Medicaid EHR Incentive Program Audits

CMS Multi-Regional Meeting - Regions 1, 2 & 3
September 4, 2014
Presenters

• Elizabeth LeBreton
  – Health IT Coordinator, CMS

• Paul Messino
  – Chief, Health IT Policy, Maryland Medicaid

• Mary Marinari
  – Medicaid HIT Coordinator, Information Systems Unit, Delaware

• Patrick Julian
  – CPA, CGMA, Mercadien, P.C.

• Bob Nowell
  – Medicaid EHR Team (MeT) Subject Matter Expert
CMS Audit Resources

• Audit Toolkit
  – Contains six phases of information for states to leverage when planning and executing a state audit program for eligible professionals (EPs) and eligible hospitals (EHs) that are demonstrating Meaningful Use (MU).

• Audit Frequently Asked Questions (FAQs)
  – Audit specific FAQs that are gathered from states directly during the Auditing Communities of Practice (CoP) and/or other methods, and organized in a searchable format.

• Adverse Audit Findings
  – State de-identified audit documentation that illustrates adverse audit findings in different states. Located within the Audit Toolkit, documentation is organized into folders based on the adverse finding.

• Office of the National Coordinator for Health Information Technology (ONC) Certified Health IT Product List (CHPL)
  – Tool that allows for searches for certified complete Electronic Health Record (EHR) products or modules by entering a CMS certification number to conduct a search, or browse all products at once.
Audit Strategy Matrix

• CMS Audit Strategy Tracking Tool
• Specific criteria for review of state Audit Strategies
• Additional criteria added as of January 2014
  – primarily pre-payment review criteria
• States can use the criteria in the matrix when developing your next Audit Strategy Update
## Audit Strategy Matrix

### Evaluation Criteria

<table>
<thead>
<tr>
<th>Audit Criteria</th>
<th>Evaluation Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audits done by State Medicaid Agency (SMA) or Contractor</td>
<td>Audit Document Sources</td>
</tr>
<tr>
<td>Who conducts Eligible Hospital (EH) Meaningful Use (MU) audits?</td>
<td>Field Audit Triggers</td>
</tr>
<tr>
<td>Pre-payment Patient Volume (PV) Verification*</td>
<td>How report audits to CMS</td>
</tr>
<tr>
<td>Pre-payment Certified EHR Technology (CEHRT) Verification*</td>
<td>Who conducts appeals?</td>
</tr>
<tr>
<td>Pre-payment MU Verification*</td>
<td>Does the SMA have an All-Payer Claims Database (APCD)?</td>
</tr>
<tr>
<td>Number of Staff Reviewing Pre-payment*</td>
<td>Automated interfaces to Public Health Association (PHA)</td>
</tr>
<tr>
<td>Provider Letter Template*</td>
<td>How you receive documentation from providers</td>
</tr>
<tr>
<td>Audit Checklist*</td>
<td>How do you store audit documentation?</td>
</tr>
<tr>
<td>How many risk categories?</td>
<td>Recoupment process</td>
</tr>
<tr>
<td>Audit selection % by risk category</td>
<td>Risk factors or categories for MU</td>
</tr>
<tr>
<td>Audit All or Questionable</td>
<td></td>
</tr>
</tbody>
</table>
Audit Strategy Matrix Findings

Audits Done by State Medicaid Agency (SMA) or Contractor

- In house (SMA) 35%
- Vendor 55%
- Combination 10%

Who Conducts EH Audits

- Dual - CMS; Medicaid Only - CMS 45%
- Dual - CMS; Medicaid Only - SMA 10%
- Dual - SMA; Medicaid Only - SMA 10%
Audit Strategy Findings

How Many Risk Categories

- None: 6%
- 4 or more: 42%
- 3 or less: 52%

Audit Selection % by Risk Category

- Not Identified: 3%
- No: 26%
- Yes: 71%
Audit Strategy Matrix Findings

What Triggers a Field Audit

- Adverse Desk Audit: 77%
- All Audits: 7%
- Target: 16%

Reporting to CMS Research & Support (R&S) User Interface (UI) or E7

- Systematic: 39%
- Manual: 32%
- None: 29%
Medicare
Meaningful Use Auditing
Overall

• CEHRTs ability to produce adequate documentation?
  – No improvement in CEHRTs capabilities; still remains difficult to get audit trails, and some CEHRTs are unable to produce detailed reporting (no experience with 2014 Edition CEHRTs).
  – However, there has been improvement in the number and quality of reports produced, largely due to providers’ increased understanding of the program.
Overall

• What does Medicare do when they cannot get sufficient documentation from the provider?
  – The EP/EH fails the audit.

• What does Medicare do when the provider cannot recreate the data submitted in their attestation?
  – If the documentation they are able to produce meets the threshold, the changes are noted in the audit and the provider meets the requirements. (The Medicare system does not facilitate a corrected attestation or re-attestation).

