Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CMS Made an Estimated $93.6 Million in Incorrect Medicare Electronic Health Record Incentive Payments to Acute-Care Hospitals, or Less Than 1 Percent of $10.8 Billion in Total Incentive Payments

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December 2019
A-09-18-03020

Office of Inspector General

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Report in Brief
Date: December 2019
Report No. A-09-18-03020

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

CMS Made an Estimated $93.6 Million in Incorrect Medicare Electronic Health Record Incentive Payments to Acute-Care Hospitals, or Less Than 1 Percent of $10.8 Billion in Total Incentive Payments

Why OIG Did This Audit

The Federal Government makes Medicare payments to acute-care and critical-access hospitals as an incentive for using electronic health records (EHRs). A prior OIG audit found that the Centers for Medicare & Medicaid Services (CMS) made an estimated $729 million in Medicare EHR incentive payments to eligible professionals who did not comply with Federal requirements. In addition, 17 prior OIG audits of Medicaid EHR incentive payments found that States overpaid hospitals by $66.7 million and would in the future overpay these hospitals an additional $13.3 million. These overpayments resulted from inaccuracies in the hospitals' calculations of total incentive payments. This audit focuses on Medicare EHR incentive payments made to acute-care hospitals from January 1, 2013, through September 30, 2017 (audit period). Another OIG audit will focus on Medicare EHR incentive payments made to critical-access hospitals.

Our objective was to determine whether CMS made Medicare EHR incentive payments to acute-care hospitals in accordance with Federal requirements.

How OIG Did This Audit

Our audit covered $10.8 billion for 8,297 Medicare EHR net incentive payments made to acute-care hospitals during our audit period. We reviewed a statistical sample of 99 net incentive payments, totaling $152.2 million, of which 53 were final and 46 were non-final payments.

What OIG Found

CMS did not always make Medicare EHR incentive payments to acute-care hospitals in accordance with Federal requirements. Specifically, of 99 sampled net incentive payments, 50 net incentive payments were incorrect (totaling $1.3 million, or less than 1 percent of $152.2 million reviewed). The incorrect net incentive payments occurred because (1) the Medicare administrative contractors did not review the supporting documentation for all hospitals to identify errors in the hospitals' cost-report numbers used to calculate the incentive payments; and (2) CMS did not include labor and delivery services in the incentive payment calculations, which resulted in hospitals receiving inflated incentive payments. On the basis of our sample results, we estimated that CMS made incorrect net incentive payments of $93.6 million, or less than 1 percent of the $10.8 billion in total incentive payments for our audit period.

What OIG Recommends and CMS Comments

To address the 50 incorrect net incentive payments in our sample, we recommend that CMS (1) recover from acute-care hospitals the portion of the $1.3 million in incorrect net incentive payments that are within the reopening period; and (2) for the remaining portion of the $1.3 million, which is outside of the reopening period, notify the acute-care hospitals associated with the incorrect payments so that those hospitals can exercise reasonable diligence to investigate and return any identified similar incorrect payments. To attempt recovery of the $93.6 million in estimated incorrect net incentive payments made during our audit period and to ensure that all final and non-final payments made after our audit period are correct, we also made two procedural recommendations to CMS (detailed in the report).

CMS concurred with our recommendations and described actions that it planned to take to address our recommendations. Regarding our first recommendation, CMS said that it considers only final payments to be the payments of record upon which recoupment should be initiated. CMS said that it concurs with our two procedural recommendations to the extent that they apply to non-final payments. After reviewing CMS's comments, we maintain that our findings and recommendations are valid. CMS should initiate recoupment for final payments and ask the Medicare contractors to adjust the cost reports for non-final payments. In addition, our procedural recommendations apply to both payment types; 63 percent of the total overpayments we identified were final payments.

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INTRODUCTION

WHY WE DID THIS AUDIT

To improve the quality and value of American healthcare, the Federal Government promotes the use of certified electronic health record (EHR) technology. As an incentive for using EHRs, the Federal Government makes Medicare payments to eligible hospitals[1] that attest to the "meaningful use" of EHRs.[2] As of September 30, 2017, Medicare had made approximately $15.2 billion in EHR incentive payments to eligible hospitals.

The Government Accountability Office identified improper incentive payments as the primary risk to the Medicare and Medicaid EHR incentive programs.[3] A Department of Health and Human Services, Office of Inspector General (OIG), report described the obstacles that the Centers for Medicare & Medicaid Services (CMS) faces in overseeing the Medicare EHR incentive program.[4] A subsequent OIG audit found that CMS made an estimated $729 million in Medicare EHR incentive payments to eligible professionals who did not comply with Federal requirements.[5] In addition, 17 OIG audits of Medicaid EHR incentive payments found that States overpaid hospitals by $66.7 million and would in the future overpay these hospitals an additional $13.3 million. These overpayments resulted from inaccuracies in the hospitals' calculations of total incentive payments. (Appendix B lists all the related OIG reports.)

This audit focuses on Medicare EHR incentive payments made to acute-care hospitals from January 1, 2013, through September 30, 2017. Another OIG audit will focus on Medicare EHR incentive payments made to critical-access hospitals.

OBJECTIVE

Our objective was to determine whether CMS made Medicare EHR incentive payments to acute-care hospitals in accordance with Federal requirements.

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[1] Eligible hospitals are acute-care hospitals (i.e., general, short-term-care hospitals) and critical-access hospitals.

[2] To meaningfully use certified EHRs, eligible hospitals must use numerous functions defined in Federal regulations, including functions meant to improve healthcare quality and efficiency, such as computerized order entry, electronic prescribing, and the exchange of key clinical information.

