

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**WASHINGTON STATE MADE INCORRECT  
MEDICAID ELECTRONIC HEALTH  
RECORD INCENTIVE PAYMENTS  
TO HOSPITALS**

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## EXECUTIVE SUMMARY

***Washington State made incorrect Medicaid electronic health record incentive payments to hospitals, resulting in a net overpayment of \$9.2 million over approximately 4 years.***

### WHY WE DID THIS REVIEW

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

The Government Accountability Office has identified improper incentive payments as the primary risk to 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 making incentive payments to providers that do not fully meet requirements.

The Washington State Health Care Authority (State agency) made approximately \$250 million in Medicaid EHR incentive program payments from October 1, 2011, through December 31, 2014. Of this amount, \$130 million was paid to 5,116 health care professionals, and \$120 million was paid to 87 hospitals. This review is one in a series of reviews focusing on the Medicaid EHR incentive program for hospitals.

The objective of this review was to determine whether the State agency made Medicaid EHR incentive program payments to eligible hospitals in accordance with Federal requirements.

### BACKGROUND

The Health Information Technology for Economic and Clinical Health Act (HITECH Act), enacted as part of the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5, established Medicare and Medicaid EHR incentive programs to promote the adoption of EHRs. Under the HITECH Act, State Medicaid programs have the option of receiving from the Federal Government 100 percent of their expenditures for incentive payments to certain providers. The State agency administers the Medicaid program and monitors and makes EHR incentive payments.

To receive an incentive payment, eligible hospitals attest that they meet program requirements by self-reporting data using the CMS National Level Repository (NLR). The NLR is a provider registration and verification system that contains information on providers participating in the Medicaid and Medicare EHR incentive programs. To be eligible for the Medicaid EHR

incentive program, hospitals must meet Medicaid patient-volume requirements. In general, patient volume is calculated by dividing a hospital's total Medicaid patient encounters by total patient encounters. For hospitals, patient encounters are defined as discharges, not days spent in the hospital.

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

## **HOW WE CONDUCTED THIS REVIEW**

From October 1, 2011, through December 31, 2014, the State agency made \$119,803,843 in Medicaid EHR incentive payments to eligible hospitals. We (1) reviewed and reconciled hospital incentive payments reported on the State agency's Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, with the NLR and (2) selected for further review the 20 hospitals that each received a first-year incentive payment exceeding \$1 million. The State agency paid the 20 hospitals \$61,129,006, which was 51 percent of the total paid from October 1, 2011, through December 31, 2014. The State agency made additional payments to 4 of the 20 hospitals, totaling \$2,653,485 as of December 31, 2015, which we also reviewed.

## **WHAT WE FOUND**

Although the State agency made Medicaid EHR incentive program payments to eligible hospitals, it did not always make these payments in accordance with Federal requirements. Specifically, from October 1, 2011, through December 31, 2015, the State agency made incorrect Medicaid EHR incentive payments to 19 of the 20 hospitals reviewed, totaling \$11,315,824. These incorrect payments included both overpayments and underpayments, resulting in a net overpayment of \$9,206,388. Because the incentive payment is calculated once and then paid out over 4 years, payments made after December 31, 2015, will also be incorrect. The adjustments to these payments total \$2,482,882.

The State agency made incorrect hospital incentive payments because it did not review supporting documentation from the hospitals to help identify errors in its calculations.

## **WHAT WE RECOMMEND**

We recommend that the State agency:

- refund to the Federal Government \$9,206,388 in net overpayments made to the 19 hospitals,
- adjust the 19 hospitals' remaining incentive payments to account for the incorrect calculations (which will result in cost savings of \$2,482,882 after December 31, 2015),

- review the calculations for the hospitals not included in the 20 we reviewed to determine whether payment adjustments are needed and refund to the Federal Government any overpayments identified, and
- review supporting documentation from all hospitals to help identify any errors in incentive payment calculations.

## **STATE AGENCY COMMENTS AND OUR RESPONSE**

In written comments on our draft report, the State agency said that (1) we used current hospital accounting records as the data source for the incentive payment calculations, whereas the State agency used Medicare cost reports and (2) we did not reconcile the two data sources to determine which records were more accurate. The State agency commented that because different data sources were used, it was uncertain as to which calculations were correct. Regarding our first and second recommendations, the State agency concurred that unallowable costs should be refunded and any incentive payment should be adjusted to account for incorrect calculations, but it did not concur with the net overpayment and cost savings amounts. The State agency commented that it would work with CMS and the hospitals to identify and refund unallowable costs. Regarding our third and fourth recommendations, the State agency provided information on actions that it planned to take to address our recommendations.