• How does Medicare verify the Clinical Quality Measures (CQMs)?
  – The Auditors do not verify the CQMs; the system’s front end edits do the verification.
EP Core Measures

• **EP Core Measure 2 - Drug Interaction Checks**
  – This measure is often difficult to verify; often see screen shots (beginning of reporting period and end of reporting period); audit trails showing the function is enabled would be best, but very few audit trails can be produced.

• **EP Core Measure 4 - e RX**
  – While the ability to verify this measure has improved over the past year, this measure has been problematic. They usually get reports with the number of scripts. They have not seen exclusions based on the 10 mile radius exclusion.
EP Core Measures

EP Core Measure 11 - Clinical Decision Support Rules

- This measure is slightly difficult to verify, although generally not a big problem. Most of the verification is done via screen shots. The ideal verification tool would be an audit trail, but very few audit trails have been produced.

EP Core Measure 12 - Electronic Copy of Health Information

- It is difficult to verify the number of patients who have requested an e-copy. While EPs can usually generate a list of who has received e-copies, it is difficult to verify if they have received.
EP Core Measures

- **EP Core Measure 13 - Clinical Summaries**
  - This has been a problem to verify; very often an appointment log is needed to verify the number of office visits. Sometimes specialists (non-primary care EPs) claim an exclusion.

- **EP Core Measure 14 - Electronic Exchange of Clinical Information**
  - Generally this measure has not been a problem; it is usually verified with screen shots. Most EPs can generate a copy of what is sent. Sometimes it is difficult to verify if the data is sent to a separate CEHRT; mainly in establishing the CEHRT is a separate legal entity. Verifications are usually generated from CEHRTs fairly easily or the EPs can generate an ad hoc report.
  - This measure was discontinued beginning with program year 2013.
EP Core Measures

• **EP Core Measure 15 - Protect Electronic Health Information**
  – This has been the single most failed measure, and although it has improved over the past year, it is still the most problematic. EPs frequently do not understand what is required of the assessment. One of the biggest issues is that they need to implement corrections to any findings resulting from the assessment. They are supposed to implement during the reporting period; although Medicare accepts implementation by the time the audit is done.
EP Menu Measures

• EP Menu Measure 1 - Drug Formulary Checks
  – This measure is similar to Core Measure 2 and is difficult to verify; often see screen shots (beginning of reporting period and end of reporting period); audit trails showing the function is enabled would be best, but very few can be produced.

• EP Menu Measure 7 - Medication Reconciliation
  – This measure is not seen a lot; very few attest to this measure. Those that do attest usually produce sufficient documentation to verify the transitions. It is sometimes difficult to verify the exclusion.

• EP Menu Measure 8 - Transition of Care Summary
  – This measure is not seen a lot; very few attest to this measure. Those that do usually produce sufficient documentation from their CEHRT.
EP Menu Measures

• EP Menu Measure 10 - Syndromic Surveillance Data Submission
  – Not seeing as many of these as the Immunization Registry, but the numbers have been increasing over the last year. As with the Immunization Registry, most EPs either produce a transmission log from the CEHRT or a letter from the agency collecting the data.
Maryland Adopt, Implement, Upgrade (AIU) Audit Strategy

Overview

Paul Messino, MPP
Chief, Health IT Policy, Maryland Medicaid
Outline

• Program Overview
  – Pre-payment Verification
  – Risk Assessment
  – Post-payment Audit
  – On-site Visits
• Lesson Learned
  – Values of On-site Visits
  – Effective Risk Assessment Approach
• Best Practices
  – Dashboard
  – In-house Database
Pre-payment Verification

• Quick Stats (as of August 8, 2014)
  – Number of AIU: 2,107
  – Amount of AIU Payments: $44,249,878

• Electronic Medicaid Incentive Program Payment (eMIPP) System
  – Interface with CMS Registration and Attestation (R&A), eMedicaid, and Medicaid Management Information System (MMIS)
  – Performs eligibility and certified EHR technology (CEHRT) verification
  – Uploading Feature

• Manual Patient Volume Queries
  – In-house database: performs instant query on Fee-for-Service (FFS) claims and Managed Care Organization (MCO) encounters data
**Risk Assessment**

