Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ARKANSAS MADE INCORRECT MEDICAID ELECTRONIC HEALTH RECORD INCENTIVE PAYMENTS TO HOSPITALS

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Regional Inspector General
for Audit Services

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Office of Inspector General

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EXECUTIVE SUMMARY

Arkansas made incorrect Medicaid electronic health record incentive payments to hospitals totaling $1.2 million over nearly 2 years. Incorrect payments included both overpayments and underpayments, for a net overpayment of $79,428.

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 (OIG), 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 Arkansas Department of Human Services (State agency) made approximately $54 million in Medicaid EHR incentive program payments to providers during the period November 2011 through June 2013. Of this amount, the State agency paid approximately $30 million to hospitals and $24 million to professionals. This review is one in a series of reports focusing 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 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 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 November 1, 2011, through June 30, 2013, the State agency paid $53,782,323 for Medicaid EHR incentive payments. We (1) reconciled both professional and hospital incentive payments reported on the State's Form CMS-64, Quarterly Medicaid Assistance Expenditures for the Medical Assistance Program, with the NLR and (2) selected for further review 20 hospitals paid the highest total dollars of incentive payments. The State agency paid the 20 hospitals $19,125,371, which is 65 percent of the total paid during the audit period. This amount included second-year payments for 9 of the 20 hospitals, totaling $3,504,223. The State agency made additional incentive payments to 18 of the 20 hospitals, totaling $6,417,265 as of September 30, 2014.

WHAT WE FOUND

The State agency did not always pay EHR incentive program payments in accordance with Federal and State requirements. The State agency made incorrect EHR incentive payments to 14 hospitals. Specifically, for 13 hospitals, the State agency made incorrect payments totaling $1,225,734. Of the 13 hospitals, 8 were overpaid a total of $652,581, and 5 were underpaid a total of $573,153, for a net overpayment of $79,428. Because the hospital calculation is computed once and then paid out over 4 years, payments after September 30, 2014, will also be incorrect. The net adjustments to these payments total $134,295. We were unable to determine what portion of the incentive payment to one hospital was incorrect and are setting aside the entire payment of $1,534,708 for the State agency to work with the hospital to determine the correct incentive payment.

These errors occurred because (1) the State agency did not follow Federal requirements specific to cost report data elements on calculating the hospital incentive payment and (2) State agency personnel did not review supporting documentation for the numbers provided in the cost reports that were used to calculate incentive payments or, in one instance, use the correct cost report period.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund to the Federal Government $79,428 in net overpayments made to the 13 hospitals;

- adjust the 13 hospitals' remaining incentive payments to account for the incorrect calculations (which will result in future cost savings of $134,295);

- work with the one hospital for which the $1,534,708 total incentive amount was set aside to recalculate the incentive payment using the June 2009 cost report;

- review the calculations for the hospitals not included in the 20 we reviewed to determine whether payment adjustments are needed, and refund any overpayments identified;

- review supporting documentation for the numbers provided in the cost reports and ensure that the correct cost report periods were used; and

- provide guidance to the hospitals that states that inpatient nonacute-care services and unpaid Medicaid services should be excluded from bed-days and discharge lines of the incentive payment calculation, that neonatal intensive care unit bed-days and discharges should be included, and that bad debts, courtesy discounts, and any other unallowable charges should be excluded from charity care charges.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency concurred with four of the six recommendations. The State agency did not concur with the recommendation to refund the net overpayment of $79,428 but stated that the incentive payments for 8 of the 13 hospitals had already been adjusted in accordance with our findings. The State agency also stated that it expected the incentive payments for the other five hospitals to be adjusted in accordance with our findings. The State agency also did not concur with our recommendation to work with the one hospital for which the total incentive amount was set aside to recalculate the incentive payment using the June 2009 cost report data. The State agency said that, on the basis of communications between OIG and the hospital, it concluded that OIG agreed that the use of the 2010 cost report was appropriate.

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid.

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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 (OIG), 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 Arkansas Department of Human Services (State agency) made approximately $54 million in Medicaid EHR incentive payments to providers during the period November 2011 through June 2013. Of this amount, the State agency paid approximately $30 million to hospitals and $24 million to professionals. This review is one in a series of reports focusing only on the Medicaid EHR incentive program for hospitals. (Appendix A lists previous reviews of the Medicaid EHR incentive program.)

OBJECTIVE

Our objective was to determine whether the State agency made Medicaid EHR incentive program payments to eligible hospitals in accordance with Federal and State requirements.