After reviewing the State agency's comments, we maintain that our finding and recommendations are valid. The State agency used amounts from the Medicare cost reports in its incentive payment calculations without adjusting the data elements. For certain aspects of the incentive payment calculation, Federal regulations and guidance require that specific data elements be included in or excluded from the calculation, and Medicare cost reports do not provide detailed information on the data elements that should be included or excluded. We started our review with the Medicare cost-report data that the State agency provided to us, but we did not rely solely on those data for all 20 hospitals we reviewed. Rather, we obtained supporting documentation from all 20 hospitals and applied the relevant Federal requirements to ensure that the specific data elements were included or excluded. We provided the State agency with our calculations showing the data elements that we used for each hospital.

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## INTRODUCTION

### WHY WE DID THIS REVIEW

To improve the quality and value of American health care, the Federal Government promotes the use of certified electronic health record (EHR) technology by health care professionals and hospitals (collectively, “providers”). As an incentive for using EHRs, the Federal Government is making payments to providers that attest to the “meaningful use” of EHRs.<sup>1</sup> 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.<sup>2</sup> 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.<sup>3</sup> The obstacles leave the programs vulnerable to making incentive payments to providers that do not fully meet requirements.

The Washington State Health Care Authority (State agency) made approximately \$250 million in Medicaid EHR incentive program payments from October 1, 2011, through December 31, 2014. Of this amount, \$130 million was paid to 5,116 health care professionals, and \$120 million was paid to 87 hospitals. This review is one in a series of reviews focusing on the Medicaid EHR incentive program for hospitals. Appendix A lists previous reviews of the Medicaid EHR incentive program.

### OBJECTIVE

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

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<sup>1</sup> 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.

<sup>2</sup> *Electronic Health Records: First Year of CMS’s Incentive Programs Shows Opportunities to Improve Processes to Verify Providers Met Requirements* (GAO-12-481), published April 2012.

<sup>3</sup> *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, 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 (§ 4201). The Federal Government reimburses 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 Washington, the State agency administers the program.

States use the standard Form CMS-64, Quarterly Medicaid Statement of 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 of the CMS-64 report.

### **National Level Repository**

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

### **Incentive Payment Eligibility Requirements**

To receive an incentive payment, eligible hospitals attest that they meet program requirements by self-reporting data using the NLR.<sup>4</sup> To be eligible for the Medicaid EHR incentive program,

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<sup>4</sup> 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)).

hospitals must meet Medicaid patient-volume requirements (42 CFR § 495.304(e)). In general, patient volume is calculated by dividing a hospital's total Medicaid patient encounters by total patient encounters.<sup>5</sup>

To meet program eligibility requirements, a hospital must:

- be a permissible provider type that is licensed to practice in the State;
- participate in the State Medicaid program;
- not be excluded, sanctioned, or otherwise deemed ineligible to receive payments from the State or Federal Government;
- have an average length of stay of 25 days or less;<sup>6</sup>
- have adopted, implemented, upgraded, or meaningfully used certified EHR technology;<sup>7</sup> and
- meet Medicaid patient-volume requirements.<sup>8</sup>

### **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.<sup>9</sup> The total incentive payment calculation consists of two main components: the overall EHR amount and the Medicaid share.

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<sup>5</sup> For hospitals, patient encounters are defined as discharges, not days spent in the hospital. 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)).

<sup>6</sup> The definition of “acute-care hospital” in 42 CFR § 495.302. Children’s hospitals do not have to meet the average-length-of-stay requirement.

<sup>7</sup> A provider may only adopt, implement, or upgrade certified EHR technology in the first year it is in the program (42 CFR § 495.314(a)(1)). In subsequent years, the provider must demonstrate that during the EHR reporting period it was a meaningful EHR user, as defined in 42 CFR § 495.4.

<sup>8</sup> 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)).