<table>
<thead>
<tr>
<th>Circumstance</th>
<th>Reason for Post-Payment Audit</th>
<th>Risk Level</th>
<th>Type of Audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any eligible professional (EP) who renders services in a facility where Medicaid requires only the Group National Provider Identifier (NPI) when billing</td>
<td>Currently, Medicaid does not require rendering providers to submit their individual NPIs when rendering services in an Federally Qualified Health Center (FQHC), Outpatient Mental Health Clinic (OMHC), or Local Health Departments. If the provider is not using the group proxy approach, Medicaid cannot validate Medicaid patient volume using their individual NPI.</td>
<td>High Risk</td>
<td>100% Mandatory on-site audits.</td>
</tr>
<tr>
<td>Out-of-State providers</td>
<td>At this time, Medicaid has no consistent and reliable approach to receiving out-of-state patient volume information from neighboring Medicaid agencies.</td>
<td>High Risk</td>
<td>100% Mandatory on-site audits.</td>
</tr>
<tr>
<td>Providers whose Medicaid patient volume variance is between 15 and 20 % of MMIS paid claims/encounters</td>
<td>Timely filing for Medicaid claims and encounters is one year from the date of service. Because of this and any appeals that may come from a denied claim, Medicaid considers a 15-20 percent margin of error reasonable, but additional documentation will be required.</td>
<td>Moderate Risk</td>
<td>Depending on the reasonableness of the data submitted, no additional auditing may be required. 30% random selection.</td>
</tr>
<tr>
<td>Providers whose Medicaid patient volume variance is between 11 and 15 % of MMIS claims/encounters</td>
<td>Timely filing for Medicaid claims and encounters is one year from the date of service. Because of this and any appeals that may come from a denied claim, Medicaid considers an 11-15 percent margin of error reasonable.</td>
<td>Low Risk</td>
<td>In most cases, a desk review is sufficient. 30% random selection.</td>
</tr>
</tbody>
</table>
# Post-Payment Audit

## Table 1: Total Number of Audited and Closed Cases

<table>
<thead>
<tr>
<th></th>
<th>Number of Cases</th>
<th>Number Closed Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total AIU Audits (2011 and 2012)</td>
<td>498</td>
<td>248</td>
</tr>
<tr>
<td>Total Sampled</td>
<td>161</td>
<td>30</td>
</tr>
<tr>
<td>Total Mandatory Site Visits</td>
<td>330</td>
<td>218</td>
</tr>
</tbody>
</table>

Note:

1) Current AIU audit complete rate is 50%
2) Seven out-of-state providers did not receive site visits because they voluntarily gave back the payments before we initiated the audit.
### Table 2: Audited Cases From Sampling Methodology

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total From Sample</td>
<td>161</td>
</tr>
<tr>
<td>Escalated Site Visits</td>
<td>17</td>
</tr>
<tr>
<td>Negative Findings</td>
<td>0</td>
</tr>
</tbody>
</table>

Note: One provider from the sample voluntarily gave back the payment because of hospital-based status.

### Table 3: Audited Cases From Risk Assessment Methodology

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Mandatory Site Visits</td>
<td>330</td>
</tr>
<tr>
<td>Negative Findings</td>
<td>5</td>
</tr>
</tbody>
</table>

Note: Five out-of-state providers were determined ineligible because they did not meet the patient volume threshold.
Post-Payment and On-site Audit

• Each audit case has an audit log contains information of patient volume, AIU proof, and communication with the EPs
• Documentation request letters- 30, 60, 90 days
• If no response or documentation submitted is insufficient, will be escalated to on-site audits
• On-Site Training and Comprehensive Site Visit Package
  – Two site visitors were trained and accompanied by the Electronic Health Record (EHR) program staff for first few visits
  – Site visit package is prepared by the audit coordinator prior to the visit; the package includes site visit report form, documentation request form, and medical records request form
Lessons Learned

• Values of site visits
  – Verify AIU status
  – Inspect the infrastructure and compliance with EHR Incentive Program rules and general Medicaid regulatory requirements
  – Opportunity to survey best practices

• Effective risk assessment approach
  – High risk group: out of 5 negative findings, 5 are classified as high risk (out-of-state providers)
Best Practices

• Attestation and Audit Dashboard
  – Evenly distribute cases to analysts
  – Effectively track individual and group performance
  – Closely monitor case status and average time per attestation and audit review
### APRIL ATTESTATIONS

| Analyst | 1  | 2  | 3  | 4  | 5  | 6  | 7  | 8  | 9  | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|---------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| Analyst 1 | 5  | 0  | 0  | 4  | 0  | 6  | 0  | 4  | 1  | 6  | 6  | 26 | 0  | 7  | 0  | 4  | 0  | 0  | 5  | 0  | 2  | 0  | 2  | 0  | 1  | 0  | 8  | 0  | 1  | 1  | 0  | 1  | 0  | 2  | 0  | 27 | 1  | 0  | 0  | 37 | 3  |
| Analyst 2 | 1  | 0  | 0  | 0  | 1  | 0  | 0  | 3  | 0  | 0  | 1  | 0  | 0  | 0  | 0  | 1  | 0  | 4  | 1  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  |
| Analyst 3 | 9  | 1  | 1  | 0  | 0  | 0  | 0  | 6  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 12 | 0  | 0  | 0  | 42 | 0  | 0  | 0  | 0  | 2  | 0  | 8  | 0  | 6  | 0  | 1  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 1  |
| Analyst 4 | 2  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  |
| TOTAL    | 17 | 1  | 1  | 0  | 4  | 0  | 7  | 0  | 10 | 1  | 9  | 6  | 26 | 0  | 8  | 0  | 16 | 0  | 0  | 0  | 48 | 0  | 6  | 1  | 4  | 0  | 9  | 0  | 14 | 0  | 2  | 1  | 1  | 0  | 5  | 0  | 2  | 0  | 27 | 1  |

