Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

WEST VIRGINIA 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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for Audit Services

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Office of Inspector General

http://oig.hhs.gov

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EXECUTIVE SUMMARY

West Virginia made incorrect Medicaid electronic health record incentive payments to hospitals, resulting in a total overpayment of $295,962 over two and a half 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 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 West Virginia Department of Health and Human Resources, Department of Medical Assistance Services (the State agency) made approximately $70.6 million in Medicaid EHR incentive program payments to providers between July 1, 2011, and December 31, 2013. Of this amount, the State agency paid approximately $20.3 million to health care professionals and $50.3 million to hospitals. This review is one in a series of reports 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 providers attest that they meet program requirements by self-reporting data using the CMS National Level Repository. The National Level Repository is a provider registration and verification system that contains information on providers

participating in the Medicare and Medicaid EHR incentive programs. To be eligible for the Medicaid EHR incentive program, providers must meet Medicaid patient-volume requirements. In general, patient volume is calculated by dividing the provider's total Medicaid patient encounters by the provider's total patient encounters. For hospitals, patient encounters are defined as discharges, not days spent in the hospital.

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

HOW WE CONDUCTED THIS REVIEW

From July 1, 2011, through December 31, 2013, the State agency paid $50,302,276 to 42 eligible hospitals in West Virginia for Medicaid EHR incentive payments. We (1) reconciled hospital incentive payments reported by the State agency on Form CMS-64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program) with the National Level Repository and (2) identified for further review five hospitals that each received total incentive payments exceeding $1 million. The State agency paid the five hospitals a total of $22,813,822, which represents approximately 45 percent of the total amount paid to all hospitals in West Virginia during the audit period. The State agency made additional incentive payments totaling $1,967,251 to three of the five hospitals as of December 31, 2015.

WHAT WE FOUND

The State agency did not make EHR incentive payments in accordance with Federal and State requirements for three of the five West Virginia hospitals we reviewed. Specifically, the State agency paid three hospitals a total of $13,968,023 when it should have paid $13,672,061, resulting in a total overpayment of $295,962. Because the hospital calculation is computed once and then paid out over 3 years, payments after December 31, 2013, will also be incorrect. The net adjustments to these payments total $208,117. These errors occurred because the State agency calculated the EHR payment using hospital-provided data that were not supported by data contained in the hospitals' cost reports or other source documentation. The State agency accepted the data provided by the hospitals without verifying the accuracy of the data.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government $295,962 in net overpayments made to the three hospitals;

- adjust the two hospitals' remaining incentive payments to account for the incorrect calculations (which will result in future cost savings of $208,117); and

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

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency concurred with our recommendations but stated that the number of Medicaid managed-care inpatient days for hospital 2 should have been 20,682 instead of 20,215, the number we used in our computation. Accordingly, we adjusted our calculation of hospital 2's overpayment amount to $80,016. This resulted in a total overpayment of $295,962. Further, the State agency noted that some of the amounts we identified as future year payments have now been made and that adjustments to the final year payments would reflect the overpayments identified in the report. Our report reflects payments made at the time of our review.

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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 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 West Virginia Department of Health and Human Resources, Department of Medical Assistance Services (the State agency) made approximately $70.6 million in Medicaid EHR incentive program payments to providers during calendar years 2011 through 2013. Of this amount, the State agency paid approximately $20.3 million to health care professionals and $50.3 million to hospitals. This review is one in a series of reports focusing on the Medicaid EHR incentive program for hospitals. See Appendix A for a list of reports related to payments made for the Medicaid EHR incentive program.

OBJECTIVE

Our objective was to determine whether the State agency made Medicaid EHR incentive program payments 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 (the Recovery Act), P.L. No. 111-5. Title XIII of Division A and Title IV of Division B of

[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.

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 section 4201 of the HITECH Act, State Medicaid programs have the option of receiving from the Federal Government Federal financial participation for expenditures for incentive payments to certain Medicare and Medicaid providers to adopt, implement, upgrade, and meaningfully use certified EHR technology. The Federal Government pays 100 percent of Medicaid incentive payments (42 CFR § 495.320).

