements. Other U.S. Department of Health and Human Services, Office of Inspector General, reports describe the obstacles that the Centers for Medicare & Medicaid Services (CMS) and States face overseeing the Medicare and Medicaid EHR incentive programs. The obstacles leave the programs vulnerable to paying incentive payments to providers that do not fully meet requirements. The Massachusetts Executive Office of Health and Human Services, Office of Medicaid (State agency), made approximately $130 million in Medicaid EHR incentive program payments to providers during calendar years (CYs) 2011 and 2012. Of this amount, the State agency paid approximately $66 million to professionals and $64 million to hospitals. This review focuses only on the Medicaid EHR incentive program for hospitals.

The objective of this review was to determine whether the State agency made Medicaid EHR incentive program payments 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 pays EHR incentive payments.

To receive an incentive payment, eligible hospitals attest that they meet program requirements by self-reporting data using CMS's 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 the hospital's total Medicaid patient encounters by the hospital's total patient encounters. For hospitals, patient encounters are defined as discharges, not days spent in the hospital (bed-days).

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

HOW WE CONDUCTED THIS REVIEW

From January 1, 2011, through December 31, 2012, the State agency paid $64,353,541 to eligible hospitals for Medicaid EHR incentive payments. We (1) reconciled hospital incentive payments reported on the State's Form CMS-64, Quarterly Medicaid Assistance Expenditures for the Medical Assistance Program (CMS-64 report), with the NLR and (2) selected for further review 25 hospitals with the largest incentive payment amounts. The State agency paid the 25 hospitals $45,789,269, which is 71 percent of the total paid to all hospitals during CYs 2011 and 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 19 hospitals totaling $3,259,436. Specifically, the State agency overpaid 13 hospitals a total of $2,695,314 and underpaid 6 hospitals a total of $564,122, for a net overpayment of $2,131,192. Because the hospital calculation is computed once and then paid out over 3 years, payments subsequent to CY 2012 will also be incorrect. The adjustments to these payments total $1,715,362. Additionally, the State agency did not report two hospital incentive payments to the NLR.

These errors occurred because State agency instructions on the hospital incentive payment calculations lacked needed information, and the State agency did not reconcile the CMS-64 report to the NLR.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund to the Federal Government $2,131,192 in net overpayments made to the 19 hospitals;

- adjust the 19 hospitals' remaining incentive payments to account for the incorrect calculations, which will result in future cost savings of $1,715,362;

- review the calculations for the hospitals not included in the 25 we reviewed to determine whether payment adjustments are needed, review supporting documentation for the numbers provided in the cost reports, and refund any overpayments identified;

- modify the hospital calculation worksheet to state that inpatient nonacute-care services should be excluded from the incentive payment calculation; and

- work with CMS to ensure that the 2 hospital incentive payments not posted to the NLR are posted and establish a policy to reconcile the CMS-64 report to the NLR each quarter.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency agreed in part and disagreed in part with our findings and recommendations. Specifically, the State agency agreed that it made incorrect hospital incentive payments but disagreed with the amount of the net overpayment included in our draft report. The State agency also disagreed with our finding that it did not always report incentive payments to the NLR.

We reviewed the State agency's comments on our draft report as well as information that it provided under separate cover. On the basis of that review, we adjusted one finding and its monetary recommendations. Regarding the hospitals for which the State agency has identified additional adjustments that may reduce the net overpayment that we identified, the State agency may share that information with CMS as part of the audit resolution process.

We maintain that the State agency did not report the incentive payments for two hospitals to the NLR. We reviewed the NLR database and confirmed that the payments' details were not transmitted to the NLR. We commend the State agency for taking steps to implement a reconciliation process between the CMS-64 report and the NLR, which will help identify any future transmission errors.

