Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

THE DISTRICT OF COLUMBIA MADE CORRECT MEDICAID ELECTRONIC HEALTH RECORD INCENTIVE PAYMENTS TO HOSPITALS

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INTRODUCTION

The District of Columbia made Medicaid electronic health record payments to Hospitals in accordance with Federal and State requirements.

WHY WE DID THIS REVIEW

To improve the quality and value of American health care, the Federal Government promotes the use of certified electronic health record (EHR) technology by health care professionals 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 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 Center 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 District of Columbia Agency for Health Care Administration (State agency) made approximately $12.8 million in Medicaid EHR incentive program payments during calendar year 2013. Of this amount, the State agency paid a total of $21,250 to one health care professional. Therefore, this review focuses on the Medicaid EHR incentive program for hospitals.

OBJECTIVE

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

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[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 Show 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 section 4201 of the HITECH Act, State Medicaid programs have the option of receiving from the Federal Government Federal financial participation for expenditures for incentive payments to certain Medicare and Medicaid providers to adopt, implement, upgrade, and meaningfully use certified EHR technology. 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 the District of Columbia, 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, hospitals must meet Medicaid patient volume requirements (42 CFR § 495.304(c)). In general,

[4] Eligible hospitals may be acute-care hospitals or children's hospitals (42 CFR §§ 495.304(a)(2) and (3); acute-care hospitals include critical access hospitals or cancer hospitals (75 Fed. Reg. 44314, 44484 (July 28, 2010)).

patient volume is calculated by dividing the hospital's total Medicaid patient encounters by the provider's total patient encounters.[5]

The program eligibility requirements for hospitals are as follows:

- The hospital is a permissible provider type that is licensed to practice in the State.
- The hospital participates in the State Medicaid program.
- The hospital is not excluded, sanctioned, or otherwise deemed ineligible to receive payments from the State/Federal Government.
- The hospital has an average length of stay of 25 days or less.[6]
- The hospital has adopted, implemented, upgraded or meaningfully used certified EHR technology.[7]
- The hospital meets 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 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

[5] Generally stated, 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] 42 CFR §§ 495.314(a)(1)(i) or (ii).

[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)(l) 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 to distribute incentive payments over a 3-year period with the first payment being 50 percent of the total; the second payment, 40 percent; and the remaining payment, 10 percent.

[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)).

multiplied by the transition factors, all 4 years are totaled to determine the overall EHR amount. The table below provides three examples of the overall EHR amount calculation.

Table: Overall EHR Amount Calculation

Type of Hospital	Hospitals With 1,149 or Fewer Discharges During the Payment Year	Hospitals With at Least 1,150 But Less Than 23,000 Discharges During the Payment Year	Hospitals With 23,000 or More Discharges During the Payment Year
Base Amount	$2 million	$2 million	$2 million
Plus Discharge-Related Amount (adjusted in years 2 through 4 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 approximately 6.4 million, depending on the number of discharges	Limited by law to Approximately $6.4 million
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 acute inpatient-bed-days,[11] 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 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, hospitals must attest to the "meaningful use" of EHRs and meet that year's program requirements. A hospital

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

may not qualify for the future years' payments or could elect to end its participation in the EHR incentive program. In addition, the amount may change because of adjustments to supporting numbers used in the calculations.

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

HOW WE CONDUCTED THIS REVIEW

From January 1 through December 31, 2013, the State agency paid $12,734,155 to five hospitals. We (1) reconciled both hospital and health care professional incentive payments reported on the State's CMS-64 report with the NLR and (2) reviewed the payments that the State Agency made to the five hospitals.

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

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

RESULTS OF AUDIT

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

APPENDIX: AUDIT SCOPE AND METHODOLOGY

SCOPE

From January 1 through December 31, 2013,[12] the State agency paid $12,734,155 to five hospitals. We (1) reconciled hospital and health care professional incentive payments reported on the State's CMS-64 report with the NLR and (2) reviewed the payments that the State Agency made to the five hospitals.

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 and at five hospitals in the District of Columbia.

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;
- reconciled the incentive payments reported on the CMS-64 report to the NLR;
- determined that the State agency made incentive payments to five hospitals during calendar year 2013;
- reviewed the State agency's supporting documentation related to the five hospitals;
- reviewed the hospitals' documentation and verified the information submitted to the State agency;
- verified that hospitals met eligibility requirements;
- determined whether hospital incentive-payment calculations were correct; and
- discussed the results of our review with 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

[12] The District of Columbia did not participate in the Medicaid EHR program until 2013.

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.