

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**TEXAS 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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Office of Inspector General

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EXECUTIVE SUMMARY

Texas made incorrect Medicaid electronic health record incentive payments totaling \$15.3 million. Incorrect payments included both overpayments and underpayments, for a net overpayment of \$12.5 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 Texas Health & Human Services Commission (State agency) was one of the largest payers of incentive payments, making approximately \$448 million in Medicaid EHR incentive program payments during calendar years (CYs) 2011 and 2012. Of this amount, the State agency paid approximately \$111 million to professionals and \$337 million to hospitals. This review is one in a series of reports focusing only 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 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).

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

During CYs 2011 and 2012, the State agency paid \$336,608,215 to eligible hospitals for Medicaid EHR incentive payments. We (1) reconciled hospital incentive payments reported on the State's Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, with the NLR and (2) selected for further review all of the 45 hospitals that received an incentive payment totaling \$1.5 million or more. The State agency paid the 45 hospitals \$168,893,113, which is 50 percent of the total paid during CYs 2011 and 2012. The State agency made additional payments to 44 of the 45 hospitals, totaling \$64,984,985 as of December 31, 2014.

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 38 hospitals totaling \$15,344,300. Specifically, the State agency overpaid 26 hospitals a total of \$13,904,716 and underpaid 12 hospitals a total of \$1,439,584, for a net overpayment of \$12,465,132. Because the hospital calculation is computed once and then paid out over 3 years, payments made after December 31, 2014, will also be incorrect. The adjustments to these payments total \$163,201.

These errors occurred because the State agency instructed hospitals not to include inpatient nonacute-care services in the calculation but did not ensure that hospitals removed these services from their calculations. Also, the State agency followed CMS's general guidance on cost report data elements suggested for use when calculating a hospital incentive payment but did not follow more specific Federal regulations, which say that certain items (e.g., nursery, rehabilitation, psychiatric, and skilled nursing facility services; unpaid Medicaid services; and bad debts) should be excluded from the data elements when the hospital incentive payment is calculated. Furthermore, the State agency did not review supporting documentation for the numbers provided in the cost reports that were used to calculate incentive payments or use the correct cost report periods.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund to the Federal Government \$12,465,132 in net overpayments made to the 38 hospitals and adjust the 38 hospitals' remaining incentive payments to account for the incorrect calculations (which will result in future cost savings of \$163,201);
- review the calculations for the hospitals not included in the 45 we reviewed to determine whether payment adjustments are needed and refund any overpayments identified;
- review supporting documentation for the numbers provided in the cost reports and ensure that the correct cost report periods are used; and
- provide guidance to the hospitals stating that (1) inpatient nonacute-care services and unpaid Medicaid services should be excluded from bed-days and discharge lines of the incentive payment calculation, (2) neonatal intensive care unit bed-days and discharges should be included, and (3) bad debts, courtesy discounts, and any other unallowable charges should be excluded from charity care charges.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency did not agree or disagree with our recommendations. However, it provided information on corrective actions taken and actions to be implemented. State agency officials stated that they will initiate recoupments and refund the \$12,465,132 in net overpayments to the Federal Government and will use an independent audit firm to conduct indepth reviews as part of the postpayment audit process. The State agency explained that the postpayment audits, in concert with specific actions outlined in its comments, will address the issues identified in the audit. Although we did not verify that the State agency took these actions, it is our opinion that the actions described could address our findings and recommendations.

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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 Texas Health & Human Services Commission (State agency) was one of the largest payers of incentive payments, making approximately \$448 million in Medicaid EHR incentive program payments during calendar years (CYs) 2011 and 2012. Of this amount, the State agency paid approximately \$111 million to professionals and \$337 million to hospitals. This review is one in a series of reports focusing only 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 and State requirements.

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

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

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

BACKGROUND

Health Information Technology for Economic and Clinical Health Act

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

Under the HITECH Act, § 4201, State Medicaid programs have the option of receiving from the Federal Government Federal financial participation for expenditures for incentive payments to certain Medicare and Medicaid providers to adopt, implement, upgrade, and meaningfully use certified EHR technology. The Federal Government pays 100 percent of Medicaid incentive payments (42 CFR § 495.320).

Medicaid Program: Administration and Federal Reimbursement

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In Texas, 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 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 hospitals attest that they meet program requirements by self-reporting data using the NLR.⁴ To be eligible for the Medicaid EHR incentive program,

⁴ 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(c)). In general, patient volume is calculated by dividing a hospital's total Medicaid patient encounters by total patient encounters.⁵

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;⁶
- have adopted, implemented, upgraded, or meaningfully used certified EHR technology;⁷and
- meet Medicaid patient-volume requirements.⁸

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.

