

July 29, 2011

SOUTH  
CAROLINA  
DEPARTMENT  
OF HEALTH &  
HUMAN  
SERVICES

# STATE MEDICAID HIT PLAN (SMHP) VERSION 4.0 CHANGE CONTROL DOCUMENT

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

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*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 #
<b>1. Coordination with REC</b>	<b>Page 90:</b> SCDHHS also includes an advertisement with every e-bulletin blast to encourage providers to contact CITIA for assistance.
<b>2. Registration Deadline</b>	<p><b>Page 95:</b> An EP may attest for a payment year's incentives up until February 28 or 29 of the following calendar year; e.g., an EP could submit an attestation for 2011 incentives up until February 28 or 29 of 2012.</p> <p>An EH may attest for a payment year's incentives up until November 30 of the following fiscal year; e.g., an EH could submit an attestation for 2011 incentives up until November 30, 2011.</p>
<b>3. PA-led pre-payment check</b>	<b>Page 96:</b> SCDHHS has collaborated with the South Carolina Office of Rural Health (SCORH) and the South Carolina Primary Healthcare Association (SCPHCA) in order to identify the PAs who are eligible in South Carolina.
<b>4. Definition of Pediatric Subspecialist</b>	<b>Page 96:</b> For physicians who are pediatricians that will meet the reduced patient volume threshold, they must be listed in the MMIS with a provider type 20. For pediatric subspecialists, the provider must also have a practice specialty of 40, 41, 42, 68, or 49. If a provider is unsure if he/she is enrolled as a pediatrician with the South Carolina Medicaid program, he/she may contact provider enrollment.
<b>5. Catawba Indian Nation clinic designation</b>	<b>Page 99:</b> It is important to note that the Catawba Indian Nation clinic is reimbursed as an IHS clinic and is therefore not treated as an FQHC. However, EPs at the Catawba Indian Nation clinic may qualify for incentive payments by reporting Medicaid or needy patients in the numerator of their patient volume calculations.
<b>6. Hospital-based EP determination</b>	<p><b>Page 99-100: Hospital-based Status:</b> To qualify as an Eligible Professional under the Medicaid EHR Incentive Program, a provider may not be "hospital-based," defined as any provider who furnishes 90% or more of his or her professional services in a hospital setting (inpatient, Place of Service 21; or emergency room, Place of Service 23) in the year preceding the payment year. The statutory definition of hospital-based EP provides that to be considered a hospital-based EP, the EP must provide "substantially all" of his or her covered professional services in a hospital setting. "Services" does not mean "encounters" as defined for the EHR Incentive Program.</p> <p>It is important to note that if an EP "practices predominantly" in an FQHC or RHC, the EP is not subject to the hospital-based exclusion. An EP who attests to needy patient</p>

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	<p>volume is also attesting that they practice predominantly in an FQHC or RHC. Therefore, an EP who attests to needy patient volume is not subject to the hospital-based exclusion. For these EPs, the HIT Division does not perform a pre-payment review of “hospital-based” or “practices predominantly”. However, the SCDHHS reserves the right to validate a provider’s hospital-based status attestation along with other attestations through post payment audits.</p> <p>Where the physician or certified nurse midwife attests to Medicaid patient volume, the HIT Division will validate an attestation of not being hospital-based by examining fee-for-service and encounter claims by servicing provider for all visits, all hospital visits, and all emergency room visits from the previous calendar year to determine if the provider’s claims activity indicates hospital-based status. However, since a nurse practitioner may file claims under another provider’s NPI, a claims-based report by servicing provider is not an accurate reflection of the nurse practitioner’s services.</p> <p><u>Physicians and certified nurse midwives:</u> Place of Service (POS) 21 and 23 codes are used to develop a report, by calendar year, to validate non-hospital-based status for physicians and certified nurse midwives. The criteria for the hospital-based EP report are as follows:</p> <ul style="list-style-type: none"> <li>• Date of Service = 01/01/2010 to 12/31/2010 (dos from previous CY)</li> <li>• Servicing Provider Type = 32 (Osteopathy), 33 (Opticians), 20 (Physician Individual), 19 (Medical Professional)</li> <li>• Fee for service and encounter claims included</li> <li>• Voids and deleted lines removed</li> <li>• Inpatient hospital and emergency room place of services identified using the 2-byte POS codes of “21” and “23”</li> </ul> <p>The report shows the following fields:</p> <ul style="list-style-type: none"> <li>• Provider ID, NPI, Provider Name,</li> <li>• Provider Type, Primary Specialty,</li> <li>• Total All Visits</li> <li>• Total hospital inpatient and ER visits</li> <li>• Total record count</li> <li>• Total IP and ER record count</li> <li>• % IP/ER visits</li> </ul>

