DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

Relog to Supra, per Giese on 11-5-12

TO	DATE
Supra	10-31-12

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10-136	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Mr. Keck, Singleton, Deps, CUS file Cleared 10/31/12, letter attached.	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

Annmarie McCanne

From: Valeria Williams
Sent: Friday, November 02, 2012 10:45 AM
To: Annmarie McCanne; Alissa Robinson
Subject: log letter
Attachments: SKMBT_28312110207120.pdf

The attached log letter should be assigned to Susan Hartnett. Please have Brenda to reassign. Val

-----Original Message-----
From: copier@scdhhs.gov [mailto:copier@scdhhs.gov]
Sent: Friday, November 02, 2012 8:12 AM
To: Valeria Williams
Subject: Scan from Copier.

Scan from Copier Do Not reply. Any problems scanning or faxing contact Greg Mattison. Have a nice Day.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Giese	10-31-12

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10-136	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Mr. Keck, Singleton, Deps, CMS file	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

CENTERS FOR MEDICARE & MEDICAID SERVICES

Consortium for Medicaid and Children's Health Operations

October 16, 2012

Tony Keck
Director
State of South Carolina, Department of Health & Human Services
1801 Main Street PO Box 8206
Columbia, SC 29201-8206

Dear Mr. Keck:

Thank you for submitting South Carolina's comprehensive audit strategy for the Medicaid Electronic Health Record (EHR) Incentive Program. This audit strategy was submitted to the Centers for Medicare & Medicaid Services (CMS) for review on May 25, 2012.

CMS approves the general audit strategy but requires a more comprehensive audit strategy submission. Our approval is subject to provisions in regulations at 42 CFR Part 495, Subpart D. Issues we have identified and included in Enclosure A should be addressed in the next version of the audit strategy that the state submits to CMS for review and approval. When submitting that version of the audit strategy, please include a change control document specifying where in the document the state has addressed these items.

CMS appreciates South Carolina's work in service of this important new program that will lead to improved healthcare for populations served by the Medicaid Program.

If there are any questions concerning this information, please contact Jason McNamara at (312) 353-4240 or via email at Jason.McNamara@cms.hhs.gov.

Sincerely,

Jackie Garner
Administrator

Enclosure A

The following issues must be addressed in a revised comprehensive audit strategy and submitted for CMS review and approval.

General Comments:

1. Provide information on the states' intent to report audit findings to CMS.

2. The Meaningful Use (MU) audit approach should be clearly defined and focused on each measure. CMS would like to review the MU audit approach, as well as risks associated with each measure. Some of the MU measures are more difficult to audit and should carry a higher risk, while other measures can easily be validated during a pre-payment process. We recommend the state review the Medicare MU audit strategy or the Medicaid MU Toolkit made available to states.

3. We did not identify where the state has provided CMS with the authority to complete MU audits for eligible hospitals. The state is responsible for conducting eligibility audits (both pre-payment and post-payment).

4. We did not identify where or how the agency is auditing the hospital calculation. What is the process to audit data elements in the calculation?

Log #136

South Carolina Department of Health & Human Services

Anthony E. Keck, Director
Nikki R. Haley, Governor

October 31, 2012

Jason McNamara, Technical Director for Health IT
Centers for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
233 North Michigan Avenue
Chicago, Illinois 60601

Re: *South Carolina Electronic Health Record Audit Plan*

Dear Mr. McNamara:

Enclosed is the revised South Carolina Department of Health and Human Services (DHHS) "Audit Plan for the South Carolina Medicaid Electronic Health Records (EHR) Incentive Program" (Audit Plan) dated October 2012 for your consideration. The approved Audit Plan will be included as an Appendix to the November 2011 S.C. Medicaid State Medicaid HIT Plan (SMHP), but will not be made available to the public.

The Audit Plan was originally submitted to CMS in early 2012 in accordance with the Centers for Medicare and Medicaid Services' (CMS) request regarding State Medicaid agencies provide audit plans for the Medicaid Electronic Health Records Incentive Program. Upon our early 2012 submission, CMS responded to DHHS regarding various issues and concerns with our Audit Plan. Those concerns have been addressed and information is now incorporated in our revised Audit Plan in response to CMS's questions and issues. Also, we have developed a risk assessment process and enhanced our provider selection process for post payment audits.

If you have any questions or concerns regarding the revised DHHS Audit Plan, please contact me at (803) 898-2527 or by email at nowells@scdhhs.gov.

Sincerely,

Stephen C. Nowell II, Director
Division of Audits

scn

c: Kathleen Snider, Bureau Chief
Susan Hartnett, HIT Division Director
Bryon Gibbs, Senior Auditor
Andrew Grimes, Senior Auditor

Compliance and Performance Review
Division of Audits
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-8881 • Fax (803) 255-8217

October 2012

SOUTH CAROLINA DEPARTMENT OF HEALTH & HUMAN SERVICES

AUDIT PLAN FOR THE S.C. MEDICAID ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PROGRAM

South Carolina Medicaid Electronic Health Record (EHR) Incentive Program
2010-2015

Table of Contents

I. Audit Objectives

The South Carolina Department of Health and Human Services (SCDHHS) Division of Audits, along with the divisions of Program Integrity (PI) and Surveillance and Utilization Review (SUR), comprise the Department's Bureau of Compliance and Performance Review. This bureau ensures that Medicaid and other funds are used effectively and in compliance with federal and state regulations. Existing processes were expanded to include audits of the S.C. Medicaid EHR Incentive Program (Program).

The Division of Audits shares responsibility with the SCDHHS Health Information Technology (HIT) Division for ensuring Program incentive recipients have met the federal regulations governing Program disbursements. The processes and procedures already in place and in development are for the purpose of ensuring Program incentive payments are made only to providers that meet Program criteria as defined in the federal regulations. This is the primary objective of this Audit Plan.

Detailed audit testing and risk-assessment for compliance with Meaningful Use will be based on the rate of provider attestations. Beginning January 2013 the number of audits will be determined by the results of risk assessments completed every six months for the preceding six months. All providers and hospitals determined to be high-risk will be audited, and a portion of all medium and low-risk will also be audited for post-payment compliance. Selection and details are explained in Section VI, Risk Assessment and Provider Selection.

II. Program Staffing

The SCDHHS HIT Division staff performs pre-payment eligibility verification checks in addition to interfacing with the provider community and receiving all attestations through the State Level Repository (SLR). The SCDHHS Division of Audits completes all risk-assessments of attesting providers, groups and hospitals, and performs post-payment eligibility audits.

Staffing currently includes four temporary grant employees in the HIT Division and two temporary grant employees in the Division of Audits (with a third audit position to be filled by the end of the year).