Medicaid Program: Administration and Federal Reimbursement

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

States use the standard Form CMS-64[4] to report actual Medicaid expenditures for each quarter, and CMS uses it to reimburse States for the Federal share of Medicaid expenditures. The amounts reported on Form CMS-64 and its attachments must represent actual expenditures and be supported by documentation. States claim EHR incentive payments on lines 24E and 24F of the Form CMS-64.

National Level Repository

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

Incentive Payment Eligibility Requirements

To receive an incentive payment, eligible providers attest that they meet program requirements by self-reporting data using the NLR.[5] To be eligible for the Medicaid EHR incentive program, providers must meet Medicaid patient-volume requirements (42 CFR § 495.304(c)). In general, patient volume is calculated by dividing the provider's total Medicaid patient encounters by the provider's total patient encounters.[6]

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

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

[6] Generally stated, a hospital encounter is either the total services performed during an inpatient stay or services performed in an emergency department on any one day for which Medicaid paid for all or part of the services or paid the copay, cost-sharing, or premium for the services (42 CFR § 495.306(e)(2)).

The program eligibility requirements for hospitals are as follows:

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

Eligible Hospital Payments

Hospital incentive payments are based on a one-time calculation of a total incentive payment, which is distributed by States over a minimum of 3 years and a maximum of 6 years.[10] The total incentive payment calculation consists of two main components—the overall EHR amount and the Medicaid share.

Generally stated, the overall EHR amount is an estimated dollar amount based on a total number of inpatient acute-care discharges over a theoretical 4-year period.[11] The overall EHR amount consists of two components—an initial amount and a transition factor. Once the initial amount is multiplied by the transition factors, all 4 years are totaled to determine the overall EHR amount. Table 1 provides three examples of the overall EHR amount calculation.

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

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

[9] Hospitals must have a Medicaid patient volume of at least 10 percent, except for children's hospitals, which do not have a patient volume requirement (42 CFR §§ 495.304(e)(l) and (e)(2)).

[10] No single year may account for more than 50 percent of the total incentive payment, and no 2 years may account for more than 90 percent of the total incentive payment (42 CFR §§ 495.310(f)(3) and (f)(4)). The State agency elected to distribute incentive payments over a 3-year period with the first payment being 50 percent of the total; the second payment, 40 percent; and the remaining payment, 10 percent.

[11] The 4-year period is theoretical because the overall EHR amount is not determined annually; it is calculated once on the basis of how much a hospital might be paid over 4 years. An average annual growth rate (calculated by averaging the annual percentage change in discharges over the most recent 3 years) is applied to the first payment year's number of discharges to calculate the estimated total discharges in years 2 through 4 (42 CFR § 495.310(g)).

Table 1: Overall EHR Amount Calculation

Type of Hospital	Hospitals With 1,149 or Fewer Discharges During the Payment Year	Hospitals With 1,150 Through 23,000 Discharges During the Payment Year	Hospitals With More Than 23,000 Discharges During the Payment Year
Base Amount	$2 million	$2 million	$2 million
Plus Discharge-Related Amount (adjusted in years 2 through 4 based on the average annual growth rate)	$0.00	$200 multiplied by (*n* - 1,149) where *n* is the number of discharges.	$200 multiplied by (23,000 – 1,149)
Equals Total Initial Amount	$2 million	Between $2 million and $6,370,200, depending on the number of discharges	Limited by law to $6,370,200
Multiplied by Transition Factor	Year 1 – 1.00 Year 2 – 0.75 Year 3 – 0.50 Year 4 – 0.25	Year 1 – 1.00 Year 2 – 0.75 Year 3 – 0.50 Year 4 – 0.25	Year 1 – 1.00 Year 2 – 0.75 Year 3 – 0.50 Year 4 – 0.25
Overall EHR Amount	Sum of all 4 years	Sum of all 4 years	Sum of all 4 years

The Medicaid share is calculated as follows:

- The numerator is the sum of the estimated Medicaid inpatient acute-care bed-days[12] for the current year and the estimated number of Medicaid managed-care acute inpatient bed-days for the current year (42 CFR § 495.310(g)(2)(i)).

