

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**LOUISIANA MADE 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.*



**Gloria L. Jarmon
Deputy Inspector General
for Audit Services**

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EXECUTIVE SUMMARY

Louisiana made incorrect Medicaid electronic health record incentive payments totaling \$4.4 million. Incorrect payments included both overpayments and underpayments, for a net overpayment of \$1.8 million.

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 Louisiana Department of Health & Hospitals (State agency) was one of the first State agencies to pay incentive payments, making approximately \$93 million in Medicaid EHR incentive program payments during calendar year (CY) 2011.

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 January 1 through December 31, 2011, the State agency paid \$93,394,502 for Medicaid EHR incentive payments. We (1) reconciled both professional and hospital incentive payments reported on the State's Form CMS-64, Quarterly Medicaid Assistance Expenditures for the Medical Assistance Program (CMS-64 report), with the NLR and (2) selected for further review all of the 25 hospitals that received an incentive payment totaling \$1 million or more. The State agency paid the 25 hospitals \$53,180,619, which is 57 percent of the total paid during CY 2011 for first-year payments. In addition, the State agency made second-year payments to 15 of the 25 hospitals, totaling \$14,512,894 as of June 30, 2013.

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 20 hospitals totaling \$4,431,518. Specifically, the State agency overpaid 13 hospitals a total of \$3,090,946 and underpaid 6 hospitals a total of \$1,340,572 for a net overpayment of \$1,750,374. The State agency made an incorrect payment to an additional hospital; however, we confirmed that the payment had been recovered during our audit. Additionally, the State agency did not ensure that hospitals correctly calculated patient volume for 24 hospitals, made incorrect incentive payments to 13 professionals for a total overpayment of \$3,250, and did not report 13 professional incentive payments to the NLR.

These errors occurred because (1) State agency instructions on the hospital incentive payment and patient-volume calculations were incorrect or lacked needed information, (2) the hospital calculation worksheet had an error in the formula used to calculate the discharge-related amounts, (3) State agency personnel did not use the correct cost report periods or review supporting documentation for the numbers provided in the cost reports that were used to calculate incentive payments, (4) State agency personnel made clerical errors, (5) the State agency did not have system edits in place to prevent overpayments to professionals, and (6) the State agency did not reconcile the CMS-64 report with the NLR.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund to the Federal government \$1,750,374 in net overpayments made to the 20 hospitals, adjust the 20 hospitals' remaining incentive payments to account for the incorrect calculations, review the calculations for the hospitals not included in the 25 we reviewed to determine whether payment adjustments are needed, and refund any overpayments identified;
- modify the hospital calculation worksheet to state that inpatient nonacute-care services should be excluded from the discharge lines of the incentive payment calculation, correct the formula to calculate the discharge-related amounts, ensure that the correct cost report periods are used, and review supporting documentation for the numbers provided in the cost reports;
- modify the patient-volume worksheet to clarify that inpatient discharges—not bed-days—should be used in the patient-volume calculation and review the patient-volume calculation for the other hospitals not included in the 25 we reviewed to determine whether they met the patient-volume requirement and refund any overpayments identified if the patient-volume requirement is not met;
- refund to the Federal government \$3,250 in overpayments made to the 13 professionals, implement system edits to prevent payments that exceed threshold amounts, and ensure that personnel are knowledgeable about the EHR program requirements; and
- work with CMS to ensure that the 13 professional incentive payments not posted to the NLR are posted and establish a policy to reconcile the CMS-64 report to the NLR each quarter.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations and described corrective actions that have been implemented.

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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 Louisiana Department of Health & Hospitals (State agency) was one of the first State agencies to pay incentive payments, making approximately \$93 million in Medicaid EHR incentive program payments during calendar year (CY) 2011.

OBJECTIVE

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

BACKGROUND

Health Information Technology for Economic and Clinical Health Act

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

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

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

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.

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 Louisiana, 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.

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

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

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.

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)).

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 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.

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.