⁵ There are multiple definitions of "encounter." Generally stated, a patient encounter with a health care professional is any one day for which Medicaid paid for all or part of a service or Medicaid paid the copay, cost-sharing, or premium for the service (42 CFR § 495.306(e)(1)). A hospital encounter is either the total services performed during an inpatient stay or services performed in an emergency department on any one day for which Medicaid paid for all or part of the services or paid the copay, cost-sharing, or premium for the services (42 CFR § 495.306(e)(2)).

⁶ 42 CFR § 495.302 definition of "acute-care hospital." Children's hospitals do not have to meet the average length of stay requirement.

⁷ Providers may only adopt, implement, or upgrade the first year they are in the program (42 CFR § 495.314(a)(1)). In subsequent years, providers must demonstrate that during the EHR reporting period it is a meaningful EHR user, as defined in 42 CFR § 495.4.

⁸ 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 3-year period with the first payment being 50 percent of the total; the second payment, 40 percent; and the third payment, 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. The table provides three examples of the overall EHR amount calculation.

Table: 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 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)).

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 reattest 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)).

HOW WE CONDUCTED THIS REVIEW

During CYs 2011 and 2012, the State agency paid \$336,608,215 to eligible hospitals for Medicaid EHR incentive payments. We (1) reconciled hospital incentive payments reported on the State's CMS-64 report with the NLR and (2) selected for further review all of the 45 hospitals that received an incentive payment totaling \$1.5 million or more. The State agency paid the 45 hospitals \$168,893,113, which is 50 percent of the total paid during CYs 2011 and 2012. The State agency made additional payments to 44 of the 45 hospitals, totaling \$64,984,985 as of December 31, 2014.

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

The State agency did not always pay EHR incentive program payments to eligible hospitals in accordance with Federal and State requirements. The State agency made incorrect EHR incentive payments to 38 hospitals totaling \$15,344,300. Specifically, the State agency overpaid 26 hospitals a total of \$13,904,716 and underpaid 12 hospitals a total of \$1,439,584, for a net overpayment of \$12,465,132.¹² Because the hospital calculation is computed once and then paid out over 3 years, payments made after December 31, 2014, will also be incorrect. The adjustments to these payments total \$163,201.

¹² 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 for each hospital.

These errors occurred because the State agency instructed hospitals not to include inpatient nonacute-care services in the calculation but did not ensure that hospitals removed these services from their calculations. Also, the State agency followed CMS's general guidance on cost report data elements suggested for use when calculating a hospital incentive payment but did not follow more specific Federal regulations, which say that certain items (e.g., nursery, rehabilitation, psychiatric, and skilled nursing facility services; unpaid Medicaid services; and bad debts) should be excluded from the data elements when calculating the hospital incentive payment. Furthermore, the State agency did not review supporting documentation for the numbers provided in the cost reports that were used to calculate incentive payments or use the correct cost report periods.

THE STATE AGENCY MADE INCORRECT HOSPITAL INCENTIVE PAYMENTS

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)).

Furthermore, CMS guidance states that nursery, rehabilitation, psychiatric, and skilled nursing facility (SNF) days and discharges (inpatient nonacute-care services) may not be included as inpatient acute-care services in the calculation of hospital incentive payments.¹³

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)).

The Medicaid share amount for a hospital is essentially the percentage of a hospital's inpatient, noncharity care days that are attributable to Medicaid inpatients (75 Fed. Reg. 44314, 44498 (July 28, 2010)). Also, if hospital data on charity care necessary to use in the calculation are not available, a hospital may use its uncompensated care data; however, it must include a downward adjustment to eliminate bad debt (42 CFR § 495.310(h)).

Additionally, Medicaid managed care days included in the incentive payment calculation must be paid inpatient bed-days (75 Fed. Reg. 44314, 44500 (July 28, 2010)).

Of the 45 hospital incentive payment calculations reviewed, 38, or 84 percent, did not comply with regulations, guidance, or both. Some calculations had multiple deficiencies. Specifically, the calculations included:

- nursery services (21 hospitals);
- bad debt within charity care charges (14 hospitals);
- clerical errors, such as using the wrong line on the cost report (11 hospitals);

¹³ CMS Frequently Asked Questions. Available online at <https://questions.cms.gov/> FAQs 2991, 3213, 3261, and 3315. Accessed on February 20, 2015.