- The denominator is the product of the estimated total number of inpatient acute-care bed-days for the eligible hospital during the current year multiplied by the noncharity percentage. The noncharity percentage is the estimated total amount of the eligible hospital's charges during that period, not including any charges that are attributable to charity care, divided by the estimated total amount of the hospital's charges during that period (42 CFR § 495.310(g)(2)(ii)).

The total incentive payment is the overall EHR amount multiplied by the Medicaid share. The total incentive payment is then distributed over several years. (See footnote 9.) It is possible that a hospital may not receive the entire total incentive payment. Each year, hospitals must attest to the "meaningful use" of EHRs and meet that year's program requirements. A hospital may not qualify for the future years' payments or could elect to end its participation in the EHR incentive program. In addition, the amount may change because of adjustments to supporting numbers used in the calculations.

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

Hospitals may receive incentive payments from both Medicare and Medicaid within the same year; however, they may not receive a Medicaid incentive payment from more than one State (42 CFR §§ 495.310(e) and (j)).

HOW WE CONDUCTED THIS REVIEW

From July 1, 2011, through December 31, 2013, the State agency paid $50,302,276 to 42 eligible hospitals in West Virginia for Medicaid EHR incentive payments.[13] We (1) reconciled hospital incentive payments reported by the State agency on Form CMS-64 with the NLR and (2) identified for further review the five hospitals that each received total incentive payments exceeding $1 million. The State agency paid the five hospitals a total of $22,813,822, which represents approximately 45 percent of the total amount paid to all hospitals in West Virginia during the audit period. The State agency made additional payments totaling $1,967,251 to three of the five hospitals as of December 31, 2015.

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.

FINDINGS

The State agency did not make EHR incentive payments in accordance with Federal and State requirements for three of the five West Virginia hospitals we reviewed. Specifically, the State agency paid three hospitals a total of $13,968,023 when it should have paid $13,672,061, resulting in a total overpayment of $295,962. These errors occurred because the State agency calculated the EHR payment using hospital-provided data that were not supported by data contained in the hospitals' cost reports or other source documentation.[14] The State agency accepted the data provided by the hospitals without verifying the accuracy of the data.[15]

THE STATE AGENCY MADE INCORRECT HOSPITAL INCENTIVE PAYMENTS

CMS guidance[16] allows a hospital to use financial data obtained from multiple sources when calculating its requested Medicaid EHR incentive payment. These sources include: the hospital's Medicare cost report, State-specific Medicaid cost reports, State payment and

[13] Although one hospital was located in the District of Columbia, the State of West Virginia was responsible for making the EHR incentive payment.

[14] The State agency uses the term "attestation" when referring to the documentation it receives from hospitals.

[15] The undocumented or inaccurate data included one or more of the following: Medicaid inpatient days, Medicaid managed-care inpatient days, total inpatient bed-days, total hospital charges, and charity-care charges.

[16] *Medicaid Hospital Incentive Payments Calculations*, May 2013. Available online at www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/MLN_TipSheet_MedicaidHospitals.pdf. Accessed on May 26, 2015.

utilization information,[17] and hospital financial statement and accounting records. When data, like charity-care charges, were not available on the Medicare cost report, hospitals used comparable information from other sources. Three of the five West Virginia hospitals we reviewed did not compute the EHR incentive payment correctly, resulting in a total overpayment of $295,962. Table 2 shows the overpayment amounts for each hospital.

