VERMONT
DEPARTMENT OF VERMONT HEALTH ACCESS

EHR INCENTIVE PROGRAM

VT Medicaid EHR Incentive Program Audits

Semi-Annual Blueprint Conference
October 20, 2014

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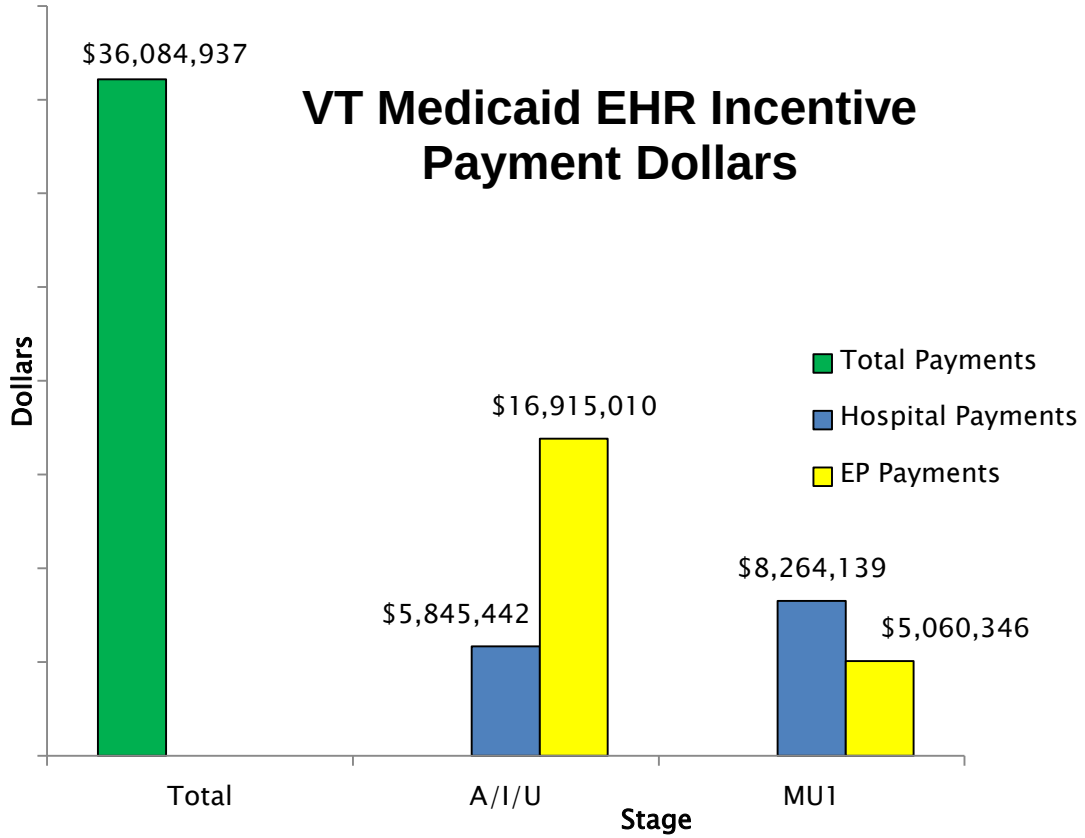
Agenda

- Incentive program audit background
- Who conducts the Audits
- VT Medicaid EHR Incentive Program audit process
- Essential documentation needed
- VT Medicaid appeals process
- Returning an incentive payment

VT Medicaid EHR Incentive Payments



Eligible Professional (EP) payments:

- 810 A/I/U
- 604 MU
- 1,414 total

Eligible Hospital (EH) payments:

- 10 A/I/U
- 21 MU
- 31 total

2011 A/I/U ➡ MU Conversion Rate

- 354 EPs attested to A/I/U, 256 of these EPs have also attested to Meaningful Use: **72.3% !**

Authority to Conduct Audits

*Federal Regulation **42 CFR § 495.368** of the Health Information Technology for Economic & Clinical Health (HITECH) Act, **Combating fraud and abuse***

(a) *General rule*

(1) The State must comply with Federal requirements to:

(i) Ensure the qualifications of the providers who request Medicaid EHR incentive payments;

(ii) Detect improper payments; and

(iii) In accordance with § 455.15 and § 455.21 of this chapter, refer suspected cases of fraud and abuse to the Medicaid Fraud Control Unit.

(2) The State must take corrective action in the case of improper EHR payment incentives to Medicaid providers.

Who will Conduct Audits?