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	<ul style="list-style-type: none"> <li>• % IP/ER record count</li> </ul> <p><u>Nurse practitioners</u>: As the claims-based report does not provide a good picture of whether this provider type provides substantially all services in a hospital setting, SCDHHS will use alternative means to analyze their hospital-based status. The HIT Division will request that these EPs provide a statement of employment from the EP’s employer(s) for whom the EP provided professional services in the previous calendar year, on the employer’s letterhead, that describes the terms of the EP’s employment during the calendar year, including date of hire, full-time/part-time, and if part-time the number of hours per week. The letters should be addressed to the S.C. Medicaid EHR Incentive Program and signed by the appropriate Human Resources authority within the employer’s organization. Upon receipt of this information, the HIT Division will make a determination of the nurse practitioner’s hospital-based status.</p> <p><u>Dentists</u>: The HIT Division does not verify hospital-based status on these professional types, as dentists would not perform substantially all of their services in an inpatient or emergency department setting.</p> <p><u>Physician Assistants</u>: Physician Assistants are eligible to participate in the Medicaid EHR Incentive Program when they are practicing in an FQHC or RHC that is PA-led. The HIT Division will rely on information provided by the South Carolina Office of Rural Health, and the South Carolina Primary Health Care Association, to verify that a PA is not hospital-based.</p>
<b>7. Out-of-state recipients in volume calculation</b>	<b>Page 100:</b> EPs are allowed to count out-of-state Medicaid recipients when calculating their patient volume. However, EPs must be able to supply an auditable data source that supports their calculations.
<b>8. CHIP report metrics</b>	<p><b>Page 102:</b> The criteria for the CHIP impact report are as follows:</p> <ul style="list-style-type: none"> <li>• Dates of Service (not paid dates) = 1/1/20010 through 12/31/2010 (dos from previous CY)</li> <li>• Claim types “A” (professional claims) and “B” (dental claims) (Note: the five types of professionals eligible for Medicaid incentive payments are physicians, dentists, certified nurse midwives, nurse practitioners and physician assistants in an FQHC led by a PA. These professionals would use a claim type A to file claims; dentists use type B.)</li> <li>• Both FFS and encounter (managed care) claims data included. This required the SUR analyst to pull data from MMIS for fee for service claims as well as from encounter data submitted by managed care organizations.</li> <li>• County refers to the servicing provider who provided services in that county</li> </ul>

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	<p>based on their place of business (not county of residence for the beneficiaries).</p> <ul style="list-style-type: none"> <li>• Voids and deleted lines removed.</li> <li>• One encounter equals all services rendered to a single patient by the same provider on the same day, which is roughly equal to claims at the header level.</li> <li>• Determination of CHIP on the claim was based on logic that took into account eligibility category and a CHIP indicator.</li> </ul> <p>The report shows the total number of Medicaid and CHIP encounters for the physicians practicing in each county, with the CHIP encounters expressed as a percentage. The EP Medicaid numerator encounters are reduced by the CHIP percentage for the county the EP is attesting from.</p> <p><b>Page 106:</b> The criteria for the hospital CHIP report are slightly different from the EP report:</p> <ul style="list-style-type: none"> <li>• Last date of service = 10/01/2009 - 09/30/2010 (i.e., discharge date) (dos from previous FFY)</li> <li>• Provider type “01” (inpatient hospital) and “02” with a facility revenue code like '*450', '*459' (to designate emergency room)</li> <li>• Both FFS and encounter (managed care) claims data included. This required the SUR analyst to pull data from MMIS for fee for service claims as well as from encounter data submitted by managed care organizations.</li> <li>• County refers to location of hospital</li> </ul>
<b>9. Volume post payment check</b>	<b>Page 102:</b> Providers’ volume attestations will be audited through the standard post payment audit process.
<b>10. EP employment outside of 90 day period</b>	<b>Page 103:</b> An EP whose date of hire by a clinic/group falls after the 90-day period selected for the clinic/group patient volume calculation may not utilize the clinic/group patient volume as a proxy for his or her own patient volume, as it would not be appropriate as a patient volume methodology calculation for the EP (the EP would not have been able to contribute any encounters included in the group/clinic volume calculation).
<b>11. New MHNs</b>	<b>Page 105:</b> South Carolina Medicaid MHN: South Carolina Solutions, Carolina Medical Homes, Palmetto Physician Connections
<b>12. EH Checklist</b>	<p><b>Page 107-109: EH Checklist</b></p> <p>The Bureau of Reimbursement Methodology and Policy developed a checklist to assist EHs that are seeking incentive payments. This checklist was distributed through the SCHA to EHs:</p> <p style="text-align: center;"><u><a href="#">Checklist for Hospitals Seeking Medicaid EHR Incentive Payments</a></u></p> <ul style="list-style-type: none"> <li>• Has your hospital’s fiscal year (HFY) end 2010 Medicare/Medicaid cost report</li> </ul>

