JUL 15 2011

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Administrator
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FROM: /S/
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SUBJECT: Memorandum Report: *Early Review of States' Planned Medicaid Electronic Health Record Incentive Program Oversight*, OEI-05-10-00080

This memorandum report describes States' plans to verify that health care practitioners and hospitals meet program eligibility requirements for State Medicaid Electronic Health Record (EHR) incentive programs for 2011 and what limitations, if any, they anticipate in their oversight.

SUMMARY

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act (ARRA), established Medicare and Medicaid EHR incentive programs to promote adoption of EHRs. An EHR system is a computerized recordkeeping system that contains patients' health-related information, including medical history.

State Medicaid agencies (hereinafter referred to as States) administer their own Medicaid EHR incentive programs and are responsible for overseeing their integrity. The Centers for Medicare & Medicaid Services (CMS) identified Medicaid EHR incentive program eligibility as an oversight priority for States' Medicaid EHR incentive programs in 2011.

We found that all 13 States in our study reported that they plan to verify at least half of eligibility requirements prior to making EHR incentive payments. To verify eligibility requirements, States plan to compare self-reported eligibility information to other data sources. Verifying self-reported eligibility information prior to making payments helps States ensure the integrity of

their EHR incentive payments. In addition, all States plan to audit eligibility requirements after payment.

We also found that data availability limits both the number of eligibility requirements that States plan to verify prior to payment and the completeness of those verifications. Depending on the eligibility requirement, States may have none, some, or all of the data they need to conduct a complete verification. Most States do not plan to start collecting all of the necessary data because the effort would be resource intensive and not logistically practical for most States. States cannot conduct complete verifications for eligibility requirements without the necessary data.

BACKGROUND

The HITECH Act, enacted as part of ARRA, established EHR incentive programs for both Medicare and Medicaid to promote adoption of EHRs.[1] Between 2011 and 2019, the Federal Government will spend an estimated $20.6 billion on the Medicare and Medicaid EHR incentive programs—$7.2 billion for the Medicare EHR incentive program and $13.4 billion for the Medicaid EHR incentive program.[2]

An EHR system is a computerized recordkeeping system that contains patients' health-related information, including medical history. Among other functions, EHR systems have the capacity to provide clinical decision support, which helps practitioners make evidence-based treatment decisions.[3]

Medicaid EHR Incentive Programs

States oversee their own Medicaid EHR incentive programs (hereinafter referred to as EHR incentive programs) and make incentive payments directly to health care practitioners and hospitals.[4, 5] As of June 30, 2011, 13 States had paid over $166 million in incentive payments.[6] CMS provides enhanced Federal financial participation (FFP) to States for their EHR incentive programs. CMS provides 100 percent FFP to States for the cost of incentive payments made to health care practitioners and hospitals and 90 percent FFP for administrative expenses and planning activities related to the EHR incentive program.[7] For example, a State would receive

[1] ARRA §§ 4101 and 4201, amending Titles XVIII and XIX of the Social Security Act.
[2] CMS Justification of Estimates for Appropriations Committees, Fiscal Year 2012. Accessed at www.cms.gov on July 5, 2011.
[3] Clinical decision support is contained in an interactive computer program or application that helps health care practitioners make treatment decisions for better patient care. Clinical decision support could provide a range of assistance, such as patient management best practices and clinical research findings.
[4] States are not required to create Medicaid EHR incentive programs.
[5] Health care practitioners and hospitals refer to Eligibile Practitioners (EP) and Eligible Hospitals (EH), respectively. EP and EH are defined in 42 CFR § 495.304.
[6] CMS Spotlight and Upcoming Events page. Accessed at www.cms.gov on July 11, 2011.
[7] Social Security Act § 1903(a)(3)(F)(i) and (ii).

90 percent FFP to create a Web-based registration system for health care practitioners and hospitals to use to register for incentive payments.[8]

States are responsible for overseeing their EHR incentive programs and ensuring the integrity of incentive payments.[9] Specifically, States must have an oversight plan to combat fraud, waste, and abuse, which includes checking that health care practitioners and hospitals are eligible for incentive payments.[10]

States must submit their oversight plans to CMS, which reviews and approves them before States receive FFP for their EHR incentive programs.[11] According to CMS, States are encouraged to revise their plans as they make changes to their EHR incentive programs.