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.

[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.

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 Arkansas, 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.[3] 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.[4]

[3] 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)).

[4] 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)).

A hospital must meet the following requirements to receive an incentive payment:

- 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.[5]
- The hospital has adopted, implemented, upgraded, or meaningfully used certified EHR technology.[6]
- The hospital meets Medicaid patient volume requirements.[7]

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.[8] 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.[9] 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. The table below provides three examples of the overall EHR amount calculation.

[5] 42 CFR § 495.302 definition of "acute care hospital." Children's hospitals do not have to meet the average length of stay requirement.

[6] 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.

[7] 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)).

[8] No single year may account for more than 50 percent of the total incentive payment, and no 2 years may account for more than 90 percent of the total incentive payment (42 CFR §§ 495.310(f)(3) and (f)(4)). The State agency elected for incentive payments to be made over a 4-year period with the first payment being 40 percent of the total and each of the remaining three payments 20 percent.

[9] 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 1,150 Through 23,000 Discharges During the Payment Year	Hospitals With More Than 23,000 Discharges During the Payment Year
Base amount	$2 million	$2 million	$2 million
Plus discharge-related amount (adjusted in years 2 through 4 that are based on the average annual growth rate)	$0.00	$200 multiplied by ($n$ – 1,149) where n is the number of discharges	$200 multiplied by (23,000 – 1,149)
Equals total initial amount	$2 million	Between $2 million and $6,370,200 depending on the number of discharges	Limited by law to $6,370,200
Multiplied by transition factor	Year 1 – 1.00 Year 2 – 0.75 Year 3 – 0.50 Year 4 – 0.25	Year 1 – 1.00 Year 2 – 0.75 Year 3 – 0.50 Year 4 – 0.25	Year 1 – 1.00 Year 2 – 0.75 Year 3 – 0.50 Year 4 – 0.25
Overall EHR amount	Sum of all 4 years	Sum of all 4 years	Sum of all 4 years

The Medicaid share is calculated as follows:

- The numerator is the sum of the estimated Medicaid inpatient acute-care bed-days[10] 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

[10] 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 November 1, 2011, through June 30, 2013, the State agency paid $53,782,323 for Medicaid EHR incentive payments. We (1) reconciled both professional and hospital incentive payments reported on the State's CMS-64 report with the NLR and (2) selected for further review 20 hospitals paid the highest total dollars of incentive payments. The State agency paid the 20 hospitals $19,125,371, which is 65 percent of the total paid during the audit period. This amount includes second-year payments for 9 of the 20 hospitals totaling $3,504,223. The State agency made additional incentive payments to 18 of the 20 hospitals, totaling $6,417,265 as of September 30, 2014.

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 always pay EHR incentive program payments in accordance with Federal and State requirements. Specifically, the State agency made incorrect incentive payments to 14 hospitals. The payments to 13 hospitals resulted in a net overpayment of $79,428. We were unable to determine what portion of the incentive payment to one hospital was incorrect and are setting aside the entire payment of $1,534,708[11] for the State agency to work with the hospital to determine the correct incentive payment.

These errors occurred because (1) the State agency did not follow Federal requirements specific to cost report data elements on calculating the hospital incentive payments and (2) State agency personnel did not review supporting documentation for the numbers provided in the cost reports that were used to calculate incentive payments or, in one instance, use the correct cost report period.

THE STATE AGENCY MADE INCORRECT HOSPITAL INCENTIVE PAYMENTS

CMS issued a final rule that explains restrictions on use of discharges and inpatient bed-days to those from the acute-care portion of a hospital; psychiatric and rehabilitation units, which are distinct parts of a hospital, may not be included in the incentive payment calculation (75 Fed.

[11] As of September 30, 2014, the State agency had paid $920,825 of the $1,534,708 incentive payment.

Reg. 44314, 44450, 44454, and 44498 (July 28, 2010)). Also, the final rule states that bed-days include all inpatient bed-days paid under the acute-care payment system and exclude nursery bed-days, except for those in intensive care units of the hospital (75 Fed. Reg. 44314, 44453, 44454, 44498, and 44500 (July 28, 2010)).

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

To calculate incentive payments, a hospital uses information for the 12-month period ending in the Federal fiscal year before the fiscal year that serves as the hospital's first payment year (42 CFR § 495.310(g)(1)(i)(B)).

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)). The final rule states that uncompensated care can be used to determine an appropriate proxy for charity care, but the charges must be adjusted to eliminate bad debts, courtesy allowances, or discounts (75 Fed. Reg. 44456, 44580 (July 28, 2010)).