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	<p>been filed with the South Carolina Department of Health and Human Services (SCDHHS)</p> <ul style="list-style-type: none"> <li>• Does the total number of discharges reported on your HFY 2010 Medicare/Medicaid cost report (W/S S-3, Part I, Line 1, Columns 14 and 15) include newborn discharges as well as discharges relating to psych or rehab units (if applicable)? If the answer is yes, then please identify the total number of newborn discharges as well as the total number of psych discharges as well as rehab discharges.</li> <li>• Has your hospital completed the “Patient Volume” page in the State Level Repository and met the minimum Medicaid Patient Volume requirement of ten percent (10%) for a consecutive ninety (90) day period which has been defined as three (3) consecutive calendar months incurred during 2010 FFY (federal fiscal year)?</li> <li>• Assuming that your hospital meets the minimum 10% Medicaid patient volume requirement, we will need the following information in order to verify the statistical information used in the determination of your hospital’s Medicaid Patient Volume percentage. <b>Your hospital is required to submit information described in A and B below directly to the SC Department of Health and Human Services, Bureau of Reimbursement Methodology and Policy, P.O. Box 8206, Columbia, S.C. 29202-8206.</b></li> </ul> <p><b>A.</b> The hospital will be required to submit summary encounter information consisting of both inpatient discharges and ER visits as the basis for the three month (i.e. 90 day) period for both in state and out of state qualifying Medicaid eligibles. <b>Medicaid newborn discharges will need to be reported separately and eventually be excluded from the Medicaid discharge data but Medicaid discharges related to psych and rehab units should be included if applicable.</b> The summary encounter information should separately identify the South Carolina Medicaid eligibles from the out of state Medicaid eligibles and be reported by type Medicaid eligible (see list below). The SCDHHS State Level Repository will include an adjustment to remove the estimated CHIP encounter percentage from the Medicaid fee for service encounters.</p> <ol style="list-style-type: none"> <li>1. Medicaid Fee for Service Program;</li> <li>2. Medicaid MCOs;</li> <li>3. Medicaid PIHPs;</li> <li>4. Medicaid PAHPs;</li> <li>5. Medicaid PACE Programs;</li> <li>6. Medicaid with commercial insurance carrier;</li> <li>7. Dual Eligible (Medicaid/Medicare) individuals (where Medicaid paid for all or part of the service, or Medicaid paid for all or part of the premiums, co-payment, or cost-sharing); and</li> </ol>

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	<p>8. Total encounters provided during the three month period. <b>All newborn discharges will need to be reported separately and eventually be excluded from total discharges but discharges related to psych and rehab units should be included if applicable.</b></p> <p>B. The hospital will be required to submit excerpts from their monthly Board Meeting Minutes or their monthly financial statements to support the total number of inpatient discharges and ER visits incurred during the three month period used for patient volume qualification as identified in section (A)(8) above. <b>All newborn discharges will need to be reported separately and eventually be excluded from total discharges but discharges related to psych and rehab units should be included if applicable.</b></p> <p>C. The SCDHHS will determine the number of SC Medicaid eligible encounters (i.e. inpatient discharges and ER visits) by using its MMIS paid claims data, its Medicaid MCO encounter data, and the CHIP exclusion adjustment factor percentage for the three month qualification period used by the provider to perform a reasonableness check on that data submitted by the hospital. In the event that the in house Medicaid MCO encounter data cannot be readily used to determine the total number of encounters incurred by the hospital for analysis purposes, the SCDHHS will seek this information from the applicable Medicaid MCO(s) and reconcile accordingly with the qualifying hospital.</p> <p>D. The SCDHHS will use its CHIP adjusted SC Medicaid eligible encounter information provided via its claim payment system (MMIS) and its Medicaid MCO encounter data to determine if the hospital meets the patient volume requirement of 10% using SC Medicaid eligibles only. If the 10% patient volume requirement is met using this methodology, then no further analysis will be performed. However, if the 10% patient volume requirement is not met using the SC Medicaid eligibles data identified above, then the SCDHHS will request additional detail and perform various sampling techniques on the data submitted to determine the reasonableness of the out of state data submitted for the 10% patient volume eligibility determination.</p> <ul style="list-style-type: none"> <li>Once the Medicaid Patient Volume percentage has been verified, the SCDHHS will initiate the calculation of the aggregate EHR incentive payment amount for your hospital. As we begin this process, we may contact your hospital with additional information requests at a later date.</li> </ul>
<b>13. Attestation of Meaningful Use</b>	<b>Page 110-111:</b> In 2011, SCDHHS will only accept AIU attestations. SCDHHS is modeling its meaningful use attestation module in the SLR after the CMS Registration and Attestation System. EPs and EHS will attest to each measure in the SLR by entering numerator, denominator, and exclusion information. The format of the SLR site will allow for each measure to be displayed individually on a page. For measures that a provider meets the exclusion criteria, the provider will be able to attest to meeting the exclusion criteria in the SLR. Once an EP or EH completes the meaningful use