<sup>9</sup> No single year may account for more than 50 percent of the total incentive payment, and no 2 years may account for more than 90 percent of the total incentive payment (42 CFR §§ 495.310(f)(3) and (f)(4)). The State agency elected for incentive payments to be made over a 4-year period. Of the total, the first payment was 40 percent, the second payment was 25 percent, the third payment was 20 percent, and the fourth payment was 15 percent.

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.<sup>10</sup> The overall EHR amount consists of two components: an initial amount and a transition factor. Once the initial amount is multiplied by the transition factor, all 4 years are totaled to determine the overall EHR amount. The table provides examples of the overall EHR amount calculation for three types of hospitals, with differing numbers of discharges during the payment year.

**Table: Examples of Overall Electronic Health Record Amount Calculation**

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

The Medicaid share is calculated as follows:

- The numerator is the sum of the estimated Medicaid inpatient acute-care bed-days<sup>11</sup> 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)).<sup>12</sup>

<sup>10</sup> The 4-year period is theoretical because the overall EHR amount is not determined annually; it is calculated once, on the basis of how much a hospital might be paid over 4 years. An average annual growth rate (calculated by averaging the annual percentage change in discharges over the most recent 3 years) is applied to the first payment year's number of discharges to calculate the estimated total discharges in years 2 through 4 (42 CFR § 495.310(g)).

<sup>11</sup> A bed-day is 1 day that one Medicaid beneficiary spends in the hospital.

<sup>12</sup> For reporting purposes, we refer to the numerator of the Medicaid share as the "Medicaid-bed-days-only portion of the Medicaid share."

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

The total incentive payment is the overall EHR amount multiplied by the Medicaid share. The total incentive payment is then distributed over several years. (See footnote 9.) It is possible that a hospital may not receive the entire total incentive payment. Each year, a hospital must reattest that it met 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 addition, the amount may change because of adjustments to supporting numbers used in the calculations.

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

## **HOW WE CONDUCTED THIS REVIEW**

From October 1, 2011, through December 31, 2014, the State agency made \$119,803,843 in Medicaid EHR incentive payments to eligible hospitals. We (1) reviewed and reconciled hospital incentive payments reported on the State agency's CMS-64 report with the NLR and (2) selected for further review the 20 hospitals that each received a first-year incentive payment exceeding \$1 million. The State agency paid the 20 hospitals \$61,129,006, which was 51 percent of the total paid from October 1, 2011, through December 31, 2014. The State agency made additional payments to 4 of the 20 hospitals, totaling \$2,653,485 as of December 31, 2015, which we also reviewed.

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.

## **FINDING**

Although the State agency made Medicaid EHR incentive program payments to eligible hospitals, it did not always make these payments in accordance with Federal requirements. Specifically, from October 1, 2011, through December 31, 2015, the State agency made incorrect Medicaid EHR incentive payments to 19 of the 20 hospitals reviewed, totaling \$11,315,824. These incorrect payments included both overpayments and underpayments, resulting in a net

overpayment of \$9,206,388.<sup>13</sup> Because the incentive payment is calculated once and then paid out over 4 years, payments made after December 31, 2015, will also be incorrect. The adjustments to these payments total \$2,482,882.

The State agency made incorrect hospital incentive payments because it did not review supporting documentation from the hospitals to help identify errors in its calculations.

## **FEDERAL REQUIREMENTS**

Federal regulations require that unpaid Medicaid bed-days be excluded from the incentive payment calculation (75 Fed. Reg. 44314, 44500 (July 28, 2010)). CMS guidance further clarifies that unpaid Medicaid bed-days must be excluded from the Medicaid-bed-days-only portion of the Medicaid share component of the incentive payment calculation.<sup>14</sup>

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 (42 CFR § 495.310(g)(1)(i)(B)).

Federal regulations restrict discharges and inpatient bed-days to those from the acute-care portion of a hospital and further explain that an eligible hospital, for purposes of the incentive payment provision, does not include psychiatric or rehabilitation units, which are distinct parts of the hospital (75 Fed. Reg. 44314, 44450, and 44497 (July 28, 2010)). Also, Federal regulations state that bed-days include all inpatient bed-days under the acute-care payment system and exclude nursery bed-days, except for those in intensive-care units of the hospital (75 Fed. Reg. 44314, 44453, 44454, 44498, and 44500 (July 28, 2010)).

