Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW YORK MADE SOME INCORRECT MEDICAID ELECTRONIC HEALTH RECORD INCENTIVE PAYMENTS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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Assistant Inspector General
for Audit Services

October 2016
A-02-14-01020

Office of Inspector General

http://oig.hhs.gov

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EXECUTIVE SUMMARY

New York made incorrect Medicaid electronic health record incentive payments totaling $175,000.

WHY WE DID THIS REVIEW

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

The Government Accountability Office has identified improper incentive payments as the primary risk to the EHR incentive programs. These programs may be at greater risk of improper payments than other programs because they are new and have complex requirements. Other U.S. Department of Health and Human Services, Office of Inspector General, reports describe the obstacles that the Centers for Medicare & Medicaid Services (CMS) and States face overseeing the Medicare and Medicaid EHR incentive programs. The obstacles leave the programs vulnerable to paying incentive payments to providers that do not fully meet requirements.

The New York State Department of Health (State agency) made approximately $589 million in Medicaid EHR incentive program payments to providers from October 1, 2011, to June 30, 2014. Of this amount, the State agency paid approximately $350 million to hospitals and $239 million to professionals. This review is one in a series of reviews focusing on the Medicaid EHR incentive program for hospitals and professionals.

The objective of this review was to determine whether the State agency made Medicaid EHR incentive program payments 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 providers 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, providers must meet Medicaid patient-volume requirements. In general,

patient volume is calculated by dividing the provider's total Medicaid patient encounters by the provider's total patient encounters. For hospitals, patient encounters are defined as discharges, not days spent in the hospital (bed-days).

The amount of an incentive payment depends on the type of provider. Hospitals may receive annual incentive payments that are based on a formula that consists of two main components—the overall EHR amount and the Medicaid share. Professionals receive a fixed amount of $21,250 in the first year and $8,500 in subsequent years; the total may not exceed $63,750 over a 6-year period.

HOW WE CONDUCTED THIS REVIEW

From October 1, 2011, through June 30, 2014 (audit period), the State agency paid $588,899,058 for Medicaid EHR incentive payments. We (1) reconciled EHR incentive payments reported on the State's Form CMS-64, Quarterly Medicaid Assistance Expenditures for the Medical Assistance Program (CMS-64 report), with the NLR and (2) selected for further review all 30 hospitals whose health systems received an incentive payment totaling $4 million or more during our audit period and 5 judgmentally selected paid professionals. The State agency paid the 30 hospitals $179,399,827, approximately 51 percent of the total paid to all hospitals during our audit period. The State agency paid the five professionals a total of $259,250 during our audit period.

WHAT WE FOUND

The State agency did not always pay EHR incentive payments in accordance with Federal and State requirements. The State agency made incorrect EHR incentive payments to two hospitals totaling $175,322. Because the incentive payment is calculated once and then paid out over 3 years, payments after June 30, 2014, will also be incorrect. The adjustments to these payments total $19,480. The State agency correctly paid the five professionals.

These errors occurred because the State agency allowed for a variance within a 5-percent margin of error for incorrectly calculated hospital incentive payments. Specifically, when it calculated the two hospitals' EHR incentive payments, the State agency used hospital cost report data that were later determined to be incorrect. However, the State agency did not revise its payment calculations for the hospitals after information regarding the incorrect data was brought to its attention.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund to the Federal Government $175,322 in overpayments made to the 2 hospitals,

- adjust the 2 hospitals' remaining incentive payments to account for the incorrect calculations (which will result in future cost savings of $19,480), and

- review the incentive payment calculations for the hospitals not included in the 30 we reviewed to determine whether payment adjustments are needed, and refund any overpayments identified.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency did not agree with our first two recommendations and agreed with our third recommendation. Under separate cover, the State agency provided additional documentation, including correspondence from CMS to the State agency. The State agency stated that, in a December 2012 letter, CMS approved the State agency's plan for auditing its EHR incentive payments. According to the State agency, CMS did not object to the State agency's application of a 5-percent variance as part of its plan. Therefore, according to the State agency, its EHR incentive payments to five hospitals we questioned in our draft report were not overpayments.

Regarding our third recommendation, the State agency stated that it will conduct an analysis of payments to hospitals not included in our sample and take appropriate action.

After reviewing the State agency's comments and additional documentation, we revised our findings and related recommendations to allow three of the five hospital EHR incentive payment calculations (two overpayments and one underpayment) that we questioned in our draft report. We also removed a recommendation that is no longer relevant.