CMS has identified EHR incentive program eligibility requirements as an oversight priority for States' EHR incentive programs in 2011.[12] States must have a plan for how they will ensure that health care practitioners and hospitals meet EHR incentive program eligibility requirements. States' oversight plans may include verifying eligibility requirements prior to payment or auditing eligibility requirements after payment.

EHR Incentive Program Eligibility Requirements

To receive EHR incentive payments, health care practitioners and hospitals must meet certain eligibility requirements, as defined in HITECH and CMS regulation.

Only certain types of health care practitioners and hospitals may receive incentive payments from States.[13] Types of health care practitioners (hereinafter referred to as practitioners) that are eligible include physicians, dentists, certified nurse midwives, nurse practitioners, and physician assistants (PA) practicing in federally qualified health centers (FQHC) or rural health centers (RHC) that are led by PAs. Practitioners must not be hospital-based (i.e., must not have 90 percent or more of their Medicaid patient volume in a hospital inpatient or emergency department setting).[14] Types of hospitals that are eligible include acute care hospitals with an average length of stay of 25 days or less and children's hospitals.[15] Practitioners and hospitals must be licensed and not otherwise sanctioned from receiving Medicaid reimbursement.[16]

All practitioners and hospitals must also meet defined patient volume percentage requirements. Practitioners must have at least 30 percent Medicaid patient volume (20 percent for

[8] CMS State Medicaid Director Letter, August 17, 2010 (SMD# 10-016), Enclosure A. Accessed at www.cms.gov on July 11, 2011.
[9] Social Security Act § 1903(t)(9)(B).
[10] 42 CFR § 495.332(b), (c), (d), and (e).
[11] 42 CFR §§ 495.316(b) and 495.332.
[12] CMS State Medicaid Director Letter, August 17, 2010 (SMD# 10-016). Accessed at www.cms.gov on July 11, 2011.
[13] Social Security Act §§ 1903(t)(2) and (t)(3)(B); 42 CFR § 495.304.
[14] Social Security Act § 1903(t)(2)(A); 42 CFR § 495.304(c); 42 CFR § 495.4.
[15] Social Security Act § 1903(t); 42 CFR § 495.302.
[16] 42 CFR § 495.368(a)(1)(i); CMS State Medicaid Director Letter, August 17, 2010 (SMD# 10-016), Enclosure B. Accessed at www.cms.gov on July 11, 2011.

pediatricians).[17] If, however, a practitioner is practicing predominantly in an FQHC or RHC, then the practitioner can be eligible by having at least 30 percent needy individual patient volume.[18] Acute care hospitals must have at least 10 percent Medicaid patient volume. There are no patient volume requirements for children's hospitals.[19]

Patient volume percentages are calculated by dividing a specified patient volume by total patient volume. For example, to calculate a Medicaid patient volume percentage, a State must divide Medicaid patient volume by total patient volume. Likewise, to calculate the needy patient volume percentage, a State must divide needy patient volume by total patient volume.[20]

Practitioners and hospitals must also adopt, implement, or upgrade certified EHRs to receive incentive payments.[21] The terms adopt, implement, and upgrade are defined by CMS in regulation as follows:[22]

- Adopt: Acquire, purchase, or secure access to certified EHR technology.
- Implement: Install or commence utilization of certified EHR technology.
- Upgrade: Expand the functionality of certified EHR technology, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology.

EHR technology is certified according to processes defined by the Office of the National Coordinator for Health Information Technology.[23] Certification criteria require EHRs to accommodate certain functions, including physician order entry and electronic prescribing.[24]

Finally, to receive an incentive payment, practitioners and hospitals must register for the incentive program in their States and attest that they meet eligibility requirements.[25] To do this, practitioners and hospitals self-report eligibility information (e.g., patient volume, practitioner specialty) to the State to show that they meet each of the eligibility requirements described above.[26]

