



Office of the
Medicaid Inspector
General

ANDREW M. CUOMO
Governor

THOMAS R. MEYER
Acting Medicaid Inspector General

February 19, 2015

[REDACTED]
Saratoga Hospital
211 Church Street
Saratoga Springs, NY 12866

Re: Medicaid EHR Incentive Program
Project # 15-1061
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 adjustment amount of \$199,152.69 has been established by your adjustment attestation, signed May 22, 2014, for the NYS Medicaid EHR Incentive Program. As a result, The New York State Office of Medicaid Inspector General (OMIG) is providing you with repayment instructions.

See the following repayment instructions:

Please 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
Phone #: [REDACTED]
Fax#: [REDACTED]

[REDACTED]
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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), please contact the NY Medicaid EHR Incentive Program Support at [REDACTED] or [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]
Saratoga Hospital
211 Church Street
Saratoga Springs, NY 12866

PROVIDER ID # [REDACTED]

PROJECT#15-1061

AMOUNT DUE: \$199,152.69

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 #15-1061HIT
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
Phone #: [REDACTED]
Fax#: [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:

Registration ID:

Transaction Number:

Date of Submission:

Please remit all forms to:

NY Medicaid EHR Incentive Program Administrative Support Service
| P.O. Box 809 | Rensselaer, NY 12144-0809
██████████ www.emedny.org

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E14147.0102.008

E14147 . 0102 . 008

New York Medicaid EHR Incentive Program Attestation

Federal Information:

Hospital Name:	The Saratoga Hospital		
Provider Type:	Acute Care Hospitals		
Address:	211 Church St		
City, State Zip:	Saratoga Springs, NY 12866-1046		
Phone:	[REDACTED]		
E-mail:	thenderson@saratogacare.org		
Payee NPI:	[REDACTED]	Payee TAX ID:	[REDACTED]

Eligibility Information:

Reporting Period	Start Date:	10/01/2009	End Date:	12/29/2009
Encounter Information	Medicaid Encounters:	1733	Total Encounters:	10753
EHR Certification Information				
EHR Status:	Upgrade	EHR Certification Number:	30000001SVKJEA0	

Medicaid Volume Threshold: 16.11 %

Discharge Information

Base/Fiscal Year:	<input type="text" value="01/01/2009"/>	To:	<input type="text" value="12/31/2009"/>
Total Acute Discharges for Reporting Year:	<input type="text" value="8187"/>		
Total Acute Discharges for Prior Year1:	<input type="text" value="7974"/>		
Total Acute Discharges for Prior Year2:	<input type="text" value="7524"/>		
Total Acute Discharges for Prior Year3:	<input type="text" value="7583"/>		
Medicaid Acute Inpatient Bed Days for Reporting Year:	<input type="text" value="3050"/>		
Total Acute Inpatient Bed Days for Reporting Year:	<input type="text" value="44922"/>		
Total Charity Care Charges:	<input type="text" value="5532323"/>		
Total Charges:	<input type="text" value="477395874"/>		

Payment Amount

Year 1: \$	<input type="text" value="296,330.73"/>	Year 2: \$	<input type="text" value="237,064.58"/>	Year 3: \$	<input type="text" value="59,266.14"/>
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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.

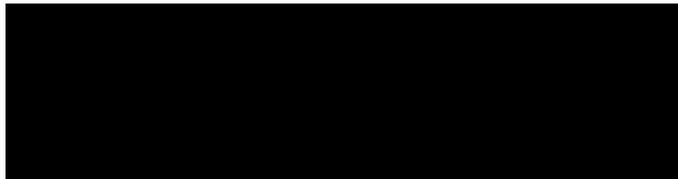
I hereby agree to keep such records as are necessary to demonstrate that I met all Medicaid EHR Incentive Program requirements and to furnish those records to the New York State Department of Health (DOH), Department of Health and Human Services, or contractor acting on their behalf.

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)

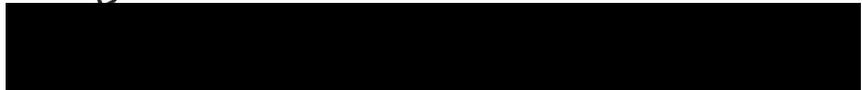
ROUTINE USE(S): Information from this Medicaid EHR Incentive Program registration form and subsequently submitted information and documents may be given to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment of any overpayment made. 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.



(Provider Signature)



(Title)

5/22/14

(Date)