Medicare

- CMS contracted with Figliozzi and Company
  - Medicare Eligible Professionals (EPs) and Eligible Hospitals (EHs)
  - Medicare & Medicaid dually eligible EH Meaningful Use (MU) attestations

Medicaid

- Department of Vermont Health Access auditors:
  - EPs that attested to adopting, implementing, upgrading (A/I/U).
  - EPs that attested to MU of certified EHR technology.
  - Medicaid & dually EHs that attested to A/I/U.
  - The eligibility portion of Medicaid & dually eligible hospital MU attestations.
- EPs are audited, not the organization
  - Except Eligible Hospitals/Critical Access Hospitals

Vermont Audit Plan

- CMS must approve state audit strategy
- Pre-payment validation
- Post payment audits
  - Procedures vary depending upon year and stage in the program
    - Adopt/Implement/Upgrade (A/I/U)
    - Meaningful Use (MU)
    - Patient encounter definition
  - Time frame

What Generates an Audit?

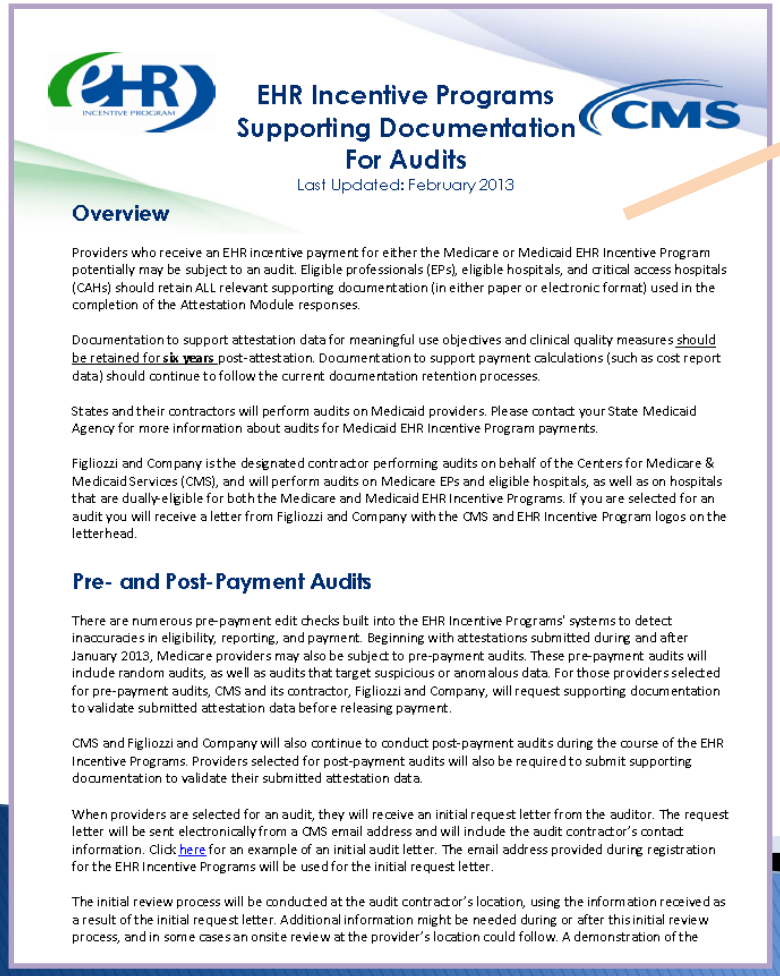
- Risk assessments
  - CMS-approved risk factors
  - Performed on all Eligible Professionals (EPs) & Hospitals (EHs)
- Random sampling

Post Payment Audits

- A/I/U stage – primarily desk audits
  - Eligibility requirements
- MU stages – desk & onsite audits
  - Eligibility requirements
  - MU measure requirements
- Fraud, waste, or abuse
  - Suspected cases will be referred to the Attorney General's Medicaid Fraud Unit

Preparing for an Audit: CMS Resources

CMS Guidance for EHR Incentive Program Audits



EHR Incentive Programs
Supporting Documentation
For Audits

Last Updated: February 2013

Overview

Providers who receive an EHR incentive payment for either the Medicare or Medicaid EHR Incentive Program potentially may be subject to an audit. Eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) should retain ALL relevant supporting documentation (in either paper or electronic format) used in the completion of the Attestation Module responses.

Documentation to support attestation data for meaningful use objectives and clinical quality measures should be retained for **six years** post-attestation. Documentation to support payment calculations (such as cost report data) should continue to follow the current documentation retention processes.

States and their contractors will perform audits on Medicaid providers. Please contact your State Medicaid Agency for more information about audits for Medicaid EHR Incentive Program payments.

Figliozzi and Company is the designated contractor performing audits on behalf of the Centers for Medicare & Medicaid Services (CMS), and will perform audits on Medicare EPs and eligible hospitals, as well as on hospitals that are dually-eligible for both the Medicare and Medicaid EHR Incentive Programs. If you are selected for an audit you will receive a letter from Figliozzi and Company with the CMS and EHR Incentive Program logos on the letterhead.