- unsupported hospital data (10 hospitals);
- unpaid Medicaid bed-days (8 hospitals);
- rehabilitation services (7 hospitals);
- incorrect cost report periods (5 hospitals);
- psychiatric services (4 hospitals);
- data for more than 12 months included in a cost report (4 hospitals); and
- SNF services (1 hospital).

The incentive payment calculations for 13 hospitals did not include labor and delivery services (11 hospitals), neonatal intensive care unit services (1 hospital), or intensive care services (1 hospital), which should have been included.

The State agency made incorrect hospital incentive payments for the following reasons:

- The State agency instructed hospitals not to include inpatient nonacute-care services in their incentive payment calculations. However, the State agency did not ensure that hospitals removed these services from their calculations.
- The State agency followed CMS's guidance on the cost report data elements suggested for use when calculating a hospital incentive payment but did not follow more specific Federal regulations. CMS's guidance¹⁴ tells providers where to find certain data elements on the cost report but did not include which items Federal regulations say should be removed from these data elements. For example, two hospitals informed the State agency that, against Federal regulations, bad debt was included in their allowable uncompensated care charges, but the State agency instructed the hospitals to use the incorrect amount because it was following the cost report guidance set by CMS.
- The State agency did not review supporting documentation for the numbers provided in the cost reports for the incentive payment calculations. Such a review would have shown that the supporting documentation incorrectly included inpatient nonacute-care services, clerical errors, unsupported costs, unpaid Medicaid days, and data from more than 12 months.
- The State agency did not use the correct cost report period for hospitals with a hospital fiscal year ending in December. For example, for hospitals receiving their first payment in 2011, the State agency used cost reports ending December 2010, during the hospital's

¹⁴ CMS Frequently Asked Questions. Available online at <https://questions.cms.gov/> FAQ 3471. Accessed on May 5, 2015.

first payment year, to calculate the incentive payments.¹⁵ The State agency should have used December 2009 cost reports, which ended in the Federal fiscal year before the hospital's first payment year.

As a result, the State agency made incorrect incentive payments totaling \$15,344,300. Specifically, the State agency overpaid 26 hospitals a total of \$13,904,716 and underpaid 12 hospitals a total of \$1,439,584, for a net overpayment of \$12,465,132. Because the hospital calculation is computed once and then paid out over 3 years, payments after December 31, 2014, will also be incorrect. The adjustments to these payments total \$163,201.¹⁶

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government \$12,465,132 in net overpayments made to the 38 hospitals and adjust the 38 hospitals' remaining incentive payments to account for the incorrect calculations (which will result in future cost savings of \$163,201);
- review the calculations for the hospitals not included in the 45 we reviewed to determine whether payment adjustments are needed, and refund any overpayments identified;
- review supporting documentation for the numbers provided in the cost reports and ensure that the correct cost report periods are used; and
- provide guidance to the hospitals that states that (1) inpatient nonacute-care services and unpaid Medicaid services should be excluded from bed-days and discharge lines of the incentive payment calculation, (2) neonatal intensive care unit bed-days and discharges should be included, and (3) bad debts, courtesy discounts, and any other unallowable charges should be excluded from charity care charges.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency did not agree or disagree with our recommendations. However, it provided information on corrective actions taken and actions to be implemented. State agency officials stated that they will initiate recoupments and refund the \$12,465,132 in net overpayments to the Federal Government and will use an independent audit firm to conduct indepth reviews as part of the postpayment audit process. The State agency explained that the postpayment audits, in concert with specific actions outlined in its comments, will address the issues identified in the audit. The State agency's comments are included in their entirety as Appendix C.

¹⁵ Hospitals are paid based on the 12-month Federal fiscal year beginning October 1 of the prior calendar year and ending September 30 of the relevant year.

¹⁶ The adjusted amount is the total net overpayment for 13 of 38 hospitals that did not receive their second- and/or third-year payments.

