



## Tips for Eligible Professionals Selected for a Post Payment Review of the Connecticut Medicaid Electronic Health Record (EHR) Incentive Program Payment.

Why is the State conducting audits of the Connecticut Medicaid EHR Incentive Program payments?

Section 1903(t)(2) of the HITECH Act states that all eligible professionals need to meet certain patient volume thresholds in order to be eligible for incentive payments. The *Medicare and Medicaid Program Electronic Health Record Incentive Program Final Rule* issued by the Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) explains that states are responsible for auditing the program and must have reliable sources of data. Because the Connecticut Department of Social Services is accountable to CMS for the incentive payments made, we are conducting reviews of some incentive payments. It is possible that you might be selected for a review for any installment of the incentive payments.

### What can I expect if I am selected for a desk review or on-site review?

You will receive a notification letter that will indicate if the review will be completed as a desk review or an on-site review by our contractor, Myers and Stauffer LC. You can also expect to be contacted by e-mail and/or phone by Myers and Stauffer. The letter will list the initial documentation needed to complete the review. Providing the documentation in a secure electronic format is preferable to paper documents. Depending on the information provided, Myers and Stauffer may request additional information. In the event that Myers and Stauffer determines the information to which you attested was not in accordance with the Final Rule or does not support the minimum eligibility threshold, Myers and Stauffer will work with you to try to identify an eligibility period for which you can provide documentation that supports the minimum eligibility threshold using appropriate calculation methods. Failure to document eligibility or failure to cooperate with Myers and Stauffer may result in recoupment of the incentive payment. DSS will notify you of the results of the review, which will also contain instructions on the recoupment process if a recoupment is necessary. If you do not agree with the results you may appeal the decision in accordance with our appeals process described in the General Statutes of Connecticut in Sec.17b-99 which can be accessed at: <https://www.cga.ct.gov/current/pub/titles.htm>

In accordance with accounting standards, you will receive a representation letter to be signed by you or your authorized representative. Myers and Stauffer will provide details about the representation letter during the review.

**All** information under attestation is subject to audit. This documentation should be readily available because it was needed for attestation. These documents should be maintained for **6 years** following the date of attestation. Documentation that would be necessary to complete the eligibility portion of the review may require, at a minimum (see next item for meaningful use documentation requirements):

- **Numerator:** A detailed list of Medicaid encounters during your selected 90-day period for which Medicaid was the patient's guarantor regardless of the amount paid.
- **Denominator:** A detailed list of all encounters (the numerator should be an identifiable sub-set of the denominator) that occurred during the 90-day period.
- At a minimum, the detailed information to validate the numerator and denominator should include patient name, date of service, payer source, and rendering provider.
- **Locations:** If encounter volume being attested to is for more than one location, the documentation should include all locations included in the attestation.
- **Group Proxy:** If the attestation utilizes the group proxy methodology, documentation should include all providers with the group during the selected 90-day period. Personnel or other records (tax documents, payroll documents,...) should be maintained to validate the group proxy was calculated using encounters from all providers and was not limited in any way.



- **Practice Predominantly:** If the attestation utilized needy patient encounters and the EP practices at more than one location which is not an FQHC/RHC, documentation should be maintained that supports that the EP practices predominantly at an FQHC or RHC. An EP practices predominantly when the clinical location for over 50% of the EP's total patient encounters over the required six-month period occurs at an FQHC or RHC.

There are several documents that can be used to assist in calculating the patient volume percentage, as long as the documentation adheres to standards of the Final Rule, the following are **examples of acceptable documents:**

- **Appointment Sheets:** Must be able to document cancellations, no-shows, walk-ins, the date of service along with the servicing provider, and paid amount for the Medicaid patients.
- **Accounts Payable Log, Activity Reports and Billing Journals:** Must calculate encounter volume based on a unique encounter, not based on units billed or procedure codes.
- Supporting documentation should be maintained in an audit friendly format such as Excel or text file.
- If a change in billing companies, EHR or EMR software vendors or software companies from which detailed documentation was generated, a copy of the data should be saved so that prior records can be retrieved in the event a provider is selected for an audit. The documentation should be readily available.

### **Will DSS be conducting audits of meaningful use measures and clinical quality measures?**

Yes. It is important for you to maintain detailed documentation supporting your eligibility and meaningful use attestations. This documentation includes the information listed above for eligibility plus the system generated core, menu, and clinical quality measures reports for the EHR reporting period to which you attested. You must also maintain documentation supporting exclusions, and "yes"/"no" attestations, including the security risk analysis (SRA) completed during the program year.

### **Acceptable forms of Meaningful Use Documentation:**

- Percentage based measures – System generated report which contains the provider name, system name, and the MU reporting period along with the numerator and denominator.
- "Yes/No" measures –
  - Dated screenshot from CEHRT, vendor letter for appropriate time period, state letter for appropriate time period.
  - Screenshots should include timestamp for the appropriate reporting period under review, contain the provider or practice name and measure title.
  - For certain measures, copies of email transmissions or specification sheet from CEHRT vendor validating if a measure is always on and never can be turned off.
- Exclusions – Letters from the state, letters from CEHRT vendor, copies of emails.
- Public Health Reporting – Copies of transmission to support submitting data to registry for:
  - Immunization, Syndromic Surveillance, Specialized Registry

For meaningful use attestations, group patient volume is allowable to meet the patient volume criteria; however, **each provider attesting for a meaningful use incentive payment should attest to their own individual meaningful use measures** (core, menu and CQMs).

### **Resource documents available to assist in post payment audit process:**

1. All Prior Program Years - <https://www.cms.gov/RegulationsandGuidance/Legislation/EHRIncentivePrograms/RequirementsforPreviousYears.html>
2. Program Year 2016 – <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2016ProgramRequirements.html>