III. Audit Standards and Procedures

The pre-payment and post-payment audit procedures followed by the EHR auditors are based on the standard operating procedures (SOP) of the SCDHHS Division of Audits. The Division of Audits follows the *Generally Accepted Government Auditing Standards (GAGAS)* (revised December 2011) issued by the United States Governmental Accountability Office. Where applicable, the Division of Audits may follow professional standards issued by other bodies such as *Generally Accepted Auditing Standards* (GAAS) issued by the American Institute of Certified Public Accountants, and The Institute of Internal Auditors' (IIA) *Codification of Standards for the Professional Practice of Internal Auditing*.

The EHR auditors report to SCDHHS Division of Audits management and follow the division's SOPs. These SOPs closely align with GAGAS, GAAS, and IIA standards and include:

- Independence, Professional Judgment, Competence, Quality Assessment - EHR auditors are required to acknowledge and conduct assignments in accordance with these General Standards.
- Planning – EHR auditors are required to prepare and have approved by Division of Audits management a detailed audit planning memo that describes each audit's objectives, scope, planned methodology, expected sources of data, staff assignments, supervision, and staff qualifications.
- Audit Documentation – EHR auditors are required to develop and maintain work papers to support testing conducted and resulting findings.
- Reporting – at the conclusion of each EHR audit, EHR auditors draft and complete a report or internal memorandum in accordance with industry standards for contents and quality.

In addition, EHR auditors are required to prepare a detailed audit program defining the planned steps that will be taken in conducting the audit. The audit program defines the objectives of each audit step and aligns closely with the structure of the Center for Medicare & Medicaid Services (CMS) Audit Strategy Toolkit Pre-Payment and Post-Payment Audit Programs for evaluating all Program requirements. This includes evaluating attestation compliance with the requirements for Medicaid patient volume (individual and group, fee-for-service and panel), Needy Individual patient volume (individual and group, fee-for-service and panel), and documentation that would show the attesting provider has adopted, implemented, or upgraded to certified EHR technology.

On-site audits follow the same procedures and are determined necessary only when discrepancies are identified with supporting information from the attesting provider, group, or hospital.

IV. Sources and Resources for Compliance Testing

Generally Accepted Government Auditing Standards (GAGAS) discuss the field work standards for the use of sufficient, appropriate evidence based on the audit objectives to support a sound basis for audit findings, conclusions, and recommendations. One of the primary factors influencing the assurance associated with a performance audit is the appropriateness of the evidence in relation to the audit objectives. The SCDHHS Division of Audits follows GAGAS in planning and conducting compliance audits for the EHR Incentive Program.

SCDHHS uses the following data sources to identify sufficient, appropriate evidence:

- Medicaid Management Information System (MMIS);
- Provider enrollment files maintained by the Medicaid Claims Control System (MCCS);
- Managed Care Organization (MCO) database;
- Program Integrity State exclusion list, State licensing boards;
- Office of the National Coordinator (ONC) Certified Health IT Product List;
- Data provided through the South Carolina Office of Rural Health (SCORH);
- Data provided through the Rural Health Center (RHC) association and the Federally Qualified Health Care (FQHC) association;
- Healthcare Cost Report Information System (HCRIS);
- Medicaid Budget & Expenditure System (MBES);
- CMS Quality Measure metrics;
- Hospital Quality Initiative Clinical Quality Measure metrics.

SCDHHS contracts for the services of Truven (formerly the Health Care Business of Thompson Reuters) and uses Advantage Suite to query the state's historical Medicaid claims data. The Division of Audits personnel extract and analyze historic claims and other data that provide for audit evaluation and risk-assessment. Eligible Professional (EP) attestations to patient volume are evaluated by comparison to historic claims data.

CMS guidance is followed and includes drawing from and implementing procedures and programs such as the Risk Assessment Tool, Sample Risk Factors and Criteria, and Audit Strategy Toolkit programs and methodologies. Meaningful Use and Hospital audits are also developed based on CMS guidance on risk-assessment and recommended audit procedures.

V. Scope and Methodology

AIU Pre-payment

The HIT Division evaluates 100% of provider attestations pre-payment with the following checks:

- Provider is one of the permissible provider types (Physician, Dentist, Certified Nurse Midwife, Nurse Practitioner, Physician Assistant (PA), or Inpatient Hospital);
- Provider demographic data including NPI, and Payee data including TIN, etc. are verified;
- Payee is actively enrolled as a provider in the S.C. Medicaid Program;
- Provider/Payee is not sanctioned in the State or otherwise deemed ineligible to receive payments from the State including licensure and expulsion status;
- Provider is not hospital-based;
- Physician Assistants (PA) practice at an FQHC/RHC that is "so led" by a PA;
- Provider's attestation to certified EHR technology crosswalks to the correct CMS EHR Certification ID;
- Providers attesting to patient volume exception for "Pediatrician with reduced Medicaid volume" is enrolled as a pediatrician, or is in the CMS registration system as a pediatrician;
- Provider has attested to a legal/financial commitment to certified EHR technology.
- Provider has attested in compliance with the group Medicaid patient volume requirements (if applicable) including that all group providers must attest using the same method.

Through the end of 2012 SCDHHS determines the average Children's Health Insurance Program (CHIP) rates by county that are automatically applied to offset provider attestations of Medicaid patient volume. It is important to note that SCDHHS will not audit the CHIP adjustment applied to EPs and EHs that attest to meeting the Medicaid patient volume threshold. The CHIP adjustment factor is included as an automatic offset in the SLR, and EHs and EPs do not provide the CHIP adjustment factor. For Participation Year 2013 and beyond, due to changes from the Stage 2 Final Rule, SCDHHS will no longer offset the provider's Medicaid encounters by a CHIP percentage.

The CMS National Level Repository maintains a database of all providers requested and paid by the Medicare and Medicaid EHR Incentive Programs. Prior to disbursing incentives, the HIT Division verifies

that CMS has returned a positive D16R (Locked for Payment) transaction, indicating that the provider has not already received an incentive payment for that particular participation year.

AIU Post-payment

Post-payment desk reviews and on-site audits follow SCDHHS Division of Audits Standard Operating Procedures which includes close supervision, review, and required approvals of the Division of Audits Director. All reporting is reviewed and requires the approval of the Compliance and Performance Review Bureau Chief. EHR Incentive Program audits conform to the CMS Medicaid EHR Incentive Program Audit Strategy Post-Payment Audit Program, adjusted for segments performed pre-payment.