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INTRODUCTION

WHY WE DID THIS REVIEW

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

The Government Accountability Office has identified improper incentive payments as the primary risk to the EHR incentive programs.[2] These programs may be at greater risk of improper payments than other programs because they are new and have complex requirements. Other U.S. Department of Health and Human Services, Office of Inspector General, reports describe the obstacles that the Centers for Medicare & Medicaid Services (CMS) and States face overseeing the Medicare and Medicaid EHR incentive programs.[3] The obstacles leave the programs vulnerable to paying incentive payments to providers that do not fully meet requirements. The Massachusetts Executive Office of Health and Human Services, Office of Medicaid (State agency), made approximately $130 million in Medicaid EHR incentive program payments to providers during calendar years (CYs) 2011 and 2012. Of this amount, the State agency paid approximately $66 million to professionals and $64 million to hospitals. This review focuses only on the Medicaid EHR incentive program for hospitals.

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.

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 meaningfully use certified EHR technology. The Federal Government pays 100 percent of Medicaid incentive payments (42 CFR § 495.320).

Medicaid Program: Administration and Federal Reimbursement

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

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

National Level Repository

The National Level Repository (NLR) is a CMS Web-based provider registration and verification system that contains information on providers participating in the Medicare and Medicaid EHR incentive programs. The NLR is the designated system of records that checks for duplicate payments and maintains the incentive payment history files.

Incentive Payment Eligibility Requirements

To receive an incentive payment, eligible 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(c)). In general, patient volume is calculated by dividing a hospital's total Medicaid patient encounters by total patient encounters.[5]

[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)).

[5] There are multiple definitions of "encounter." Generally stated, a patient encounter with a health care 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)).

The program eligibility requirements for hospitals are as follows:

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

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 on the next page provides three examples of the overall EHR amount calculation.

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[6] 42 CFR § 495.302 definition of "acute care hospital." Children's hospitals do not have to meet the average length of stay requirement.

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

[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 3-year period with the first payment being 50 percent of the total, the second payment 30 percent, and the last payment 20 percent.

[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)).

Table: Overall Electronic Health Record Amount Calculation

Type of Hospital	Hospitals With 1,149 or Fewer Discharges During the Payment Year	Hospitals With at Least 1,150 but Less Than 23,000 Discharges During the Payment Year	Hospitals With 23,000 or More 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)).

- 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 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

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

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 January 1, 2011, through December 31, 2012, the State agency paid $64,353,541 to eligible hospitals for Medicaid EHR incentive payments. We (1) reconciled hospital incentive payments reported on the State's CMS-64 report with the NLR and (2) selected for further review 25 hospitals with the largest incentive payment amounts. The State agency paid the 25 hospitals $45,789,269, which is 71 percent of the total paid to all hospitals during CYs 2011 and 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 the details of our audit scope and methodology.

FINDINGS

The State agency did not always pay EHR incentive payments to eligible hospitals in accordance with Federal and State requirements. Specifically, the State agency:

- made incorrect incentive payments to 19 hospitals for a net overpayment of $2,131,192 and

- did not report 2 hospital incentive payments to the NLR.

These errors occurred because State agency instructions on the hospital incentive payment calculations lacked needed information, and the State agency did not reconcile the CMS-64 report to the NLR.

THE STATE AGENCY MADE INCORRECT HOSPITAL INCENTIVE PAYMENTS

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)).

Furthermore, CMS guidance states that nursery, rehabilitation, psychiatric, and skilled nursing facility (SNF) days and discharges (inpatient nonacute-care services) may not be included as inpatient acute-care services in the calculation of hospital incentive payments.[12]

Of the 25 hospital incentive payment calculations reviewed, 19, or 76 percent, did not comply with regulations, guidance, or both. Some calculations had multiple deficiencies. Specifically, the calculations included:

- nursery services (16 hospitals),
- psychiatric services (2 hospitals), and
- SNF services (1 hospital).

The calculations for eight hospitals did not include neonatal intensive care unit services, which should have been included.

The State agency initially provided an incentive payment calculation worksheet to hospitals that did not include any instructions on excluding inpatient nonacute-care services. Also, the State agency did not review the cost reports and supporting documentation submitted by the hospitals to ensure that the hospitals had removed the inpatient nonacute-care services from all of the line items of the worksheet.