### MTD ATTESTATIONS

<table>
<thead>
<tr>
<th>Analyst</th>
<th>MTD</th>
<th>MTD TOTAL</th>
<th>ASSIGN.</th>
<th>AVG.</th>
<th>% A</th>
<th>% R</th>
<th>% TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analyst 1</td>
<td>149</td>
<td>12</td>
<td>193</td>
<td>1.15</td>
<td>77%</td>
<td>6%</td>
<td>83%</td>
</tr>
<tr>
<td>Analyst 2</td>
<td>11</td>
<td>1</td>
<td>12</td>
<td>1.32</td>
<td>31%</td>
<td>3%</td>
<td>34%</td>
</tr>
<tr>
<td>Analyst 3</td>
<td>103</td>
<td>2</td>
<td>105</td>
<td>1.06</td>
<td>97%</td>
<td>2%</td>
<td>99%</td>
</tr>
<tr>
<td>Analyst 4</td>
<td>6</td>
<td>0</td>
<td>6</td>
<td>1.13</td>
<td>85%</td>
<td>0%</td>
<td>86%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>269</td>
<td>15</td>
<td>284</td>
<td>1.16</td>
<td>78.9%</td>
<td>4.4%</td>
<td>83.3%</td>
</tr>
</tbody>
</table>

### KEY

- 1: GRP 1-5
- 2: GRP 6-15
- 3: GRP 16-30
- 4: GRP 31-50
- 5: GRP 51+

### Pie Charts

- Analyst 1
- Analyst 2
- Analyst 3
- Analyst 4
Best Practices

• In-house Database
  – Interface with MMIS
  – Performs instant query on FFS claims and MCO encounters
  – Verifies hospital-based status
  – Stores attestation and audit case reviewing history
  – Retrieves Incentive payments from MMIS
**Attestation Information**

- **Out of State Ind**: No
- **Audit Request Ind**: Yes
- **Old Data That Was imported**: Yes
- **Group NPI**: 999999999
- **Group or Individual**: INDIVIDUALS - NO GROUP
- **Attestation Year**: 01
- **Begin Date**: 10/1/2011
- **End Date**: 12/30/2011
- **MMA Encounters**: 1,131
- **Total Encounters**: 1,230
- **Self Report %**: 92%
- **Decision**: APPROVED
- **Decision Date**: 3/8/2013
- **Amount**: $21,250.00
- **Over / Under %**: -12%
- **Hospital %**: 0%

**Attestation Comments**: IMPORTED ATTESTATION: 0

**MMIS Attestation Data**

- **FFS Clms**: 1136
- **MCO Encounters**: 152
- **HOSP Clms**: 0
- **Total Clms**: 1288

**MMIS Comments**: IMPORTED SUMMARY RECORD

**Attestation Audit**

- **Audit Year**: 01
- **Begin Date**: 10/1/2011
- **End Date**: 12/30/2011
- **MMA Encounters**: 1,131
- **Total Encounters**: 1,230
- **Self Report %**: 92%
- **Decision**: PENDING
- **Decision Date**: 8/7/2014
- **Reqst Audit Recoupmnt Amt**: $0.00
- **Over / Under %**: -12%
- **Hospital %**: 0%

**Audit Comments**: NO COMMENT

**MMIS Audit Data**

- **FFS Clms**: 1136
- **MCO Encounters**: 152
- **HOSP Clms**: 0
- **Total Clms**: 1288

**MMIS Comments**: ADDED BY STORED PROCEDURE

**Attestation Audits**

- **Attestations**: 1 of 1

**Attestations**

- **Attestations**: 1 of 1
Contact information:

paul.messino@maryland.gov

dhmh.marylanddehr@maryland.gov
Delaware Electronic Health Records (EHR)
Provider Incentive Payment Program
Auditing Progress

Mary Marinari
Division of Medicaid & Medical Assistance
Medicaid Health Information Technology Coordinator
Delaware EHR Incentive Payment Program Milestones