Pre- and Post-Payment Audits

There are numerous pre-payment edit checks built into the EHR Incentive Programs' systems to detect inaccuracies in eligibility, reporting, and payment. Beginning with attestations submitted during and after January 2013, Medicare providers may also be subject to pre-payment audits. These pre-payment audits will include random audits, as well as audits that target suspicious or anomalous data. For those providers selected for pre-payment audits, CMS and its contractor, Figliozzi and Company, will request supporting documentation to validate submitted attestation data before releasing payment.

CMS and Figliozzi and Company will also continue to conduct post-payment audits during the course of the EHR Incentive Programs. Providers selected for post-payment audits will also be required to submit supporting documentation to validate their submitted attestation data.

When providers are selected for an audit, they will receive an initial request letter from the auditor. The request letter will be sent electronically from a CMS email address and will include the audit contractor's contact information. Click here for an example of an initial audit letter. The email address provided during registration for the EHR Incentive Programs will be used for the initial request letter.

The initial review process will be conducted at the audit contractor's location, using the information received as a result of the initial request letter. Additional information might be needed during or after this initial review process, and in some cases an onsite review at the provider's location could follow. A demonstration of the

Providers who receive an EHR incentive payment for either the Medicare or Medicaid EHR Incentive Program potentially may be subject to an audit.

- Retain ALL relevant supporting documentation used in the completion of your attestation, including documentation to support data for meaningful use objectives and clinical quality measures (CQMs), for **six years** post-attestation.
- Retain documentation that is in either paper or electronic format, including relevant screenshots.
- Download and/or print a copy your MU report *at the time of attestation* for your records.

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHR_SupportingDocumentation_Audits.pdf

Preparing for an Audit

"An audit may include a review of any of the documentation needed to support the information that was entered in the attestation."

- Maintain copies or have access to:
  - Signed attestations submitted via MAPIR
  - Purchase orders, contracts, etc. related to your CEHRT
    - EHR Certification ID

Program Year	Sample Certified EHR Number	Description
2011 & 2012	A000001CFES9EAB	Original Certified EHR Number
2013	A0H1301CFES9EAB	3rd – 5th digits denoted by 'H' & '13'
2011-2014 combo*	A0H1301CFES9EAB	3rd – 5th digits denoted by 'H' & '13'
2014	A014E01CFES9EAB	3rd – 5th digits denoted by '14' & 'E'

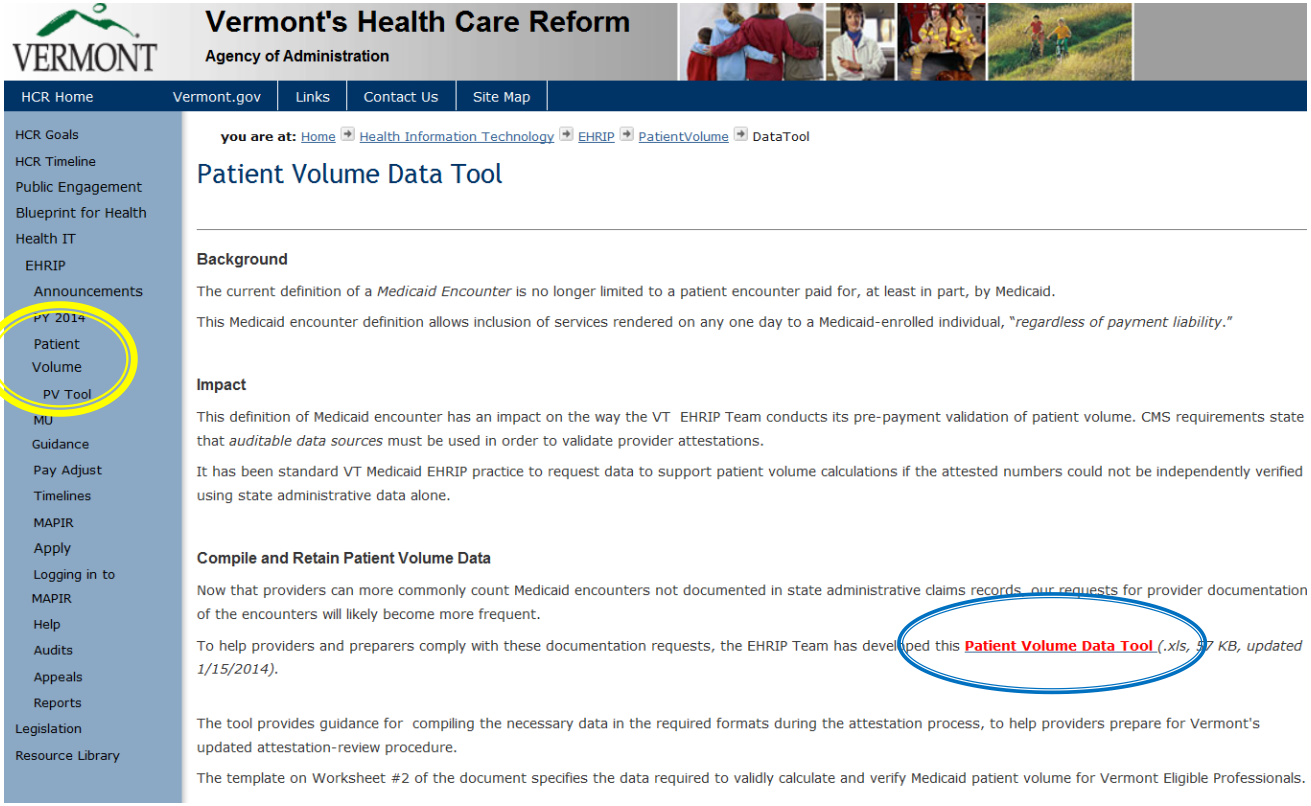
*CEHRT flexibility for Program Year 2014 only

