



Office of the
Medicaid Inspector
General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

December 03, 2015

[REDACTED]

United Memorial Medical Center
217 North Street
Batavia, NY 14020

Re: Medicaid EHR Incentive Program
Project # 15-5960
NPI # [REDACTED]
Provider ID # [REDACTED]

Dear [REDACTED]

The New York State Department of Health (DOH) has previously identified your organization as being subject to an adjustment to your NYS Medicaid EHR incentive payment(s) as a result of updated guidance.

For additional information on the updated guidance, please see the Amendment to Hospital Incentive Payment Calculation <https://www.emedny.org/meipass/archive/AmendedHospitalCalculation-20120308.pdf>.

Your agreement to the overpayment amount of \$32,849.30 has been established by your adjustment attestation, signed January 28, 2015, for the NYS Medicaid EHR Incentive Program. As a result, The New York State Office of The Medicaid Inspector General (OMIG) is providing you with repayment instructions.

See the following repayment instructions:

OPTION #1: Make full payment by check or money order within 20 days of the date of this letter. The check should be made payable to the New York State Department of Health and be sent with the attached Remittance Advice to:

[REDACTED]
Bureau of Collections Management
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
[REDACTED]

OPTION #2: Enter into a repayment agreement with the Office of the Medicaid Inspector General. If your repayment terms exceed 365 days from the date of this Letter, recoveries of amounts due are subject to interest charges at the prime rate plus 2%. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days at the following:

[REDACTED]
Bureau of Collections Management
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
[REDACTED]

For questions regarding repayment, please contact the OMIG Bureau of Collections Management at [REDACTED].

For questions regarding the original incentive payment adjustment determination(s) made by the Department of Health (DOH), [REDACTED]
[REDACTED]

Sincerely,

[REDACTED]

Division of Medicaid Audit
Office of the Medicaid Inspector General

CERTIFIED MAIL # [REDACTED]
RETURN RECEIPT REQUESTED

**NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE**

[REDACTED]

United Memorial Medical Center
217 North Street
Batavia, NY 14020

PROVIDER ID # [REDACTED]

PROJECT# 15-5960

AMOUNT DUE: \$32,849.30

PROJECT	<input type="checkbox"/>	PROVIDER
	<input type="checkbox"/>	RATE
	<input type="checkbox"/>	PART B
TYPE	<input checked="" type="checkbox"/>	OTHER

CHECKLIST

1. To ensure proper credit, please enclose this form with your check.
2. Make checks payable to: *New York State Department of Health*
3. Record Project #15-5960HIT
4. Mail check to:

[REDACTED]
Bureau of Collections Management
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
[REDACTED]

Thank you for your cooperation.

**NY Medicaid EHR Incentive Program
Administrative Support Service**

**IN ORDER TO EXPEDITE THE PROCESSING OF YOUR
INCENTIVE PAYMENT APPLICATION PLEASE RETURN THE ENTIRE
ATTESTATION PACKET, INCLUDING THE SIGNATURE PAGE. THIS PACKET
SHOULD BE MAILED WITHIN 30 DAYS FROM THE DATE OF ATTESTATION.**

DO NOT WRITE ON THIS FORM

NPI:	<input type="text" value="██████████"/>
Registration ID:	<input type="text" value="██████████"/>
Transaction Number:	<input type="text" value="██████████"/>
Date of Submission:	<input type="text" value="01/28/2015"/>

Please remit all forms to:

NY Medicaid EHR Incentive Program Administrative Support Service



New York Medicaid EHR Incentive Program Attestation

Federal Information:

Hospital Name:

Provider Type:

Address:

City, State Zip:

Phone:

E-mail:

Payee NPI:

Payee TAX ID:

Eligibility Information:

Reporting Period

Start Date:

End Date:

Encounter Information

Medicaid Encounters:

Total Encounters:

EHR Certification Information

EHR Status:

EHR Certification Number:

Medicaid Volume Threshold: %

Discharge Information

Base/Fiscal Year:	01/01/2009	To:	12/31/2009
Total Acute Discharges for Reporting Year:	4769		
Total Acute Discharges for Prior Year1:	4996		
Total Acute Discharges for Prior Year2:	4913		
Total Acute Discharges for Prior Year3:	4734		
Medicaid Acute Inpatient Bed Days for Reporting Year:	6245		
Total Acute Inpatient Bed Days for Reporting Year:	25304		
Total Charity Care Charges:	824644		
Total Charges:	151584639		

Payment Amount

Year 1: \$	845,860.39	Year 2: \$	676,688.31	Year 3: \$	169,172.07
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New York Medicaid Incentive Payment Attestation

This is to certify that the foregoing information is true, accurate, and complete. I understand that Medicaid EHR incentive payments submitted under this provider number will be from Federal funds, that by filing this registration I am submitting a claim for federal funds, and that the use of any false claims, statements, or documents, or the concealment of a material fact used to obtain a Medicaid EHR Incentive Program payment, may be prosecuted under Federal and State laws and may also be subject to civil penalties.

I hereby agree to keep such records as are necessary to demonstrate that I met all Medicaid EHR Incentive Program requirements and to furnish those records to the New York State Department of Health (DOH), Department of Health and Human Services, or contractor acting on their behalf.

No Medicaid EHR Incentive Program payment may be paid unless this registration form is completed and accepted as required by existing law and regulations (42 CFR 495.10)

ROUTINE USE(S): Information from this Medicaid EHR Incentive Program registration form and subsequently submitted information and documents may be given to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment of any overpayment made. Appropriate disclosures may be made to other federal, state, local, private business entities, and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation related to the operation of the Medicaid EHR Incentive Program.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of EHR incentive payment. With the one exception listed below, there are no penalties under this program for refusing to supply information. However, failure to furnish information on this registration form will prevent the EHR incentive payment from being issued. Failure to furnish subsequently requested information or documents will result in the issuance of an overpayment demand letter followed by recoupment procedures.

It is mandatory that you tell DOH if you believe that you have been overpaid under the Medicaid EHR Incentive Program. The Patient Protection and Affordable Care Act, Section 6402, Section 1128J, provides penalties for withholding this information.



1/28/2015
(Date)