Of the 20 hospital incentive payment calculations reviewed, 14, or 70 percent, did not comply with regulations, guidance, or both. Some calculations had multiple deficiencies. Specifically, the calculations included:

- bad debt and other unallowable charges, such as courtesy discounts within charity care charges (9 hospitals);
- revised hospital data (7 hospitals);
- nursery services (4 hospitals);
- unpaid Medicaid bed-days (2 hospitals);
- rehabilitation services (1 hospital);
- hospice services (1 hospital); and
- use of an incorrect cost report period (1 hospital).

The incentive payment calculation for four hospitals did not include neonatal intensive care unit days and/or discharges (3 hospitals), intensive care days (1 hospital), and labor and delivery days (1 hospital), which should have been included.

The State agency made incorrect hospital incentive payments for the following reasons:

[12] CMS Frequently Asked Questions: https://questions.cms.gov/ FAQs 2991, 3213, 3261, and 3315; last accessed on March 17, 2014.

- The State agency followed CMS's general guidance on the cost report data elements suggested for use when calculating a hospital incentive payment but did not follow more specific guidance from CMS. CMS guidelines tell providers where to find certain data elements on the cost report but did not include which items that CMS identified in its final rule that should be removed from these data elements (e.g., remove bad debts from uncompensated care). For example, three hospitals asked the State agency where to obtain the charity care charges, and the State agency instructed them to use an amount from a specific line on the cost report, as instructed by CMS's general guidelines, but did not instruct them to remove certain items in accordance with the final rule.

- The State agency did not review supporting documentation for the numbers provided in the cost reports in the incentive payment calculations. Such a review would have shown that the supporting documentation incorrectly included inpatient nonacute-care services and unpaid Medicaid bed-days.

- The State agency used a cost report ending December 2010, which was in the hospital's first payment year, to calculate the incentive payments. The State agency should have used June 2009 cost reports, which ended in the Federal fiscal year before the hospital's first payment year.

As a result, for 13 hospitals, the State agency made incorrect incentive payments totaling $1,225,734. Specifically, the State agency overpaid eight hospitals a total of $652,581 and underpaid five hospitals a total of $573,153, for a net overpayment of $79,428. Because the hospital calculation is computed once and then paid out over 4 years, payments after September 30, 2014, will also be incorrect. The net adjustments to these payments total $134,295.

We were unable to determine what portion of the incentive payment to one hospital was incorrect. The incentive payment was calculated using a cost report ending December 2010, but the payment should have been calculated based on a cost report ending June 2009. The hospital changed owners in December 2009 and the current owner was unable to provide adequate documentation for the June 2009 cost report. Therefore, we are setting aside the entire payment of $1,534,708.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government $79,428 in net overpayments made to the 13 hospitals;

- adjust the 13 hospitals' remaining incentive payments to account for the incorrect calculations (which will result in future cost savings of $134,295);

- work with the one hospital for which the $1,534,708 total incentive amount was set aside to recalculate the incentive payment using the June 2009 cost report;

- review the calculations for the hospitals not included in the 20 we reviewed to determine whether payment adjustments are needed, and refund any overpayments identified;

- review supporting documentation for the numbers provided in the cost reports and ensure that the correct cost report periods were used; and

- provide guidance to the hospitals that states that inpatient nonacute-care services and unpaid Medicaid services should be excluded from bed-days and discharge lines of the incentive payment calculation, that neonatal intensive care unit bed-days and discharges should be included, and that bad debts, courtesy discounts, and any other unallowable charges should be excluded from charity care charges.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency concurred with four of the six recommendations. The State agency did not concur with the recommendation to refund the net overpayment of $79,428 but stated that the incentive payments for 8 of the 13 hospitals had already been adjusted in accordance with our findings. The State agency also stated that it expected the incentive payments for the other five hospitals to be adjusted in accordance with our findings. The State agency also did not concur with our recommendation to work with the one hospital for which the total incentive amount was set aside to recalculate the incentive payment using the June 2009 cost report data. The State agency said that, on the basis of communications between OIG and the hospital, it concluded that OIG agreed that the use of the 2010 cost report was appropriate. The State agency's comments are included in their entirety as Appendix C.