Table 2: Hospital Overpayment Calculations

Hospital	State Payment	OIG Calculation	Overpayment
1	$1,143,572	$944,346	$199,226
2	6,022,179	5,942,163	80,016
3	6,802,272	6,785,552	16,720
Total	$13,968,023	$13,672,061	$295,962

These errors occurred because the State agency calculated the EHR payment using hospital-provided data that were not supported by data contained in the hospitals' cost reports or other source documentation. The State agency accepted the data provided by the hospitals without verifying its accuracy. As a result, the State agency overpaid three hospitals a total of $295,962. Because the hospital calculation is computed once and then paid out over 3 years, payments after December 31, 2013, will also be incorrect. The net adjustments to these payments total $208,117.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government $295,962 in net overpayments made to the three hospitals;
- adjust the two hospitals' remaining incentive payments to account for the incorrect calculations (which will result in future cost savings of $208,117); and
- review the calculations for the hospitals not included in the five we reviewed to determine whether payment adjustments are needed, and refund any overpayments identified.

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

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency concurred with our recommendations but stated that the number of Medicaid managed-care inpatient days for hospital 2 should have been 20,682 instead of 20,215, the number we used in our computation. Accordingly, we adjusted our calculation of hospital 2's overpayment amount to $80,016. This resulted in a total overpayment of $295,962. Further, the State agency noted that some of the amounts we identified as future year payments have now been made and that adjustments to the final year payments would reflect the overpayments identified in the report. Our report reflects payments made at the time of our review.

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

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

Report Title	Report Number	Date Issued
Delaware Made Incorrect Medicaid Electronic Health Record Incentive Payments	A-03-14-00402	09-30-2015
Texas Made Incorrect Medicaid Electronic Health Record Incentive Payments	A-06-13-00047	08-31-2015
Arkansas Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals	A-06-14-00010	06-22-2015
The District of Columbia Made Correct Medicaid Electronic Health Record Incentive Payments to Hospitals	A-03-14-00401	01-15-2015
Massachusetts Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals	A-01-13-00008	11-17-2014
Louisiana Made Incorrect Medicaid Electronic Health Record Incentive Payments	A-06-12-00041	08-26-2014
Florida Made Medicaid Electronic Health Record Payments to Hospitals in Accordance With Federal and State Requirements	A-04-13-06164	08-08-2014
Early Review of States' Planned Medicaid Electronic Health Record Incentive Program Oversight	OEI-05-10-00080	07-15-2011

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

From July 1, 2011, through December 31, 2013, the State agency paid $50,302,276 to 42 eligible hospitals in West Virginia for Medicaid EHR incentive payments. We (1) reconciled hospital incentive payments reported by the State agency on Form CMS-64 with the NLR and (2) identified for further review five hospitals that each received total incentive payments exceeding $1 million. The State agency paid the five hospitals $22,813,822, which represents approximately 45 percent of the total amount paid to all hospitals in West Virginia during the audit period. The State agency made additional payments to three of the five hospitals, totaling $1,967,251 as of December 31, 2015.

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 our review from August 2014 through September 2015.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- held discussions with CMS officials to gain an understanding of the Medicaid EHR incentive program;
- held discussions with State agency officials to gain an understanding of State policies and controls as they relate to the Medicaid EHR incentive program;
- reconciled the incentive payments reported on Form CMS-64 to the NLR;
- reviewed the five hospitals that received incentive payments exceeding $1 million during calendar years 2011 through 2013;
- reviewed the State agency's supporting documentation related to the five hospitals;
- reviewed hospital documentation and verified the information submitted to the State agency;
- verified that hospitals met eligibility requirements;
- determined whether hospital incentive payment calculations were correct; and
- discussed the results of our review and provided our recalculations to State officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain

sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX C: STATE AGENCY COMMENTS

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

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Re: Report Number **A-03-14-00406**

Dear Mr. Jelen:

The West Virginia Department of Health and Human Resources (DHHR} is in receipt of the Department of Health and Human Services, Office of Inspector General's draft report (A-03-14-00406} titled *"West Virginia Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals."* Thank you for the opportunity to review and respond to the draft report.

According to the "Executive Summary" section of the draft report, the OIG reviewed five hospitals that each received total incentive payments exceeding $1 million from July 1, 2011 through December 31, 2013. The DHHR paid the five hospitals a total of $22,813,822. The "Executive Summary" further states that the DHHR made additional incentive payments to three of the five hospitals, totaling $1,967,251 as of December 31, 2015.