[3] *Electronic Health Records: First Year of CMS's Incentive Programs Shows Opportunities to Improve Processes to Verify Providers Met Requirements* (GAO-12-481), issued April 2012. Accessed on April 17, 2018.

[4] *Early Assessment Finds That CMS Faces Obstacles in Overseeing the Medicare EHR Incentive Program* (OEI-05-11-00250), issued November 28, 2012.

[5] *Medicare Paid Hundreds of Millions in Electronic Health Record Incentive Payments That Did Not Comply With Federal Requirements* (A-05-14-00047), issued June 7, 2017.

BACKGROUND

Establishment and Extension of the Medicare Incentive Payment Program

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 the EHR incentive program for Medicare in the 50 States and the District of Columbia[6] to promote the adoption of EHRs and to improve healthcare quality, safety, and efficiency through the promotion of health information technology and electronic health information exchange.[7]

Eligibility Requirements for Medicare Incentive Payments

The Medicare EHR incentive program provides incentive payments to eligible hospitals[8] that demonstrate they are meaningful users of certified EHR technology. To receive an incentive payment, an eligible hospital attests that it meets meaningful use requirements[9] by self-reporting data using the National Level Repository (NLR). The NLR is a CMS web-based registration and verification system that contains information on eligible hospitals participating in the Medicare EHR incentive program. The NLR checks for duplicate payments and maintains incentive payment history files.[10]

[6] Title VI of the Consolidated Appropriations Act of 2016 added acute-care hospitals in Puerto Rico as eligible hospitals under the Medicare EHR incentive program (P.L. No. 114-113, Dec. 18, 2015).

[7] On August 17, 2018, CMS published a final rule that renamed the Medicare EHR incentive payment program to the Medicare Promoting Interoperability Program and made several changes to the program requirements (83 Fed. Reg. 41144).

[8] Eligible hospitals consist of acute-care and critical-access hospitals. Acute-care hospitals are paid under the Inpatient Prospective Payment System (IPPS) (42 CFR § 495.100). Critical-access hospitals, which are facilities that have been certified as critical-access hospitals, are reimbursed 101 percent of the reasonable costs of providing services (42 CFR § 495.4). Eligible hospitals do not include psychiatric, rehabilitation, children's, long-term-care, or cancer hospitals; hospitals outside of the 50 States, the District of Columbia, or Puerto Rico; and hospitals reimbursed under special arrangements (42 CFR § 412.23).

[9] A hospital attests to meeting meaningful use requirements for a 90-day reporting period in its first year. The hospital must demonstrate meaningful use of certified EHR technology every year afterward to receive subsequent incentive payments.

[10] Effective January 2, 2018, the QualityNet Secure Portal replaced the NLR; it performs the same functions as the NLR.

Timeframe for Acute-Care Hospitals To Receive Medicare Incentive Payments

Acute-care hospitals in the 50 States and the District of Columbia that demonstrated meaningful use of certified EHR technology for the first time in Federal fiscal years (FFYs)[11] 2011, 2012, or 2013 could have received up to 4 years of incentive payments.[12] Acute-care hospitals that demonstrated meaningful use of certified EHR technology for the first time in FFY 2014 could have received up to 3 years of incentive payments, and acute-care hospitals that demonstrated meaningful use of certified EHR technology for the first time in FFY 2015 could have received up to 2 years of incentive payments (42 CFR § 495.104(c)(5)).[13]

CMS's Calculation of Medicare Incentive Payments to Acute-Care Hospitals

CMS uses the following data from a hospital's cost report as the basis for making an incentive payment to an acute-care hospital:

- the number of hospital acute-care inpatient discharges,
- the number of Medicare Parts A and C acute-care inpatient bed-days,[14]
- the number of total acute-care inpatient bed-days,
- total hospital charges,[15] and
- charity-care charges[16] (42 CFR §§ 495.104(c)(2) and (c)(4)).

The incentive payment is calculated by multiplying four components: (1) a discharge-related amount, (2) the Medicare share, (3) a transition factor, and (4) a 2-percent reduction in

[11] FFYs begin on October 1 and end on September 30.

[12] FFYs 2016, 2017, or 2018 in Puerto Rico.

[13] FFYs 2019 and 2020 in Puerto Rico (83 Fed. Reg. 41144, 41674 (Aug. 17, 2018)).

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

[15] The amount that a hospital charges for inpatient services, ancillary services, outpatient services, and other reimbursable services (CMS *Provider Reimbursement Manual*, part 2, Pub. No. 15-2 (*Provider Reimbursement Manual*), chapter 40, § 4023).

[16] Charity care results from a hospital's policy to provide all or a portion of services free of charge to patients who meet the hospital's charity-care policy or financial assistance policy (FAP). Charity care can include full or partial discounts. For Medicare purposes, charity care is not reimbursable, and unpaid amounts associated with charity care are not considered as an allowable Medicare bad debt. For charity-care charges, hospitals report the total initial payment obligation (measured at full charges) for patients, including uninsured patients, who are given a full or partial discount based on the hospital's charity-care policy or FAP for healthcare services delivered during the cost-reporting period for the entire facility (*Provider Reimbursement Manual*, chapter 40, § 4012).

incentive payments to acute-care hospitals that attested to meeting meaningful use requirements on or after April 1, 2013.

Discharge-Related Amount

The discharge-related amount is the sum of a base amount and a calculated amount based on the number of discharges during a program year. The base amount is $2 million, and the amount based on the number of discharges provides an additional $200 for each acute-care inpatient discharge during a program year, beginning with a hospital's 1,150th discharge of the year and ending with a hospital's 23,000th discharge of the year. No additional payment is made for discharges before the 1,150th discharge or after the 23,000th discharge (42 CFR § 495.104(c)(3)).

Table 1 shows the discharge-related-amount calculation based on the number of discharges during the program year.