Furthermore, CMS guidance states that nursery, rehabilitation, and psychiatric days and discharges (non-acute-care services) may not be included as inpatient acute-care services in the calculation of hospital incentive payments.<sup>15</sup>

## **THE STATE AGENCY MADE INCORRECT HOSPITAL INCENTIVE PAYMENTS**

Of the 20 hospital incentive payment calculations reviewed, 19, or 95 percent, did not comply with Federal regulations or guidance or both. Some calculations had multiple deficiencies. Specifically, the calculations included:

- unpaid Medicaid bed-days in the Medicaid-bed-days-only portion of the Medicaid share (16 hospitals),

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<sup>13</sup> Several hospitals had multiple deficiencies in their incentive payment calculations, which resulted in both overpayments and underpayments. We reported the net effect of these deficiencies.

<sup>14</sup> CMS Frequently Asked Questions (FAQ), FAQ 7649. Available online at <https://questions.cms.gov/>. Accessed on March 18, 2016.

<sup>15</sup> CMS guidance for nursery, rehabilitation, and psychiatric days and discharges from CMS FAQs 2991, 3213, and 3261. Available online at <https://questions.cms.gov/>. Accessed on January 28, 2016.

- incorrect cost-report periods (6 hospitals), and
- non-acute-care services (5 hospitals).<sup>16</sup>

The incentive payment calculation for two hospitals did not include labor and delivery services, which should have been included.

The State agency followed CMS's guidance on cost-report data elements suggested for use when calculating hospital incentive payments but did not follow more specific Federal regulations and guidance. CMS's cost-report guidance tells providers where to find certain data elements on the cost report but does not include which items Federal regulations state should be removed from these data elements.<sup>17</sup> According to State agency officials, the State agency completed the hospitals' incentive payment calculations but did not review the hospitals' supporting documentation to help identify these types of errors in the calculations.

As a result, for the 19 hospitals, the State agency made incorrect incentive payments totaling \$11,315,824. Specifically, the State agency overpaid 17 hospitals a total of \$10,261,106 and underpaid 2 hospitals a total of \$1,054,718, for a net overpayment of \$9,206,388. Because the incentive payment is calculated once and then paid out over 4 years, payments after December 31, 2015, will also be incorrect. The adjustments to these payments total \$2,482,882.<sup>18</sup>

## RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government \$9,206,388 in net overpayments made to the 19 hospitals,
- adjust the 19 hospitals' remaining incentive payments to account for the incorrect calculations (which will result in cost savings of \$2,482,882 after December 31, 2015),
- review the calculations for the hospitals not included in the 20 we reviewed to determine whether payment adjustments are needed and refund to the Federal Government any overpayments identified, and
- review supporting documentation from all hospitals to help identify any errors in incentive payment calculations.

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<sup>16</sup> These services consisted of nursery, rehabilitation, and psychiatric services.

<sup>17</sup> CMS guidance for cost-report data elements from CMS FAQ 3471. Available online at <https://questions.cms.gov/>. Accessed on January 28, 2016.

<sup>18</sup> The adjusted amount is the total net overpayment for 11 of 19 hospitals that did not receive their second-, third-, and/or fourth-year payments.

## STATE AGENCY COMMENTS

In written comments on our draft report, the State agency said that (1) we used current hospital accounting records as the data source for the incentive payment calculations, whereas the State agency used Medicare cost reports and (2) we did not reconcile the two data sources to determine which records were more accurate. The State agency also commented that for 1 of the 20 hospitals reviewed, we accepted the Medicare cost report as valid and accurate; the State agency questioned why we did not accept this report for the other 19 hospitals. The State agency commented that it agreed that our calculations for the 19 hospitals were different from its original calculations but was not certain which calculations were correct.

Regarding our first and second recommendations, the State agency concurred that unallowable costs should be refunded to the Federal Government and any incentive payment should be adjusted to account for incorrect calculations, but it did not concur with the net overpayment and cost savings amounts. The State agency commented that it would work with CMS and the hospitals to identify and refund unallowable costs. Regarding our third and fourth recommendations, the State agency commented that it would incorporate hospital audits into its EHR audit plan going forward. In addition, the State agency commented that it would use a risk-based approach and would work with CMS to determine which hospitals should be subject to additional validation or postaudits.