Risk assessments determine high, medium, and low-risk attestations. Based on the risk assessment results, providers are selected for post-payment audit. In addition, the HIT Division identifies certain providers as high-risk when unusual circumstances are noted. Complete details on Risk Assessment are found in Section IV. Risk Assessment and Provider Selection.

Providers selected for post-payment audit are sent an engagement letter and request for supporting documentation. The engagement letter explains SCDHHS Audit's role in reviewing provider attestation data and requests supporting documents that include:

- Documentation for calculation of Medicaid or Needy Individual patient volume;
- Documentation for calculation of total patient volume;
- Identification of practice professionals with titles and dates of employment if applicable;
- Identification of any practice professionals that work or have worked during the reporting period concurrently at an additional practice if applicable;
- Documentation of a legal or financial commitment to certified EHR technology.

While the provider or group representative is preparing the information that supports their attestation, the auditor conducts a preliminary review and fact gathering by:

- Obtaining all data submitted through the State's SLR;
- Compiling in-house correspondence and emails with the provider;
- Researching the provider/group on the internet;
- Reviewing any previous audits of providers/groups by the Division of Program Integrity.

Once the supporting documentation is received from the provider/group, the documents are analyzed to evaluate compliance with AIU to certified EHR technology and all applicable patient volume and additional program requirements by using following procedures:

- Reasonableness checks to identify outliers are conducted on EP's patient volume denominator attestation as it relates to the patient volume numerator.
- Information submitted by the provider is reviewed for reasonableness in that it looks complete, appears accurate, and that there are no unusual items that would call for additional investigation.
- A comparison of the attestation patient volume percentage is made with the supporting documentation submitted by the EP. The attesting provider is requested to explain any differences.
- A comparison is made of MMIS claims / encounter data with the attestation and the supporting documentation. If the supporting documentation is + / - 15% it is considered consistent.
- For group attestations documentation supporting the attesting provider's practice locations is completed by reviewing claims/ encounter data in MMIS.
- For group attestations MMIS data is reviewed to determine if any attesting providers practice or have practiced at multiple locations.
- Practice locations where the EPs attested as part of a group are reviewed to confirm that the patient encounters reported in the patient volume calculations were not duplicated.
- Verifying providers practiced predominantly in a Federally Qualified Health Center (FQHC) or a Rural Health Center (RHC) with a 30% needy individual patient volume threshold.
- Verifying EHR technology by obtaining supporting receipts, contracts, maintenance agreements, or other documentation of the certified EHR technology.
- Reviewing the supporting documentation to verify the AIU of the certified system occurred during the 1st incentive payment year or prior.

Based on the results of the audit, either a detailed audit report or audit memo is prepared. An audit report is prepared if there are significant findings that would indicate non-compliance with any eligibility requirements of the Final Rule, with the conclusion that the EP or EH is not eligible for the Medicaid EHR incentive payment. An audit memo is prepared if there are not any significant findings that would indicate non-compliance with the Final Rule. The audit report or audit memo is sent to the auditor's supervisor and the Director of the HIT program informing them of the findings of the audit. The Director of the HIT program sends a post audit letter informing the group/provider the results of the audit.

AIU On-site Audits

When there are significant unexplained discrepancies that cannot be resolved with a desk review, an on-site audit is scheduled. The auditor notifies the group/provider of the proposed date and time of the upcoming on-site audit and request the provider/group have all of the relevant supporting documentation (in either paper or electronic format) used in the completion of their attestation responses. During the onsite review, more testing is done to verify Medicaid patient volume and total patient volume. Also, the EHR technology being used is compared to the AIU certified technology documentation of which the provider attested to. In subsequent participation years, on-site audits will include procedures to determine whether documentation provides reasonable assurance that EP's are meaningfully using certified EHR technology.

Stage 2 changes

The audit scope, methodology, and audit programs and procedures will be altered in 2013 in accordance with the Stage 2 final rule. Changes include recognition of the revised definition of Medicaid encounters. Medicaid encounters will be counted toward patient volume if the patient is enrolled in the S.C. Medicaid program at the time of service without the requirement of Medicaid payment liability.

Additionally, patient encounters of the Children's Health Insurance Program (CHIP) will be considered appropriate if included as part of Medicaid patient volume attestations. There are no standalone CHIP programs in South Carolina.

Meaningful Use Pre-payment

The HIT Division evaluates 100% of provider attestations related to meaningful use objectives pre-payment by performing the following checks:

- Meaningful Use Reporting Period: The reporting period information is reviewed to ensure a minimum of 90 days for the first year of meaningful use and a full year thereafter.

- Unique Patients: Selected objectives that have as their denominator "Number of unique patients seen by the EP during the EHR reporting period" (Core Measures 3, 5, 6, and 7), and if selected, Menu Measures 5 / 10 (Patient Electronic Access) and 6 / 10 (Patient Specific Education) all report the same number of unique patients (denominators match).

- Exclusions: Where an EP has excluded Core Objective 1 or 4, a report is run to determine if there is evidence that the EP did write 100 or more prescriptions during the EHR reporting period. Where an EP has excluded Core Objective 13, a report is run to determine if there is evidence that the EP did have office visits during the EHR reporting period.

- Core Objective 14 (Electronic Exchange of Clinical Information): Required documentation uploaded as part of the attestation process is reviewed to compare against information provided in the additional fields on the Core 14 attestation screen ("With whom was the test of exchange of a CCD/CCR done?" and "What were the results?"). The documentation should include proof that there was a test of the exchange of information from the EP's certified EHR technology to another provider of care or patient authorized entity, the file name of the CCD/CCR file that was exchanged, and the test was in the Participation Year, no later than the last day of the MU reporting period.

- Menu Objective 9 (Immunization Registries Data Submission) (If selected as the Public Health objective and no Exclusion elected): Required documentation uploaded as part of the attestation process is reviewed to check that it supports the attestation of testing with the S.C. Department of Health and Environmental Control (DHEC) Immunization Registry (a confirmation email from the SCDHEC to the provider reasonably documents a test or live submission and the test/live submission was in the Participation Year and no later than the last day of the MU reporting period). HIT staff may contact the staff at the Immunization Registry to clarify as needed.

- Data Reported: Where the EP has supplied a copy of the report from the certified EHR technology used for the attestation, the information from the report has been accurately keyed into the attestation tool (SLR).

Meaningful Use Post-payment Review

Risk assessments determine the highest-risk attestations as well as the largest dollar amounts to provider groups and separate all of the attestations into categories of high, medium-high, medium, low medium, and low-risk. Based on the risk assessment results, providers are selected for post-payment audit. In addition, the HIT Division identifies certain providers as high-risk.

