

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**OKLAHOMA MADE INCORRECT
MEDICAID ELECTRONIC HEALTH
RECORD INCENTIVE PAYMENTS TO
HOSPITALS**

*Inquiries about this report may be addressed to the Office of Public Affairs at
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**Brian P. Ritchie
Assistant Inspector General
for Audit Services**

**August 2016
A-06-15-00032**

Office of Inspector General

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EXECUTIVE SUMMARY

Oklahoma made incorrect Medicaid electronic health record incentive payments to hospitals, resulting in a net overpayment of \$680,368.

WHY WE DID THIS REVIEW

To improve the quality and value of American health care, the Federal Government promotes the use of certified electronic health record (EHR) technology by health care professionals and hospitals (collectively, “providers”). As an incentive for using EHRs, the Federal Government is making payments to providers that attest to the “meaningful use” of EHRs. The Congressional Budget Office estimated 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 Oklahoma Health Care Authority (State agency) was one of the first State agencies to pay incentive payments, making approximately \$110 million in Medicaid EHR incentive program payments for program years 2011 and 2012. Of this amount, the State agency paid approximately \$37.8 million to health care professionals and \$72 million to hospitals. This review is one in a series of reviews focusing on the Medicaid EHR incentive program for hospitals.

The objective of this review was to determine whether the State agency made Medicaid EHR incentive program payments to eligible hospitals in accordance with Federal 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 hospitals attest that they meet program requirements by self-reporting data using the CMS National Level Repository (NLR). The NLR is a provider registration and verification system that contains information on providers participating in the

Medicaid and Medicare EHR incentive programs. To be eligible for the Medicaid EHR incentive program, hospitals must meet Medicaid patient-volume requirements. In general, patient volume is calculated by dividing a hospital's total Medicaid patient encounters by total patient encounters. During the audit period, the State agency defined patient encounters as inpatient bed-days for all discharges.

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

For program years 2011 and 2012, the State agency paid \$72,015,953 to eligible hospitals for Medicaid EHR incentive payments. We reconciled hospital incentive payments reported on the State's Form CMS-64, Quarterly Medicaid Assistance Expenditures for the Medical Assistance Program with the NLR and selected for further review 25 hospitals that received incentive payments totaling \$44,791,246 (62 percent of all hospital incentive payments).

WHAT WE FOUND

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 11 hospitals totaling \$1,483,888. Specifically, the State agency overpaid seven hospitals a total of \$1,082,128 and underpaid four hospitals a total of \$401,760, for a net overpayment of \$680,368. Because the incentive payment is computed once and then paid out over 3 years, payments made to 3 of the 11 hospitals after December 31, 2015, will also be incorrect. The adjustments to these payments total \$13,932.

Although the State agency reviewed hospitals' supporting documentation and found and corrected numerous errors, it did not review all numbers provided in the calculations. Such a review would have shown that the supporting documentation incorrectly included inpatient nonacute-care services, unsupported hospital data, and data from more than 12 months, and incorrectly excluded neonatal intensive care unit services.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund to the Federal Government \$680,368 in net overpayments made to the 11 hospitals and adjust the 3 hospitals' remaining incentive payments to account for the incorrect calculations (resulting in future cost savings of \$13,932),
- review all numbers provided in calculations for the hospitals not included in the 25 we reviewed to determine whether payment adjustments are needed and refund any overpayments identified, and

- educate hospitals to ensure that they follow Federal and State requirements for calculating their incentive payments.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our first recommendation but did not specifically state that it did or did not concur with our second and third recommendations. Regarding our second recommendation, the State agency responded that it had recently contracted with a vendor to provide audit services specifically for the EHR program and that it will work with the vendor to determine the method of review for the hospitals not included in our audit. Regarding our third recommendation, the State agency responded that it will continue to provide hospitals with education materials to ensure that they follow Federal and State requirements and that it will educate hospitals on the common errors discovered in our audit.