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	<p>attestation, the user will be directed to a summary screen of all attestation information. Each measure will have a “pass” or “fail” indicator based upon the information entered. In leveraging the format that CMS uses for Medicare meaningful attestations, SCDHHS hopes to provide a clear and easy to use process. Further, providers who switch from the Medicare Incentive Program to the Medicaid Incentive Program will have the benefit of using similar systems to attest to meaningful use. SCDHHS envisions a different approach for the longer-term and is working with its stakeholders to identify a solution that will lessen the provider burden to submit meaningful use data and leverage opportunities to collect other quality measures.</p> <p>SCDHHS will be leveraging contract staff to make the necessary adjustments to the SLR. Testing of the updates will begin mid October 2011 and run through mid-November 2011. SCDHHS will launch a provider education campaign on the meaningful use attestation in December 2011 to ensure providers are informed of the upcoming changes. SCDHHS will update its SLR guides to include step-by-step guidance on the meaningful use attestation process.</p> <p>Meaningful use attestations will be verified through a mix of pre- and post-payment activities. SCDHHS will work with DHEC and ORS to verify public health measures and connection to SCHIEx. As SCDHHS identifies other means of pre-payment verification, they will be included in the pre-payment verification activities. All other aspects of meaningful use attestations will be verified post-payment via audits.</p>
<b>14. Clinical Quality Reporting</b>	<b>Page 112:</b> For 2012, SCDHHS will accept attestations for clinical quality measures in the SLR via the meaningful use attestation module. For future years of clinical quality measures, SCDHHS will be developing a more detailed plan in the coming months in order to collect clinical quality measures.
<b>15. Pending Applications</b>	<b>Page 113:</b> When a provider is under suspicion of fraud, the provider’s application is pended until further information is available concerning their standing as a Medicaid provider. If the provider is proven innocent, their application can be processed for payment if they meet all of the eligibility criteria. If the provider is proven guilty and is excluded from the Medicaid program, the provider will be excluded from participation in the incentive program until the exclusion expires.
<b>16. Suspension of Payment</b>	<b>Page 114:</b> In addition, SCDHHS will suspend all Medicaid payments to a provider after the agency, in conjunction with the Medicaid Fraud Control Unit, determines there is a credible allegation of fraud. In situations where SCDHHS determines there is a credible allegation of fraud against a provider who otherwise has met EHR eligibility requirements, any pending EHR incentive payments would be withheld in accordance with agency policy.