Table 1: Calculation of the Discharge-Related Amount[17]

Components of the Calculation	Hospitals With 1,149 or Fewer Discharges	Hospitals With 1,150 Through 23,000 Discharges	Hospitals With More Than 23,000 Discharges
Base Amount	$2 million	$2 million	$2 million
Plus Amount Based on the Number of Discharges During a Program Year	$0	$200 multiplied by ($n$ – 1,149), where n is the number of discharges during the program year	$200 multiplied by (23,000 – 1,149)
Equals Total Discharge-Related Amount	$2 million	From $2,000,200 through $6,370,200	Limited by law to $6,370,200

Medicare Share

The Medicare share is calculated according to the formula shown in the figure.

Figure: Calculation of the Medicare Share

$$\frac{\text{Number of Medicare Part A Acute-Care Inpatient Bed-Days} + \text{Number of Medicare Part C Acute-Care Inpatient Bed-Days}}{\text{Total Number of Acute-Care Inpatient Bed-Days} \times ((\text{Total Hospital Charges} - \text{Charity-Care Charges}) / \text{Total Hospital Charges})}$$

[17] 42 CFR § 495.104(c)(3).

The numerator and denominator of the calculation are described as follows:[18]

- The numerator is the sum of (1) the number of acute-care inpatient bed-days attributable to individuals for whom payment may be made under Medicare Part A and (2) the number of acute-care inpatient bed-days attributable to individuals who are enrolled with a Medicare Advantage organization under Medicare Part C.

- The denominator is the product of (1) the total number of acute-care inpatient bed-days for the eligible hospital and (2) the total amount of the eligible hospital's charges, not including any charges that are attributable to charity care, divided by the total amount of the hospital's charges.

Transition Factor

A hospital's transition factor reduces the amount of the incentive payment a hospital can receive for each year of the program and is based on the current program year. For example, the transition factors for a hospital that receives its first payment in program year 2011 would be 1.00 for 2011, 0.75 for 2012, 0.5 for 2013, and 0.25 for 2014 (42 CFR § 495.104(c)(5)).

Two-Percent Reduction in Incentive Payments to Hospitals That Attested to Meeting Meaningful Use Requirements on or After April 1, 2013

Section 302 of the Budget Control Act of 2011, P.L. No. 112-25, imposed a 2-percent reduction for Medicare payments. Enacted January 2, 2013, the American Taxpayer Relief Act of 2012, P.L. No. 112-240, made the 2-percent reduction effective for Medicare services with dates of service on or after April 1, 2013. For the EHR incentive payment program, a hospital's incentive payment is reduced by 2 percent for payments related to the hospital's attesting to meeting meaningful use requirements on or after April 1, 2013.

The example on the following page shows a calculation of a hospital's Medicare EHR incentive payment.

[18] 42 CFR § 495.104(c)(4).

Example of Calculating a Hospital's Medicare EHR Incentive Payment

A hospital in California attested to being a meaningful user of certified EHR technology for the first time during program year 2012. The hospital reported the following information on its fiscal year 2011 cost report:

Number of Acute-Care Inpatient Discharges	2,000
Number of Medicare Part A Acute-Care Inpatient Bed-Days	5,000
Number of Medicare Part C Acute-Care Inpatient Bed-Days	7,000
Number of Total Acute-Care Inpatient Bed-Days	20,000
Total Hospital Charges	$2 million
Charity-Care Charges	$10,000

Based on the information above, the hospital would receive an incentive payment of $1,308,631 for program year 2012, calculated as follows:

Discharge-Related Amount: $2,000,000 + ($200 × (2,000 – 1,149)) = $2,170,200
Medicare Share: (5,000 + 7,000) / (20,000 × (($2,000,000 – $10,000) / $2,000,000) = 0.603
Transition Factor: 1.00
2-Percent Reduction Applicable?: No

Incentive Payment Calculation: $2,170,200 × 0.603 × 1.00 × 100% = $1,308,631

Determination of Initial and Final Incentive Payments to Acute-Care Hospitals

Initial incentive payments are determined based on data from a hospital's most recently submitted 12-month cost report (42 CFR § 495.104(c)(2)). According to CMS, initial payments may be adjusted before final payments are made when (1) a hospital files an amended cost report, (2) the Medicare administrative contractor (MAC) becomes aware of payment data errors, or (3) a hospital files its 12-month cost report for the hospital's fiscal year (FY) that begins on or after the first day of the program year.[19]

Final payments are determined when the MAC settles the first 12-month hospital cost report for the hospital FY that begins on or after the first day of the program year and are settled on the basis of data from that cost-reporting period. If there is no 12-month hospital cost-reporting period beginning on or after the first day of the program year, final payments may be determined and settled on the basis of data from the most recently submitted 12-month hospital cost report (42 CFR § 495.104(c)(2)).[20]

[19] A program year refers to an FFY. For the purpose of this report, we refer to initial incentive payments and adjustments made to the initial payments before the final incentive payments are made as "non-final payments."

[20] In other words, the data used to determine the initial incentive payment could be used to determine the final incentive payment.

Medicare Requirements for Acute-Care Hospitals To Identify and Return Overpayments

OIG believes that this audit report constitutes credible information of potential overpayments. Acute-care hospitals that receive notification of these potential overpayments must (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify any overpayment amount over a 6-year lookback period, and (3) report and return any overpayments by the later of either 60 days of identifying those overpayments or the date any corresponding cost report is due, if applicable (60-day rule).[21]

HOW WE CONDUCTED THIS AUDIT

Our audit covered $10.8 billion for 8,297 Medicare EHR net incentive payments[22] made to acute-care hospitals from January 1, 2013, through September 30, 2017 (audit period). We selected for review a statistical sample of 99 net incentive payments totaling $152.2 million.[23] CMS adjusted the payments for 7 of the 99 sampled net incentive payments, totaling $36,264 in additional payments as of March 31, 2018,[24] and we also reviewed them.[25] Of these 99 net incentive payments, 53 were final payments (totaling $87.6 million), and 46 were non-final payments and subject to adjustments based on the MACs' settlement of the associated hospitals' cost reports (totaling $64.6 million).