Although we did not verify that the State agency took these actions, it is our opinion that the actions described could address our findings and recommendations.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Arkansas Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals</i>	<u>A-06-14-00010</u>	6-22-2015
<i>The District of Columbia Made Correct Medicaid Electronic Health Record Incentive Payments to Hospitals</i>	<u>A-03-14-00401</u>	1-15-2015
<i>Massachusetts Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals</i>	<u>A-01-13-00008</u>	11-17-2014
<i>Louisiana Made Incorrect Medicaid Electronic Health Record Incentive Payments</i>	<u>A-06-12-00041</u>	8-26-2014
<i>Florida Made Medicaid Electronic Health Record Payments to Hospitals in Accordance With Federal and State Requirements</i>	<u>A-04-13-06164</u>	8-8-2014
<i>Early Review of States' Planned Medicaid Electronic Health Record Incentive Program Oversight</i>	<u>OEI-05-10-00080</u>	7-15-2011

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

During CYs 2011 and 2012, the State agency paid \$336,608,215 to eligible hospitals for Medicaid EHR incentive payments. We (1) reconciled hospital incentive payments reported on the State's CMS-64 report with the NLR and (2) selected for further review all of the 45 hospitals that received an incentive payment totaling \$1.5 million or more. The State agency paid the 45 hospitals \$168,893,113, which is 50 percent of the total paid during CYs 2011 and 2012. In addition, the State agency made additional payments to 44 of the 45 hospitals, totaling \$64,984,985 as of December 31, 2014.

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 Austin, Texas.

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 45 hospitals that were paid an incentive payment of \$1.5 million or more during CYs 2011 and 2012 and (2) all payments made to the 45 hospitals from January 1, 2013, through December 31, 2014;
- reviewed the State agency's supporting documentation related to the 45 selected hospitals;
- reviewed and reconciled the appropriate lines from the CMS-64 report to supporting documentation and the NLR;
- 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



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

KYLE L. JANEK, M.D.
EXECUTIVE COMMISSIONER

June 29, 2015

Ms. Patricia Wheeler
Regional Inspector General for Audit Services
Office of Inspector General, Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

Reference Report Number A-06-13-00047

Dear Ms. Wheeler:

The Texas Health and Human Services Commission (HHSC) received a draft audit report entitled "Texas Made Incorrect Medicaid Electronic Health Record Incentive Payments" from the Department of Health and Human Services Office of Inspector General. The cover letter, dated May 19, 2015, requested that HHSC provide written comments, including the status of actions taken or planned in response to report recommendations.

I appreciate the opportunity to respond. Please find the attached HHSC management response which includes comments related to the content of the findings and recommendations, and detailed actions HHSC has completed or planned.

If you have any questions or require additional information, please contact Robert Anderson, Manager, External Audit Coordination, HHS Risk and Compliance Management. Mr. Anderson may be reached at (512) 487-3311 or by e-mail at Robert.Anderson@hhsc.state.tx.us.

Sincerely,

A handwritten signature in blue ink that reads "Kyle L. Janek".

Kyle L. Janek, M.D.

P. O. Box 13247 • Austin, Texas 78711 • 4900 North Lamar, Austin, Texas 78751 • (512) 424-6500

Texas Health and Human Services Commission
Management Response to the
U.S. Department of Health and Human Services Office of Inspector General Report:

Texas Made Incorrect Medicaid Electronic Health Record Incentive Payments

Summary of Management Response

As authorized by the American Recovery and Reinvestment Act of 2009, the Texas Health and Human Services Commission (HHSC), upon approval from the Centers for Medicare and Medicaid Services (CMS), implemented a Medicaid Electronic Health Records (EHR) Incentive Program (Program). Prior to implementing the Program, CMS reviewed and approved HHSC's design and proposed technology solution for accepting incentive payment attestations, and reviewing and calculating the hospital incentive payment amounts. Eligible hospitals began receiving EHR incentive payments in May 2011, in accordance with the CMS approved methodology. To validate the Program's alignment with these approvals, CMS conducted an on-site review of the Program in August 2013 and reviewed, among other things, the pre and post-payment verification processes, and CMS reported that the "state's Medicaid EHR Incentive Program meets Federal requirements".

While the methodologies approved by CMS may not have included the level of detail expected by the Office of Inspector General (OIG), hospital EHR incentive payments were made in accordance with approvals and guidance in place at the time the payments were made. The post-payment audit process, including use of an independent certified public accounting (CPA) audit firm to conduct the audits, is the most appropriate and effective method to verify reported cost report and other information supporting EHR incentive payments. Post-payment audits, in concert with specific actions outlined in the detailed section below, will address the issues identified in the audit.

Detailed responses to each of the recommendations included in the report follow.

DHHS - OIG Recommendation: *We recommend that the State agency refund to the Federal Government \$12,465,132 in net overpayments made to the 38 hospitals and adjust the 38 hospitals' remaining incentive payments to account for the incorrect calculations (which will result in future cost savings of \$163,201).*

HHSC Management Response:

HHSC has completed an incentive payment adjustment and refund for 1 of the 38 hospitals reviewed in the audit. With the finalization of the OIG Draft Report, HHSC will proceed with notifying the remaining affected hospitals and initiate recoupments or payment adjustments based on the revised incentive payment calculations.

