

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Supra</i>	DATE <i>10-25-11</i>
------------------------	-----------------------------

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <div style="text-align: center; font-size: 1.2em;">100180</div>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____ <input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>11-14-11</i> <input type="checkbox"/> FOIA DATE DUE _____ <input type="checkbox"/> Necessary Action
2. DATE SIGNED BY DIRECTOR <div style="text-align: center;"> <i>cc: Mr. Jack, Depo, CMS file</i> <i>Cleared 11/21/11, letter</i> <i>attached.</i> </div>	

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

Department of Health & Human Services
Centers for Medicare & Medicaid Services
Consortium for Medicare and Children's
Health Operations
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601



October 20, 2011

RECEIVED

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

Department of Health & Human Services
OFFICE OF THE DIRECTOR

Re: CMS Site Visit (September 26, 2011 – September 28, 2011)

Dear Mr. Keck:

Thank you for accommodating staff from the Centers for Medicare & Medicaid Services (CMS) as we conducted a site visit with South Carolina's Medicaid EHR Incentive Program staff and various other EHR Incentive Program stakeholders around the State between September 26 and September 28, 2011.

Over the three-day site visit, CMS met with over 30 different stakeholders (representing the State's EHR Incentive Program staff, contractor staff, providers, hospitals, provider associations, the hospital association, public health staff, and regional extension centers). The purpose of the site visit was for CMS to not only gain a better understanding of how the State is implementing its Medicaid EHR Incentive Program and how the program is being received by the provider community, but to make recommendations so that State staff can better operationalize the program within federal regulations and guidance.

During the site visit, CMS identified issues where the State's EHR Incentive Program is operating outside of Federal regulation found at 42 CFR Part 495, Subpart D, and subsequent sub-regulatory guidance. We have identified and included these issues in Enclosure A of this letter. These issues must be addressed in a revised, red-lined State Medicaid Health Information Technology Plan (SMHP) and submitted to CMS for our review and approval by November 21, 2011. When submitting the revised SMHP, please include a change control document specifying where in the SMHP the State has addressed the required changes. Federal financial participation towards the State's expenses for administration and oversight of the Medicaid EHR Incentive Program is predicated upon compliance with Federal regulations and guidance. CMS views the SMHP as the vehicle to communicate the State's policies and activities to CMS and stakeholders.

We are also providing additional comments and recommendations in Enclosure B that we hope will benefit South Carolina's EHR Incentive Program. The State is not required to implement these recommendations. However, if any of these comments and recommendations are adopted, the changes should be notated in submission of a revised SMHP in the future.

Mr. Keck, Page 2

CMS appreciates South Carolina's commitment and dedication to administering 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 Rick Friedman at (410) 786-4451, or via email at Richard.Friedman@cms.hhs.gov.

Sincerely,

A handwritten signature in cursive script, reading "Jackie Garner".

Jackie Garner
Consortium Administrator

Enclosure A

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

1. The South Carolina provider attestation screens currently display fields related to the "Net Average Allowable Cost" (NAAC) as part of the provider attestation process. Per the Medicaid and Medicare Extenders Act of 2010, and the subsequent State Medicaid Directors letter (#11-002) issued by CMS on April 8, 2011, this requirement has been removed from the program. As such, NAAC should not be included as part of provider attestation. Please remove it from the provider attestation screens.
2. For eligible professionals (EPs) who decide to use the group patient volume proxy in place of their individual patient volume, the State is disallowing providers who were not part of the group or clinic during the group/clinic proxy reporting period. EPs who were not part of the group/clinic during the reporting period can still use the group proxy data so long as they are eligible for the EHR Incentive Program and their use of the group proxy calculation is appropriate (i.e., they currently see Medicaid patients).
3. During the site visit, it was not clear how a hospital attests to the data they submit for the Medicaid hospital calculation. The State Level Repository (SLR) does not capture this attestation and hospitals are required to send in their reports to the State hospital staff. The State must define a process (preferably through the provider attestation tool) to capture data entered in the Medicaid Hospital Calculation and that requires an eligible hospital to legally attest to the integrity and compliance of the data. Please define this process to CMS.
4. South Carolina's Audit Team informed CMS that eligible professionals who are selected for a State audit are required to respond to a questionnaire so that the desk auditor can become "more familiar with the practice." While we support the use of a questionnaire for this purpose, the State cannot require an eligible professional or hospital to provide documentation verifying that the provider had adopted, implemented or upgraded to certified EHR technology (AIU) in addition to what was described in the Medicare and Medicaid EHR Incentive Programs Final Rule issued on July 28, 2010. Specifically, the questionnaire required the provider to produce documentation beyond the CMS regulatory definition of adopting, implementing or upgrading to certified EHR technology (AIU). The State cannot ask providers to provide documentation to support their attestation that exceeds the definition of what qualified them for the incentive payment, at risk of recoupment.