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INTRODUCTION

WHY WE DID THIS REVIEW

To improve the quality and value of American health care, the Federal Government promotes the use of certified electronic health record (EHR) technology by health care professionals and hospitals (collectively, “providers”). As an incentive for using EHRs, the Federal Government is making payments to providers that attest to the “meaningful use” of EHRs.¹ The Congressional Budget Office estimated 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 Oklahoma Health Care Authority (State agency) was one of the first State agencies to pay incentive payments, making approximately \$110 million in Medicaid EHR incentive program payments for program years 2011 and 2012. Of this amount, the State agency paid approximately \$37.8 million to health care professionals and \$72 million to hospitals. This review is one in a series of reviews focusing on the Medicaid EHR incentive program for hospitals. Appendix A lists previous reviews of the Medicaid EHR incentive program.

OBJECTIVE

Our objective was to determine whether the State agency made Medicaid EHR incentive program payments to eligible hospitals in accordance with Federal 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 *Electronic Health Records: First Year of CMS’s Incentive Programs Shows Opportunities to Improve Processes to Verify Providers Met Requirements* (GAO-12-481), published April 2012.

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 Oklahoma, 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 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(e)). 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;⁷ and
- 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.

Generally stated, the overall EHR amount is an estimated dollar amount based on a total number

⁵During the audit period, the State agency defined patient encounters as inpatient bed-days for all discharges.

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

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.

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 examples of the overall EHR amount calculation for three types of hospitals, with differing numbers of discharges during the payment year.

Table: Examples of the 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.

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

For program years 2011 and 2012, the State agency paid \$72,015,953 to eligible hospitals for Medicaid EHR incentive payments. We reconciled hospital incentive payments reported on the State's CMS-64 report with the NLR and selected for further review 25 hospitals that received incentive payments totaling \$44,791,246 (62 percent of all hospital incentive payments).

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 11 hospitals totaling \$1,483,888. Specifically, the State agency overpaid seven hospitals a total of \$1,082,128 and underpaid four hospitals a total of \$401,760, for a net overpayment of \$680,368.¹² Because the incentive payment is computed once and then paid out over 3 years, payments made to 3 of the 11 hospitals after December 31, 2015, will also be incorrect. The adjustments to these payments total \$13,932.

Although the State agency reviewed hospitals' supporting documentation and found and corrected numerous errors, it did not review all numbers provided in the calculations. Such a

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.

review would have shown that the supporting documentation incorrectly included inpatient nonacute-care services, unsupported hospital data, and data from more than 12 months, and incorrectly excluded neonatal intensive care unit services.

FEDERAL AND STATE REQUIREMENTS

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

Furthermore, CMS guidance states that nursery, rehabilitation, psychiatric, and skilled nursing facility 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)).

THE STATE AGENCY MADE INCORRECT HOSPITAL INCENTIVE PAYMENTS

Of the 25 hospital incentive payment calculations reviewed, 11, or 44 percent, did not comply with regulations, guidance, or both. Some calculations had multiple deficiencies. Specifically, the calculations included:

- nonacute-care services (6 hospitals),
- unsupported hospital data (5 hospitals), and
- data for more than 12 months (2 hospitals).

The incentive payment calculation for one hospital did not include neonatal intensive care unit services, which should have been included.

¹³ CMS Frequently Asked Questions. FAQs 2991, 3213, 3261, and 3315. Available online at <https://questions.cms.gov/>. Accessed on June 16, 2016.

Although the State agency reviewed hospitals' supporting documentation and found and corrected numerous errors, it did not review all numbers provided in the calculations. Such a review would have shown that the supporting documentation incorrectly included inpatient nonacute-care services, unsupported hospital data, and data from more than 12 months, and incorrectly excluded neonatal intensive care unit services.