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, Appendix C contains our statistical sampling methodology, and Appendix D contains our sample results and estimates.

[21] Social Security Act § 1128J(d); 42 CFR part 401, subpart D; 42 CFR §§ 401.305(a)(2) and (f); and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016).

[22] A net incentive payment is the sum of the initial and adjusted incentive payment amounts that a hospital received for a program year.

[23] The 99 net incentive payments were made to 98 separate acute-care hospitals. Our sample included two net incentive payments made to one hospital in two separate program years.

[24] An adjustment is an additional payment received or a portion of a payment refunded based on revisions to an acute-care hospital's incentive payment calculation for a specific program year.

[25] We reviewed a total of $152,221,113 for the 99 net sampled incentive payments.

FINDINGS

CMS did not always make Medicare EHR incentive payments to acute-care hospitals in accordance with Federal requirements. Specifically, of 99 sampled net incentive payments, 50 net incentive payments were incorrect[26] (totaling $1.3 million,[27] or less than 1 percent of $152.2 million reviewed). Of these 50 incorrect net incentive payments, 26 were final payments (totaling $802,748), and 24 were non-final payments (totaling $463,363). The incorrect net incentive payments occurred because (1) the MACs did not review the supporting documentation for all hospitals to identify errors in the hospitals' cost-report numbers used to calculate the incentive payments, and (2) CMS did not include labor and delivery services in the incentive payment calculations, which resulted in hospitals receiving inflated incentive payments.

On the basis of our sample results, we estimated that CMS made incorrect net incentive payments of $93.6 million,[28] or less than 1 percent of the $10.8 billion in total incentive payments for our audit period.

FEDERAL REQUIREMENTS

CMS uses data on hospital acute-care inpatient discharges, Medicare Part A acute-care inpatient bed-days, Medicare Part C acute-care inpatient bed-days, total acute-care inpatient bed-days, total hospital charges, and charity-care charges from the most recently submitted 12-month hospital cost report as the basis for making initial incentive payments to acute-care hospitals (42 CFR §§ 495.104(c)(2) and (c)(4)).

For purposes of the incentive payment provision, Federal regulations restrict discharges and inpatient bed-days to those from the acute-care portion of a hospital and further explain that a hospital does not include psychiatric or rehabilitation units, which are distinct parts of the hospital (75 Fed. Reg. 44314, 44450, and 44497 (July 28, 2010)). In addition, bed-days include all inpatient bed-days under the IPPS and exclude nursery bed-days, except for those in intensive-care units of the hospital (75 Fed. Reg. 44314, 44453–44454 (July 28, 2010)).

CMS states that nursery, rehabilitation, psychiatric, and skilled nursing facility days and discharges may not be included as inpatient acute-care services in the calculation of hospital incentive payments (*EHR Incentive Program Frequently Asked Questions*, last updated February 2012).[29] In addition, Federal regulations consider observation services to be outpatient services

[26] Of the 49 correct net incentive payments, 27 were final payments and 22 were non-final payments.

[27] The incorrect payments totaled $1,266,111.

[28] The estimated incorrect payment amount was $93,591,531.

[29] Available at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/FAQsRemediatedandRevised.pdf. Accessed on August 6, 2018.

(75 Fed. Reg. 44314, 44484 (July 28, 2010)). Therefore, outpatient and observation services should not be included in the calculation of hospital incentive payments.

The Medicare share amount for a hospital is essentially the percentage of a hospital's inpatient, noncharity-care days that are attributable to Medicare inpatients (75 Fed. Reg. 44314, 44498 (July 28, 2010)). If the hospital data on charity care necessary to use in the calculation are not available, a hospital may use its uncompensated care data; however, the hospital must include a downward adjustment to eliminate bad debt. The final rule also 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 (75 Fed. Reg. 44314, 44456 (July 28, 2010)).

The incentive payment calculation includes care unit services, including services provided in an intensive care unit, a coronary care unit, a burn intensive-care unit, a surgical intensive-care unit, or another special care unit (*EHR Incentive Program Frequently Asked Questions,* last updated February 2012).[30]

For incentive payment calculations that used cost reports with cost-reporting periods beginning on or after October 1, 2013, labor and delivery inpatient days should be included in the determination of a hospital's number of Medicare and total inpatient days, regardless of whether a patient actually occupied a routine bed before occupying an ancillary labor and delivery bed and regardless of whether a patient occupies a "maternity suite" in which labor, delivery, recovery, and postpartum care are all provided in the same room (78 Fed. Reg. 50496, 50730–50731 (Aug. 19, 2013)).[31] The instructions for preparing Medicare cost reports require hospitals to include the total number of days located in the distinct ancillary labor and delivery rooms on line 32 of Worksheet S-3, part I, of the cost report. Maternity patients must be admitted to the hospital as inpatients for their labor and delivery days to be included on line 32 (*Provider Reimbursement Manual*, chapter 40, § 4005.1).

CMS MADE INCORRECT INCENTIVE PAYMENTS TO ACUTE-CARE HOSPITALS

Of the 99 sampled net incentive payments reviewed, 50 payments were incorrect. Some of the net incentive payment calculations had multiple deficiencies. Specifically, the calculations included:

- clerical errors, such as hospitals using data for more than 12 months for their cost-reporting periods or hospitals using the incorrect cost-reporting-period data when

[30] See footnote 29.