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, we maintain that our finding and recommendations are valid. The State agency used amounts from the Medicare cost reports in its incentive payment calculations without adjusting the data elements. For certain aspects of the incentive payment calculation, Federal regulations and guidance require that specific data elements be included in or excluded from the calculation, and Medicare cost reports do not provide detailed information on the data elements that should be included or excluded. For example, as explained in our report, CMS required, in its final rule and in guidance, that unpaid Medicaid bed-days be excluded from the incentive payment calculation.<sup>19</sup>

We started our review with the Medicare cost-report data that the State agency provided to us, but we did not rely solely on those data for all 20 hospitals we reviewed. Rather, we obtained supporting documentation from all 20 hospitals and applied the relevant Federal requirements to ensure that the specific data elements were included or excluded, such as excluding unpaid Medicaid bed-days and including labor and delivery services. We provided the State agency with our calculations showing the data elements that we used for each hospital.

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<sup>19</sup> 75 Fed. Reg. 44314, 44500 (July 28, 2010) and CMS FAQ 7649.

**APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS**

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<i>New Jersey Made Incorrect Medicaid Electronic Health Record Incentive Payments</i>	<a href="#"><u>A-02-14-01009</u></a>	8/25/2016
<i>Pennsylvania Made Correct Medicaid Electronic Health Record Incentive Payments to Hospitals</i>	<a href="#"><u>A-03-15-00403</u></a>	8/10/2016
<i>Arizona Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals</i>	<a href="#"><u>A-09-15-02036</u></a>	8/4/2016
<i>Delaware Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals</i>	<a href="#"><u>A-03-14-00402</u></a>	9/30/2015
<i>Oklahoma Made Incorrect Medicaid Electronic Health Record Incentive Payments to Health Care Professionals</i>	<a href="#"><u>A-06-14-00030</u></a>	9/3/2015
<i>Texas Made Incorrect Medicaid Electronic Health Record Incentive Payments</i>	<a href="#"><u>A-06-13-00047</u></a>	8/31/2015
<i>Arkansas Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals</i>	<a href="#"><u>A-06-14-00010</u></a>	6/22/2015
<i>The District of Columbia Made Correct Medicaid Electronic Health Record Incentive Payments to Hospitals</i>	<a href="#"><u>A-03-14-00401</u></a>	1/15/2015
<i>Massachusetts Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals</i>	<a href="#"><u>A-01-13-00008</u></a>	11/17/2014
<i>Louisiana Made Incorrect Medicaid Electronic Health Record Incentive Payments</i>	<a href="#"><u>A-06-12-00041</u></a>	8/26/2014
<i>Florida Made Medicaid Electronic Health Record Payments to Hospitals in Accordance With Federal and State Requirements</i>	<a href="#"><u>A-04-13-06164</u></a>	8/8/2014
<i>Early Review of States' Planned Medicaid Electronic Health Record Incentive Program Oversight</i>	<a href="#"><u>OEI-05-10-00080</u></a>	7/15/2011

## **APPENDIX B: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

From October 1, 2011, through December 31, 2014, the State agency made \$119,803,843 in Medicaid EHR incentive payments to eligible hospitals. We (1) reviewed and reconciled hospital incentive payments reported on the State agency's CMS-64 report with the NLR and (2) selected for further review the 20 hospitals that each received a first-year incentive payment exceeding \$1 million. The State agency paid the 20 hospitals \$61,129,006, which was 51 percent of the total paid from October 1, 2011, through December 31, 2014. The State agency made additional payments to 4 of the 20 hospitals, totaling \$2,653,485 as of December 31, 2015, which we also reviewed.

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

We conducted audit work from May 2015 to May 2016, which included contacting the State agency in Olympia, Washington.

### **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal 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 related to the Medicaid EHR incentive program;
- reviewed and reconciled the appropriate lines from the CMS-64 report with supporting documentation and the NLR;
- selected for further review (1) the 20 hospitals that each received a first-year incentive payment exceeding \$1 million during the period October 1, 2011, through December 31, 2014, and (2) all payments made to the 20 selected hospitals from January 1 through December 31, 2015;
- reviewed and verified the selected hospitals' supporting documentation;
- verified that the selected hospitals met eligibility requirements;
- determined whether the selected hospital patient-volume calculations were correct;

- determined whether the selected hospital incentive-payment calculations were correct and adequately supported; and
- discussed the results of our review with State agency officials and provided them with our recalculations.