As a result, the State agency made incorrect EHR incentive payments totaling $3,259,436. Specifically, the State agency overpaid 13 hospitals a total of $2,695,314 and underpaid 6 hospitals a total of $564,122, for a net overpayment of $2,131,192.[13] Because the hospital calculation is computed once and then paid out over 3 years, payments subsequent to CY 2012 will also be incorrect. The adjustments to these payments total $1,715,362.

THE STATE AGENCY DID NOT ALWAYS REPORT INCENTIVE PAYMENTS TO THE NATIONAL LEVEL REPOSITORY

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

The State agency did not report to the NLR $2,427,812 in incentive payments made to two hospitals. State agency officials stated that the two payments had been reported to the NLR from its EHR payment tracking system. However, the State agency was unaware that the files had not been transferred successfully. The State agency did not catch the error because it did not

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

[13] Several hospitals had multiple deficiencies in the incentive payment calculation that resulted in both overpayments and underpayments. We reported the net effect of these deficiencies for each hospital.

reconcile the CMS-64 report to the NLR. As a result, the NLR information was not complete, and the providers could have been paid by another State.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government $2,131,192 in net overpayments made to the 19 hospitals;
- adjust the 19 hospitals' remaining incentive payments to account for the incorrect calculations, which will result in future cost savings of $1,715,362;
- review the calculations for the hospitals not included in the 25 we reviewed to determine whether payment adjustments are needed, review supporting documentation for the numbers provided in the cost reports, and refund any overpayments identified;
- modify the hospital calculation worksheet to state that inpatient nonacute-care services should be excluded from the incentive payment calculation; and
- work with CMS to ensure that the 2 hospital incentive payments not posted to the NLR are posted and establish a policy to reconcile the CMS-64 report to the NLR each quarter.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed in part and disagreed in part with our findings and recommendations. Specifically, the State agency agreed that it made incorrect hospital incentive payments but disagreed with the amount of the net overpayment included in our draft report. The State agency also disagreed with our finding that it did not always report incentive payments to the NLR.

The State agency agreed with our recommendations to refund the net overpayments made to the 19 hospitals and to adjust 19 hospitals' remaining incentive payments. The State agency stated that it has refunded approximately $1.3 million of overpayments that pertained to 15 of the 19 hospitals that received incorrect payments. However, the State agency identified additional adjustments for the remaining four hospitals related to excluded services, charity care, and data sources discrepancies that may reduce the remaining overpayment amount.

Additionally, the State agency agreed with our recommendation to review the calculations for the hospitals not included in our review. The State agency has begun recalculating the payments and will refund to CMS any overpayments made to these hospitals. The State agency also agreed with our recommendation to modify the hospital calculation worksheet and has already implemented this corrective action.

The State agency disagreed with our finding that it did not report the incentive payments for two hospitals to the NLR. As an attachment to its response, the State agency provided screen shots

that showed the two payments were posted to the NLR. Nevertheless, the State agency agreed with our recommendation to implement a reconciliation between the CMS-64 report and the NLR.

The State agency's comments, excluding the attachment, are included in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

We reviewed the State agency's comments on our draft report as well as information that it provided under separate cover. On the basis of that review, we adjusted one finding and its monetary recommendations. Regarding the hospitals for which the State agency has identified additional adjustments that may reduce the net overpayment that we identified, the State agency may share that information with CMS as part of the audit resolution process.

We maintain that the State agency did not report the incentive payments for two hospitals to the NLR. We reviewed the NLR database and confirmed that the payments' details were not transmitted to the NLR. We commend the State agency for taking steps to implement a reconciliation process between the CMS-64 report and the NLR, which will help identify any future transmission errors.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

From January 1, 2011, through December 31, 2012, the State agency paid $64,353,541 to eligible hospitals for Medicaid EHR incentive payments. We (1) reconciled hospital incentive payments reported on the State's CMS-64 report with the NLR and (2) selected for further review 25 hospitals with the largest incentive payment amounts. The State agency paid the 25 hospitals $45,789,269, which is 71 percent of the total paid during CYs 2011 and 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 Boston, Massachusetts.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- held discussions with CMS officials to gain an understanding of the Medicaid EHR incentive program;
- held discussions with State agency officials to gain an understanding of State policies and controls as they relate to the Medicaid EHR incentive program;
- selected for review 25 hospitals that were paid the largest amounts in incentive payments during CYs 2011 and 2012;
- reviewed the State agency's supporting documentation related to the 25 selected hospitals;
- reviewed and reconciled the appropriate lines from the CMS-64 report to supporting documentation and the NLR;
- 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 and provided our recalculations to State agency officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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Department of Health and Human Services
Audit of Medicaid Electronic Health Record (EHR) Incentive Payments
Report Number A-01-13-00008
Response to Draft Report Issued by the Office of Inspector General on July 28, 2014