[31] Before October 1, 2013, labor and delivery inpatient days were not specifically required to be included in the incentive payment calculation. After analyzing the impact of adding labor and delivery inpatient bed-days to the Medicare-share portion of the incentive payment calculation, CMS required the inclusion of these bed-days effective for cost-reporting periods beginning on or after October 1, 2013 (78 Fed. Reg. 50496, 50729–50730 (Aug. 19, 2013)).

preparing their cost reports (30 net incentive payments);

- non-acute-care services (26 net incentive payments);[32] and

- bad debt within charity-care charges (5 net incentive payments).

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

- labor and delivery services for net incentive payment calculations that used cost reports with cost-reporting periods beginning on or after October 1, 2013 (13 net incentive payments),

- intensive-care-unit-related services (3 net incentive payments), and

- services under the IPPS (1 net incentive payment).

The 50 incorrect incentive payments in our sample totaled $1.3 million,[33] or less than 1 percent of the $152.2 million reviewed. Of these payments, 26 were final payments (totaling $802,748), and 24 were non-final payments (totaling $463,363).

On the basis of our sample results, we estimated that CMS made incorrect net incentive payments of $93.6 million, or less than 1 percent of the $10.8 billion in total incentive payments for our audit period.

CAUSES OF INCORRECT MEDICARE INCENTIVE PAYMENTS TO ACUTE-CARE HOSPITALS

CMS made incorrect Medicare EHR incentive payments to acute-care hospitals because (1) the MACs did not review supporting documentation for all hospitals to identify errors in the hospitals' cost-report numbers used to calculate the incentive payments, and (2) CMS did not include labor and delivery services in the incentive payment calculations that used cost reports with cost-reporting periods beginning on or after October 1, 2013.

Medicare Administrative Contractors Did Not Review Supporting Documentation Used in Determining the Hospitals' Cost-Report Numbers

The MACs did not review supporting documentation for all hospitals to identify errors in the hospitals' cost-report numbers that CMS used to calculate the incentive payments. According

[32] These services consisted of nursery, observation, psychiatric, outpatient, skilled nursing facility, and rehabilitation services.

[33] For 41 payments, CMS overpaid hospitals a total of $1,436,399, and for 9 payments, CMS underpaid hospitals a total of $170,288.

to CMS, it makes an initial incentive payment to a hospital without reviewing supporting documentation to "ensure a timely EHR payment [is] made soon after [the hospital's] attestation [of meeting meaningful use requirements]." The MACs then may review the cost-report numbers used in the incentive payment calculation in one or both of the following ways:

- As part of the MACs' dedicated cost-report audits specific to Medicare EHR incentive payments, the MACs review for some hospitals some or all of the cost-report data used in the incentive payment calculation (e.g., the number of hospital acute-care inpatient discharges and the number of total acute-care inpatient bed-days). To perform these reviews, the MACs use a specific desk review and audit program.

- As part of the MACs' routine desk reviews of Medicare cost reports and cost-report audit efforts, the MACs review Medicare cost-report settlement data specific to the Medicare portion of the incentive payment calculation.

CMS uses the results of the MACs' reviews to adjust the hospitals' initial incentive payments.

CMS Did Not Include Labor and Delivery Services in the Incentive Payment Calculations

The incentive payment calculations that used cost reports with cost-reporting periods beginning on or after October 1, 2013, did not account for all labor and delivery services. According to CMS's instructions for preparing Medicare cost reports, hospitals are required to report total labor and delivery inpatient days on line 32 in column 8 of Worksheet S-3, part I.[34] CMS also determined that for incentive payment calculations prepared using cost reports with cost-reporting periods beginning on or after October 1, 2013, labor and delivery services should be included in the determination of a hospital's number of Medicare and total inpatient days.[35] However, CMS did not include line 32 when determining the total number of inpatient bed-days when performing the incentive payment calculations. This improper exclusion of inpatient labor and delivery services understated total inpatient days, which resulted in hospitals receiving inflated incentive payments.[36]

[34] *Provider Reimbursement Manual*, chapter 40, § 4005.1.

[35] 78 Fed. Reg. 50496, 50730–50731 (Aug. 19, 2013).

[36] Of the 99 net incentive payments reviewed, 28 were calculated using cost reports with cost-reporting periods beginning on or after October 1, 2013. Of these 28 payments, 13 excluded labor and delivery inpatient days from their calculations because the hospitals reported labor and delivery inpatient days on line 32. The remaining 15 payments either (1) had labor and delivery inpatient days included in their calculations because the hospitals reported labor and delivery days on a line in their cost reports other than line 32 that was already part of the incentive payment calculation (8 payments) or (2) did not have labor and delivery inpatient days included in their calculations because the hospitals did not perform labor and delivery services during that cost-reporting period (7 payments).

CONCLUSION

CMS made incorrect Medicare EHR incentive payments to acute-care hospitals, regardless of whether those payments were final or non-final payments. In fact, in our sample, more final than non-final payments were incorrect, and the total overpayment for final payments was higher: 26 of 53 final incentive payments were incorrect (totaling $802,748), while 24 of 46 non-final incentive payments were incorrect (totaling $463,363).

The calculations for both final and non-final payments had similar numbers and types of deficiencies, such as including non-acute-care services (12 final payments and 14 non-final payments) and excluding labor and delivery services for net incentive payments that used cost reports with cost-reporting periods beginning on or after October 1, 2013 (6 final payments and 7 non-final payments).