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-days¹¹ 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

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)).

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

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 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 January 1 through December 31, 2011, the State agency paid \$93,394,502 for Medicaid EHR incentive payments. We (1) reconciled both professional and hospital incentive payments reported on the State's CMS-64 report with the NLR and (2) selected for further review all of the 25 hospitals that received an incentive payment totaling \$1 million or more. The State agency paid the 25 hospitals \$53,180,619, which is 57 percent of the total paid during CY 2011 for first-year payments. In addition, the State agency made second-year payments to 15 of the 25 hospitals, totaling \$14,512,894 as of June 30, 2013.

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).

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

Appendix A contains the details of our audit scope and methodology.

FINDINGS

The State agency did not always pay EHR incentive payments in accordance with Federal and State requirements. Specifically, the State agency:

- made incorrect incentive payments to 20 hospitals for a net overpayment of \$1,750,374
- did not ensure hospitals correctly calculated patient volume for 24 hospitals,
- made incorrect incentive payments to 13 professionals for a total overpayment of \$3,250, and
- did not report 13 professional incentive payments to the NLR.

These errors occurred because (1) State agency instructions on the hospital incentive payment and patient-volume calculations were incorrect or lacked needed information, (2) the hospital calculation worksheet had an error in the formula to calculate the discharge-related amounts, (3) State agency personnel did not use the correct cost report periods or review supporting documentation for the numbers provided in the cost reports that were used to calculate incentive payments, (4) State agency personnel made clerical errors, (5) the State agency did not have system edits in place to prevent overpayments to professionals, and (6) the State agency did not reconcile the CMS-64 report with the NLR.

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, CMS guidance states that nursery, rehabilitation, psychiatric, and skilled nursing facility (SNF) days and discharges (inpatient nonacute-care services) cannot be included as inpatient acute-care services in the calculation of hospital incentive payments.¹⁵

Of the 25 hospital incentive payment calculations reviewed, 20, or 80 percent, did not comply with regulations, guidance, or both. Some calculations had multiple deficiencies. Specifically, the calculations included:

- nursery services (13 hospitals);
- clerical errors, such as using the wrong line on the cost report (5 hospitals);
- incorrect cost report periods (4 hospitals);
- rehabilitation services (4 hospitals);
- psychiatric services (3 hospitals);
- incorrect discharge-related amounts (3 hospitals); and
- SNF services (1 hospital).

The calculations for two hospitals did not include neonatal intensive care unit discharges, which should have been included.

The State agency initially provided an incentive payment calculation worksheet to hospitals that did not include any instructions to exclude inpatient nonacute-care services. A revised worksheet included instructions on excluding inpatient nonacute-care services from some line items; however, the instructions should have applied to all line items. Also, the State agency did not ensure that the hospitals had removed the inpatient nonacute-care services from all of the line items of the worksheet. Furthermore, the incentive payment calculation worksheet had an error in the formula that calculated the discharge-related amounts. The formula included \$200 for discharges greater than the 23,000th discharge.

In addition, the State agency did not use the correct cost report period for hospitals with a hospital fiscal year ending in December. The State agency used cost reports ending December 2010, which ended during the hospital's first payment year, to calculate the incentive payments. The State agency should have used December 2009 cost reports, which ended in the Federal fiscal year before the hospital's first payment year. Also, the State agency did not review supporting documentation for the numbers provided in the cost reports in the incentive payment calculation. Such a review would have shown that the incorrect cost report periods were used, and the supporting documentation would have shown when hospitals included inpatient nonacute-care services.

¹⁵ CMS Frequently Asked Questions: <https://questions.cms.gov/> FAQs 2991, 3213, 3261, and 3315; last accessed on April 1, 2014.

As a result, the State agency made incorrect incentive payments totaling \$4,431,518. Specifically, the State agency overpaid 13 hospitals a total of \$3,090,946 and underpaid 6 hospitals a total of \$1,340,572, for a net overpayment of \$1,750,374. The State agency made an incorrect payment to an additional hospital; however, we confirmed that the payment had been recovered during our audit. Because the hospital calculation is computed once and then paid out over 4 years, future payments will also be incorrect and will need to be adjusted.