- Planning Advance Planning Document (PAPD) approved October 22, 2010
- State Medicaid HIT Plan (SMHP) approved August 16, 2011
- Implementation Advance Planning Document (IAPD) approved September 2011
- First incentive payment November 2011
- Audit Strategy approved December 4, 2012
- SMHP-U and Audit Strategy-U for Meaningful Use (MU) approved November 26, 2013
- Current Federal Fiscal Year (FFY) 14, 15 IAPD approved January 29, 2014
Delaware EHR Incentive Payment Program Resources

- Two full time State merit staff – Health Information Technology (HIT) Coordinator and HIT Analyst
- One Program Integrity nurse reviewer joined audit team end of Calendar Year 2014.
- Contractual HPES Provider Incentive Payment Team – 5 provider reps and 1 systems engineer – manages Medical Assistance Provider Incentive Repository (MAPIR) upgrades, attestations, provider outreach, pre and post payment audits.
- State staff manages program, regulatory requirements including reporting SMHP, IAPD, Audit strategy, Health Information Exchange (HIE) and HIT initiatives impacting Medicaid.
Delaware facts that influence our attestation numbers:
- 49th largest state
- Population approximately 925,749

Provider Payments as of 8/25/2014

<table>
<thead>
<tr>
<th>EP AIU</th>
<th>532</th>
<th>$11,276,668.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>EP MU</td>
<td>567</td>
<td>$5,084,417.00</td>
</tr>
<tr>
<td>EP Total</td>
<td>1099</td>
<td>$16,361,085.00</td>
</tr>
<tr>
<td>EH AIU</td>
<td>7</td>
<td>$7,691,538.43</td>
</tr>
<tr>
<td>EH MU</td>
<td>7</td>
<td>$5,539,169.90</td>
</tr>
<tr>
<td>EH Total</td>
<td>14</td>
<td>$13,230,708.33</td>
</tr>
<tr>
<td>Overall AIU</td>
<td>539</td>
<td>$18,968,206.43</td>
</tr>
<tr>
<td>Overall MU</td>
<td>574</td>
<td>$10,623,586.90</td>
</tr>
<tr>
<td>Overall Total</td>
<td>1113</td>
<td>$29,591,793.33</td>
</tr>
</tbody>
</table>
First eligible professional (EP) audit - 60 EPs

- Preparation
  - Risk assessment
    - Used Risk Assessment tool in Audit Toolkit to select 60 EPs
    - Audited for Adopt, Implement, Upgrade (A/I/U)

- Changes in staff
  - Program Integrity Staff change prior to audit kick off
  - Major impact on audit team

Performed audit June/July 2013 for A/I/U

- Lessons learned:
  - Have a rigorous pre-payment audit review
  - Engage all team members up front
  - Performed 60 desk audits and six (6) site audits

Report audit summary to HIT Steering Committee
<table>
<thead>
<tr>
<th>Description of Finding</th>
<th>Observations Noted</th>
<th>Recommendation</th>
<th>Action Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Audit Issues related to Claims Payments or Fraud (0)</td>
<td>Open end date letter of reprimand on file.</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>2. Patient Volume Percentage close to threshold or inaccurate (36)</td>
<td>Verified volume differs from provider attestation of volume.</td>
<td>Desk Audit</td>
<td>Audit passed</td>
</tr>
<tr>
<td>3. Duplication of Patient Volume (1)</td>
<td>Provider moved to new practice during attestation period.</td>
<td>Site Audit</td>
<td>Confirmed attestation information for past and current provider groups</td>
</tr>
<tr>
<td>4. Improper Incentive Payment Amount (0)</td>
<td>None found in attestations for 2011.</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>5. Low Percentage of Electronic Claims Submissions (4)</td>
<td>Less than 40% billed electronic.</td>
<td>Site Audit</td>
<td>Suggested Provider signed up for electronic claims processing; Audit passed.</td>
</tr>
<tr>
<td>6. Newly enrolled Medicaid providers (1)</td>
<td>Attesting with group volumes new to Medicaid.</td>
<td>Desk Audit of group</td>
<td>Audit passed</td>
</tr>
<tr>
<td>7. Resubmittal of Application (0)</td>
<td>None found in 2011 applications.</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>8. Managed Care Organization (MCO)/Diamond State Partners (DSP) Complaints, Sanctions or Grievances (20)</td>
<td>Multiple closed MCO grievances merited investigation.</td>
<td>Desk Audit/ Site Audit</td>
<td>Audit passed</td>
</tr>
</tbody>
</table>

- Preparation for second audit/first MU audit
  - Engaged staff
    - New fully engaged, Program Integrity nurse reviewer added to audit team
  - Thorough review of audit procedures/tasks
    - Prepared written procedures/tasks January – April 2014
  - Delays, trials, errors, and triumphs
    - Delaware Medicaid Enterprise System (old Medicaid Management Information System (MMIS)) implementation
    - Staff changes/losses
    - Learning curve for new staff
    - Learn to use team member strengths
    - Start auditing!!!!
Second Audit *(continued)*

- Progress
  - Delaware uses the CMS risk assessment templates.
  