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<b>17. Notification of Payment</b>	<b>Page 118:</b> The HIT Division notifies the provider of the payment via e-mail; and, if the provider has reassigned the incentive, the HIT Division will mail a printed letter to the Payee via USPS.
<b>18. Reducing payments against public debts and holding checks</b>	<p><b>Page 119: Recouping Incentive Payments Based on Debts and Wage Garnishment</b></p> <p>SCDHHS maintains a check pull list that is updated weekly in order to hold provider checks that require a legal basis to withhold monies. There are many reasons a provider could be placed on the check pull list, but some examples include suspicion of fraud, state and federal withholding, hospital advances, and failure to submit cost reports.</p> <p>SCDHHS is required to recoup public debts. Therefore, any provider who meets the requirements to receive an incentive payment from the SC Medicaid EHR Incentive Program who has an outstanding public debt will have his/her incentive payment reduced to account for the debt.</p> <p>SCDHHS also maintains a record of providers with an outstanding debit balance. If a provider has an outstanding debit balance and is not on the check pull list, the incentive payment will be reduced to account for the outstanding debit balance.</p>
<b>19. Audit Strategy</b>	<p><b>Page 121-122:</b> Provider attestations that raise no concerns are approved for payment but remain subject to random selection for audit. Providers that fail any HIT validation tests are automatically referred to the Division of Audits for detailed review prior to release of incentive payment.</p> <p>SCDHHS will validate provider eligibility and AIU attestations before payments are disbursed. This will avoid improper payments and ensure only EPs and EHS that meet all incentive funding requirements receive funds.</p> <p>CITIA will also advise providers of their obligation to retain auditable documentation for at least six years from the last year of participation in the program in the event that SCDHHS invokes its right to audit and review such records.</p> <p>To avoid making improper or duplicate payments, the policies and procedures of SCDHHS require that the HIT Division verifies receiving a positive D16 response from the NLR that ensures that the provider has not yet been paid for the payment year. An audit trail will be maintained containing the date/time of NLR files sent and received.</p>
<b>20. CHIP adjustment factor and audit impact</b>	<b>Page 121:</b> 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 determined by SCDHHS therefore SCDHHS believes it would impose an unfair requirement to audit as EHS and EPs do not provide the CHIP

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	adjustment factor.
<b>21. Methods to Ensure Compliance with AIU and Meaningful Use Requirements</b>	<p><b>Page 123:</b> Providers must attest that they have adopted, implemented, or upgraded to certified EHR technology and that they are able to provide documentation of legal or financial commitment to the certified EHR technology. EPs and EHs selected for audit may also be requested to provide invoice copies and payment histories.</p> <p>SCDHHS project coordinators in the HIT Division will conduct initial validation and monitoring of AIU and meaningful use.</p>
<b>22. Methods to Identify Improper Payments, Overpayments, Fraud, and Abuse</b>	<p><b>Page 124:</b> As noted, the HIT Division will be responsible for up-front review of provider eligibility and AIU attestations. This is a thorough initial screening that identifies providers with irregularities that can include license issues, eligibility restrictions, and pending or past investigations by several authorities. Providers that fail any HIT validation tests are automatically referred to the Division of Audits for detailed review prior to release of incentive payment.</p> <p><b>Audit Protocols</b></p> <p>The Division of Audits has developed a detailed audit protocol designed to meet the specific objectives of the audit function described in this section. This protocol addresses the entire audit process and includes:</p> <ul style="list-style-type: none"> <li>• Steps to obtain additional verification of a provider’s license and eligibility to participate in the Medicaid program when needed for initial validation</li> <li>• Steps to validate Medicaid and needy patient volume including claims data analysis</li> <li>• On-site verification of selected providers’ patient accounts</li> <li>• Steps to verify adoption, implementation, and upgrade, which may include on-site review of the provider’s use of EHR technology; obtaining documentation for proof of purchase, vendor agreements, etc; review of staff training records; and determination that the EHR technology used is certified</li> <li>• Steps to provider verification and support when the HIT management staff determine that a provider may not be meeting meaningful use criteria, and a recoupment of funds is required</li> </ul> <p>Audit steps will vary based on the choices EPs make in attestation:</p> <ul style="list-style-type: none"> <li>• Individual/Encounter Method</li> <li>• Individual/Panel (Assigned) Method</li> <li>• Group Volume/Encounter</li> <li>• Group Volume/Panel (Assigned) Method</li> </ul>

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	<ul style="list-style-type: none"> <li>• PA at an FQHC/RHC</li> </ul> <p>Before initial contact is made with the providers selected for post-payment audit, the auditors will conduct a preliminary review and fact gathering. This will include obtaining all data submitted through the State’s SLR; compiling in-house correspondence, emails, etc. with the provider, including any previous contacts with the Division of Program Integrity; determining who has already submitted invoices to support purchase of certified EHR products; categorizing those that have worked with CITIA to implement their technology; and confirming CMS EHR Certification ID.</p> <p>The Division of Audits will also send providers an Audit Survey Packet, which will include a questionnaire and an engagement letter. The letter will explain SCDHHS Audit’s role in review provider attestation data and will request supporting documents that may include:</p> <ul style="list-style-type: none"> <li>• Documentation for calculation of Medicaid or needy patient volume</li> <li>• Documentation for calculation of total volume</li> <li>• Identification of practice professionals with titles, licenses and dates of employment</li> <li>• Identification of any practice professionals that work or have worked during the reporting period concurrently at an additional practice</li> <li>• Explanation of current uses of the certified EHR technology, and supporting documentation if the provider has attested to upgrading from existing EHR technology</li> </ul>