Preparing for an Audit

Maintain copies or have access to:

- Reports or other documentation to support patient volume numerator & denominator

- http://hcr.vermont.gov/hit/ehrip/patientvolume/datatool



Preparing for an Audit

Patient Volume Data Tool Template

ColumnName	Description
AtndNpi	Attending (or rendering) provider NPI.
Pid	Patient unique ID. (Do not include social security numbers or names.)
Ruid	Medicaid Recipient Unique ID. (If patient was a Medicaid enrollee on the date of service.)
MdState	State in which the patient was enrolled in Medicaid. (If the patient was enrolled in Medicaid at the time of the encounter.)
CtmtId	Catamount Health Plan Recipient Unique ID. (If patient was a **Catamount Health Plan enrollee** on the date of service.) *Note, a multiplier of 83.8% will be applied to the total # of Catamount cases included, to reflect the percentage of Catamount Health Plan enrollees that receive premium assistance, per market analysis, *http://www.shadac.org/files/shadac/publications/VermontIssueBriefFinalReport.pdf*
EnctrDate	Patient encounter date.
BillNpi	For all **group attestations**: Billing provider NPI.
Group	For all **group attestations** based on a subpart of the billing provider NPI: Clinic name, group practice name, service location, or organizational subpart NPI.
Needy	For **Federally Qualified Health Centers** only: Did the patient encounter involve services to a non-Medicaid "needy individual" who was furnished uncompensated care by the provider, or who was furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay? (**Yes/No**)
FamPlan	For **Planned Parenthood of Northern New England** only: Was the patient encounter sponsored under the Vermont Medicaid Family Planning Initiative Grant? (**Yes/No**)
	Note: The data provided should include each and all of the direct patient encounters which were counted in either the patient-volume numerator or the patient-volume denominator of the attestation (i.e., we need data to support **both** the numerator and the denominator).

Preparing for an Audit

- Maintain copies or have access to:
  - Reports or other documentation to support meaningful use Core, Menu, & Clinical Quality Measures (CQMs)
    - Numerators and denominators for measures
    - Time period covered by report
    - Evidence to support it was generated for that EP, e.g. name, NPI#
    - Documentation to support yes/no measures
    - screen shots & other non-numerical supporting documentation should be dated
    - Proof to support each exclusion
    - CQMs: no percentage to meet, but data should come directly from CEHRT

Non-Percentage-Based MU Objectives

- Not all certified EHR systems are capable of tracking compliance for yes/no measures.

Meaningful Use Objective	Audit Validation	Suggested Documentation
Drug Formulary Checks	Functionality is available, enabled, & active for the duration of the reporting period.	One or more screen shots from the certified EHR that are dated during the selected reporting period.
Exclusions	Documentation to support each exclusion to a measure claimed by the provider.	Report from the EHR that shows a zero denominator for the measure or otherwise documents that the provider qualifies for the exclusion

CPOE for Medication Orders

Documentation to support measure

- Report generated from EHR or from an external data source supporting the numerator and denominator reported.

Documentation to support an exclusion

- Report from your EHR or from an external data sources demonstrating fewer than 100 prescriptions were written during the reporting period.