Providers selected for post-payment audit are sent an engagement letter, questionnaire, and request for supporting documentation. The engagement letter explains SCDHHS Audit's role in reviewing provider attestation data.

The questionnaire will be based on the responses received for each objective and may differ from provider to provider. The questionnaire will request general information regarding the practice and the strategy implemented to meet Stage 1: Meaningful Use requirements. The EP will enter responses to each objective and provide supporting documentation when applicable.

The request for supporting documentation includes but is not limited to:

- Copies of MU reports(or other documentation) the EP used to perform his attestation
- Any EHR or ancillary system reports which support the conclusion that the EP have has met one of the exclusions criteria or core menu measure
- Evidence to support the EP's submission of electronic data for the Public Health measure(s) the EP attested to. This could include email communication to the agency, contact information for the registry, print screens of the active interface within the EHR, etc.
- Checklist or program used to perform the security risk analysis, written report listing deficiencies as a result of the review, and/or corrective action plan to address the deficiencies of the EHR system
- Evidence to support the EP's attestation that a test or exchanging of electronic clinical information was performed. This may include an email confirmation from the testing partner or a message from the EHR confirming generation/receipt of the transmission.

Once the supporting documentation is received from the provider/group, the documents are analyzed to evaluate compliance with patient volume and verify each provider has met all of the requirements of each Meaningful Use objective and measure.

Based on the results of the audit, either a detailed audit report or audit memo will be prepared. An audit report will be prepared if there are significant findings that would indicate non-compliance with any eligibility requirements of the Final Rule and conclude that the EP or EH is not eligible for the Medicaid EHR incentive payment. An audit memo will be prepared if there are not any significant findings that would indicate non-compliance with the Final Rule. The audit report or audit memo will be sent to the auditor's supervisor and the Director of the HIT program informing them of the findings of the audit. The Director of the HIT program will send a post audit letter informing the group/provider the results of the audit.

Hospital Attestations

SCDHHS evaluates attesting hospital eligibility for the Program with reviews and verifications of Final Rule Program requirements including Medicaid patient volume; average length of stay; adopt, implement, or upgrade to certified EHR technology (where the EH is attesting to AIU); and the elements of the aggregate payment calculation. The Centers for Medicare and Medicaid Services will audit Meaningful Use attestations for all Eligible Hospitals.

Pre-payment

Hospital attestations are received through the SLR and initially evaluated by the HIT Division to determine compliance with requirements for Licensure (by verifying license numbers), and ensure there are no sanctions that would prohibit participation in the Program. In addition, where the EH is attesting to the Adopt, Implement or Upgrade of certified EHR technology, the HIT Division evaluates hospital attestations for requirements related to Adopt, Implement, or Upgrade to certified EHR technology.

Hospitals are required to complete and submit with their attestations a *HIT Hospital Worksheet*. On the spreadsheet attesting hospitals identify discharges and ER visits detailed by categories that include Medicaid fee-for-service discharges and ER visits, Medicaid Managed Care, Medicaid / Medicare crossovers, Medicaid 2nd to other insurance, and those included that originated out-of-state.

The SCDHHS Bureau of Reimbursement Methodology and Policy (BRM) verifies that the Eligible Hospital had the minimum Medicaid patient volume and average length of stay by completing comparisons with MMIS claims history prior to developing the calculations of the aggregate incentive amount. Note: Children's Hospitals are exempt from a patient volume requirement.

BRM's draft of the aggregate incentive payment calculation is developed by taking information from the most recent and prior hospital cost reports. The number of discharges, average length of stay, in-patient bed days, and total hospital charges are input to the aggregate payment calculation worksheet. The BRM draft aggregate payment calculation is completed independent of data submitted by the attesting hospital.

The SCDHHS Division of Audits completes a risk-assessment of all hospitals paid the EHR incentive. There are approximately 60 hospitals in the state that may be eligible for the Incentive and it is expected that approximately half will have attested in 2012 and the remainder in 2013. Details of the hospital risk-assessment process are included in Section VI.

Post-payment Review

Hospitals determined to be the highest risk will be audited with testing covering:

- Documentation of certified EHR technology;
- Patient volume;
- Average length of stay;
- Patient discharges;
- Medicaid fee-for-service In-patient bed days;
- Medicaid managed care In-patient bed days;
- Total In-patient bed days;
- Total hospital charges; and
- Charity care charges.

Summary of Hospital attestation checks:

Eligible Provider Type validated – HIT Division Pre-payment;

Licensure and sanctions check – HIT Division Pre-payment;

AIU to certified EHR technology – HIT Division Pre-payment;

Average Length of Stay (ALOS) – BRM Division Pre-payment;

Discharge figures (4 years) – BRM Division Pre-payment;

Total In-patient bed days – BRM Division Pre-payment;

Total charges ($) – BRM Division Pre-payment;

Charity care charges ($) – BRM Division Pre-payment.

Analysis and reviews completed by BRM Division Pre-payment are then audited by the Division of Audits Post-payment based on risk-assessment and selection.

VI. Risk Assessment and Provider Selection

In January 2011, the SCDHHS started accepting Year One AIU attestations from Eligible Professionals (EPs) and Eligible Hospitals (EHs). The SCDHHS, Audit Division, has adopted a risk based approach for selecting Eligible Professionals (EPs) and Eligible Hospitals (EHs) for post payment audits. Individual risk assessments will be completed on each EP and EH. Once the individual risk assessments are completed, the EP or EH will be placed in either a low, medium, or high risk category based on their overall risk score. That score will be used to determine the sample of EPs and EHs selected for post payment audit. The providers with the overall highest risk score may have the highest potential for fraud, waste, or abuse and become the primary targets for audits.

Effective January 1, 2013, all EPs and EHs who received their Year One Medicaid incentive payment from July 1, 2012 thru December 31, 2012 will be placed in a risk category according to their overall risk score and are subject to audit. Each subsequent attestation year, from January 1 thru June 30 and July 1 thru December 31, EPs and EHs will be placed in a risk category and will be subject to audit. Since EPs and EHs have been receiving incentive payments throughout the year, post-payment audits for 2012 that were already planned will continue to be conducted.

Risk Factors for Eligible Professionals

The DHHS has elected to follow the sample risk assessment tool (Appendix I) from CMS's website to use as a guide for the risk assessment and scoring Methodology. The risk factors DHHS will be using are as follows:

1. Patient volume that is close to the 30% threshold - The risk associated with an EP/Group fraudulently adjusting or duplicating the patient encounters to meet the minimum patient volume requirements.
2. Audit issues related to claims payments - The risk associated with an EP/Group having a history of material weaknesses, reportable conditions, documented sanctions, and/or significant deficiencies relating to improper billing claims.
3. Audit issues related to fraud investigations - The risk associated with an EP/Group having documented sanctions, and/or significant deficiencies that led to a fraud investigation.
4. Resubmitting the application for the EHR incentive program - The risk associated with an EP/Group who had to modify or correct their applications to meet eligibility requirements.