[17] Social Security Act § 1903(t)(2); 42 CFR § 495.304(c).
[18] Social Security Act § 1903(t)(2) and 42 CFR § 495.304(c). A needy individual is defined as someone who receives either Medicaid or Children's Health Insurance Program (CHIP) medical assistance, receives uncompensated care, or receives care at no cost or on a sliding scale determined by ability to pay. 42 CFR § 495.302. Practicing predominantly in an FQHC or RHC means that a practitioner treats over 50 percent of his or her total patient volume over a period of 6 months in an FQHC or RHC. 42 CFR § 495.302.
[19] Social Security Act § 1903(t)(2)(B); 42 CFR § 495.306(f).
[20] 42 CFR § 495.306.
[21] Social Security Act § 1903(t)(6)(C)(i); 42 CFR § 495.314.
[22] 42 CFR § 495.302.
[23] Social Security Act § 1903(t)(3). In a July 2010 final rule (75 Fed. Reg. 44590), the Office of the National Coordinator for Health Information Technology specified the technical criteria that EHRs must meet to be certified.
[24] 45 CFR §§ 170.302 and 170.304.
[25] 42 CFR § 495.8. Practitioners who register for the Medicare EHR Incentive program and receive a Medicare incentive payment are prohibited from receiving a Medicaid EHR incentive payment. Eligible hospitals may receive both Medicare and Medicaid incentive payments. See Social Security Act § 1903(t)(7).
[26] 42 CFR § 495.312.

Related Office of Inspector General Work

This study on State oversight of Medicaid EHR incentive programs is the first in a series of studies by the Office of Inspector General (OIG) on CMS's EHR incentive programs. In a subsequent review, we will examine the Medicare EHR incentive program.

Previously, OIG published a report reviewing States' initiatives on health information technology and health information exchange. OIG identified 25 States involved in planning and developing statewide health information exchange networks. The report also found that nine States had implemented systems that allowed practitioners and hospitals to look at Medicaid beneficiaries' claims history.[27]

METHODOLOGY

Scope

We reviewed 13 of the 14 States that had approved Medicaid EHR incentive program plans, officially known as State Medicaid Health IT Plans, as of January 14, 2011. We reviewed these States' 2011 prepayment and postpayment oversight plans for their EHR incentive programs. Specifically, we focused on States' oversight plans to ensure that practitioners and hospitals met EHR incentive program eligibility requirements. We did not review any eligibility requirements or aspects of payment that CMS elected to verify on behalf of States, such as verifying that hospitals are an eligible hospital type or preventing duplicate Medicare incentive payments to practitioners.

Data Collection and Analysis

We collected States' oversight plans and held structured interviews with CMS and State staff. We requested from CMS the current version of States' oversight plans for the 14 States with CMS approval as of January 14, 2011.

We conducted structured phone interviews with 13 of these 14 States between January and February 2011. One State was unavailable for an interview so we did not include it in our final analysis. In these interviews, we asked States to clarify details of their oversight plans and provide any recent updates to those plans. We also asked about any anticipated limitations or challenges to their planned oversight.

Finally, we interviewed CMS staff to better understand their review and approval of States' oversight plans.

To describe States' planned oversight, we conducted document reviews of 13 States' approved oversight plans and analyzed State and CMS structured interview data. We analyzed States' oversight plans and interview data to see whether States were verifying self-reported eligibility

[27] OIG, *State Medicaid Agencies' Initiatives on Health Information Technology and Health Information Exchange*, OEI-02-06-00270, August 2007.

information prior to payment. We defined a verification prior to payment as a State's comparison of self-reported eligibility information to another data source prior to making an incentive payment. We also reviewed States' plans to check eligibility requirements after payment. Table 1 shows the eligibility requirements that we included in our analysis.

