

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**FLORIDA MADE MEDICAID  
ELECTRONIC HEALTH RECORD  
PAYMENTS TO HOSPITALS IN  
ACCORDANCE WITH FEDERAL AND  
STATE REQUIREMENTS**

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# *Office of Inspector General*

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## INTRODUCTION

*Florida made Medicaid electronic health record payments to Hospitals in accordance with Federal and State requirements.*

### 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 paying 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 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 Center 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 paying incentive payments to providers that do not fully meet requirements. The Florida Agency for Health Care Administration (State agency) was one of the first State agencies to make incentive payments, making approximately \$178 million in Medicaid EHR incentive program payments from January 1, 2011, through April 30, 2012.

### OBJECTIVE

Our objective was to determine whether the State agency made Medicaid EHR Incentive Program payments in accordance with Federal and State requirements.

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<sup>1</sup> To meaningfully use certified EHRs, providers must use numerous functions defined in Federal regulations as improving health care quality and efficiency, such as computerized provider order entry, electronic prescribing, and the exchange of key clinical information.

<sup>2</sup> *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 HER 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 13 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). HITECH established EHR Incentive Programs for both Medicare and Medicaid to promote the adoption of EHRs.

Under HITECH, State Medicaid programs have the option of receiving from the Federal Government Federal financial participation (FFP) 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 Florida, the State agency administers the program.

States use the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64) 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 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 professionals and 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, hospitals and professionals must meet Medicaid patient volume requirements (42 CFR § 495.304(c)). In general, patient volume is calculated by dividing the provider’s encounters with Medicaid patients by the provider’s total number of service encounters.<sup>5</sup> See Table 1 for program eligibility requirements for providers.

**Table 1: Eligibility Requirements for Professionals and Hospitals**

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

## Provider Payments

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

<sup>4</sup> 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, critical access hospitals or cancer hospitals (75 Fed. Reg. 44314, 44484 (July 28, 2010)).

<sup>5</sup> There are multiple definitions of “encounter.” Generally stated, a patient encounter is any one day on which Medicaid paid for all or part of a service or Medicaid paid the co-pays, cost-sharing, or premiums for a service (42 CFR §495.30(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)).

<sup>6</sup> 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)).

<sup>7</sup> 42 CFR §§ 495.314(a)(1)(i) or (ii).

<sup>8</sup> 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)).

*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.

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 factors, all 4 years are totaled to determine the overall EHR amount. Table 2 provides three examples of the overall EHR amount calculation.

**Table 2: Overall Electronic Health Record Amount Calculation**

<b>Type of Hospital</b>	<b>Hospitals With 1,149 or Fewer Discharges During the Payment Year</b>	<b>Hospital 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>
<b>Base Amount</b>	\$2 million	\$2 million	\$2 million
<b>Plus Discharge-Related Amount</b> (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)
<b>Equals Total Initial Amount</b>	\$2 million	Between \$2 million and \$6,370,200 depending on the number of discharges	Limited by law to \$6,370,200
<b>Multiplied by Transition Factor</b>	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
<b>Overall EHR Amount</b>	Sum of all 4 years	Sum of all 4 years	Sum of all 4 years

<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 with the first payment being 50 percent of the total; the second payment, 30 percent; and the two remaining payments, 10 percent.

<sup>10</sup> It is a theoretical 4-year period because the overall EHR amount is not determined on an annual basis; rather, it is calculated once on the basis of the estimated amount a hospital should be paid over a 4-year period. 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)).

The Medicaid share is calculated as follows:

- The numerator is the sum of the estimated Medicaid acute inpatient-bed-days,<sup>11</sup> for current year and the estimated number of Medicaid managed care acute inpatient-bed-days for the current year (42 CFR § 495.310(g)(2)(i)).
- The denominator is the product of the estimated total number of inpatient acute -bed-days for the eligible hospital during the current year multiplied by the non-charity percentage. The non-charity 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 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 programs 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.<sup>12</sup> Incentive payments for pediatricians who meet 20 percent Medicaid patient volume but fall short of 30 percent are reduced to two-thirds of the incentive payment.<sup>13</sup> 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.<sup>14</sup>

Professionals may not receive 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.

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

<sup>12</sup> 42 CFR §§ 495.310(a)(1)(in), (a)(2)(in), and (a)(3).

<sup>13</sup> 42 CFR §§ 495.310(a)(4)(i), (a)(4)(ii), and (b).

<sup>14</sup> 42 CFR § 495.310(a)(4)(iii).

## **HOW WE CONDUCTED THIS REVIEW**

From January 1, 2011, through April 30, 2012, the State agency paid \$178,474,674 for Medicaid EHR incentive payments. We (1) reconciled both professional and hospital incentive payments reported on the State's CMS-64 to the NLR and (2) selected for further review all of the 42 hospitals that received an incentive payment totaling \$1 million or more. The State agency paid the 42 hospitals \$72,441,032, which is 65 percent of the total payments of \$112,231,325 made to all the hospitals during the audit period. We did not audit the eligible professionals because of prior reviews conducted by State contractors.

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.

The appendix contains the details of our audit scope and methodology.

## **RESULTS OF AUDIT**

The State agency made the EHR incentive payments in accordance with Federal and State requirements.

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

### **SCOPE**

From January 1, 2011, through April 30, 2012, the State agency paid \$178,474,674 for Medicaid EHR incentive payments. We (1) reconciled both professional and hospital incentive payments reported on the State's CMS-64 to the NLR and (2) selected 42 hospitals that received an incentive payment totaling \$1 million or more. The State agency paid the 42 hospitals \$72,441,032, which is 65 percent of the total payments of \$112,231,325 made to the hospitals for the 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 in Tallahassee, Florida, and at hospitals throughout Florida.

### **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- held discussions with State agency officials to gain an understanding of State policies and controls as they relate to the Medicaid EHR Incentive Program;
- selected a nonstatistical sample of 42 hospitals that were paid an incentive payment of \$1 million or more from January 1, 2011, through April 30, 2012;
- reviewed the State's supporting documentation related to hospitals in our sample;
- reviewed and reconciled the appropriate lines from the CMS-64 to supporting documentation and the NLR;
- visited sample hospitals and verified the information submitted to the State agency;
- verified that hospitals met eligibility requirements;
- determined whether sampled hospital incentive-payment calculations were correct; and
- discussed the results of our review and provided our recalculations to State officials.

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