Record Vital Signs (Stage 1 2014)

Exclusion 1: Sees no patients 3 or older is excluded from recording BP

- Documentation: De-identified report showing ages of patients seen during reporting period

Exclusion 2: Believes vital signs not relevant to scope of practice

- Documentation: Statement describing irrelevance of vital signs

Exclusion 3&4: BP or height/weight not relevant

- Documentation: Statement describing irrelevance of vital signs being excluded

Clinical Decision Support Rule (yes/no)

Examples of documentation to support implementation of CDSR for reporting period

- Dated screenshots of rule being implemented
  - and statement of process/methodology of how rule was implemented
  - for Stage 2, statement of how rules relate to CQMs, or high-priority health conditions if no CQMs related to scope of practice
- Report or log from EHR showing that rule was triggered during reporting period

Protect Electronic Health Information

Security Risk Analysis Report

- Vendor built in check list not enough
- Dated before the end of your reporting period
- Evidence to support it was generated for EPs system
  - NPI, name, CCN for hospitals
- Inventory of assets or PHI
- Identifies Risks
- Corrective action plan for identified deficiencies

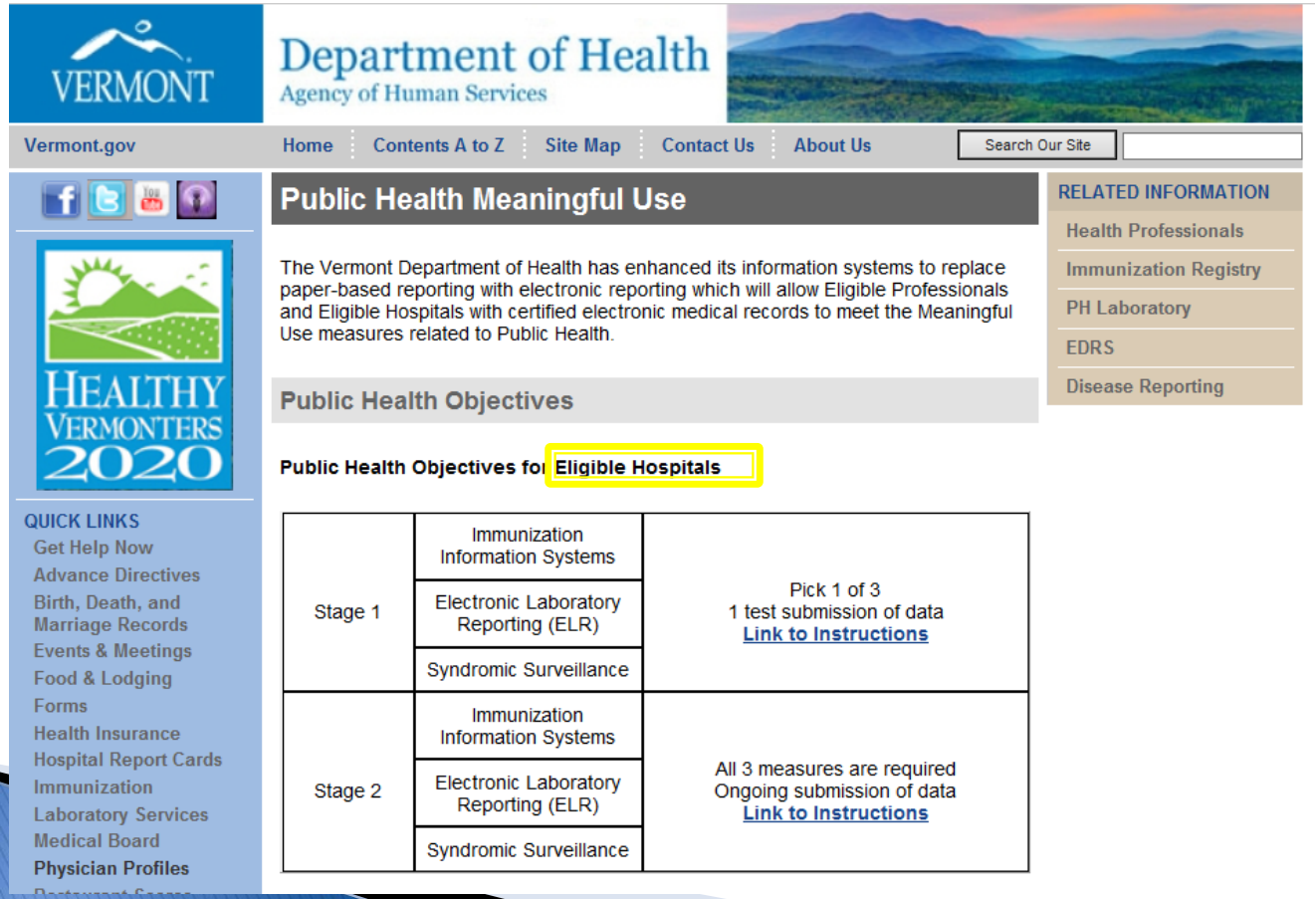
Security Risk Assessment Tool

http://www.healthit.gov/providers-professionals/security-risk-assessment

Public Health MU Measures

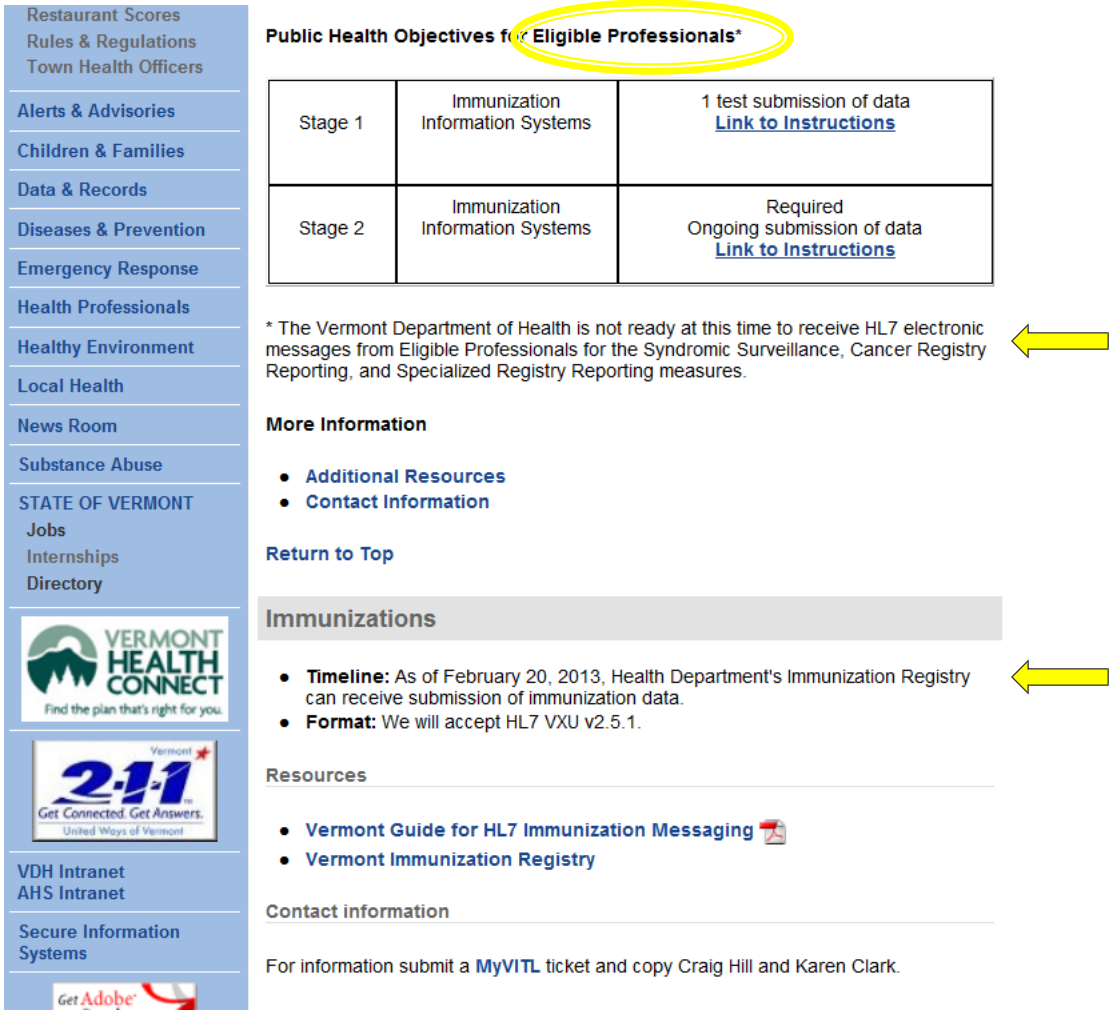
Vermont Department of Health website:

http://healthvermont.gov/hc/meaningful_use.aspx



Public Health MU Measures

Vermont Department of Health website:



Immunization Registry Data Submission

- **Need to actively participate in onboarding process after register**

- **Documentation to Support Measure**
  - Test Submission (Stage 1): A copy of the email, MyVITL ticket, screen shot, or letter from registry acknowledging the test for the practice, with provider's NPI indicated and the date
  - Ongoing Submission (Stage 2): A copy of the email, My VITL ticket, screen shot, or letter from registry acknowledging registration of intent (w/in 60 days of start of reporting period) & still engaged in testing or waiting for invitation to test, or ongoing submission, with NPI and date

Immunization Registry Data Submission

Documentation to Support Exclusion

- Report from EHR or an external data source demonstrating no immunizations were done during the reporting period
- Evidence of why provider could not onboard with registry, such as email or letter containing HL7 version details from vendor (applies to MU Stage 1only)

Desk Audit Letter

- If selected for an audit, likely receive a desk audit notification letter
  - Sent by both email & certified mail
  - Request for documentation to support attestation, such as:
    - Patient volume data
    - MU report
    - Audit tool questionnaire
  - Due date
  - Use secure email portal to submit data
- Auditor will follow up as necessary