The following criteria will be used to determine the scoring factors that may indicate a higher potential of fraud, waste, or abuse for Eligible Professionals:

Risk Factor #1	Description
Patient Volume Percentage Close to Threshold.	The risk associated with an EP/Group fraudulently adjusting or duplicating the patient encounters to meet the minimum patient volume requirements.
High Criteria	The EP's/Group's Medicaid patient volume attestation is between 20% and 35.99%.
Medium Criteria	The EP's/Group's Medicaid patient volume attestation is between 36% and 40.99%.
Low Criteria	The EP's/Group's Medicaid patient volume attestation is 41% and over.
Weight	5

Risk Factor #2	Description
Audit Issues Related to Claims Payments.	The risk associated with an EP/Group having a history of material weaknesses, reportable conditions, documented sanctions, and/or significant deficiencies relating to improper billing claims.
High Criteria	The EP/Group is on the Program Integrity list.
Medium Criteria	N/A
Low Criteria	The EP/Group is not on the Program Integrity list.
Weight	5

Risk Factor #3	Description
Audit Issues Leading to Fraud Investigations.	The risk associated with an EP/Group having documented sanctions, and/or significant deficiencies that led to a fraud investigation.
High Criteria	The EP/Group has been referred to the SC Attorney General for Fraud Investigation.
Medium Criteria	N/A
Low Criteria	The EP/Group has not been referred to the SC Attorney General for Fraud Investigation.
Weight	5

Risk Factor #4	Description
Resubmitting of Application for the EHR Incentive Program.	The risk associated with an EP/Group who had to modify or correct their application to meet eligibility requirements.
High Criteria	The EP has submitted a modified application to meet the eligibility requirement(s).
Medium Criteria	N/A
Low Criteria	The EP has not requested or submitted a modified application
Weight	1

Risk Assessment for Hospitals

The SCDHHS Division of Audits completes a risk-assessment of all hospitals paid the EHR incentive. There are approximately 60 hospitals in the state that may be eligible for the Incentive and it is expected that approximately half will have attested in 2012 and the remainder in 2013.

The Division of Audits plans to audit hospitals determined to be the highest risk. The risk assessment process includes equally weighted risk factors for hospitals with:

1. Adverse audit results – The risk associated with Hospitals having documented sanctions and/or significant deficiencies in prior audits over the last three years.
2. Medicaid patient volume (when applicable) - The risk associated with Hospitals fraudulently adjusting or duplicating the patient encounters to meet the minimum patient volume requirements.
3. Ratio of discharges per in-patient day - The risk associated with Hospitals having a high ratio of discharges per in patient day compared to all attesting hospitals.
4. Percentage of Medicaid to total in-patient days - The risk associated with Hospitals having a high percentage of Medicaid to total in-patient days compared to all attesting hospitals.

The following criteria will be used to determine the scoring factors that may indicate a higher potential of fraud, waste, or abuse for Eligible Hospitals:

Risk Factor #1	Description
Adverse audit results	The risk associated with Hospitals having documented sanctions and/or significant deficiencies in prior audits over the last three years.
High Criteria	Documented sanctions or significant deficiencies in the last three years
Medium Criteria	N/A
Low Criteria	No documented sanctions or significant deficiencies in the last three years
Weight	3

Risk Factor #2	Description
Patient Volume Percentage Close to Threshold	The risk associated with an EH fraudulently adjusting or duplicating the patient encounters to meet the minimum patient volume requirements.
High Criteria	The EH Medicaid patient volume is between 10% and 14.99.
Medium Criteria	The EH Medicaid patient volume is between 15% and 19.99%.
Low Criteria	The EH Medicaid patient volume is over 20%.
Weight	3

Risk Factor #3	Description
Ratio of discharges per in-patient day	The risk associated with Hospitals having a high ratio of discharges per in patient day compared to all attesting hospitals.
High Criteria	High Ratio of Discharges per in patient day.
Medium Criteria	N/A
Low Criteria	Low Ratio of Discharges per in-patient day.
Weight	3

Risk Factor #4	Description
Percentage of Medicaid to total in-patient days	The risk associated with Hospitals having a high percentage of Medicaid to total in-patient days compared to all attesting hospitals.
High Criteria	High Percentage of Medicaid to in-patient days.
Medium Criteria	N/A
Low Criteria	Low Percentage of Medicaid to in-patient days.
Weight	5

Scoring Methodology

The scoring methodology provides a risk score that will be used to determine the sample of Eligible Professionals and Eligible Hospitals selected for post payment audit. This will allow the auditor to score and weight criteria that can be associated with an Eligible Professional or Eligible Hospital using both qualitative and quantitative data elements. The higher the weight, the more impact the risk factor will have on the Eligible Professional and Eligible Hospital's overall risk rating.

Once the individual risk assessments are completed for each selected EP, the consolidated risk assessment tab will be populated automatically for an overall summary. Any provider, who gets a score in the overall risk rating scale between 1 and 1.49, falls in the low risk category. Any provider, who gets a score in the overall risk rating scale between 1.5 and 2.24, falls in the medium risk category. Any provider, who gets a score in the overall risk rating scale between 2.25 and 3, falls in the high risk category.

This summary will give management a high level view of how the selected EPs scored, along with commonalities of similar risks that may need to be further analyzed. The providers with the overall highest risk score may have the highest potential for fraud, waste, or abuse and becomes the primary targets for audits.

Overall Risk Rating Scale	
1 - 1.49	Low
1.5 - 2.24	Medium
2.25 – 3	

Risk Scoring	Methodology For EPs
Low Risk Providers	A random sample of EPs whose overall risk score was assessed as "low" will be selected for post-payment audit. Sample sizes for EPs participating will be the largest of 10 EPs or 5% of the EPs. ** Also, a random sample from South Carolina's three major hospitals (Palmetto Health, Greenville Hospital System, and Medical University of SC) with multiple EPs attesting that received a substantial incentive payment paid to a single group will be selected for post payment audit.
Medium Risk Providers	A random sample of EPs whose overall risk score was assessed as "medium" will be selected for post-payment audit. Sample sizes for EPs participating will be the largest of 30 EPs or 15% of the EPs.
High Risk Providers	All EPs who fall into this category will be selected for post payment audit.