Per federal guidance, the State is allowed to define what is considered acceptable documentation of a legal and/or financial commitment to certified EHR technology. The South Carolina SMHP included the list of that documentation and was approved by CMS. It is not acceptable to require more of eligible providers than is defined in Federal regulation or was approved by CMS in the

SMHP. The audit teams can only require that eligible professionals and hospitals provide the approved AIU documentation during a formal audit. It would not be acceptable for a provider to have his/her EHR incentive payment recouped by the State on the basis of failure to submit documentation to support activities above and beyond how AIU is defined in Federal regulation and the approved South Carolina SMHP. Therefore, prior to requiring any providers to complete any audit questionnaire, please submit the State's revised questionnaire to CMS for approval. Please cease administering the current questionnaire to providers in the interim.

Enclosure B

The following comments and recommendations may assist with administration activities and help further improve the State's Medicaid EHR Incentive Program. Any comments or recommendations that the State chooses to adopt should be notated in submission of a revised SMHP.

1. Overall, the provider attestation tool is very hard to follow. This could be a problem for eligible professionals and hospitals that are using the system. Areas to consider revising include the following:
 - a. The Children's Health Insurance Program (CHIP) discount factor is computed and applied in a confusing manner.
 - b. We consider accepting documentation of AIU during attestation a "best practice." Although this is not required, this helps the State understand how providers are interpreting guidance as to what the State considers an acceptable document. Adding this process to provider attestation can also help the pre-payment and post-payment audit process.
 - c. The State analyzes the data from provider attestations through a manual process. Once a pre-payment verification is complete, the report is sent to CMS for payment processing. CMS encourages a more automated long-term solution that can build in some pre-payment verification checks and reduce the risk of improper payments.
2. From CMS conversations with eligible hospitals and the State hospital association, it appears that State communication to hospitals and their professional associations about the EHR Incentive Program have been minimal to date. The States with the highest percentages of eligible providers that have registered and attested are States that have included provider professional associations as part of their outreach efforts. We recommend that the hospital association be included in the State's efforts to reach out to hospitals about the EHR Incentive Program in general and the hospital payment calculation in particular.

Log # 180

November 21, 2011

Ms. Jackie Glaze
Associate Regional Administrator
Division of Medicaid and Children's Health Operations
Centers for Medicare and Medicaid Services-Region IV
61 Forsyth Street, SW, Suite 4120
Atlanta, Georgia 30303-8909

Dear Ms. Glaze:

Thank you for the Centers for Medicare and Medicaid Services (CMS) recent response and approval of the South Carolina Health and Human Services' (SCDHHS) updated South Carolina State Medicaid Health Information Technology Plan (SMHP), Version 4.1, and of the Health Information Technology (HIT) Implementation Advanced Planning Document (IAPD), Version 2.1, for the South Carolina Medicaid EHR Incentive Program.

In response to CMS' requirements for changes to the SMHP generated from the September 2011 CMS site visit, as specified in Enclosure A to your letter dated October 20, 2011, we respectfully submit changes to the SMHP, enclosed as Version 4.2.

Please note that Issue #1 on the CMS Enclosure A was already addressed in our current SMHP Version 4.1. The following information appears on page 114: "Initially, Medicaid agencies were required to verify that an EP demonstrates 'net allowable costs, contributions from other sources, and a 15% provider contribution in order to participate in the Medicaid EHR Incentive Program. However, as detailed in the State Medicaid Director's Letter dated April 8, 2011, the Medicare and Medicaid Extenders Act of 2010 now provides that an EP has met this responsibility, as long as the incentive payment is not in excess of 85% of the NAAC (this equals \$21,250 for payment year one). The documentation originally required by an EP to demonstrate that he or she has contributed 15% of the NAAC is also no longer needed." However, in response to CMS' Issue #1, we have removed the "View Only" information in the S.C. Medicaid State Level Repository that displayed how the payment amount of \$21,250 was originally calculated; this had been available to providers to select for informational purposes only. Said differently, this was a static display that did not accept data input from the provider.

Please note that Issue #2 on the CMS Enclosure A (regarding SCDHHS disallowing new providers of a group from using group patient volume as a proxy for their own) was already addressed in our most recent SMHP update, SMHP version 4.1, on page 103.