Mr. David Lamir
Office of Audit Services
JFK Federal Building
15 New Sudbury Street, Room 2425
Boston, MA 02203

Dear Mr. Lamir:

The Commonwealth of Massachusetts Executive Office of Health and Human Services (EOHHS) has reviewed your findings and we appreciate the opportunity to respond to draft report number A-01-13-00008. We have valued the collaborative process with the Office of the Inspector General (OIG) during the audit. This has been especially productive as we have worked through the estimated overpayment amounts identified by the OIG in its findings and the amounts reported by EOHHS in this response.

We appreciate that the OIG and EOHHS are continuing to work through many of the issues identified in our response. Please contact us with any additional questions or if any further clarification is required.

Finding 1

"The state agency made incorrect hospital incentive payments."

Audit Recommendations

1. "Refund to the Federal Government $3,242,391 in net overpayments made to the 19 hospitals,"
2. "Adjust the 19 hospitals remaining incentive payments to account for the incorrect calculations which will result in future cost savings of $1,871,365,"
3. "Modify the hospital calculation worksheet to state that inpatient non-acute care services should be excluded from the incentive payment calculation," and
4. "Review the calculations for the hospitals not included in the 25 we reviewed to determine whether payment adjustments are needed, review supporting documentation

for the numbers provided in the cost reports, refund any overpayments identified."

EOHHS Response to the Finding

With regards to the OIG Recommendations, EOHHS addresses them as follows:

1.) "Refund to the Federal Government $3,242,391 in net overpayments made to the 19 hospitals."

Response

EOHHS agrees with the OIG that EOHHS initially made incorrect hospital incentive payments due to the inclusion of certain non-acute services in hospital calculations. EOHHS has corrected its methodology and processes and implemented the corrections effective program year 2013. EOHHS has refunded the federal government amounts accounting for 15 of the 19 hospitals that have made adjustments and is working with the remaining four audited hospitals to make the necessary adjustments.

However, EOHHS' calculated incentive overpayment amount differs from the OIG's. EOHHS calculated an aggregate net overpayment amount of $1,311,103 for 15 of the 19 hospitals, which has been refunded. While EOHHS continues to work with the remaining four hospitals to make adjustments, such adjustments will not account for the $1,931,288 difference between the OIG's and EOHHS' calculations. As detailed below, EOHHS contends that the OIG's calculations need to be adjusted to account for data source and methodological discrepancies that reduce the aggregate net overpayment. We understand that the OIG is closely reviewing this issue and we look forward to working together to resolve it prior to the final report being published.

Excluded Services

The OIG correctly pointed out that incentive payments should only consider the acute services provided by a hospital for calculation of acute discharges and acute care inpatient bed days and should not include rehabilitation units and services, as well as skilled nursing facility services. For psychiatric and nursery services, however, EOHHS contends that certain additional services must be evaluated to ascertain whether or not a service is acute. For psychiatric services, while non-acute psychiatric units and services should be excluded, *acute* psychiatric services should be included. In addressing this very question, CMS stated in a January 7, 2014 email that acute psychiatric units could be included, "[i]f they are not distinct from the inpatient unit and fall under the IPPS."

Similarly, the OIG is correct that nursery services should be excluded from acute care counts and Neonatal Intensive Care Services should be included. However, EOHHS asserts that labor and delivery services should be included in acute care counts, because labor and delivery services are acute services.

Additionally, pursuant to 42 CFR § 495.310(g)(2)(iii), EOHHS must remove dually eligible (Medicare/Medicaid) bed days from the total acute care inpatient bed days.