Actions Planned: HHSC will notify the remaining affected hospitals, revise the incentive payment calculation, and initiate recoupments and refund \$12,465,132 in net overpayments to the federal government, and

adjust future payments based on revisions to the incentive payment calculations.

Estimated Completion Date: October 2015

Title of Responsible Person: Director of Medicaid Health Information Technology

DHHS - OIG Recommendation: *We recommend that the State agency review the calculations for the hospitals not included in the 45 we reviewed to determine whether payment adjustments are needed and refund any overpayments identified.*

DHHS - OIG Recommendation: *We recommend that the State agency review supporting documentation for the numbers provided in the cost reports and ensure that the correct cost report periods are used.*

HHSC Management Response:

CMS allows flexibility and approves how states conduct pre-payment reviews and post-payment audits, and does not require a formal audit during the pre-payment process. HHSC reviews, but does not 'audit', the cost report and other information supporting hospital incentive payments when providers attest. Providers may submit additional documentation during the attestation payment process, and HHSC does request and review additional information when discrepancies in the attested cost report and other information supporting the incentive payment are identified. However, HHSC limits its review of the information supporting the attestation and opts, again with CMS approval, to conduct an in-depth review as part of the post-payment audit process, where hospitals and other Program providers are selected for audit based on a number of risk-based factors. HHSC utilizes an independent CPA audit firm, experienced in audits of Medicaid providers, to conduct the audits. Post-payment audits of hospitals began in earnest in 2013 and are expected to continue through 2018, the final year for EHR incentive payments for hospitals. The post-payment audit process, approved by CMS, is the most appropriate and efficient way to verify reported cost report information that support the hospital incentive payments.

Prior to the issuance of the OIG draft report, 101 of the 331 participating hospitals received and are responding to a cost report questionnaire to verify that the correct information was used in the incentive payment calculation. An additional 25 hospitals are being reviewed as part of HHSC's post-payment audit strategy by an independent CPA audit firm. In March 2013, HHSC implemented an automated decision tool, used during the pre-payment review process that systematically determines the proper cost report period based on various factors. In May 2014, HHSC conducted a review of every hospital that received an incentive payment and confirmed that the improper cost report periods used in incentive payment calculations were limited to periods prior to introduction of the automated decision tool. HHSC considers the use of the improper cost report period fully resolved.

Actions Planned:

HHSC will continue to conduct risk-based audits of hospital incentive payments and will work with CMS, through the audit resolution process, to determine what additional steps, and funding may be necessary, to further validate the reported cost report information underlying the incentive payments for hospitals not subject to the OIG audit.

Estimated Completion Date:

60 days following issuance of final report	Define additional post-payment audit/validation processes
Dependent on scope of additional processes	Implement additional post-payment audit/validation processes

Title of Responsible Person: Director of Medicaid Health Information Technology

DHHS - OIG Recommendation: *We recommend that the State agency provide guidance to the hospitals stating that (1) inpatient nonacute-care services and unpaid Medicaid services should be excluded from bed-days and discharge lines of the incentive payment calculation, (2) neonatal intensive care unit bed-days and discharges should be included, and (3) bad debts, courtesy discounts, and any other unallowable charges should be excluded from charity care charges.*

HHSC Management Response:

The process and procedures for participating hospitals seeking EHR incentive payments has always included the recommended guidance noted in the audit. HHSC's attestation system includes instructional text related to appropriate inclusions and exclusions in the hospital payment calculation.

Prior to the issuance of the OIG draft report, HHSC took the following steps to raise provider awareness of the appropriate inclusions and exclusions in the incentive payment calculation.

- In November 2014, a "cost report questionnaire" requirement was implemented. The questionnaire is completed by every hospital during attestation and includes a signed acknowledgement.
- In December 2014, the hospital calculation worksheet tool was revised (available to hospitals as a resource) to help estimate potential incentive payments. Detailed instructions were incorporated into the worksheet tool to reiterate the allowable inclusions and exclusions in the incentive payment calculation.

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- In January 2015, updates to the attestation system were implemented that strengthen and reinforce hospital awareness of the appropriate inclusions and exclusions in the incentive payment calculation.

Estimated Completion Date: Completed

Title of Responsible Person: Director of Medicaid Health Information Technology