Table 1: Eligibility Requirements Analyzed*

Requirement	Applies to Practitioners	Applies to Hospitals
Practitioner Type		
Practitioners must be one of the permissible practitioner types	✔	-
Qualifications		
Practitioners and hospitals must be licensed to practice in the State	✔	✔
Practitioners and hospitals must not be excluded, sanctioned, or otherwise deemed ineligible to receive payments from the State	✔	✔
Patient Volume		
Practitioners must have at least a 30% Medicaid patient volume (or 20% for pediatricians) if they are not practicing predominantly in an FQHC or RHC	✔	-
Practitioners must have at least a 30% needy individual patient volume if they are practicing predominantly in an FQHC or RHC	✔	-
Hospitals must have at least 10% Medicaid patient volume (acute care hospital only)		✔
Practice Location		
Practitioners must not be hospital-based	✔	-
If practitioner is a PA, he or she must practice in a PA-led FQHC or RHC	✔	-
Average Length of Stay		
Must have an average length of stay of 25 days or less (acute care hospital only)	-	✔
Adoption, Implementation, or Upgrade of Certified EHR Technology		
Practitioners and hospitals must adopt, implement, or upgrade an EHR	✔	✔
Practitioners and hospitals must have certified EHR technology	✔	✔

Source: OIG analysis of CMS Regulations, 2011.

*These represent the subset of eligibility requirements for which States have primary responsibility.

Limitations

This study reports on States' oversight plans, which may change as States implement them. We did not verify the accuracy of States' reports regarding the availability of data.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

RESULTS

All 13 States Reported That They Plan To Verify at Least Half of Eligibility Requirements Prior To Making EHR Incentive Payments

Thirteen States reported that they plan to verify self-reported eligibility information for at least half of eligibility requirements prior to payment. States compare self-reported eligibility information to other data sources to verify an eligibility requirement. Although CMS does not require States to verify self-reported eligibility information prior to payment, doing so helps States proactively ensure the integrity of their EHR incentive payments. Table 2 shows the number and percentage of eligibility requirements that each State plans to verify prior to payment.

Table 2: Number of Eligibility Requirements That States Plan To Verify Prior to Payment

State	Number of Eligibility Requirements That State Plans To Verify	Percentage of Total Eligibility Requirements
Kentucky	11	100%
Alaska	10	91%
Alabama	10	91%
Mississippi	9	82%
Tennessee	9	82%
North Carolina	8	73%
Michigan	8	73%
Texas	7	64%
Oklahoma	7	64%
South Carolina	7	64%
Iowa	7	64%
Pennsylvania	7	64%
Wisconsin	6	55%

Source: OIG analysis of State oversight plans and State interviews, 2011.

In addition, all 13 States reported that they plan to audit eligibility requirements after payment. States reported that they are still developing their specific plans but 11 States plan to begin audits in 2011. One State plans to begin audits in 2012 and another State had not decided when it would start its audits.

Data Availability Limits Both the Number of Eligibility Requirements That States Plan To Verify Prior to Payment and the Completeness of Those Verifications

States can only completely verify an eligibility requirement if data are available for comparison to self-reported eligibility information.

Over half of States did not report plans to verify three specific eligibility requirements prior to payment because necessary data are not currently collected. These States do not have the data they need to verify three eligibility requirements because they do not typically collect the necessary data. In the past, States did not need to collect these data for Medicaid operations. Further, the few States that plan to collect all the necessary data to verify these three eligibility requirements are doing so by contacting each practitioner or hospital, which is resource intensive and logistically impractical for most States. Table 3 shows the number of States that do not plan to verify certain eligibility requirements prior to payment.

Table 3: Eligibility Requirements That Most States Do Not Plan To Verify Prior to Payment

Eligibility Requirement	Number of States That Plan Complete Verification	Number of States That Plan Partial Verification	Examples of Data Sources Used for Complete or Partial Verification	Number of States That Plan No Verification
Practitioners must have at least a 30% needy individual patient volume if they are practicing predominantly in an FQHC or RHC	1	2	Contact FQHC or RHC, FQHC reports, documentation submitted by practitioner	10
If practitioner is a PA, he or she must practice in a PA-led FQHC or RHC	4	-	FQHC reports; contact PA, FQHC, or RHC	9
Practitioners and hospitals must adopt, implement, or upgrade an EHR	5	-	Documentation submitted by practitioner or hospital (e.g., receipts, vendor contract)	8

Source: OIG analysis of State oversight plans and State interviews, 2011.