Risk Scoring	Methodology For EHs
Low Risk Providers	A random sample of EHs whose overall risk score was assessed as "low" will be selected for post-payment audit. The number of audits will be determined based on the results of the risk assessments.
Medium Risk Providers	A random sample of EHs whose overall risk score was assessed as "medium" will be selected for post-payment audit. The number of audits will be determined based on the results of the risk assessments.
High Risk Providers	All EHs who fall into this category will be selected for post payment audit.

Selecting EPs and EHs for Audit

The following example will show how EPs and EHs get selected for audit. Assessments 1-5 have been placed in a risk category according to their overall risk score.

Provider Last Name	Provider First Name	Overall Risk Rating	Overall Risk Rating	Patient Volume Percentage Close to Threshold - Inaccurate Patient Volume Calculation	Audit Issues Relating to Claims Payments.	Audit Issues Leading to Fraud Investigations.	Resubmitting the Application for the EHR Incentive Program
Assessment	1	1.63	Medium	High	Low	Low	Low
Assessment	2	1.75	Medium	High	Low	Low	High
Assessment	3	2.25	High	Low	High	High	Low
Assessment	4	2.38	High	Low	High	High	High
Assessment	5	1.00	Low	Low	Low	Low	Low

Assessments 3 and 4 have the highest overall risk score of 2.25 and 2.38, respectively, which places them as high risk providers. Therefore both of these providers will automatically be selected for audit.

Assessments 1 and 2 have a risk score of 1.63 and 1.75, respectively, which places them as medium risk providers. These providers will be placed in the medium risk pool and a random sample of these providers will be chosen for audit either on or around January 1 or July 1 each year.

Assessment 5 has a risk score of 1.00 which places them as a low risk provider. This provider will be placed in the low risk pool and a random sample of these providers will be chosen for audit either on or around January 1 or July 1 each year.

** EHs will be selected for audit using the same scoring methodology as EPs **

Meaningful Use for EPs

For the EPs second participation year, an EP must demonstrate the meaningful use of the certified EHR technology. Three components of meaningful use are:

1. Use of certified EHR in a meaningful manner,
2. Use of certified EHR technology for electronic exchange of health information to improve the quality of health care, and
3. Use of certified EHR technology to submit Clinical Quality Measures (CQMs) and other measures selected by CMS.

Requirements for demonstrating meaningful use will be completed in three separate stages. Stage 1 of meaningful use requires providers to meet the following objectives:

- Report on required core objectives,
- Report on selected menu set objectives, and
- Report on certain clinical quality measures.

The exact number of core and menu set requirements and clinical quality measures (CQMs) vary depending upon whether the provider is an eligible professional or eligible hospital.

The CQMs are percentage-based measures where the denominator will be either all patients seen during the EHR reporting period or a subset of patients seen during the EHR period. Further, the denominator could be zero when the applicable core objectives or elective objectives do not apply to the eligible professional's practice. When the denominator is zero for a particular CQM, the provider is excluded from having to meet that measure.

The audit procedures for verifying meaningful use will be designed to test the accuracy of the provider's reporting/calculations for core and menu set requirements and CQMs.

VII. Audit Programs

EP First Participation Year Attestations

SCDHHS Audit Programs for first-year participation have been modeled after the Medicaid EHR Incentive Program Audit Strategy Toolkit Programs. All Program testing is based on established objectives that are based on the federal regulations governing the Program as defined in the Final Rule. SCDHHS Program testing aligns with the models provided in the Toolkit. Pre-payment evaluations are completed on 100% of provider attestations notwithstanding the results of risk assessment as described in the preceding section. Post-payment evaluations are completed on 100% of provider attestations determined to be high-risk. For high-risk attestations complete audit testing is conducted and may be expanded based on information received in response to the Division of Audits Request for Supporting Documentation. On-site audits are conducted only when all desk-review testing is completed and there remain unanswered questions and / or questionable data that would indicate a higher probability the attesting provider may not have met all Program requirements.

Pre-payment evaluation of provider attestations includes testing for compliance with 42 CFR:

495.304 **(b)** – Permissible professional types.

495.332 **(b)** – Eligibility – Must be licensed to practice in the state, be a Medicaid provider, and have no state, federal or other sanctions related to medical practice.

495.332 (b) – An attesting Physician Assistant (PA) must practice at a Federally qualified health center (FQHC) lead by a PA or a rural health clinic (RHC) that is so led by a PA.

495.304 (c), (d) – Attesting providers cannot be hospital-based.

495.302 – Attesting providers must adopt, implement, or upgrade to certified EHR technology, or meaningfully use certified EHR technology, that can be identified with a CMS Certification number and ONC CHPL number.

In addition, provider demographic data including National Provider Identification and Tax Identification Numbers are verified. Provider attestation information submitted for Medicaid patient volume is reduced to account for CHIP encounters as defined in the SMHP. (Note: effective with the 2012 Participation Year, the S.C. Medicaid EHR Incentive Program will not utilize its current methodology to reduce Medicaid patient volume by a CHIP offset; S.C. does not have any free-standing CHIP program.)

Post Payment Audit Programs

The SCDHHS, Division of Audits, have developed several post-payment audit programs depending on how the EP or EH has attested. Each post-payment audit program includes testing for the following compliance requirements:

- **495.306 – Collect and verify basic information on Medicaid providers to assure patient volume**

  Medicaid patient volume – The EP must have at least 30% Medicaid patient volume (or 20% for Pediatricians) in a continuous 90-day period.

  Patient encounter method - Total Medicaid patient encounters in any representative continuous 90-day period in the preceding calendar year / Total patient encounters in the same 90 day period.

  Patient Panel Method - Total Medicaid patients assigned to the EP's panel in any representative, continuous 90-day period in the preceding calendar year when at least one Medicaid encounter took place with the Medicaid patient in the year prior to the 90-day period; plus (B) unduplicated Medicaid encounters in the same 90-day period / Total patients assigned to the provider in that same 90-day period with at least one encounter taking place with the patient during the year prior to the 90-day period; plus all unduplicated patient encounters in the same 90-day period.

  Needy Individual patient volume – EPs may qualify based on meeting a patient volume threshold of 30% Needy Individual patient volume if more than 50% of the EP's encounters over a six-month period in the most recent calendar year occurred at a FQHC or RHC.

  Total patient volume – The EP must include their total patient encounters in the same 90 day period.

  Comparing MMIS claims / encounter data with the attestation - Determine if the EP's attestation is reasonably consistent with MMIS encounter data.

  Comparing the attestation patient volume percentage with the supporting documentation submitted by the EP – Determine if the EP's attestation is reasonably consistent (for example, +/- 15%) with the documentation provided by the EP.