We agree that CMS, in its letter to the State agency, did not object to the State agency's application of a 5-percent variance as part of the State agency's auditing plan. However, we note that CMS, in other correspondence provided by the State agency, indicated that States are "obligated to adjust... payments, change the calculation, and reconcile payments" in instances in which incorrect data was put into an agency's original calculation. Therefore, we maintain that the State agency should have adjusted its EHR incentive payment calculations for two hospitals whose initial costs reports contained inaccurate data, regardless of whether a 5-percent margin of error existed.

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INTRODUCTION

WHY WE DID THIS REVIEW

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

The Government Accountability Office has identified improper incentive payments as the primary risk to the EHR incentive programs.[2] These programs may be at greater risk of improper payments than other programs because they are new and have complex requirements. Other U.S. Department of Health and Human Services, Office of Inspector General, reports describe the obstacles that the Centers for Medicare & Medicaid Services (CMS) and States face overseeing the Medicare and Medicaid EHR incentive programs.[3] The obstacles leave the programs vulnerable to paying incentive payments to providers that do not fully meet requirements.

The New York State Department of Health (State agency) made approximately $589 million in Medicaid EHR incentive program payments to providers from October 1, 2011, to June 30, 2014. Of this amount, the State agency paid approximately $350 million to hospitals and $239 million to professionals. This review is one in a series of reviews focusing on the Medicaid EHR incentive program for hospitals and professionals. 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 in accordance with Federal and State requirements.

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

[2] *First Year of CMS's Incentive Programs Shows Opportunities to Improve Processes to Verify Providers Met Requirements* (GAO-12-481), published April 2012.

[3] *Early Review of States' Planned Medicaid Electronic Health Record Incentive Program Oversight* (OEI-05-10-00080), published July 2011 and *Early Assessment Finds That CMS Faces Obstacles in Overseeing the Medicare EHR Incentive Program* (OEI-05-11-00250), published November 2012.

BACKGROUND

Health Information Technology for Economic and Clinical Health Act

On February 17, 2009, the President signed the American Recovery and Reinvestment Act of 2009 (Recovery Act), P.L. No. 111-5. Title XIII of Division A and Title IV of Division B of the Recovery Act are cited together as the Health Information Technology for Economic and Clinical Health Act (HITECH Act). The HITECH Act established EHR incentive programs for both Medicare and Medicaid to promote the adoption of EHRs.

Under the HITECH Act § 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 New York, 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 providers attest that they meet program requirements by self-reporting data using the NLR.[4] To be eligible for the Medicaid EHR incentive program, providers must meet Medicaid patient-volume requirements (42 CFR § 495.304(c)). In general, patient volume is calculated by dividing the provider's total Medicaid patient encounters by the provider's total patient encounters.[5] See Table 1 for program eligibility requirements for providers.

Table 1: Eligibility Requirements for Professionals and Hospitals

Eligibility Requirements	Professional	Hospital
Provider is a permissible provider type that is licensed to practice in the State.	x	x
Provider participates in the State Medicaid program.	x	x
Provider is not excluded, sanctioned, or otherwise deemed ineligible to receive payments from the State or Federal Government.	x	x
Professional is not hospital-based.[6]	x	
Hospital has an average length of stay of 25 days or less.		x
Provider has adopted, implemented, upgraded, or meaningfully used certified EHR technology.[7]	x	x
Provider meets Medicaid patient-volume requirements.[8]	x	x

[4] Eligible professionals may be physicians, dentists, certified nurse-midwives, nurse practitioners, or physician assistants practicing in a Federally Qualified Health Center or a Rural Health Clinic that is led by a physician assistant (42 CFR § 495.304(b)). Eligible hospitals may be acute-care hospitals or children's hospitals (42 CFR §§ 495.304(a)(2) and (a)(3)); acute-care hospitals include critical access hospitals or cancer hospitals (75 Fed. Reg. 44314, 44484 (July 28, 2010)).

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

[6] Professionals may not have performed 90 percent or more of their services in the prior year in a hospital inpatient or emergency room setting (42 CFR § 495.304(c)).

[7] 42 CFR §§ 495.314(a)(1)(i) or (ii).

[8] Professionals, with the exception of pediatricians, must have a Medicaid patient volume of at least 30 percent; pediatricians must have a Medicaid patient volume of at least 20 percent (42 CFR §§ 495.304(c)(1) and (c)(2)). 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)).

Provider Payments

The amount of an incentive payment varies depending on the type of provider.