Ten States do not plan to verify prior to payment whether practitioners who are practicing predominantly at an FQHC or RHC have at least 30 percent needy patient volume. To verify practitioners' needy patient volume percentage, States need both the practitioners' needy patient volume and total patient volume. By definition, needy patient volume and total patient volume include patient volume for which Medicaid does not reimburse. As such, some States reported that practitioners' needy patient volume and total patient volume are not reflected in States' Medicaid Management Information Systems (MMIS) and States do not otherwise regularly collect this information.[28] Without practitioners' needy patient volume or total patient volume, 10 States are unable to do any verification on this eligibility requirement prior to payment. See Figure A-1 in Appendix A to view the components of the needy patient volume percentage calculation and what data some States reported not having.

Three States plan to seek new data sources so they can verify all or part of needy patient volume percentages prior to payment. Two States plan to contact practitioners directly for supporting documentation of needy patient volume. One State plans to use patient volume information in

[28] MMIS are States' Medicaid claims processing systems.

reports that FQHCs prepare for the Health Resources and Services Administration (HRSA). However, this approach may not be viable; another State reported that HRSA stated that the data in these reports are not usable for checking needy patient volume.

Nine States do not plan to verify prior to payment whether PAs practice at PA-led FQHCs or RHCs. States do not have data that they can use to determine this. The remaining four States plan to seek out alternative data sources to verify this requirement. Examples of alternative data sources include reports that FQHCs prepare for HRSA, contacting State associations for FQHCs and RHCs, and contacting FQHCs and RHCs directly.

Finally, eight States do not plan to verify whether practitioners and hospitals actually adopted, implemented, or upgraded EHRs prior to payment. States do not have an existing data source for this. Despite this difficulty, five States plan to completely verify this eligibility requirement by having practitioners and hospitals submit documentation to demonstrate that they have adopted, implemented, or upgraded EHR technology.

Almost all States reported plans to partially verify practitioners' Medicaid patient volume percentages because only some of the necessary data are available. Eleven of thirteen States reported that they plan only partial verifications of practitioner Medicaid patient volume percentages. They plan to use Medicaid claims data in MMIS to verify self-reported Medicaid patient volume. This is a partial verification because it only verifies the Medicaid component of the Medicaid patient volume percentage calculation. Table 4 shows the number of States that plan partial verifications of this eligibility requirement.

Table 4: Eligibility Requirement That Most States Plan To Partially Verify Prior to Payment

Eligibility Requirement	Number of States That Plan Complete Verification	Number of States That Plan Partial Verification	Example of Data Source Used for Complete or Partial Verification	Number of States That Plan No Verification
Practitioners must have at least a 30% Medicaid patient volume (or 20% for pediatricians) if they are not practicing predominantly in an FQHC or RHC	1	11	Documentation submitted by practitioner	1

Source: OIG analysis of State oversight plans and State interviews, 2011.

Five of the eleven States reported that they plan to partially verify Medicaid patient volume percentages because they do not have data to do complete verifications. Complete verification of Medicaid patient volume percentages is only possible if States have data to verify total patient volume, the denominator component of the Medicaid patient volume calculation. While five States reported not having total patient volume, the remaining six States likely face similar issues because States typically have no reason to collect total patient volume data. States would not generally collect data on total patient volume because they include patient visits for which States

do not reimburse (e.g., private pay and uncompensated care). See Figure A-2 in Appendix A to view the components of the Medicaid patient volume percentage calculation and the data some States reported not having.

One State will require all practitioners to submit reports from their practice management systems supporting their self-reported total patient volume. State staff will then manually review the submitted reports and completely verify Medicaid patient volume percentages.

Further, most States reported that MMIS data they plan to use for their verifications of Medicaid patient volume may not be accurate in some cases. These cases involve Medicaid claims for services reimbursed at a bundled rate and Medicaid claims in which not all of a rendering practitioner's patient volume is reflected in MMIS claims data.

- Six of twelve States reported that the MMIS claims data they plan to use to verify practitioners' Medicaid patient volume prior to payment do not reflect actual patient volume for services reimbursed at a bundled rate. For example, some States pay one flat fee to obstetrician/gynecologist (OB/GYN) specialists for all patient visits associated with prenatal care (i.e., a bundled rate). While each distinct patient visit should be included in the OB/GYN's Medicaid patient volume, States' MMIS systems only reflect one claim for the entire series of visits. As a result, when a State compares MMIS claims to the OB/GYN's self-reported Medicaid patient volume, it may incorrectly conclude that the OB/GYN overreported his or her Medicaid patient volume.