THE STATE AGENCY DID NOT ENSURE HOSPITALS CORRECTLY CALCULATED MEDICAID PATIENT VOLUME

For purposes of calculating a hospital's patient volume, the hospital must divide the total Medicaid encounters in any representative, continuous 90-day period in the preceding fiscal year by the total encounters in the same 90-day period.¹⁶ A hospital encounter is either the services provided to an individual per inpatient discharge or services provided 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 (75 Fed. Reg. 44314, 44488 (July 28, 2010)).

The State agency did not ensure that hospitals correctly calculated Medicaid patient volume. Specifically, of the 25 hospital patient-volume calculations reviewed, 24 did not comply with regulations.¹⁷ This was because the calculations included bed-days rather than discharges (22 hospitals) and incorrect numbers (2 hospitals).

Although the calculations were in error, each hospital met the 10-percent patient-volume requirement after we applied the correct methodology. For example, the patient-volume percentage at one hospital changed from 23 to 19 percent.

The State agency provided incorrect instructions regarding the patient-volume calculation. State officials believed that encounters were defined as inpatient bed-days, not discharges. The incorrect numbers were caused by clerical errors. Although the 25 hospitals met the 10-percent requirement, it is possible that if the methodology had been applied correctly at other hospitals, some might not have qualified for incentive payments.

THE STATE AGENCY MADE INCORRECT PROFESSIONAL INCENTIVE PAYMENTS

A professional's first payment is limited to 85 percent of the \$25,000 threshold, or \$21,250.¹⁸

The State agency made incorrect initial incentive payments of \$21,500 to 13 professionals, or \$250 more than the threshold amount. A State official explained that the error occurred because personnel inputting the payment information were new and unaware of the threshold. In

¹⁶ 42 CFR § 495.306(c)(2).

¹⁷ One of the 25 was a children's hospital, which is not required to meet a minimum Medicaid patient volume.

¹⁸ 42 CFR § 495.310(a)(1).

addition, no system edits were in place to prevent the overpayment. As a result, the State agency overpaid professionals a total of \$3,250.

THE STATE AGENCY DID NOT ALWAYS REPORT INCENTIVE PAYMENTS TO THE NATIONAL LEVEL REPOSITORY

States participating in the Medicaid EHR incentive program are responsible for transmitting payment data to CMS's NLR so that CMS can ensure that providers do not receive payments from more than one State (75 Fed. Reg. 44314, 44501 (July 28, 2010)).

The State agency did not report to the NLR \$276,250 in incentive payments made to 13 professionals. State agency officials believed that the 13 payments had been reported to the NLR because the State agency had a log noting that the files had been transmitted to the NLR. However, the State agency was unaware that the files had not been transferred successfully. The State agency did not catch the error because it did not reconcile the CMS-64 report to the NLR. As a result, the NLR information was not complete, and the providers could have potentially been paid by another State.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal government \$1,750,374 in net overpayments made to the 20 hospitals, adjust the 20 hospitals' remaining incentive payments to account for the incorrect calculations, review the calculations for the hospitals not included in the 25 we reviewed to determine whether payment adjustments are needed, and refund any overpayments identified;
- modify the hospital calculation worksheet to state that inpatient nonacute-care services should be excluded from the discharge lines of the incentive payment calculation, correct the formula to calculate the discharge-related amounts, ensure that the correct cost report periods are used, and review supporting documentation for the numbers provided in the cost reports;
- modify the patient-volume worksheet to clarify that inpatient discharges—not bed-days—should be used in the patient-volume calculation and review the patient-volume calculation for the other hospitals not included in the 25 we reviewed to determine whether they met the patient-volume requirement and refund any overpayments identified if the patient-volume requirement is not met;
- refund to the Federal government \$3,250 in overpayments made to the 13 professionals, implement system edits to prevent payments that exceed threshold amounts, and ensure that personnel are knowledgeable about the EHR program requirements; and