Issue #3 on the CMS Enclosure A requires SCDHHS to define a process to capture data for the EH Medicaid Hospital Calculation and to require an eligible hospital (EH) to legally attest to the integrity and compliance of the data. For Participation Year FY2011 EH attestations, the SCDHHS Bureau of Reimbursement Methodology and Policy will prepare an Incentive Payment Calculation Worksheet that displays all of the data for an EH's aggregate payment calculation and will send that to the EH's authorized representative. The worksheet will instruct the EH to verify the data; the EH will also be required to input information to differentiate charity care and bad debt. The EH representative must then return to the EH attestation in the S.C. Medicaid

PDF File for the rest of
the log is dated 11/3/12
@ 1:13:00PM

Ms. Jackie Glaze
November 21, 2011
Page 2

State Level Repository (SLR), enter the verified data into the aggregate incentive payment calculation fields, and re-submit the EH attestation. The EH must also upload documentation that supports the attestation of patient volume. Please note: For Participation Year 2012 and beyond, the SLR will offer the functionality such that an EH will upload the patient volume documentation, and attest to the aggregate incentive data, when first submitting an attestation.

Issue #4 on the CMS Enclosure A addresses the audit questionnaire that was being used at the time of the CMS site visit. The following response has been provided by Ms. Kathleen Snider, Bureau Chief of SCDHHS Program Integrity and Compliance. "SCDHHS did immediately cease administering the questionnaire and followed up with the providers to whom it had been sent to instruct them to disregard the General Background questions, as they were not a part of the audit. CMS is requesting from all States a detailed audit plan that is to be included as an attachment to the SMHP, but not for public view. SCDHHS is drafting general audit protocols and detailed audit programs for each type of provider attesting and the encounter volume method chosen. These will be submitted to CMS for review upon completion.

However, we would also like to take this opportunity to clarify the agency's position regarding the audit questionnaire, and with all due respect, to correct CMS' misinterpretation of the audit questionnaire and how it was intended to be used. There was *never* any design on the part of SCDHHS 'to require more of eligible providers than is defined in Federal regulation or was approved by CMS in the SMHP...', nor would we *ever* have recouped the provider's incentives 'on the basis of failure to submit documentation to support activities above and beyond how ALU is defined in Federal regulation and the approved South Carolina SMHP'. This was simply not the intent.

The general background questions were intended as voluntary questions designed to get an understanding of the EHR program at the provider level. We also sought to gain an understanding of how providers are using EHR technology in their offices, so we could assess the level of risk of non-compliance with eligibility requirements. The Medicaid EHR Incentive Program is new, and we have not audited in this area before. Generally accepted governmental auditing standards tell us that the auditor should obtain an understanding of the program to be audited. For example, one of the background questions asked: 'Do you use paper charts or have you implemented an electronic system?' More importantly, the cover letter which accompanied the questionnaire encouraged the provider to call at his convenience to discuss the questionnaire so we may respond to any concerns or questions the provider might have. The audit staff did call or receive calls from several of the providers, and none voiced any concerns about the background questions. If any grant recipient had been unable or unwilling to answer the background questions, this would not have affected his EHR payment eligibility in any way, contrary to what CMS assumed.

CMS is funding the incentive payments with 100% federal funds, and in effect is engaging States to do these audits. As such, CMS quite correctly wants these audits to meet program goals – that is, to ensure that only eligible providers are receiving the incentive payments. This is certainly our goal as well. However, there has been very little guidance from CMS as to its

November 14, 2011

**SOUTH
CAROLINA
DEPARTMENT
OF HEALTH &
HUMAN
SERVICES**

STATE MEDICAID HIT PLAN (SMHP) VERSION 4.2 CHANGE CONTROL DOCUMENT

South Carolina Medicaid Electronic Health Record (EHR) Incentive Program

2010-2015

Table of Contents

South Carolina SMHP Change Control Record.....	3
--	---

A note about this document: The tables in this document identify the selected excerpts from the South Carolina State Medicaid Health Information Technology Plan (SMHP). The tables provide a brief reference to significant updates in the SMHP and therefore should be used in consultation with the complete South Carolina SMHP.