Onsite Audit Letter

- If selected for an audit, may receive *onsite* audit notification letter
  - Sent by both email & certified mail
  - Will be contacted to schedule date
  - Documentation may be requested in advance of onsite visit
- Onsite audit preparation
  - Supporting documents
    - EHR system report, audit logs, system settings
    - Evidence to support submission of data for Public Health Measures
    - Print screens demonstrating functionality
  - Coordinate with personnel knowledgeable of EHR system to be available for interviews & to discuss supporting documentation
  - EHR demonstration during onsite review

Audit Results Letter

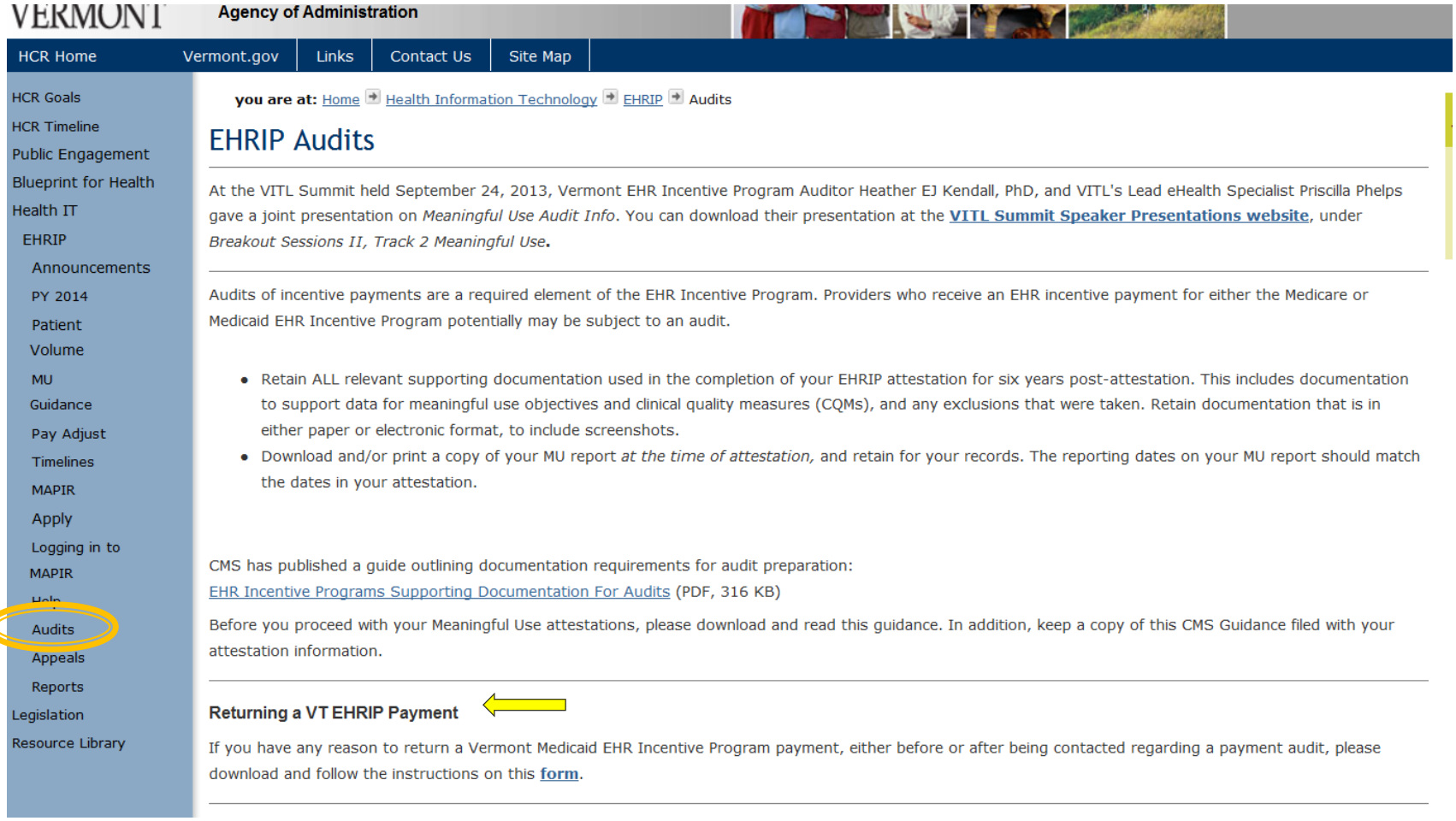
- Sent by certified mail and email
- Includes audit results and any identified discrepancies
- If EP/EH successfully meets the A/I/U or MU requirements, then they ***pass*** the audit
- If one or more of the requirements is not met, then they ***fail*** the audit
  - Must return incentive payment or appeal decision within 30 days of receiving audit results letter
  - EHR incentive program Return Payment form
  - Appeals process details included in letter

Appeals Process

The appeals process aligns with that of the VT Medicaid program, which is detailed in Section 1.26 of the Green Mountain Care Provider Manual.