- work with CMS to ensure that the 13 professional incentive payments not posted to the NLR are posted and establish a policy to reconcile the CMS-64 report to the NLR each quarter.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations and described corrective actions that have been implemented. The State agency comments are included in their entirety as Appendix B.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

From January 1 through December 31, 2011, the State agency paid \$93,394,502 for Medicaid EHR incentive payments. We (1) reconciled both professional and hospital incentive payments reported on the State's CMS-64 report to the NLR and (2) selected for further review all of the 25 hospitals that received an incentive payment totaling \$1 million or more. The State agency paid the 25 hospitals \$53,180,619, which is 57 percent of the total paid during CY 2011 for first-year payments. In addition, the State agency made second-year payments to 15 of the 25 hospitals, totaling \$14,512,894 as of June 30, 2013.

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 Baton Rouge, Louisiana, and at hospitals throughout Louisiana.

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 further review (1) all of the 25 hospitals that were paid an incentive payment of \$1 million or more during CY 2011; and (2) all payments made to the 25 hospitals from January 1, 2012, through June 30, 2013;
- reviewed the State agency's supporting documentation related to the 25 selected hospitals;
- 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 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 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 B: STATE AGENCY COMMENTS

Bobby Jindal
GOVERNOR



Kathy Kliebert
SECRETARY

State of Louisiana Department of Health and Hospitals Bureau of Health Services Financing

July 17, 2014

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

Dear Ms. Wheeler:

RE: **Report # A-06-12-00041**

Please find enclosed Louisiana Medicaid's response to recommendations offered by the Office of Inspector General (OIG) in the above-referenced report regarding the Medicaid Electronic Health Records (EHR) Incentive Program. The response includes corrective actions that have been implemented along with our position on concurrence for each recommendation.

The OIG began its audit of the EHR Incentive Program in October 2011 and examined payments issued in 2011. Louisiana Medicaid has made significant changes in its administration of the EHR Incentive Program since the audit began. The changes are described in detail in the enclosed response. Changes include the following:

- Web-based application for provider attestation and state program administration
- Adoption of robust pre-payment and post-payment review procedures for Eligible Hospitals
- Reconciliation of attestation/payment data

Louisiana Medicaid agrees with the OIG findings. The recommendations serve as confirmation that the changes already implemented were appropriate. If you need clarification or have questions, please contact Rosalyn Christopher, Medicaid Program Manager, at 225-342-8746.

Sincerely,

A handwritten signature in blue ink, appearing to read "J. Ruth Kennedy".

J. Ruth Kennedy
Medicaid Director

Enclosure

Bienville Building • 628 North 4th Street • P.O. Box 91030 • Baton Rouge, Louisiana 70821-9030
Phone: 888/342-6207 • Fax: 225/342-9508 • WWW.DHH.LA.GOV
"An Equal Opportunity Employer"