If CMS had required that the MACs review all hospitals' supporting documentation for incentive payments and had revised the incentive payment calculations to include labor and delivery services for net incentive payments that used cost reports with cost-reporting periods beginning on or after October 1, 2013, CMS could have made more correct final than non-final payments. CMS could have also reduced the number and dollar amount of both final and non-final incentive payments that were incorrect, totaling an estimated $93.6 million.

RECOMMENDATIONS

To address the 50 incorrect net incentive payments in our sample, we recommend that the Centers for Medicare & Medicaid Services:

- recover from acute-care hospitals, in accordance with CMS policies, the portion of the $1,266,111 in incorrect net incentive payments that are within the reopening period and

- for the remaining portion of the $1,266,111, which is outside of the reopening and recovery periods, notify the acute-care hospitals associated with the incorrect payments so that those hospitals can exercise reasonable diligence to investigate and return any identified similar incorrect payments in accordance with the 60-day rule, and identify and track any returned incorrect payments as having been made in accordance with this recommendation.

To attempt recovery of the $93,591,531 in estimated incorrect net incentive payments made during our audit period and to ensure that all final and non-final payments made after our audit period are correct, we recommend that the Centers for Medicare & Medicaid Services:

- instruct the MACs to review all hospitals' supporting documentation to identify errors in the hospitals' cost-report numbers used to calculate the incentive payments, including

supporting documentation for labor and delivery inpatient bed-days for cost reports with cost-reporting periods beginning on or after October 1, 2013, and

- revise the incentive payment calculations to include labor and delivery inpatient bed-days reported on line 32 in column 8 of Worksheet S-3, part I, of hospitals' Medicare cost reports for all incentive payments that were calculated using cost reports with cost-reporting periods beginning on or after October 1, 2013.

CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendations and described actions that it planned to take to address our recommendations.

Regarding our first recommendation, CMS said that it considers only final payments to be the payments of record upon which recoupment should be initiated and will use our findings to ask the MACs to make corrections to the impacted cost reports used for calculating non-final net incentive payments. Regarding our third and fourth recommendations, CMS said that it concurs with our recommendations to the extent that they apply to non-final payments. For the fourth recommendation, CMS also said that it will work to reflect the proper classification of the labor and delivery days in the payment calculation for all yet-to-be-finalized incentive payments.

CMS also provided technical comments, which we addressed as appropriate. CMS's comments, excluding the technical comments, appear as Appendix E.

OFFICE OF INSPECTOR GENERAL RESPONSE

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

Regarding our first recommendation, whether CMS initiates recoupment on final payments or asks the MACs to adjust cost reports for non-final payments, these actions should recover incorrect Medicare EHR net incentive payments to acute-care hospitals for both final and non-final payments.

Regarding our third and fourth recommendations, for both final and non-final net incentive payments, the MACs should review the supporting documentation to identify errors in the hospitals' cost-report numbers used to calculate the incentive payments, and CMS should revise incentive payment calculations to include line 32 in column 8 of Worksheet S-3, part I, of hospitals' Medicare cost reports. Of the 50 net incentive payments that we identified as incorrect, 26 were final payments, totaling $802,748 (or 63 percent of the total overpayments identified). In addition, the incentive payment calculations for 6 of the 13 final payments, or 46 percent, did not include labor and delivery inpatient bed-days that were reported on line 32 in column 8 of Worksheet S-3, part I, of hospitals' cost reports. Limiting MAC reviews of

supporting documentation to only non-final payments and revising the incentive payment calculations to include labor and delivery days only for non-final payments could result in a large portion of overpayments not being recouped. Therefore, CMS should implement both of these recommendations for final and non-final incentive payments.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $10,767,005,185 for 8,297 Medicare EHR net incentive payments made to acute-care hospitals from January 1, 2013, through September 30, 2017. We selected for review a statistical sample of 99 net incentive payments totaling $152,184,849. CMS adjusted the payments for 7 of the 99 sampled net incentive payments, totaling $36,264 in additional payments as of March 31, 2018,[37] which we also reviewed.[38] Of these 99 net incentive payments, 53 were final payments (totaling $87,634,310), and 46 were non-final payments and subject to adjustments based on the MACs' settlement of the associated hospitals' cost reports (totaling $64,586,803).

We did not perform an overall assessment of CMS's internal control structure. Rather, we reviewed only the internal controls that pertained to our objective.

We conducted our audit from July 2017 to February 2019, which included contacting CMS in Baltimore, Maryland, and the acute-care hospitals that received the 99 sampled Medicare EHR net incentive payments.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- met with CMS to discuss the results of previously audited Medicare EHR incentive payments reviewed by (1) the MACs and (2) Figliozzi and Company (the contractor), CMS's EHR incentive program audit contractor, to ensure that our work did not overlap with the work of the MACs and the contractor;
- extracted from the NLR database Medicare EHR incentive payment data for acute-care hospitals, excluding those payments that were previously audited by the MACs or the contractor;
- identified a sampling frame consisting of unique net incentive payments made to acute-care hospitals during our audit period;

[37] An adjustment is an additional payment received or a portion of a payment refunded based on revisions to an acute-care hospital's incentive payment calculation for a specific program year.

[38] We reviewed a total of $152,221,113 for the 99 sampled net incentive payments.

- selected a dollar-weighted sample of 99 net incentive payments made to acute-care hospitals during our audit period[39] (Appendix C) and:

    - reconciled the incentive payment data from the NLR with supporting documentation from the hospitals,

    - reviewed the hospitals' supporting documentation and verified the data from the hospitals' cost reports used in calculating the net incentive payment amounts,

    - determined whether the net incentive payment calculations were correct and adequately supported,

    - calculated the net incorrect payments received by the hospitals after identifying the deficiencies in their net incentive payment calculations, and

    - estimated the dollar amount for incorrect net incentive payments made to acute-care hospitals during our audit period (Appendix D); and

- discussed the results of our audit with CMS 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.