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
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 November 1, 2011, through June 30, 2013, the State agency paid $53,782,323 for Medicaid EHR incentive payments. We (1) reconciled both professional and hospital incentive payments reported on the State's CMS-64 report with the NLR and (2) selected for further review 20 hospitals paid the highest total dollars of incentive payments. The State agency paid the 20 hospitals $19,125,371, which is 65 percent of the total paid during the audit period. This amount included second-year payments for 9 of the 20 hospitals, totaling $3,504,223. In addition, the State agency made additional incentive payments to 18 of the 20 hospitals, totaling $6,417,265 as of September 30, 2014.

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 fieldwork included visiting the State agency's office in Little Rock, Arkansas, and contacting officials at our 20 selected Arkansas hospitals.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- 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 further review the 20 hospitals that were paid the most incentive payment dollars during the audit period;
- reviewed the State agency's supporting documentation related to the 20 selected hospitals;
- reviewed and reconciled the appropriate lines from the CMS-64 report with supporting documentation and the NLR;
- obtained from the selected hospitals additional supporting documentation;[13]
- verified that the selected hospitals met eligibility requirements;

[13] We considered any subsequent revisions to cost data that were supported by hospital documentation.

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

- provided the results of our review to the selected hospitals; 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

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Electronic Health Record Program

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April 23, 2015

Ms. Patricia Wheeler
Regional Inspector General
For Audit Services
Office of Audit Services, Region VI
1100 Commerce Street, Room 632
Dallas, TX 75242

Dear Ms. Wheeler:

This is a response to the findings and recommendations of the Office of Inspector General (OIG) from its audit of 20 eligible hospitals paid the highest total dollars of incentive payments from the Electronic Health Record Incentive Program. Each recommendation is listed and addressed individually as requested by OIG.

I. **Refund to the Federal Government $79,428 in net overpayments made to the 13 hospitals.**

The State does not concur and offers an alternative recoupment method. This recommendation will be satisfied as a result of the State's current practices within the EHR Incentive Program.

The State's computerized application system (HP's MAPIR) processes a reconciliation to adjust past overpayments and underpayments to a newly calculated payment structure if the application shows any change in the cost data and adjusts the current payment accordingly.

Of the 13 hospitals that resulted in the net overpayment of $79,428; eight (8) of those hospitals have already filed Program Year 2014 applications. All of these applications were filed after the OIG audit was concluded. All eight (8) of these hospitals updated the cost data on the application in accordance with the findings from the OIG audit and were issued adjustments to the payment made through the incentive program in Federal Fiscal Year 2015 Q2. These overpayments and underpayments have already been recovered by the Centers for Medicare and Medicaid Services (CMS) by virtue of the MAPIR application in place at Arkansas. Furthermore, the State expects that all but 2 of the 13 hospitals will be in compliance by the last date of the 2014 grace period for EHR payment applications, June 30, 2015. Two of the hospitals had already filed a program year 2014 payment application, and are due a refund of $146,857, in total, from the state as a result of the OIG findings. The remaining two hospitals are expected to file an amended application in program year 2015 to realize the refund.

II. Adjust the 13 hospitals' remaining incentive payments to account for the incorrect calculations.

The State concurs with this recommendation and has already satisfied this recommendation based on its current practices within the EHR Incentive Program.

The State's computerized application system (HP's MAPIR) processes a reconciliation to adjust past overpayments and underpayments to a newly calculated payment structure if the application shows any change in the cost data and adjusts the current payment accordingly.

Eight (8) out of the 13 hospitals have already filed correct Program Year 2014 applications with amended Cost Report data. The system processed a reconciliation, and current and future payments were automatically adjusted. CMS received the cost savings in reduced Federal Fiscal Year 2015 Q2 EHR Incentive Payments made.

Incentive Payment Activity

Activity	Date	Current Calculated	Reconciliation	Transaction Amount
Payment	03/29/2013 04:52:05 PM		50.00	

III. Work with the one hospital for which the total incentive amount was set aside to recalculate the incentive payment using the June 2009 report.

The State does not concur with this recommendation.

In communications dated December 3, 2014 between the lead auditor for the OIG, * * and the hospital administrator, * the OIG auditor conceded that the December 2010 cost report was appropriate in this situation. Therefore, the State gathered documentation from the provider to support the December 2010 cost report and verified the numbers in accordance with the existing CFR regulations and, in light of, the findings from the OIG auditor on other hospitals. The State determined that the incentive payment made was adequately supported by the documentation submitted.

IV. Review the calculations for the hospitals not included in the 20 we reviewed to determine whether payment adjustments are needed, and refund any overpayments identified.