Eligible Hospital Payments

Hospital incentive payments are based on a one-time calculation of a total incentive payment, which is distributed by States over a minimum of 3 years and a maximum of 6 years.[9] The total incentive payment calculation consists of two main components—the overall EHR amount and the Medicaid share.

Generally stated, the overall EHR amount is an estimated dollar amount based on a total number of inpatient acute-care discharges over a theoretical 4-year period.[10] The overall EHR amount consists of two components—an initial amount and a transition factor. Once the initial amount is multiplied by the transition factors, all 4 years are totaled to determine the overall EHR amount. Table 2 provides three examples of the overall EHR amount calculation.

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

[10] It is a theoretical 4-year period because the overall EHR amount is not determined annually; rather, 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 2: 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[11] for the current year and the estimated number of Medicaid managed care inpatient acute-care bed-days for the current year (42 CFR § 495.310(g)(2)(i)).

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

The total incentive payment is the overall EHR amount multiplied by the Medicaid share. The total incentive payment is then distributed over several years. (See footnote 9.) It is possible that a hospital may not receive the entire total incentive payment. Each year, a hospital must re-attest and meet that year's program requirements. The hospital may not qualify for the future years' payments or could elect to end its participation in the EHR incentive program. In

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

addition, the amount may change because of adjustments to supporting numbers used in the calculations.

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

Eligible Professional Payments

Professionals receive a fixed amount of $21,250 in the first year and $8,500 in subsequent years; the total may not exceed $63,750 over a 6-year period.[12] Incentive payments for pediatricians who meet the 20-percent Medicaid patient-volume threshold but fall short of the 30-percent Medicaid patient-volume threshold are reduced to two-thirds of the incentive payment.[13] Thus, some pediatricians may receive only $14,167 in the first year and $5,667 in subsequent years, for a maximum of $42,500 over a 6-year period.[14]

Professionals may not receive EHR incentive payments from both Medicare and Medicaid in the same year and may not receive a payment from more than one State. After a professional qualifies for an EHR incentive payment and before 2015, the professional may switch one time between programs.

HOW WE CONDUCTED THIS REVIEW

From October 1, 2011, through June 30, 2014, the State agency paid $588,899,058 for Medicaid EHR incentive payments. We (1) reconciled EHR incentive payments reported on the State's CMS-64 report to the NLR and (2) selected for further review all 30 hospitals whose health systems received an incentive payment totaling $4 million or more during our audit period and 5 judgmentally selected paid professionals. The State agency paid the 30 hospitals $179,399,827 which is approximately 51 percent of the total paid to all hospitals during our audit period. Additionally, the State agency paid the 5 professionals a total of $259,250 during our audit period.

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.

[12] 42 CFR §§ 495.310(a)(1)(i), (a)(2)(i), and (a)(3).

[13] 42 CFR §§ 495.310(a)(4)(i), (a)(4)(ii), and (b).

[14] 42 CFR § 495.310(a)(4)(iii).

FINDINGS

The State agency did not always pay EHR incentive payments in accordance with Federal and State requirements. The State agency made incorrect EHR incentive payments to 2 of the 30 reviewed hospitals totaling $175,322. Because the incentive payment is calculated once and then paid out over 3 years, payments after June 30, 2014, will also be incorrect. The adjustments to these payments total $19,480. The State agency correctly paid the five professionals.

The incorrect payments occurred because the State agency allowed for a variance within a 5-percent margin of error for incorrectly calculated hospital incentive payments.

THE STATE AGENCY MADE INCORRECT HOSPITAL INCENTIVE PAYMENTS

The overall EHR incentive payment amount for a hospital is based on various discharge-related information (75 Fed. Reg. 44314, 44450 (July 28, 2010)). To calculate incentive payments, a hospital uses the discharge-related amount for the 12-month period ending in the Federal fiscal year before the fiscal year that serves as the hospital's first payment year. For the 1,150th through the 23,000th discharge, the discharge-related amount is $200. Any discharge greater than the 23,000th discharge is not included in the calculation (42 CFR § 495.310(g)(1)(i)(B)).

Additionally, Federal regulations restrict discharges and inpatient bed-days to those from the acute-care portion of a hospital and further explain that an eligible hospital, for purposes of the incentive payment provision, does not include a psychiatric or rehabilitation unit of the hospital, which are distinct parts of the hospital (75 Fed. Reg. 44314, 44450 and 44497 (July 28, 2010)).

Furthermore, the Medicaid share is, in part, calculated using the noncharity percentage. This 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)).