  Two States reported solutions to this problem. One plans to use an existing State database in which OB/GYN specialists report actual utilization data to accurately count the number of distinct patient visits. Another State plans to estimate the number of visits associated with each payment for bundled services and to use that estimate to check Medicaid patient volume.

- Ten States reported that MMIS claims data do not reflect accurate patient volume for a rendering practitioner (i.e., a practitioner who treats patients) who submits claims through a billing practitioner (i.e., a practitioner who bills Medicaid for services performed by rendering practitioners). This scenario might occur, for example, when a nurse practitioner sees a patient, but the visit is billed by a supervising physician. In such cases, a State that compares the nurse practitioner's self-reported Medicaid patient volume to MMIS claims would underestimate the patient volume because there would be no claim in MMIS to represent the patient visit. No States reported a comprehensive solution to the confusion between rendering and billing practitioners.

Most States reported plans to completely verify eligibility requirements for which data are available. Twelve of the 13 States reported plans to use existing data in their MMIS systems to perform complete verifications of certain eligibility requirements. These 12 States plan to look

up specialty codes in their MMIS to verify that practitioners are eligible. These 12 States also plan to verify practitioners' and hospitals' Medicaid enrollment status using MMIS, which indicates that they are not barred from receiving Medicaid reimbursements and that they have appropriate licensure. The one additional State plans to reference records maintained by its department of health to verify that practitioners are an eligible practitioner type, and that practitioners and hospitals have appropriate licensure and are not barred from receiving Medicaid reimbursements. Finally, 10 States plan to use place of service codes on practitioners' MMIS claims to verify that practitioners do not have 90 percent or more of their professional services in a hospital inpatient or emergency room setting (i.e., practitioner is not hospital-based).

Table 5 shows the number of States that plan to completely verify certain eligibility requirements and the data sources they plan to use.

Table 5: Eligibility Requirements That Almost All States Plan To Completely Verify Prior to Payment

Eligibility Requirement	Number of States That Plan Complete Verification	Number of States That Plan Partial Verification	Examples of Data Sources Used for Complete or Partial Verification	Number of States That Plan No Verification
Practitioners must be one of the permissible practitioner types	13	-	MMIS	-
Practitioners and hospitals must be licensed to practice in the State	13	-	MMIS	-
Practitioners and hospitals must not be excluded, sanctioned, or otherwise deemed ineligible to receive payments from the State Medicaid agency	13	-	MMIS	-
Practitioners and hospitals must have certified EHR technology	13	-	Certified Health Information Technology (HIT) Product List (CHPL) database	-
Practitioners must not be hospital-based	10	-	MMIS	3
Hospitals must have at least 10% Medicaid patient volume (acute care hospital only)	9	3	Medicare hospital cost reports; MMIS	1
Hospitals must have an average length of stay of 25 days or less (acute care hospital only)	8		Medicare hospital cost reports; MMIS	5

Source: OIG analysis of State oversight plans and State interviews, 2011.

All 13 States plan to use the CHPL database to verify that practitioners and hospitals have certified EHR technology.[29] For this verification, 10 States have created electronic interfaces with the CHPL database to verify that practitioners and hospitals have submitted valid certified EHR technology codes. Three States plan to manually compare practitioners' and hospitals'

[29] The CHPL database contains a list of EHR products that have been certified according to regulations promulgated by the Office of the National Coordinator for HIT.

self-reported EHR technology codes against the CHPL database. These States reported that they may automate this process at a later date.

Finally, most States also plan to use Medicare hospital cost reports to verify two hospital eligibility requirements.[30] Nine States will use Medicare hospital cost reports to help them completely verify hospitals' reported Medicaid patient volume percentages. Eight States reported that they plan to use Medicare hospital cost reports to verify prior to payment that hospitals have an average length of stay of 25 days or less.