South Carolina SMHP Change Control Record

Item	Excerpt from SMHP and corresponding page #
1. EH Aggregate Payment Calculation: Capture of Data for Attestation	<p>Response to CMS letter dated October 20, 2011 requiring a process for capture of data, and EH attestation to the data, for calculation of EH aggregate payment:</p> <p>Page 110: "For Participation Year FY2011 EH attestations, the SCDHHS Bureau of Reimbursement Methodology and Policy will prepare an Incentive Payment Calculation Worksheet that displays all of the data for an EH's aggregate payment calculation and will send that to the EH authorized representative. The worksheet will instruct the EH to verify the data; the EH will also be required to input information to differentiate charity care and bad debt. The EH representative must then return to the EH attestation in the S.C. Medicaid State Level Repository (SLR), enter the verified data into the aggregate incentive payment calculation fields, and re-submit the EH attestation. The EH must also upload documentation that supports the attestation of patient volume. Please note: For Participation Year 2012 and beyond, the SLR will offer the functionality such that an EH will upload the patient volume documentation, and attest to the aggregate incentive data, when first submitting an attestation."</p>
2. EH Patient Volume: Information Added to Clarify Allowable Discharges to Use in the Patient Volume Calculation	<p>Eligibility Criteria for EHs, Pages 103-106: Changes in pages 103 through 106 were made in order to clarify the CCN number as the Medicare provider number as well as eliminate any reference to subprovider unit (i.e. psych and rehab units contained within the general acute care hospital) discharges in the calculation of the EH patient volume calculation unless they are coded as an inpatient hospital bill as defined by the UB-04 Manual. See EH Checklist for further information.</p>
3. EH Patient Volume: Information Added to Clarify Allowable Discharges and ER Visits to Use in the Patient Volume Calculation	<p>Eligibility Criteria for EHs, Pages 106-110: Additional changes in pages 106 through 110 were made in order to clarify that discharges and ER visits associated with Medicaid individuals with commercial insurance could only be counted when Medicaid paid for all or part of the claim. Additionally, language was provided regarding dual eligible discharges and ER visits to clarify that \$0 paid claims could be included as a discharge and ER visit since Medicaid paid for all or part of the premium. And finally, upon receipt of the patient volume data from each participating hospital, the SCDHHS will initiate the calculation of the aggregate EHR incentive payment amount (assuming that the hospital has met the 10% Medicaid</p>

Excerpt from SMHP and corresponding page #	
Item	patient volume requirement) for provider attestation purposes.
4. Attestation of AIU: Information Added to Clarify Evidence of AIU	<p>Attestation of Adopt, Implement, or Upgrade (AIU), Pages 110-111: Information has been added to provide examples of evidence of legal or financial commitment to the AIU of certified EHR technology, and to clarify that a letter from the certified EHR technology vendor, although valuable as a supplement to other evidence, will not be regarded as stand-alone evidence of AIU:</p> <p>“The EP or EH must attest to the AIU of certified EHR technology, and retain evidence that demonstrates the EP/EH’s legal or financial commitment to the AIU of certified EHR technology prior to the attestation. This evidence would serve to differentiate between activities that may not result in AIU (for example, researching EHRs, interviewing EHR vendors, contract proposals) and an actual commitment to the AIU. Documentation of the legal or financial commitment may include but is not limited to: an invoice and receipt for payment; purchase agreement; license agreement; binding contract (signed by both parties), etc. Should the documentation not specify the certified EHR technology product (product name and version), a letter from the certified EHR technology vendor that clarifies the product name and version may be retained along with the documentation as a supplement; however, such a letter will not be regarded as stand-alone evidence of AIU.</p>
5. Attestation of MU in 2012: Timeline Change	<p>Attestation of Meaningful Use, Page 111: Medicaid providers who meet the Stage 1 meaningful use criteria will be able to attest to meaningful use in the SLR beginning early 2012.</p>
6. Incentive Payments to EHS: Information Added to Clarify Source Documents/Cost Report Data Worksheet References	<p>Incentive Payments to EHS, Pages 116-119: Changes in pages 116 through 119 were made in order to clarify the Primary and Secondary source documents used in the EH incentive payment calculation as well as the hospital cost report worksheet references. Another change was made to clarify that only general acute care inpatient hospital days could be used in this payment calculation, thus eliminating subprovider unit (i.e. psych and rehab) days from the calculation. The final change under this section clarifies that hospitals must ensure that bad debt expense is excluded from any charity care charges reported in their Medicare/Medicaid cost reports.</p>

Item	Excerpt from SMHP and corresponding page #
7. Payment Schedule of Aggregate EHR Incentive Payment Amount for Qualifying Hospitals	<p>Incentive Payments to EHs, Page 119: The change on page 119 clarifies the payment schedule that SCDHHS will follow to pay the aggregate EHR incentive payment amount. The Centers for Medicare and Medicaid Services has clarified for the SCDHHS that the State must determine the payment schedule for disbursement of the EH aggregate payment amount. The SCDHHS sought input from the South Carolina Hospital Association, and was advised to disburse the incentives over three payment years. The following statement has been removed: "EHs will select the number of years over which they would like to receive the incentive payment in the SLR"; and replaced with: "An EH must continue to meet the requirements for eligibility for the incentive and submit an attestation via the S.C. Medicaid State Level Repository each payment year. SCDHHS will pay out the aggregate payment amount over three payment years as the EH continues to meet program requirements: 50% the first payment year, 40% the second payment year, and 10% the third payment year. "</p>