Of the 30 hospital incentive payment calculations reviewed, 2 (approximately 7 percent) did not comply with regulations, guidance, or both. Specifically, the calculations included:

- Medicaid acute inpatient bed days for reporting year not supported by hospital cost report;
- alcohol and drug detox discharges not included in total acute discharges; and
- miscalculated total acute inpatient bed days for reporting year.

These errors occurred because the State agency allowed for a variance within a 5-percent margin of error for incorrectly calculated hospital incentive payments. Specifically, when it calculated the two hospitals' EHR incentive payments, the State agency used hospital cost report data that were later determined to be incorrect. However, the State agency did not revise its payment calculations for the hospitals after information regarding the incorrect data was brought to its attention.

As a result of this error allowance, the State agency made incorrect EHR incentive payments to the two hospitals totaling $175,322. Because the hospital calculation is computed once and then paid out over 3 years, payments after June 30, 2014, will also be incorrect. The adjustments to these payments total $19,480.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government $175,322 in overpayments made to the 2 hospitals,
- adjust the 2 hospitals' remaining incentive payments to account for the incorrect calculations (which will result in future cost savings of $19,480), and
- review the incentive payment calculations for the hospitals not included in the 30 we reviewed to determine whether payment adjustments are needed, and refund any overpayments identified.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not agree with our first two recommendations and agreed with our third recommendation. Under separate cover, the State agency provided additional documentation, including correspondence from CMS to the State agency. The State agency stated that, in a December 2012 letter, CMS approved the State agency's plan for auditing its EHR incentive payments. According to the State agency, CMS did not object to the State agency's application of a 5-percent variance as part of its plan. Therefore, according to the State agency, its EHR incentive payments to five hospitals we questioned in our draft report were not overpayments.

Regarding our third recommendation, the State agency stated that it will conduct an analysis of payments to hospitals not included in our sample and take appropriate action.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments and additional documentation, we revised our findings and related recommendations to allow three of the five hospital EHR incentive payment calculations (two overpayments and one underpayment) that we questioned in our draft report. We also removed a recommendation that is no longer relevant.

We agree that CMS, in its letter to the State agency, did not object to the State agency's application of a 5-percent variance as part of the State agency's auditing plan. However, we note that CMS, in other correspondence provided by the State agency, indicated that States are "obligated to adjust... payments, change the calculation, and reconcile payments" in instances in

which incorrect data was put into an agency's original calculation.[15] Therefore, we maintain that the State agency should have adjusted its EHR incentive payment calculations for two hospitals whose initial costs reports contained inaccurate data, regardless of whether a 5-percent margin of error existed.

[15] Minutes of May 12, 2012, meeting of CMS's Health Information Technology for Economic Health Hospital Community of Practice. Although we could not confirm if the State agency participated in the meeting, we note that the State agency was aware of the CMS correspondence because it included the minutes from the meeting as part of its response to our draft report.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Delaware Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals	A-03-14-00402	9/30/2015
Oklahoma Made Incorrect Medicaid Electronic Health Record Incentive Payments to Health Care Professionals	A-06-14-00030	9/3/2015
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 Review of States' Planned Medicaid Electronic Health Record Incentive Program Oversight	OEI-05-10-00080	7/15/2011

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

From October 1, 2011, through June 30, 2014, the State agency paid $588,899,058 for Medicaid EHR incentive payments. We (1) reconciled EHR incentive payments reported on the State's CMS-64 report to the NLR and (2) selected for further review all 30 hospitals whose health systems received an incentive payment totaling $4 million or more during our audit period and judgmentally selected 5 paid professionals. The State agency paid the 30 hospitals $179,399,827, which is approximately 51 percent of the total paid to all hospitals during our audit period. The State agency paid the five professionals a total of $259,250 during our audit period.

We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only those internal controls related to our objective.

We performed our fieldwork at the State agency's office and the MMIS fiscal agent in Rensselaer, New York; and at 30 hospitals throughout New York State.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- held discussions with CMS officials to gain an understanding of the Medicaid EHR incentive program;
- held discussions with State agency officials to gain an understanding of State policies and controls as they relate to the Medicaid EHR incentive program;
- selected for review all 30 hospitals whose health systems were paid incentive payments of $4 million or more from October 1, 2011, to June 30, 2014; and judgmentally selected 5 paid professionals;
- reviewed and verified the State agency's supporting documentation related to the 30 hospitals and the 5 professionals;
- reviewed and reconciled the appropriate lines from the CMS-64 report to supporting documentation and the NLR;
- visited the selected hospitals and verified the supporting documentation;
- verified that the selected hospitals and professionals met eligibility requirements;