As a result, the State agency made incorrect EHR incentive payments to 11 hospitals totaling \$1,483,888. Specifically, the State agency overpaid seven hospitals a total of \$1,082,128 and underpaid four hospitals a total of \$401,760, for a net overpayment of \$680,368. Because the incentive payment is computed once and then paid out over 3 years, payments made to 3 of the 11 hospitals after December 31, 2015, will also be incorrect. The adjustments to these payments total \$13,932.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government \$680,368 in net overpayments made to the 11 hospitals and adjust the 3 hospitals' remaining incentive payments to account for the incorrect calculations (resulting in future cost savings of \$13,932),
- review all numbers provided in calculations for the hospitals not included in the 25 we reviewed to determine whether payment adjustments are needed and refund any overpayments identified, and
- educate hospitals to ensure that they follow Federal and State requirements for calculating their incentive payments.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our first recommendation but did not specifically state that it did or did not concur with our second and third recommendations. Regarding our second recommendation, the State agency responded that it had recently contracted with a vendor to provide audit services specifically for the EHR program and that it will work with the vendor to determine the method of review for the hospitals not included in our audit. Regarding our third recommendation, the State agency responded that it will continue to provide hospitals with education materials to ensure that they follow Federal and State requirements and that it will educate hospitals on the common errors discovered in our audit. The State agency's comments are included in their entirety as Appendix C.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Arizona Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals</i>	<u>A-09-15-02036</u>	8-4-2016
<i>Delaware Medicaid Electronic Health Record Payments</i>	<u>A-03-14-00402</u>	9-30-2015
<i>Oklahoma Made Incorrect Medicaid Electronic Health Record Incentive Payments to Health Care Professionals</i>	<u>A-06-14-00030</u>	9-3-2015
<i>Texas Made Incorrect Medicaid Electronic Health Record Incentive Payments</i>	<u>A-06-13-00047</u>	8-31-2015
<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

For program years 2011 and 2012, the State agency paid \$72,015,953 to eligible hospitals for Medicaid EHR incentive payments. We reconciled hospital incentive payments reported on the State's CMS-64 report with the NLR and selected for further review 25 hospitals that received incentive payments totaling \$44,791,246 (62 percent of all hospital incentive payments).

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.

Our fieldwork included visiting the State agency's office in Oklahoma City, Oklahoma, and contacting officials at our 25 selected Oklahoma hospitals.

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;
- reviewed and reconciled the appropriate lines from the CMS-64 report to supporting documentation and the NLR;
- judgmentally selected for further review the 25 hospitals and all payments and adjustments made to the selected hospitals from January 1, 2011, through December 31, 2015;
- reviewed and verified the selected hospitals' supporting documentation;
- verified that the selected hospitals met eligibility requirements;
- determined whether the selected hospital patient-volume calculations were correct;
- determined whether the selected hospital incentive payment calculations were correct and adequately supported; and
- discussed the results of our review with State agency officials and provided them with our recalculations.

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

APPENDIX C: STATE AGENCY COMMENTS

JOEL NICO GOMEZ
CHIEF EXECUTIVE OFFICER



MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

August 8, 2016

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

Dear Ms. Wheeler:

RE: Report Number: A-06-15-00032

The Oklahoma Health Care Authority (OHCA) has reviewed the July 2016 Draft Report from the U.S. Department of Health and Human Services, Office of Inspector General (OIG), entitled *Oklahoma Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals*. The following comments are provided in response to the three (3) recommendations in the draft report.

Recommendation 1:

- Refund to the Federal Government \$680,368 in net overpayments made to the 11 hospitals and adjust the 3 hospitals' remaining incentive payments to account for the incorrect calculations (resulting in future cost savings of \$13,932).

OHCA's Comment:

- OHCA concurs with OIG's finding and will refund to the Federal Government \$680,368 in net overpayments made to the 11 hospitals. Also, OHCA will adjust future incentive payments for the 3 hospitals to account for the incorrect calculations.

Recommendation 2:

- Review all numbers provided in calculations for the hospitals not included in the 25 reviewed to determine whether payment adjustments are needed and refund any overpayments identified.

OHCA's Comment:

- OHCA has recently contracted with a vendor to provide audit services specifically for the EHR program. This vendor will provide the expertise and staff to assist OHCA with compliance of both Federal and State EHR program requirements. OHCA will work with newly contracted EHR program auditor to determine the method of review for remaining hospitals not included in the audit.

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Recommendation 3:

- Educate hospitals to ensure that they follow Federal and State requirements for calculating their incentive payments.

OHCA's Response:

- OHCA will continue to provide hospitals with education materials to ensure that they follow federal and state requirements. This includes materials located on the OHCA website as well as outreach from our EHR team. OHCA will also use recommendations from the OIG audit to educate hospitals on the common errors discovered in the audit.

Sincerely,



Rebecca Pasternik-Ikard
State Medicaid Director