  - Interpret the risk definitions as they apply to Delaware.
  
  - Apply risk definitions consistently for all EPs.
  
  - Frequent quality checks of the process are necessary.
    - Review and review again if there are questions from stakeholders or members of the audit team.
  
  - Work to strike a balance with audit team members who come from different perspectives to produce a fair risk assessment.
Lessons Learned:

◦ Pay particular attention to individual provider Medicaid enrollment dates in large group volume attestations.

◦ Require careful pre-payment reviews especially during the frantic Grace Period.

◦ Be open to multiple checks of the risk assessment methodology.

◦ Prepare written tasks and procedures, no matter how time consuming.

◦ Audit review of MU measures still to come!

◦ Take the time to learn to work as a team.
Eligible hospital (EH) Audit

- Delaware opted to have CMS audit their hospitals for Meaningful Use.
- Delaware audits for A/I/U and eligibility for payments.
- Delaware uses in-house staff to audit:
  - The audit team includes both HIT Team staff and one representative from the Financial Unit.
  - All seven hospitals will be audited.
  - A risk assessment is done to determine a hospital’s weakness, not to select for audit.

- Steps to auditing:
  - Prepare procedures and tasks.
  - Desk audits will be done with site audits added as needed.

- EH audits to start in October 2014
Mary Marinari
Medicaid HIT Coordinator
Information Systems Unit
Division of Medicaid and Medical Assistance
E-mail: Mary.marinari@state.de.us
Phone: 302-255-9548
New Jersey Medicaid Electronic Health Record (EHR) Incentive Program Post Payment Inspection Hospitals and Eligible Professionals

CMS Health Information Technology for Economic and Clinical Health (HITECH) Regional Meeting
New York City
September 4, 2014

J. Patrick Julian, CPA, CGMA
Mercadien, P.C.
Overview of Post Payment Inspection Process for eligible hospitals (EHs) and eligible professionals (EPs)

History and Background:
- Mercadien, P.C. performs the inspections for the New Jersey Medicaid EHR Incentive Program
- State decided on field audits instead of desk audits
  - Logistics
    - Geographically small state with easy access
    - Most EHs and EPs concentrated outside NYC or Philly
  - Field audits may be more efficient
    - Complete audits (eligibility and Meaningful Use (MU)) for each selected EP
    - Direct access to all records
    - Team is there if additional information is needed
  - Impact
    - Strong impression on EHs and EPs
History and Background (Continued):

- **Early Milestones**
  - February 10, 2012 – Initial Incentive Payments
  - February 27, 2012 – Pilot inspections of two EHs
  - March 19, 2012 – Pilot Adopt/Implement/Upgrade (AIU) inspection of Federally Qualified Health Center (FQHC) (EPs)
  - April 2, 2012 – Pilot AIU inspection of Practice (EPs)
  - August 1, 2012 – Pilot MU inspection of Practice (EPs)

- **General Observations**
  - We have found that fieldwork can be completed in one day for most inspections
  - Try to have EH or EP send encounter data in advance
    - Allows us to make sure it is what we need
    - We select our samples prior to fieldwork
Overview of Post Payment Inspection Process for EHs and EPs (Continued)

History and Background (Continued):

- Audits Completed through June 30, 2014

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Hospitals</th>
<th>Practices</th>
<th>Eligible providers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AIU and MU</td>
<td>AIU - EPs</td>
<td>MU - EPs</td>
</tr>
<tr>
<td>2012 #</td>
<td>51</td>
<td>143</td>
<td>611</td>
</tr>
<tr>
<td>2013 #</td>
<td>32</td>
<td>177</td>
<td>564</td>
</tr>
<tr>
<td>2014 *</td>
<td>23</td>
<td>87</td>
<td>104</td>
</tr>
<tr>
<td>Totals</td>
<td>106</td>
<td>407</td>
<td>1,279</td>
</tr>
</tbody>
</table>

# EPs per practice high due to several large practices

* Six months ended June 30, 2014
**Overview of Post Payment Inspection Process for EHs and EPs (Continued)**

<table>
<thead>
<tr>
<th>Time Line</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHR Payment Received</td>
<td>Mercadien reviews payments made and statistics on weekly basis</td>
</tr>
<tr>
<td>1 Week to 2 months later</td>
<td>Hospitals / EPs (Practices) selected by Mercadien for inspection</td>
</tr>
<tr>
<td></td>
<td>Announcement Letters sent</td>
</tr>
<tr>
<td></td>
<td>For each practice selected for inspection, all EPs paid for that attestation year are included May include EPs with different payment years</td>
</tr>
<tr>
<td></td>
<td>Provides contacts at Mercadien</td>
</tr>
<tr>
<td></td>
<td>Identifies hospitals / EPs included in inspection</td>
</tr>
<tr>
<td></td>
<td>Planned week of inspection</td>
</tr>
<tr>
<td></td>
<td>Request for identification of contacts at Practice</td>
</tr>
<tr>
<td></td>
<td>Request to schedule a planning teleconference</td>
</tr>
<tr>
<td></td>
<td>Includes significant information from Attestation</td>
</tr>
</tbody>
</table>
Overview of Post Payment Inspection Process for EHs and EPs (Continued)