- determined whether the selected hospitals and professionals patient-volume calculations complied with regulations;

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

- recalculated the incentive payment calculations for hospitals whose payments were calculated using incorrect data;

- calculated the cost savings from correcting payments to these hospitals made after June 30, 2014; 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

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

July 8, 2016

Mr. James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services - Region II
Jacob Javitz Federal Building
26 Federal Plaza
New York, New York 10278

Ref. No: A-02-14-01020

Dear Mr. Edert:

Enclosed are the New York State Department of Health's comments on the United States Department of Health and Human Services, Office of Inspector General's Draft Audit Report A-02-14-01020 entitled, "New York Made Some Incorrect Medicaid Electronic Health Record Incentive Payments."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

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Jason A. Helgerson
Dennis Rosen
James Dematteo
James Cataldo
Ronald Farrell
Brian Kiernan
Elizabeth Misa
Geza Hrazdina
Diane Christensen
Lori Conway
OHIP Audit SM

New York State Department of Health
Comments on the
Department of Health and Human Services
Office of Inspector General
Draft Audit Report A-02-14-01020 entitled
"New York Made Some Incorrect Medicaid Electronic Health Record Incentive Payments"

The following are the New York State Department of Health's (Department) comments in response to the Department of Health and Human Services, Office of Inspector General (OIG) Draft Audit Report A-02-14-01020 entitled, "New York Made Some Incorrect Medicaid Electronic Health Record Incentive Payments."

Background:

New York State (NYS) is a national leader in its oversight of the Medicaid Program. With the transition to care management, the Office of the Medicaid Inspector General (OMIG) continues to improve upon our processes and direct our resources to match this changing direction in the Medicaid program. In conjunction with the Department, NYS will continue its focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse wherever it exists.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality of care for its Medicaid members. Since 2011, Medicaid spending has remained under the Global Spending Cap, while at the same time providing health care coverage to an additional 1,405,500 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient has decreased to $7,868 in 2014, consistent with levels from a decade ago.

General Comments:

The OIG has stated that incorrect payment errors occurred because the Department allowed a variance within a 5% margin of error for incorrectly calculated hospital incentive payments.

Developing an Audit Plan approved by Centers for Medicare and Medicaid Services (CMS) was required by NYS as part of the administration of the New York Medicaid Electronic Health Record (EHR) Incentive Program. The original audit plan was submitted to CMS in October 2012 and CMS approved the plan in a letter dated December 4, 2012. The use of a 5% variance is mentioned several times in the CMS approved plan (a copy of the approval letter and plan will be forwarded under separate cover). When financial and encounter data elements are compared against the hospital's Institutional Cost Report (ICR) data, a +/- 5% error for each data element is allowed. Data falling outside the allowable error percentage limit results in EHR program staff contacting the hospital to investigate the difference. If additional information cannot be provided by the hospital, the application for the Medicaid EHR Incentive Program will be rejected.

To determine percent error the following calculation is used:

$$Percent\ Error = \frac{MEIPASS\ Application\ Value - ICR\ Value}{ICR\ Value} \times 100$$

The CMS approval letter confirmed to the Department that it was aware of the variance which was used for some hospitals who attested for the program. Since CMS did not object to the use of a variance, the Department disagrees that the payments made to the 5 hospitals are incorrect.

Recommendation #1:

Refund to the Federal Government $156,164 in net overpayments made to the 5 hospitals.

Response #1:

The Department disagrees with the finding that the five hospitals identified in this audit were overpaid. The calculation used to determine these payments was approved by CMS in a letter dated December 4, 2012.

Recommendation #2:

Adjust the 4 hospitals' remaining incentive payments to account for the incorrect calculations (which will result in future cost savings of $17,344).

Response #2:

Since the original calculation was in line with CMS approved guidance, the Department has determined that there isn't a need to adjust future payments.

Recommendation #3:

Review the incentive payment calculations for the hospitals not included in the 30 we reviewed to determine whether payment adjustments are needed, and refund any overpayments identified.

Response #3:

By October 2016, the Department will conduct an analysis of the remaining hospitals and take appropriate action.

Recommendation #4:

Consider eliminating the allowed variance within a 5-percent margin of error for incorrectly calculated hospital incentive payments.

Response #4:

As of payment year 2015, the Department no longer uses a variance to determine a hospital's overall EHR incentive payment. The decision to no longer use a variance was made before the OIG finding and issuance of the draft audit report and was due to the changes made to the ICR process. Since the independent auditing of the ICRs is performed by KPMG, the ICR process is now handled outside of the area that administers the incentive program.