Charity Care

Further, the OIG's calculations of incentive payments need to be adjusted to account for Commonwealth-specific exclusions from charity care. Where EOHHS deems that an Eligible Hospital lacks available data on charity care, pursuant to 42 CFR § 495.310(h), the State may use that Eligible Hospital's data on uncompensated care to determine an appropriate proxy for charity care. Charity care is defined in the applicable EHR final rules as:

> Health services for which a hospital demonstrates that the patient is unable to pay. Charity care results from a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria. For Medicare purposes, charity care is not reimbursable and unpaid amounts associated with charity care are not considered as an allowable Medicare bad debt.
>
> [75 FR 44456 (*citing* Form CMS–2552–10, Worksheet S-10). Worksheet S-10, in turn, cites to Chapter 3 of Part 1 of the Medicare Provider Reimbursement Manual. Sections 304 and 305 of that Manual provide definitions for "Bad Debt" and included liability assessments. *See* United States Department of Health and Human Services, Provider Reimbursement Manual (1974).]

In addition, the requirement to utilize uncompensated care data necessitates that EOHHS exclude Health Safety Net reimbursement, courtesy charges, and employee charges from charity care, as these services are considered "compensated care."

Data Source Discrepancy

Finally, discrepancies are present between the EOHHS and OIG calculations of incentive payments because of differences in the data sources used to calculate the payments. For example, some hospitals incorrectly reported data to the OIG, or their cost reports may have changed as a result of amendments and/or audits.

Corrective Action

We will continue to work with the OIG and the remaining four audited hospitals to make the necessary adjustments and will return any net overpayment that is identified to the federal government. If hospitals cannot make the necessary adjustments, EOHHS will utilize an alternative recoupment methodology as necessary.

2.) "Adjust the 19 hospitals remaining incentive payments to account for the incorrect calculations which will result in future cost savings of $1,871,365."

Response

EOHHS agrees with this recommendation. We have taken corrective actions for 15 of the 19 hospitals identified and are in the process of implementing corrective action for the four remaining hospitals. All future payments processed by EOHHS will utilize the modified hospital calculation worksheet discussed in recommendation 3, corrective action, below and the methodology EOHHS implemented to resolve the over and underpayments in recommendation 1, above. The modified worksheet will eliminate overpayments and result in future cost savings.

Additionally, EOHHS has applied the same methodology to all hospitals not selected as part of the OIG's audit sample. The total future cost savings amount is still to be determined and will differ from the figure cited by the OIG due to the data source and methodological discrepancies noted above.

3.) "Modify the hospital calculation worksheet to state that inpatient non-acute care services should be excluded from the incentive payment calculation."

Response

EOHHS agrees with this recommendation and has already implemented the corrective action. A modified worksheet was used for program year 2013 payments and will continue to be used for future payment years.

4.) "Review the calculations for the hospitals not included in the 25 we reviewed to determine whether payment adjustments are needed, review supporting documentation for the numbers provided in the cost reports, refund any overpayments identified."

Response

EOHHS agrees with this recommendation. In accordance with the methodology identified in the response to Finding 1, EOHHS has started to recalculate the payments made to all hospitals not selected as part of the OIG's audit sample. EOHHS will adjust, and refund to CMS, any overpayments made to these hospitals.

Finding 2

"The state agency did not always report incentive payments to the national level repository."

Audit Recommendation

"Work with CMS to ensure that the two hospital incentive payments not posted to the NLR are posted and establish a policy to reconcile the CMS-64 report to the NLR each quarter."

Response

EOHHS disagrees with this finding. As evidenced by the attached screenshots, the two hospital incentive payments in questions were posted to the NLR. One payment was posted on 12/31/2012 and the other on 12/24/2012. We will continue to work with the OIG to resolve this issue.

Corrective Action

We will work with the EOHHS Federal Claiming Unit to determine how best to implement a reconciliation process between the CMS-64 report and the NLR.

We appreciate the opportunity to work with your office as we reviewed this report, and we thank you for the chance to respond.

Sincerely,

Amanda Carl Kraft (on behalf of Director Thorn)

Kristin L. Thorn
Medicaid Director