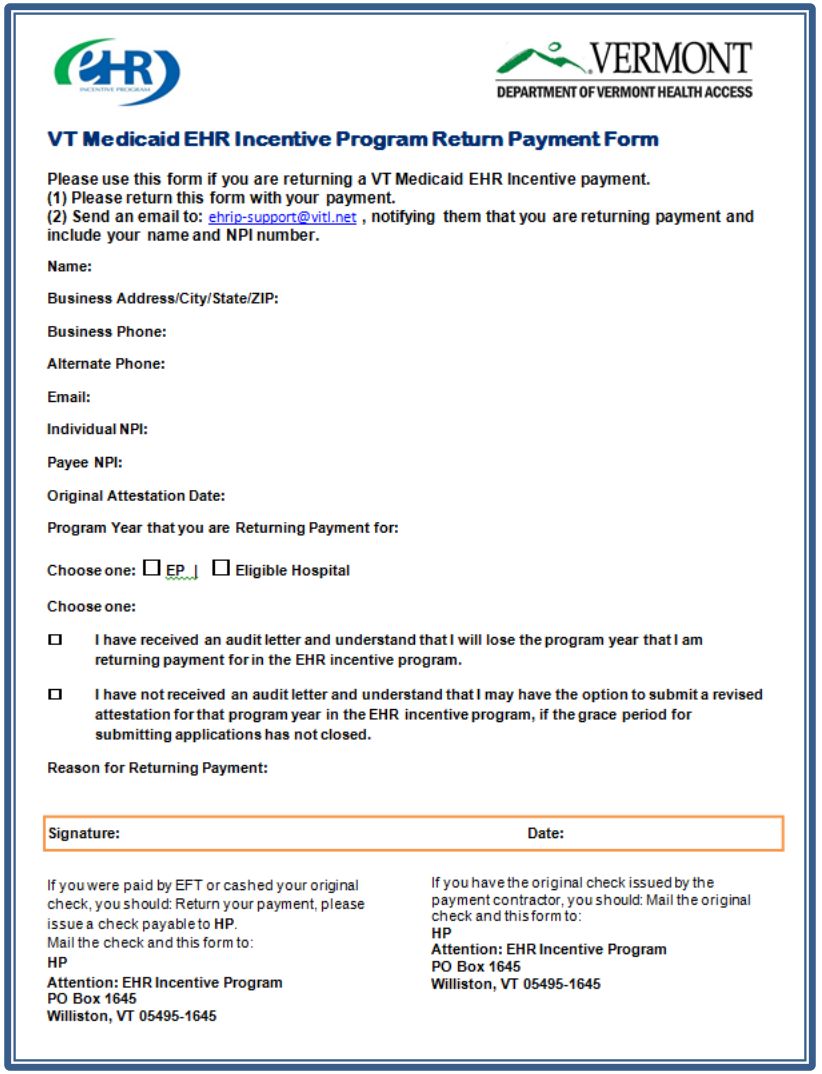
- First Level: Reconsideration by DVHA
  - Provider has 30 days to file for reconsideration from the date of receipt of the audit results letter
  - Review is performed by member of EHR audit team
  - Must submit documentation that would affect audit findings
- Second Level: DVHA Commissioner
- Third Level: Vermont Superior Court

VT EHRIP Audits



Returning a VT EHRIP Payment

- If payment is returned before audit, you do not forfeit program year
- If payment is returned after receiving an audit letter, then program year is forfeited



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VT Medicaid EHR Incentive Program Return Payment Form

Please use this form if you are returning a VT Medicaid EHR Incentive payment.
(1) Please return this form with your payment.
(2) Send an email to: ehrip-support@vitl.net , notifying them that you are returning payment and include your name and NPI number.

Name:

Business Address/City/State/ZIP:

Business Phone:

Alternate Phone:

Email:

Individual NPI:

Payee NPI:

Original Attestation Date:

Program Year that you are Returning Payment for:

Choose one: ☐ EP ☐ Eligible Hospital

Choose one:

☐ I have received an audit letter and understand that I will lose the program year that I am returning payment for in the EHR incentive program.

☐ I have not received an audit letter and understand that I may have the option to submit a revised attestation for that program year in the EHR incentive program, if the grace period for submitting applications has not closed.

Reason for Returning Payment:

Signature: Date:

If you were paid by EFT or cashed your original check, you should: Return your payment, please issue a check payable to HP.
Mail the check and this form to:
HP
Attention: EHR Incentive Program
PO Box 1645
Williston, VT 05495-1645

If you have the original check issued by the payment contractor, you should: Mail the original check and this form to:
HP
Attention: EHR Incentive Program
PO Box 1645
Williston, VT 05495-1645

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Questions?

Contact Information:

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