Within the "Findings" section of the draft report, the OIG claims that because the DHHR used data provided by the hospitals that were not supported by data contained in the hospital cost reports or other source documentation, the DHHR overpaid three of the five hospitals a total of $388,395. The "Findings" section also says that because the hospital calculation is computed once and then paid out over three years, payments after December 31, 2013 would also be incorrect; the net adjustments to these payments total $218,387.

The OIG disclosed three recommendations within the draft report. A reiteration of the three recommendations along with the DHHR's initial response to each of those recommendations is as follows:

1. The first recommendation was for the DHHR to return $388,395 in net overpayments to three hospitals, calculated by the OIG as $199,227 associated with Hospital 1, $172,448 associated with Hospital 2 and $16,720 associated with Hospital 3. Prior to concurring with this recommendation and agreeing to return $388,395 to the Federal government, the DHHR recently reviewed the numbers provided within Table 2

of the draft report in an effort to ascertain the manner by which the OIG arrived at the total Overpayment of $388,395 for Hospitals 1, 2 and 3. We offer the following comments for your review and consideration:

- For Hospital 1, while the DHHR concurs with the numbers reflected within Table 2 of the draft report, it is important to note that the State Payment of $1,143,572 reflects the payment made in Year 1 only, whereas in actuality, Hospital 1 has been paid for Year 1 ($1,143,590} and Year 2 ($914,872}. Therefore, the total State Payment to Hospital 1 should be 2,058,462 ($1,143,590 for Year 1 plus $914,872 for Year 2}. Using the same logic to calculate the total Overpayment to Hospital 1 for Years 1 and 2 combined, the total Overpayment would be $358,640. If the hospital attests and qualifies for Year 3, an additional payment of $188,869 for Year 3 would be made based on the revised Medicaid share calculated by the OIG.

- For Hospital 2, the DHHR does not concur with the numbers provided within Table 2 of the report. This is due to a difference regarding the number of Medicaid Managed Care Inpatient Days; whereas the OIG used 20,215 days, the actual days the DHHR used was 20,682, as reflected on the workbook previously submitted to the OIG by the DHHR (shown as a screenshot on the "Summary" tab of the workbook). Changing the 20,215 days to 20,682 days changes the Medicaid Share from 51.26% to 52.07%. When applying the 52.07% to the Overall EHR Amount of $12,680,800, the resulting number is $6,602,893, which agrees in total to the amount shown on the "Cabell Audit Calc" tab of the aforementioned workbook. Furthermore, the amounts included in Table 2 of the report include the Year 1 and Year 2 payments, but does not include the Year 3 payment, although the DHHR paid Hospital 2 for all three years.

- For Hospital 3, the DHHR concurs with the numbers provided within Table 2 of the report.

2. The second recommendation was for the DHHR to adjust the two remaining hospital incentive payments to account for the incorrect calculations, which would result in future cost savings of $218,387. The DHHR concurs with this recommendation and we will adjust incentive payments accordingly; however, the adjustment would only affect one of the hospital's remaining incentive payments since the DHHR has already made payments subsequent to December 31, 2013 for two of the three hospitals referenced within Table 2 of the draft report.

3. In an effort to determine whether payment adjustments are needed and to identify and refund any overpayments to the Federal government, the third recommendation was for the DHHR to review the calculations for the hospitals not included in the five hospitals reviewed by the OIG. The DHHR concurs with this recommendation and we have been utilizing the services of an independent contractor to conduct the reviews. Our contractor uses a risk-based approach sampling model. Any over/underpayments identified in those reviews will be resolved by adjusting payments.

Thank you once again for conducting the audit and for the opportunity to review and comment on the draft report. For purpose of following up on this letter and finalizing the draft report please direct any questions, concerns or requests for additional information to Tara L. Buckner, Chief Financial Officer, at 304-558-9138 or via email to Tara.L.Buckner@wv.gov.

Sincerely,

Warren D. Keefer, Chief Operating Office
West Virginia Department of Health and Human Resources

Cc: Tara L. Buckner, Chief Financial Officer
West Virginia Department of Health and Human Resources