  Individual EP reasonableness - This check is performed by considering the reasonableness of the attested to denominator in comparison to the attested to numerator. It also checks if information submitted by the provider looks complete, appears accurate, and there are no unusual items that would call for additional investigation.

EPs practicing in multiple groups and / or locations - Determining if any attesting providers practice or have practiced at multiple locations has not duplicated its patient encounters and its patient volume calculations.

- **495.366 – Collect and verify information regarding efforts to adopt, implement, or upgrade certified EHR technology**

  The EP must adopt, implement, or upgrade certified EHR technology capable of demonstrating meaningful use - Obtain the supporting receipts, contracts, maintenance agreements, or licenses from the EP, review product information (vendor and version) to verify the AIU of each of the components associated with the Certification ID, and review the supporting documentation to verify that AIU of the certified EHR technology occurred during the 1st incentive payment year or prior.

  ** Each post-payment audit program will be updated as needed **

EP Second Participation Year Attestations (Meaningful Use)

SCDHHS Audit Programs for second-year participation will be modeled after the Medicaid EHR Incentive Program Audit Strategy Toolkit Programs. All testing is based on established objectives that are derived from the federal regulations governing the EHR Incentive Program as defined in the Final Rule. SCDHHS testing aligns with the audit program models provided with the EHR Incentive Program Audit Strategy Toolkit. As with first-year attestations, pre-payment evaluations for second-year participation (meaningful use) are completed on 100% of provider attestations notwithstanding the results of risk assessment as described in the preceding section. Post-payment evaluations are completed on 100% of provider attestations determined to be high-risk. For high-risk attestations complete audit testing is conducted and may be expanded based on information received in response to the Division of Audits Request for Supporting Documentation. On-site audits are conducted only when all desk-review testing is completed and there remain unanswered questions and / or questionable data that would indicate a higher probability the attesting provider may not have met all Program requirements.

Pre-payment

Pre-payment evaluation of provider attestations includes the following:

- Verification that attestation information submitted numerically meets thresholds for all attested measures as defined in 42 CFR 495.6.
- Reasonableness checks and matching denominators for unique patients are completed, and exclusions are verified based on available internal data sources.
- Compliance with the Electronic Exchange of Clinical Information (core measure 14) is tested by reviewing information submitted that includes supporting documentation in the form of identifying specific providers involved in the data transfer and a description of results. Public health measure (menu objective 9) on the transmittal of immunization data using the certified EHR system is checked pre-payment by reviewing documentation required through the SLR system.

EP Second Participation Year Attestations (Meaningful Use) - Post Payment Audit Program

The audit program for meaningful use attestation is currently being developed and has not been finalized. The audit procedures will be designed to test the accuracy of the provider's reporting/calculations for core and menu set requirements and CQMs. After the audit program has been finalized, this Audit Plan will be updated.

VIII. Fraud, Waste, and Abuse

SCDHHS will prevent / identify suspected fraud and abuse through data analysis and selected provider audits.

Suspected fraud or abuse involving EHR incentive payments can be reported by the Division of Audits, the department's fraud hotline, and the department's fraud email account.

If an audit finds indications of fraud, a referral will be made to the South Carolina Attorney General's Office, Medicaid Fraud Control Unit (MFCU), in accordance with existing SCDHHS policies and the Memorandum of Understanding with the MFCU.

IX. Provider Appeals

The SCDHHS Division of Appeals and Hearings currently has a process for appeals filed by Medicaid providers and beneficiaries when payments or benefits have been denied (see Appendix D for the Medicaid Appeals Regulations). The procedures for appeals may be found in South Carolina Regulations at Chapter 126, Article 1, Subarticle 3. No additional rules processing time or provider notice time is needed as the policies and procedures for the existing process require no modifications to encompass EPs and EHs who appeal the following:

- Denied incentive payments
- Incorrect incentive payment amounts
- Program eligibility determinations (e.g., patient volume, hospital-based EPs)
- Demonstration of adopting, implementing, and upgrading
- Demonstration of meaningful use

Information concerning the appeals process will be available in the provider manual of policies and procedures for the South Carolina Medicaid EHR Incentive Program. EPs and EHs may submit "timely" appeals to the Division of Appeals and Hearings with relevant support documentation. "Timely" is defined as a provider filing an appeal within 30 days of notification of determination of eligibility (pertains to program eligibility, demonstration of adopt/implement/upgrade, and demonstration of meaningful use) or incentive payment receipt. SCDHHS' notification letters will reference the regulations for appeals. A hearing officer will review the appeal request, and the EP/EH will be notified and a hearing will be scheduled. The HIT Division will compile documentation for the hearing, and any appeal requests will be tracked in the appeals and hearing system maintained by the Division of Appeals and Hearings.

The current SCDHHS appeals process allows for settlement negotiations prior to any hearing. SCDHHS anticipates that these settlement negotiations will be useful for situations where providers are not clear about the requirements for program participation such as EP and EH types, volume requirements, etc.

S.C. Medicaid EHR Incentive Program Audit Plan

Changes to Audit Plan 2012_05_25 Conditionally Approved by CMS

Version	Date of Change	Reason For Change	Section/Page #
May 2012	October 2012	Defined supporting documentation for AIU	Pg.8, 9th bullet
May 2012	October 2012	Review of staff training records is not a requirement for AIU.	Removed completely from the document.
May 2012	October 2012	Added a more detailed SOP for desk and onsite reviews	Pg.7-9, AIU Post-payment
May 2012	October 2012	Added more detail on Risk Assessment and Provider Selection	Pg.14, Section VI
May 2012	October 2012	Added information about auditing hospital calculations	Pg.12-13, Hospital Attestations

Michele Johnson

From:	Susan Hartnett
Sent:	Wednesday, November 28, 2012 11:36 AM
To:	Michele Johnson
Cc:	John Supra
Subject:	Log letter response: SCDHHS Audit Plan for the S.C. Medicaid EHR Incentive Program
Attachments:	Transmittal letter for Audit Plan to CMS 2012_10_31_12. docx.pdf; S.C. Medicaid EHR Incentive Program Audit Plan 2012_10_29.pdf; S.C. Medicaid EHR Incentive Program Audit Plan October 2012_Change Control.pdf

Hi Michele,

This is the response that I sent to the individuals at CMS who review and approve the States' audit plans for the Medicaid EHR Incentive Program. The response went to all individuals who were on CMS' email distribution for their June email to us. I explained to them that we had already sent our response to their June email by the time we received their formal letter (basically they "passed in the mail"), and I attached the information that was provided to them originally at the end of October, as well as a Change Control that Audit prepared.