Louisiana Medicaid's Response
OIG Report #: A-06-12-00041

OIG Recommendation	Concur	DHH Response/Corrective Action
<p>Refund the Federal government \$1,750,373 in net overpayments made to the 20 hospitals, adjust the 20 hospitals' remaining incentive payments to account for the incorrect calculations, review the calculations for the hospitals not included in the 25 we reviewed to determine whether payment adjustments are needed, and refund any overpayments identified.</p>	<p>Yes</p>	<p>Louisiana Medicaid was advised by CMS representatives that any overpayments/underpayments be addressed through adjustment of future incentive payments. The over/underpayments identified by the OIG will be remedied through adjustment of the hospitals' subsequent incentive payments. Hospitals participate in the EHR Incentive Program for a 4-year period. Louisiana Medicaid staff will make necessary adjustment to subsequent payments based on results of established pre-payment and post-payment review procedures.</p> <p>Louisiana Medicaid has implemented robust pre- and post-payment review procedures that are effective in identifying and preventing materially incorrect incentive payments to hospitals.</p> <p>In March 2012, Louisiana Medicaid entered into a contract with the audit firm Myers and Stauffer (MSLC) to conduct post-payment review of incentive payments. To avoid duplication of effort, Louisiana Medicaid advised MSLC to exclude from its sample pool the 25 hospitals under audit by OIG. The discrepancies and errors identified by the OIG were identified by MSLC during analysis of hospital EHR Incentive Payment Applications, and Eligible Hospital payment data. The incorrect payments cited by OIG would have been identified and addressed through established post-payment review procedures. The risk-based audit strategy developed by MSLC was designed to select for audit those providers whose payment calculations indicate a higher risk of potential misstatement.</p> <p>As of October 2013, Louisiana Medicaid has implemented rigorous pre-payment review procedures. Instead of relying on hospital cost report data, Louisiana Medicaid (1) requests census reports from hospitals; (2) verifies reported data with MMIS claims data; (3) submits documents to MSLC for cursory review; and (4) considers results of audits. If variances exceed established thresholds, the hospital is required to recalculate its aggregate payment amount.</p>

Louisiana Medicaid's Response
OIG Report #: A-06-12-00041

OIG Recommendation	Concur	DHH Response/Corrective Action
<p>Modify the hospital calculation worksheet to state that inpatient non-acute care services should be excluded from the discharge lines of the incentive payment calculation, correct the formula to calculate the discharge-related amounts, ensure that the correct cost report periods are used, and review supporting documentation for the numbers provided in the cost reports.</p>	<p>Yes</p>	<p>Revisions have been made to the Eligible Hospital Payment Calculator.</p> <p>The pre-payment review procedures adopted by Louisiana Medicaid in October 2013 include confirmation of cost report data and ensure that correct cost report periods are used.</p>
<p>Modify the patient-volume worksheet to clarify that inpatient discharges – not bed-days – should be used in the patient-volume calculation and review the patient-volume calculation for the other hospitals not included in the 25 we reviewed to determine whether they met the patient volume requirement and refund any overpayments identified if the patient-volume requirement is not met.</p>	<p>Yes</p>	<p>In May 2013, Louisiana Medicaid launched its web-based EHR portal. Hospitals seeking initial payments and those returning for subsequent payments are required to enter patient volume data directly into the system. The system is equipped with pop-up messages and instructions that describe what type of data should be entered.</p> <p>Hospitals returning for payments in participation years 2 – 4 undergo rigorous pre-payment review procedures that include review of previously attested data.</p>
<p>Refund to the Federal government \$3,250 in overpayments made to the 13 professionals, implement system edits to prevent payments that exceed threshold amounts, and ensure that personnel are knowledgeable about the EHR Incentive Program requirements.</p>	<p>Yes</p>	<p>The overpayment of \$3,250 cited by the OIG involved a single payee (payments made on behalf of 13 professionals). The overpayment was identified by Myers and Stauffer through post-payment review procedures. The facility was notified of the overpayment, and arrangements are currently being made to recoup the funds.</p> <p>In May 2013, Louisiana Medicaid launched its web-based EHR portal. Since that time, an automated process is used to submit payment requests to the Medicaid fiscal intermediary, Molina, when an attestation is approved for payment. Payment information is transferred electronically through the EHR system without the use of manual Excel spreadsheets.</p>

Louisiana Medicaid's Response
OIG Report #: A-06-12-00041

OIG Recommendation	Concur	DHH Response/Corrective Action
Work with CMS to ensure that the 13 professional incentive payments not posted to the NLR are posted and establish a policy to reconcile the CMS-64 report to the NLR each quarter.	Yes	In October 2013, Louisiana Medicaid began conducting quarterly reconciliation of data. Payment records generated by the EHR system are compared to the NLR record and data sources used to generate the CMS-64 report. If missing or incorrect data is discovered, steps are taken immediately to resolve the discrepancy.