

Tips for Eligible Hospitals Selected for a Post-payment Review of the Colorado Department of Health Care Policy and Financing Electronic Health Record (EHR) Incentive Program Payment

Why is the State conducting reviews of the EHR incentive payments?

Section 1903(t)(2) of the HITECH Act states that all Eligible Hospitals (with the exception of Children's Hospitals) 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* (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 Colorado Department of Health Care Policy and Financing (the Department) 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 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 or the payment calculation, 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 and supports an appropriate payment calculation. Failure to document eligibility and the payment calculation or failure to cooperate with Myers and Stauffer may result in recoupment of the incentive payment. **The Department will notify you of the results of the review. Any payment adjustments will be reflected in the next incentive payment you receive.** If you do not agree with the results you may appeal the decision in accordance with our appeals process described in the Code of Colorado Regulations title 10 CCR 2505-10 8.050, *Provider Appeals*.

What should I be able to document?

All information under attestation is subject to review. This includes documentation for both the eligibility determination AND the payment calculation. This documentation should be readily available because it was needed for attestation.

At a minimum, the detailed information to validate eligibility should include patient name, Medicaid member ID, if applicable, date of service, payer source, and servicing physician. Information that you attested to includes:

- Numerator: A detailed list of Medicaid Inpatient and emergency Room encounters during your selected 90-day period for which Medicaid paid an amount greater than zero, excluding dually-eligible encounters, nursery days, sub-provider days, and CHIP encounters.
- Denominator: A detailed list of all Inpatient and Emergency Room 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 payment calculation includes census, financial, or other internal reports to support Discharges, Acute Medicaid Days (fee-for-service and CMO with the same exclusions listed above), Total Acute Days, Charity Care/Other Uncompensated Care Charges, and Total Hospital Charges. Cost reports are often utilized in the payment calculation; however, the cost report by itself is not sufficient documentation because cost reports are self-reported.