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

## APPENDIX C: STATE AGENCY COMMENTS



### STATE OF WASHINGTON HEALTH CARE AUTHORITY

626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

August 8, 2016

Lori A. Ahlstrand  
Regional Inspector General for Audit Services  
Office of Audit Services, Region X  
Office of Inspector General  
Department of Health and Human Services  
90 7<sup>th</sup> Street, Suite 3-650  
San Francisco, CA 94103

Dear Ms. Ahlstrand:

**SUBJECT: Report Number: A-09-16-02015**

The Washington State Health Care Authority (HCA) welcomes the opportunity to provide comments on the recommendations contained in draft report A-09-16-02015 entitled *Washington State Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals*. We appreciate the work of the Office of Inspector General (OIG) on this matter.

Section 1903(t)(5)(C) of the Social Security Act requires the Medicaid share of Electronic Health Record (EHR) payments to be calculated “in the same manner as the Medicare share.” The Final Rule for Medicare and Medicaid Electronic Health Record Incentive Program states that, “states are responsible for using auditable data sources to calculate Medicaid aggregate EHR hospital incentive amounts, as well as determining Medicaid incentive payments to those providers.” Auditable data sources include, among other sources, Medicare cost reports and hospital accounting records.

HCA elected to use Medicare cost reports to ensure that the Medicaid payments were calculated in the same manner as the Medicare share and to ensure consistency among all hospitals’ reporting methodology. HCA provided the cost reports used in the original calculations to the Office of Inspector General (OIG).

Rather than use the historic Medicare cost reports HCA provided, the OIG elected to use current hospital accounting records as their source. The OIG identified discrepancies between the Medicare Cost Report and the current accounting records. Unfortunately, the OIG did not reconcile the two data sources to determine which records were the more accurate; they assumed the data they obtained was more accurate than the data HCA used.

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Regional Inspector General  
August 8, 2016  
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In one instance, the OIG did use the same data source and the same records that HCA used. One hospital provided the OIG their Medicare Cost Report rather than hospital accounting records. In this one instance, the OIG accepted that report – the same report HCA used for all hospitals - as valid and accurate. HCA questions why the OIG did not accept this report for the other 19 hospitals tested.

We agree that the OIG's calculations in the other 19 hospitals are different from the original calculations made five to six years ago. We are not certain which calculation is correct. Only after the calculations are adjusted to account for data source and methodological discrepancies will a true over - or underpayment, if one exists, be identified.

As requested in your letter dated June 23, 2016, HCA is providing a statement of concurrence or non-concurrence for each of the recommendations contained in the draft report.

**Recommendation 1:** Refund to the Federal Government \$9,206,388 in net overpayments made to the 19 hospitals.

*HCA concurs that unallowable costs should be refunded to the Federal Government, but does not concur that unallowable costs total \$11,315,824. HCA will work with CMS and the hospitals to identify and refund unallowable costs, if any.*

**Recommendation 2:** Adjust the 19 hospitals' remaining incentive payments to account for the incorrect calculations (which will result in cost savings of \$2,482,882 after December 31, 2015).

*HCA concurs that any incentive payment should be adjusted to account for incorrect calculations. HCA does not concur that those cost savings total \$2,482,882. HCA will work with CMS and the hospitals to identify and refund unallowable costs, if any.*

**Recommendation 3:** Review the calculations for the hospitals not included in the 20 we reviewed to determine whether payment adjustments are needed and refund to the Federal Government any overpayments identified.

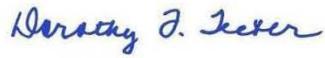
**Recommendation 4:** Review supporting documentation from all hospitals to help identify any errors in incentive payment calculations.

*HCA concurs that HCA will incorporate hospital audits into the EHR audit plan going forward. HCA will use a risk-based approach and will work with CMS to determine which hospitals should be subject to additional validation or post-audits.*

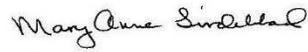
Should you have any questions or concerns, please contact Kathy E. Smith, Audit and Accountability Manager, by telephone at 360-725-0937 or via email at [kathy.smith2@hca.wa.gov](mailto:kathy.smith2@hca.wa.gov).

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Regional Inspector General  
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Sincerely,



Dorothy F. Teeter, MHA  
Director



MaryAnne Lindeblad, BSN, MPH  
Medicaid Director

By certified mail  
By email

cc: Kathy E. Smith, Audit and Accountability Manager, HCA