Thank you,
Susan

From: Susan Hartnett
Sent: Wednesday, November 21, 2012 2:42 PM
To: benjamin.thompson@cms.hhs.gov; jason.mcnamara@cms.hhs.gov
Cc: Enitan(CMS/CMCHO) Oduneye (Enitan.Oduneye@cms.hhs.gov); Jacqueline Y. (CMS/CMCS) Higgins (Jacqueline.Higgins@cms.hhs.gov); john.allison@cms.hhs.gov; Kathleen Snider; Stephen Nowell; Andrew Grimes; Bryon Gibbs; John Supra
Subject: FW: SCDHHS Audit Plan for the S.C. Medicaid EHR Incentive Program

Good afternoon,

SCDHHS initially submitted an Audit Plan for CMS review on May 25, 2012, to which CMS responded with comments on June 18. SCDHHS submitted a revised Audit Plan on October 31; however, we learned after the fact that CMS had sent a formal letter dated October 16, 2012 to comment on the May Audit Plan submission, and to request a revised Audit Plan along with a Change Control for changes made. That CMS letter was received by the SCDHHS Office of the Director on October 30, and the HIT Division received it a few days later.

Pursuant to that letter, the SCDHHS Audit Division has prepared a Change Control document (please see attached) to detail the changes reflected in the revised Audit Plan (dated 2012_10_29). Should you have any questions, please contact Stephen Nowell, Director of the SCDHHS Division of Audits (nowells@scdhhs.gov , or 803-898-2527).

Best wishes for a Happy Thanksgiving!
Susan Hartnett

From: Susan Hartnett
Sent: Wednesday, October 31, 2012 2:09 PM
To: Benjamin (CMS/CMCHO) Thompson; Jason (CMS/CMCHO) McNamara
Cc: Enitan(CMS/CMCHO) Oduneye; Jacqueline Y. (CMS/CMCS) Higgins; John R. (CMS/CMCS) Allison; Bryon Gibbs;

Andrew Grimes; Stephen Nowell; Kathleen Snider
Subject: RE: SCDHHS Audit Plan for the S.C. Medicaid EHR Incentive Program

Good afternoon, all,

SCDHHS is pleased to submit for your review and approval the *revised* SCDHHS audit plan for the S.C. Medicaid EHR Incentive Program. A cover letter from Mr. Stephen C. Nowell, Director of the Division of Audits, SCDHHS, is also included. Please contact me (hartnetts@scdhhs.gov , or 803-734-0224) or Stephen Nowell (nowells@scdhhs.gov , or 803-898-2527) with any questions. We look forward to your feedback.

Best regards,
Susan W. Hartnett
Director, SCDHHS Division of HIT

From: Benjamin (CMS/CMCHO) Thompson [mailto:Benjamin.Thompson@cms.hhs.gov]
Sent: Monday, June 18, 2012 5:20 PM
To: Jason (CMS/CMCHO) McNamara; Susan Hartnett
Cc: Enitan(CMS/CMCHO) Oduneye; Jacqueline Y. (CMS/CMCS) Higgins; John R. (CMS/CMCS) Allison; Bryon Gibbs; Andrew Grimes; Stephen Nowell; Kathleen Snider
Subject: RE: SCDHHS Audit Plan for the S.C. Medicaid EHR Incentive Program

Hi Susan,
Here are our initial comments from reviewing your audit strategy. We *cannot* approve the strategy until we have some more information. We have also added GA's audit strategy to help assist you with the development of your comprehensive strategy. We are happy to meet with you and the auditing team to discuss our comments, however, if you review the GA strategy, you should be able to understand what type of "depth" we are expecting.

General Comments: The audit plan did not include a detailed/comprehensive explanation of the auditing of meaningful use (MU)measures, nor did the audit strategy accurately identify provider risk pools and/or materialized thresholds. We recommend the State review the Medicare MU Audit Strategy, as well Georgia's Audit Strategy guide.

Page 4: Define supporting documentation for Adopt, Implement, and upgrade of Certified EHR Technology.

Page 5: Risk factors should be lower for an EP if they are working with a REC, however, the REC cannot be used anytime during a pre/post payment audit process. On this page, it was not clear if the REC was being used or not. During our review, we did not notice risk pools assigned to EPs/EHs. Does the State have risk pools and thresholds assigned to the audit process?

Page 6, second bullet: Providers must attest to AIU *or* MU before receiving an incentive payment. Please change.

Page 6: How are providers targeted for audits? We are also interested in the strategy behind random audits, i.e., the percentage of random audits per audit population strata.

Page 6: We are interested in the variables used to define irregularities from provider attestations. Please provide a more detailed list.

Page 7: The review of staff training records is not a requirement for AIU. Please remove.

Page 8, Audit Target Selection: We are interested in the thresholds used to determine if an EH/EP has an invalid or questionable attestation. It does not appear that risk pools are properly identified. For example, does a provider with a 33% threshold for patient volume move through the audit processes differently than a provider with 60% Medicaid patient volume?

Page 9: Please provide detail on the SOP's used by auditors for desk reviews and onsite audits. The audit strategy did not define the process for the field auditors.

Page 9: While we support random sampling of provider populations, a much more strategic approach is recommended. The benchmark number of 52 is low in comparison with other States.

Page 10: As mentioned in previous comments, please define the risk pools for EPs and EHs

Please let me or Jason know if you have any further questions,
Regards,
Ben

Benjamin J. Thompson
HIT Coordinator
Centers for Medicare & Medicaid Services
Consortium for Medicaid and Children's Health Operations
W: 312.886.5355| **C: 312.972.3412**| F: 443.380.6712
www.cms.gov/EHRIncentivePrograms

From: Susan Hartnett [mailto:HARTNETTS@scdhhs.gov]
Sent: Friday, May 25, 2012 11:02 AM
To: McNamara, Jason (CMS/CMCHO); Thompson, Benjamin (CMS/CMCHO)
Cc: Allison, John R. (CMS/CMCS); Stephen Nowell; Andrew Grimes; Bryon Gibbs; Kathleen Snider
Subject: SCDHHS Audit Plan for the S.C. Medicaid EHR Incentive Program

Good afternoon, all,

SCDHHS is pleased to submit for your review and approval the SCDHHS audit plan for the S.C. Medicaid EHR Incentive Program. A cover letter from Mr. Stephen C. Nowell, Director of the Division of Audits, SCDHHS, is also included. Please contact me (hartnetts@scdhhs..gov , or 803-898-0147) or Stephen Nowell (nowells@scdhhs.gov , or 803-898-2527) with any questions. We look forward to your feedback.

Best regards,
Susan W. Hartnett
Director, SCDHHS Division of HIT