Selection and Notification:
- All EHs receiving payments are selected for inspection
- EPs generally are selected for inspection after incentive payment is made
  - In certain circumstances the State requests pre-payment inspections
  - All EPs considered “high risk” are selected for inspection
    - Within 5 percentage points of minimum threshold
    - Significant adjustments or issues in previous inspection
    - Overly high Medicaid percentage for community
  - Moderate and low risk EPs selected with following criteria
    - Select a cross-section by:
      ✓ Type of practice
      ✓ Location
      ✓ Small practice / large practice / FQHC
    - Select all EPs (AIU and MU) in same attestation year
    - Most large practices / FQHCs will be selected due to dollar exposure

Overview of Post Payment Inspection Process for EHs and EPs (Continued)

<table>
<thead>
<tr>
<th>Time Line</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 2 weeks later</td>
<td>Planning Teleconference between representatives of Mercadien and Hospital / Practice</td>
</tr>
<tr>
<td></td>
<td>Discuss logistics of process</td>
</tr>
<tr>
<td></td>
<td>Answer any questions</td>
</tr>
<tr>
<td></td>
<td>Set time, date and location for inspection</td>
</tr>
<tr>
<td></td>
<td>Identify data to be sent to Mercadien in advance</td>
</tr>
<tr>
<td></td>
<td>Confirmation email is sent to Practice</td>
</tr>
<tr>
<td></td>
<td>Confirmation of time, date and location of inspection</td>
</tr>
<tr>
<td></td>
<td>Written detail of documentation and logistics</td>
</tr>
<tr>
<td></td>
<td>Mercadien contact information confirmed</td>
</tr>
<tr>
<td></td>
<td>Copy of Mercadien / NJ Business Assoc. Agreement</td>
</tr>
</tbody>
</table>
# Overview of Post Payment Inspection Process for EHs and EPs (Continued)

<table>
<thead>
<tr>
<th>Time Line</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 2 weeks later</td>
<td>If encounter information is sent in advance, selects samples and returns them to contact to generate support (EOBs) for the claims</td>
</tr>
<tr>
<td></td>
<td>Pre-Inspection Procedures Performed</td>
</tr>
<tr>
<td>1 to 2 weeks later</td>
<td>On Site Inspection</td>
</tr>
<tr>
<td></td>
<td>Typically, the team arrives at 9:00 AM</td>
</tr>
<tr>
<td></td>
<td>Generally, completed in 6 to 8 hours</td>
</tr>
<tr>
<td></td>
<td>Findings are discussed with primary contact</td>
</tr>
<tr>
<td></td>
<td>Primary contact has opportunity to review results</td>
</tr>
<tr>
<td></td>
<td>File will not be closed until practice has chance to review and understand findings</td>
</tr>
<tr>
<td>2 to 6 weeks later</td>
<td>Monthly Report Sent To State for All Hospitals / Practices</td>
</tr>
<tr>
<td></td>
<td>State reviews findings and takes action, if necessary</td>
</tr>
<tr>
<td></td>
<td>Action may include adjustment in original payment.</td>
</tr>
<tr>
<td></td>
<td>Separate monthly reports for Hospitals and EPs</td>
</tr>
</tbody>
</table>
Overview of Post Payment Inspection Database for Inspections
Primary Areas of Focus in the Inspections of EHs

- Medicaid patient volume
  - 10% for all EHs with the exception of Children’s Hospitals
  - Performed for every EH inspection

- Test Calculation of Incentive Payment
  - Testing calculation of payment
    - Use Excel template to determine impact of differences
    - Year 1 testing applies to all 3 years (50%, 40% and 10%)

- Average Length of Stay
  - Must be less than 25 days

- Adopt, Implement or Upgrade (“AIU”) / Meaningful Use (“MU”)
  - Test AIU in Year 1
  - New Jersey has delegated EH MU audits to CMS’s audit vendor
Primary Areas of Focus in the Inspections of EPs

- Medicaid patient volume
  - Test the patient volume included in the attestation
    - Group practice proxy or individual patient volume
      - If group proxy is used, obtain assurance it is a complete population
  - Verify that the minimum threshold is achieved
    - 30% for full payment
    - 20% for 2/3 payment (Pediatricians)
      - A given practice may have both full and 2/3 payments
    - If both year 1 and year 2 payments qualify using the same group proxy, Medicaid patient volume is only tested once