The State concurs with this recommendation, and this recommendation has been or will be satisfied as a result of the State's current practices within the EHR Incentive Program.

The State's computerized application system (HP's MAPIR) processes a reconciliation to adjust past overpayments and underpayments to a newly calculated payment structure if the application shows any change in the cost data and adjusts the current payment accordingly.

The problems indicated by the OIG findings do not consider the lack of program knowledge by the providers (e.g., excluding bad debt from charity care). Therefore, the State decided to perform a provider inquiry upon receiving a Payment Year 2 or Payment Year 3 application. This inquiry involves personally contacting the providers to inform them of the OIG Audit Findings and to ask them to verify their compliance. New documentation is not required unless the State determines that they are not in compliance. Any changes to cost data are always flagged and reviewed for compliance with supporting documentation. Otherwise, all Payment Year 1 and Payment Year 4 applications are subject to full review in light of Federal Regulations, State Regulations, and the OIG audit findings.

V. **Review supporting documentation for the numbers provided in the cost reports and ensure that the correct cost report periods were used.**

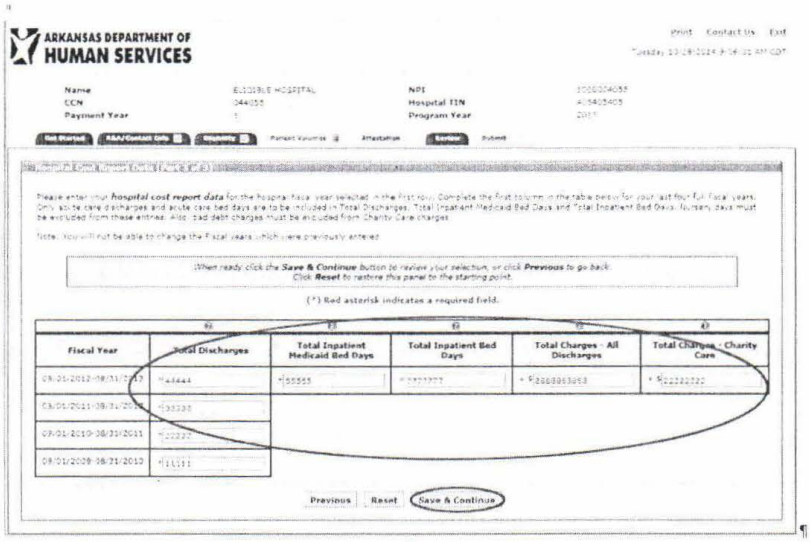
The State concurs with this recommendation and has asked HP, the State Fiscal Agent for Arkansas Medicaid and the EHR Incentive Program vendor, to run a report of all Year 1 applications to ensure that the fiscal years are in the right range for the applied program year. It is the State's understanding that the program year would equate to the federal fiscal year (e.g., Program Year 2011 = Cost report period ending in Federal Fiscal Year 2010).

If it is determined that incorrect cost report periods were used, then the State will contact the affected hospitals to request the correct cost report data and adjust incentive payments accordingly.

VI. **Provide guidance to the hospitals.**

The State concurs with this recommendation and has updated the EHR Eligible Hospital User Guide with appropriate guidance regarding non-covered days, nursery bed exclusions, and bad debt exclusions from charity care (*see Figure 1 for an Eligible Hospital User Guide example*.). In addition, an RA notice has been sent to all hospital providers informing them of the new guidance (see below):

TO: All Hospital Providers
RE: CMS' EHR Incentive Program for Eligible Hospitals (EH)
REMINDER: When submitting an Eligible Hospital (EH) EHR Incentive Payment application via MAPIR, you must EXCLUDE Nursery Days in the Hospital Cost Report Data and Bad Debt Charges from Charity Care in the Hospital Cost Report Data. For additional detail on Cost Report Data, please see the MAPIR EH User Guide.
If you have questions or concerns, please contact the Arkansas Incentive Payment Team (AIPT) at aipt@hp.com.



Hospital Cost Report Data (nursery days must be excluded from these entries; bad debt charges must be excluded from charity care charges):

Figure 1: Eligible Hospital User Guide screen shot and Hospital Cost Report Data definition

If you have questions about our response or need additional information, please feel free to call on me at (501) 320-6201 or e-mail me at ward.hanna@dhs.arkansas.gov.

Sincerely,

Ward Hanna
Business Operations Manager

* Office of Inspector General Note - The names of the OIG auditor and hospital administrator have been redacted from the State agency's comments because it is personally identifiable information.