CONCLUSION

All 13 States in our study reported that they plan to verify at least half of eligibility requirements prior to making EHR incentive payments. Where data are available to do so, States plan to compare self-reported eligibility information to other data sources. Verifying self-reported eligibility information prior to making payments helps States ensure the integrity of their EHR incentive payments. In addition, all States reported that they are in the process of developing plans to audit eligibility requirements after payment.

However, we found that data availability limits both the number of requirements that States can verify prior to payment and the completeness of those verifications. For certain eligibility requirements, States do not currently collect the data they need to conduct complete verifications. Further, not many States reported plans to start collecting all the necessary data because the effort would be resource intensive and logistically impractical for most States. Almost all States plan to conduct partial verifications of practitioners' Medicaid patient volume using existing Medicaid claims data. They do not plan to conduct complete verifications because they do not have total patient volume, which they need to completely verify practitioners' Medicaid patient volume. Finally, States plan to completely verify eligibility requirements for which they report that data are available to do so.

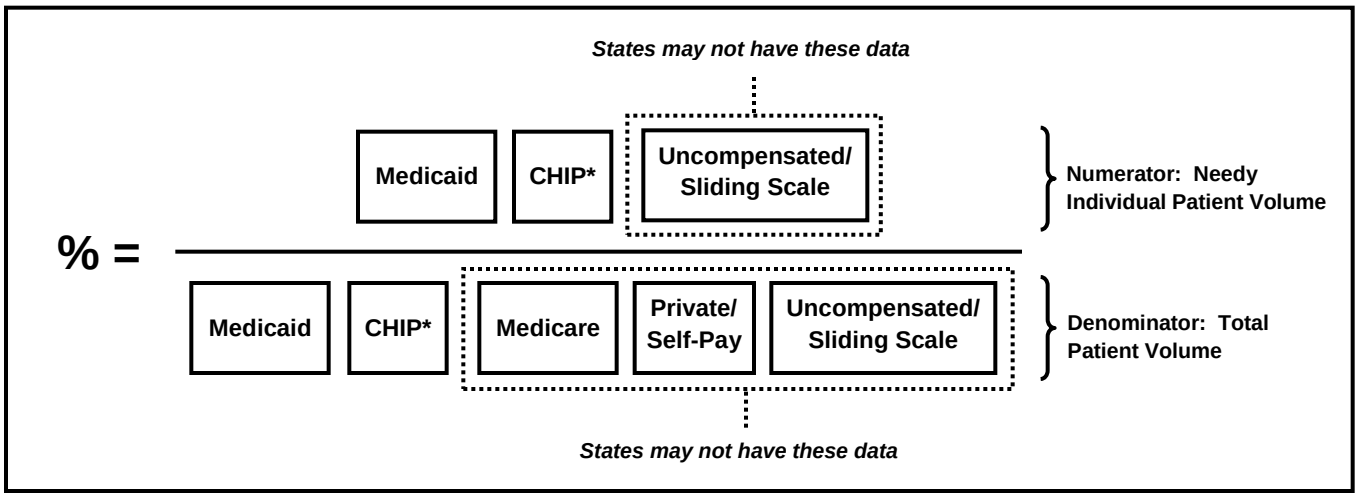
The data limitations identified in this report affect States' ability to proactively ensure the integrity of their EHR incentive payments. Therefore, States should take these limitations into account when planning their program oversight. For example, States could strengthen oversight of their EHR incentive programs by focusing postpayment audits on eligibility requirements that cannot be completely verified prior to payment. Additionally, States that have not yet started their EHR incentive programs should note the potential inaccuracies in using MMIS claims data to verify Medicaid patient volume that we highlight in this report, and plan accordingly when designing prepayment verifications.

[30] Medicare hospital cost reports include hospital utilization data, cost, and charges associated with patient care. See *Cost Reports: General Information*. Accessed at www.cms.gov on May 19, 2011.

This report is being issued directly in final form because it contains no recommendations. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number 05-10-00080 in all correspondence.

APPENDIX A

Figure A-1: Needy Individual Patient Volume Percentage Calculation for Practitioners Practicing Predominantly in a Federally Qualified Health Center or Rural Health Center



* Children's Health Insurance Program.

Figure A-2: Medicaid Patient Volume Percentage Calculation for Practitioners and Hospitals