- Some FQHCs qualify using “service to needy individual volume”
Primary Areas of Focus in the Inspections of EPs

- Medicaid patient volume (Continued)
  - We obtain a detail list of total patient encounters for the 90-day attestation period, and the immediate preceding and succeeding months (ie: 5 month period)
    - Reconcile total patient encounters and Medicaid encounters per the detail list of the 90-day period to the attestation
    - Select and test a random sample of the total patient encounters
      - Number of encounters based on risk
        - 45 encounters for moderate risk
        - 70 encounters for high risk
      - Select 10 encounters each from preceding and succeeding months
      - Test encounters against EOBs or billing support with subsequent payments or disposition
    - Based on findings, the total patient encounters and Medicaid encounters may change (Usually they do change)
Primary Areas of Focus in the Inspections of EPs

- Medicaid patient volume (Continued)
  - Recalculate the Medicaid patient volume percentage based on the total patient encounter and Medicaid encounter balances per the inspection (this usually changes)

  - Calculate EHR payment based on Medicaid patient volume percentage per the inspection
    - Determine that payment and amount were correct based on Medicaid patient volume percentage and EP type

  - If the FQHC or EP at an FQHC qualified based on providing service to needy individuals, the testing basically is the same
    - Will need to test the individual EPs to make sure each exceeded 50% of patient encounters within the 6 month period identified in the attestation
Primary Areas of Focus in the Inspections of EPs (Continued)

- Adopt, Implement or Upgrade ("AIU") / Meaningful Use ("MU")
  - AIU in Year 1 Attestation
    - Test AIU in Year 1
    - If they have achieved MU in Year 1, we will test MU
  - MU in Year 2 and Subsequent Years
    - Test MU in Year 2 and subsequent years
    - Each EP at the practice / FQHC individually must achieve MU to receive Medicaid EHR incentive payment
    - MU testing is performed separately for each EP at the practice / FQHC who receives an incentive payment for a year subsequent to year 1
  - The test of MU targets the statistics included in the attestation
    - Varies based on year and stage
Mercadien determines preliminary overall risk for MU by considering a number of factors:
- Level of expertise of personnel to train, compile and monitor the MU system
- Size of practice
- Knowledge of practice from prior inspection(s)
- Knowledge of EHR system
- Proximity of MU measures to threshold
- Use of exclusions

Consideration also given to mitigating factors or other information that may impact MU risk.

Assessment of MU risk is a separate consideration from the assessment of overall risk made in planning.
Mercaden tests MU by performing the following:

- Perform a detailed walkthrough of the MU process
  - Determine who inputs each measure and when
  - Determine the nature of the oversight and review process
  - Have contact person:
    - Demonstrate system and reporting capabilities
    - Introduce us to personnel using system to see it live
    - Discuss positives and negatives regarding system
- Determine whether initial MU risk assessment was appropriate
  - If needed, make changes to procedures and scope of MU testing
- The walkthrough gives us a very good understanding of how the client uses the system and how proficient they are with the system
Test of Meaningful Use (“MU”) (Continued)

- For each individual EP
  - Tie MU statistics in the attestation for each measure to the MU report generated by the certified EHR system
    - If the practice did not keep copies of original reports, reconcile current reports to attestation
    - Determine cause and whether the changes make sense

- Select MU EPs for detail testing based on risk
  - 20% of EPs for Moderate Risk
  - 50% of EPs for High Risk

- For EPs selected for testing
  - Review underlying supporting detail for each measure
  - For certain MU quantitative measures, select and test a sample of the underlying data for testing
Common Issues

- EPs and EHs have issues with encounter data
  - Duplicates
  - May have counted patients, not encounters
  - May not have considered secondary insurance

- Issues with two separate 90-day periods for Medicaid patient volume and MU
  - Medicaid patient volume is in prior calendar year
  - MU is within current calendar year

- Many EHR systems do not allow drill down on MU Measures
  - Cannot see where non-compliance occurs
  - Cannot test directly

- Most EHR systems will not provide same MU statistics at later date
Lessons Learned

- We meet regularly with State to go over issues found
  - In some instances, there have been changes to the system or instructions to address issues
- Use appropriate organizations (hospital groups, NJ-HITEC, etc) to proactively address issues
- If EH or EP used outside assistance or if data used in attestation is from a 3rd party, we strongly suggest they make the 3rd party aware of the date of inspection
  - May need assistance or have questions
  - 3rd party assistance may include the following:
    - NJ-HITEC
    - Outside billing service
    - EHR vendor (if providing active support)
Thank you

Contact Information:

J. Patrick Julian, CPA, CGMA
(609) 689-2323
pjulian@mercadien.com
QUESTIONS OR COMMENTS?