[39] We used a dollar-weighted sample with weights based on the net incentive payment received. The probability of selecting a sample unit was proportional to the dollar value of the sample unit. For example, a $5 million net incentive payment would be five times more likely to be selected than a $1 million net incentive payment.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Medicare Paid Hundreds of Millions in Electronic Health Record Incentive Payments That Did Not Comply With Federal Requirements	A-05-14-00047	6/7/2017
Virginia Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals	A-03-14-00404	10/19/2016
New York Made Some Incorrect Medicaid Electronic Health Record Incentive Payments	A-02-14-01020	10/17/2016
California Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals	A-09-16-02004	9/26/2016
Washington State Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals	A-09-16-02015	9/20/2016
Ohio Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals	A-05-13-00043	8/30/2016
Oklahoma Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals	A-06-15-00032	8/29/2016
New Jersey Made Incorrect Medicaid Electronic Health Record Incentive Payments	A-02-14-01009	8/25/2016
West Virginia Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals	A-03-14-00406	8/10/2016
Pennsylvania Made Correct Medicaid Electronic Health Record Incentive Payments to Hospitals	A-03-15-00403	8/10/2016
Arizona Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals	A-09-15-02036	8/4/2016
Delaware Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals	A-03-14-00402	9/30/2015
Texas Made Incorrect Medicaid Electronic Health Record Incentive Payments	A-06-13-00047	8/31/2015
Arkansas Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals	A-06-14-00010	6/22/2015
The District of Columbia Made Correct Medicaid Electronic Health Record Incentive Payments to Hospitals	A-03-14-00401	1/15/2015
Massachusetts Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals	A-01-13-00008	11/17/2014
Louisiana Made Incorrect Medicaid Electronic Health Record Incentive Payments	A-06-12-00041	8/26/2014
Florida Made Medicaid Electronic Health Record Payments to Hospitals in Accordance with Federal and State Requirements	A-04-13-06164	8/8/2014
Early Assessment Finds That CMS Faces Obstacles in Overseeing the Medicare EHR Incentive Program	OEI-05-11-00250	11/28/2012

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame consisted of 8,297 net Medicare EHR incentive payments, totaling $10,767,005,185, made to acute-care hospitals from January 1, 2013, through September 30, 2017.[40]

To identify our sampling frame, we removed Medicare EHR incentive payments that (1) were made to acute-care hospitals under investigation by OIG's Office of Investigations; (2) were previously audited by the MACs; (3) previously failed a meaningful use audit performed by the contractor;[41] (4) were paid from January 1, 2011, through December 31, 2012, and were not adjusted during our audit period; (5) were voided; (6) CMS had identified as having offset amounts;[42] or (7) were paid to critical-access hospitals.

To determine the net incentive payment amount, we summed the payment and adjustment amounts for each unique combination of acute-care-hospital CMS Certification Number (CCN)[43] and Medicare EHR incentive payment program year. We then removed net incentive payments that were less than $500,000.

SAMPLE UNIT

The sample unit was a net incentive payment.

SAMPLE DESIGN

We used a dollar-weighted sample with weights based on the net incentive payment received. The probability of selecting a sample unit was proportional to the dollar value of the sample unit. For example, a $5 million net incentive payment would be five times more likely to be selected than a $1 million net incentive payment.

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[40] We included incentive payments that were initially paid before January 1, 2013, if they were adjusted during our audit period. An adjustment is an additional payment received or a portion of a payment refunded based on revisions to an acute-care hospital's incentive payment calculation for a specific program year.

[41] The meaningful use audits included verifying whether the acute-care hospitals had access to certified EHR technology.

[42] An offset is Medicare's recovery of a non-Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness. An offset does not result from revisions to an acute-care hospital's incentive payment calculation for a specific program year.

[43] The CCN is used to identify each individual provider that has participated or currently participates in Medicare. CCNs for providers have six digits. The first two digits identify the State in which the provider is located (including the District of Columbia and Puerto Rico), and the last four digits identify the type of facility (e.g., an acute-care hospital) (CMS *State Operations Manual*, Pub. No. 100-07, chapter 2, §§ 2779A and 2779A1).

SAMPLE SIZE

We selected 99 Medicare EHR net incentive payments.

SOURCE OF RANDOM NUMBERS

We used the *sample* command in the R statistical programming software, version 3.3.3, to generate the random numbers and used the net incentive payment amounts as weights.

METHOD OF SELECTING SAMPLE UNITS

We consecutively numbered the sample units in the sampling frame. After generating 100 random numbers with replacement,[44] we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the survey package in the R statistical programming software to estimate the dollar amount for incorrect net incentive payments made to acute-care hospitals during our audit period. Our estimation methodology fully accounted for the use of sampling weights and the "with replacement" nature of the sampling design.

[44] We selected the sample with replacement to simplify the calculation of the sampling probabilities. Given this approach, the same sample item can appear in the sample multiple times. In our sample, 1 of the 100 net incentive payments was selected twice, resulting in a total of 99 unique incentive payments.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Incorrect Payments	Net Value of Incorrect Payments
8,297	$10,767,005,185	99	$152,221,113	50	$1,266,111

Table 3: Estimated Value of Incorrect Payments
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$93,591,531
Lower limit	58,323,825
Upper limit	128,859,237

APPENDIX E: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: October 10, 2019

TO: Joanne Chiedi
Acting Inspector General

FROM: Seema Verma
Administrator

SUBJECT: CMS Made an Estimated $93.6 Million in Incorrect Medicare Electronic Health Record Incentive Payments to Acute-Care Hospitals Out of $10.8 Billion in Total Incentive Payments (A-09-18-03020)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS continuously strives to responsibly operate its programs, while protecting taxpayer dollars from fraud, waste, and abuse.

The Medicare Electronic Health Record Incentive Program, now known as the Medicare Promoting Interoperability Programs, provided incentive payments to eligible hospitals and critical access hospitals that demonstrated meaningful use of certified electronic health record technology. These incentive payments were available to eligible hospitals and critical access hospitals from 2011 through 2016,[1] subject to limitations on the number of years for which an eligible hospital or critical access hospital could receive an incentive payment and an annual phase-down in the dollar amount of the incentive available. Beginning in 2015, eligible hospitals and critical access hospitals that did not successfully attest to meaningful use of certified electronic health record technology were subject to reductions in their Medicare payments.

The requirements for each year of the Electronic Health Record Incentive Program are defined in the Social Security Act and regulations. CMS calculates initial incentive payments based on data from a hospital's most recently submitted cost report. Initial payments may be adjusted before final payments are made if a hospital submits amended data, CMS becomes aware of a payment error, or a more recent cost report is filed. A final incentive payment is determined by the first cost report for the hospital fiscal year that begins on or after the first day of the program year and is settled on the basis of data from that cost-reporting period. If there is no hospital cost reporting period beginning on or after the first day of the program year, final payments may be determined and settled on the basis of data from the most recently submitted hospital cost report. Final incentive payments can be adjusted during a reopening period.

CMS focuses its program integrity efforts on those services, items, and providers and suppliers that pose the greatest financial risk to the Medicare Trust Funds and represent the best

[1] Section 602(a) of the Consolidated Appropriations Act. 2016 (Pub. L. No. 114-113) amended section 1886(n)(6)(B) of the Social Security Act (the Act) to include subsection (d) Puerto Rico hospitals in the definition of "eligible hospital," which made subsection (d) Puerto Rico hospitals eligible for the incentive payments under section 1886(n) of the Act for hospitals that are meaningful electronic health record users and subject to the payment reductions under section 1866(b)(3)(B)(ix) of the Act for hospitals that are not meaningful electronic health record users. These incentive payments are available to subsection (d) Puerto Rico hospitals from 2016 through 2021.

investment of resources. CMS sets priorities using a risk-based approach to focus medical review activities and other interventions on areas that pose the greatest risk. To examine the integrity of the Electronic Health Record Incentive Programs for eligible hospitals and critical access hospitals, CMS implemented thousands of targeted risk-based audits as well as random sampling.

First, CMS built prepayment edit checks into the Electronic Health Record Incentive Programs' systems to detect inaccuracies in eligibility, reporting, and payment. For example, prepayment edits were in place to run against Medicare provider enrollment records to validate whether the facility's CMS Certification Number was active and eligible to receive Electronic Health Record incentive payments.

Second, hospitals were selected both because of anomalous data submissions and on a random basis for prepayment audits. For those facilities selected for pre-payment audits, CMS and its contractor requested supporting documentation to validate submitted attestation data before releasing payment.

Third, CMS conducted post-payment audits, reviewing data to target certain hospitals for audit by establishing rules that reviewed the attestation data to determine the presence of specific items or relationships within the attestation considered high-risk for an overpayment. This audit strategy included identifying variations in data submissions and identifying data sources useful for validation. Hospitals selected for post-payment audits were required to submit supporting documentation to validate their submitted attestation data.

As a steward of the Medicare Trust Funds, CMS appreciates OIG's estimate that over 99 percent of the $10.8 billion in total incentive payments in this legacy program were correct.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

CMS should recover from acute-care hospitals, in accordance with CMS policies, the portion of the $1,266,111 in incorrect net incentive payments that are within the reopening period.

CMS Response

CMS concurs with this recommendation. CMS will review the list of payments from the OIG and recover any incorrect final net incentive payments that are within the cost report reopening period according to CMS policies and procedures. CMS notes that of the 99 net incentive payments that the OIG sampled, 46 were non-final payments (totaling $64.6 million of the $152.2 million sampled). Because non-final payments are subject to change, CMS considers only final payments to be the payments of record upon which recoupment should be initiated. To the extent that payments are non-final, CMS will use the OIG's findings to ask the Medicare Administrative Contractors to make corrections to the impacted cost reports.

OIG Recommendation

For the remaining portion of the $1,266,111, which is outside of the reopening and recovery periods, CMS should notify the acute-care hospitals associated with the incorrect payments so that those hospitals can exercise reasonable diligence to investigate and return any identified similar incorrect payments in accordance with the 60-day rule, and identify and track any returned incorrect payments as having been made in accordance with this recommendation.

CMS Response
CMS concurs with this recommendation. CMS will review the list of payments from OIG and notify hospitals with incorrect final payments according to CMS policies and procedures.

OIG Recommendation
CMS should instruct the Medicare Administrative Contractors to review all hospitals' supporting documentation to identify errors in the hospitals' cost-report numbers used to calculate the incentive payments, including supporting documentation for labor and delivery inpatient bed-days for cost reports with cost-reporting periods beginning on or after October 1, 2013.

CMS Response
CMS concurs with this recommendation to the extent that it applies to non-final payments. As part of their routine work to finalize incentive payments, the Medicare Administrative Contractors reconcile initial and final provider data as well as flag cost reports for further review if necessary.

OIG Recommendation
CMS should revise the incentive payment calculations to include labor and delivery inpatient bed-days reported on line 32 in column 8 of Worksheet S-3, part I, of hospitals' Medicare cost reports for all incentive payments that were calculated using cost reports with cost-reporting periods beginning on or after October 1, 2013.

CMS Response
CMS concurs with this recommendation to the extent that it applies to non-final payments. CMS will work to reflect the proper classification of the labor and delivery days into the payment calculation for all yet-to-be-finalized incentive payments.