



**STATE MEDICAID HEALTH INFORMATION TECHNOLOGY
PLAN (SMHP) UPDATE TO THE ANNUAL PLAN
FOR 2017-18 FINAL RULE MEANINGFUL USE
REGULATION**

**Alabama Medicaid Agency
In Partnership with
Health Information Exchange Advisory Commission**

**SDE Contact: Gary Parker
gary.parker@medicaid.alabama.gov
(334) 242-5011**

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CONTACT AND SUBMISSION INFORMATION

Name of State:	Alabama
Name of State Medicaid Agency:	Alabama State Medicaid Agency (A-SMA)
Name of Contact(s) at State Medicaid Agency:	Gary Parker, Director, Health Information Technology
E-Mail Address:	gary.parker@medicaid.alabama.gov
Telephone Number:	334- 242-5011
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VERSION HISTORY

Version	Approved	Notes
1	2010	Original Submission
2	Nov. 5, 2012	Annual Update
3	February 5, 2013	Annual Update and Updated for MU Stage 1
4	April 1, 2013	Audit Strategy: AIU and MU State 1
5	February 27, 2014	Annual Update and Updated for MU Stage 2
6	May 12, 2014	Response to CMS Questions and Updated for One Health Record® A-HIE
7	April 13, 2016	Annual Update 2015-17 Modified Stage 2 & Stage 3 Final Rule
8	June 29, 2018	Annual Update and Updated for 2017 SMHP Addendum, OPPS, MACRA/MIPS, Final Rule

1. PURPOSE, SCOPE, TIME FRAME, CONTENT AND STAKEHOLDER ENGAGEMENT

1.1 PURPOSE

As former Medicaid Commissioner R. Bob Mullins, Jr., MD, former chair of the Alabama Health Information Exchange (A-HIE) One Health Record^{® 1} Advisory Commission previously stated, “I made the decision early on that the development of our health-IT system had to be our primary initial goal in order for the agency to meet the demands of the fundamental changes going on in Medicaid and health care.” This principle continues to guide the current Alabama Medicaid Commissioner Stephanie McGee Azar.

The A-SMHP was initially submitted in 2010, updated on November 15, 2012, and approved as an update on February 5, 2013. It continues to provide the activities Alabama’s State Medicaid Agency (A-SMA) has engaged in and the proposed actions the state will engage in over in the near and longer term relative to implementing Section 4201 Medicaid provisions of the American Recovery and Reinvestment Act (ARRA). The April 2016 annual update of the Alabama State Medicaid Health Information Technology Plan (A-SMHP) included 2015-2017 Modified Stage 2 and Stage 3 Final Rule for Meaningful Use (MU) changes that were implemented January 1, 2016 was approved by CMS August 29, 2016 and included the current and planned activities of Alabama’s State HIE, One Health Record.

This annual update to the currently approved A-SMHP specifically addresses the Meaningful Use program changes, including the latest 2017-18 applicable rule changes e which were not addressed in previous updates. This update primarily focuses on addressing efforts and actions by the A-SMA that were implemented after January 1, 2017, and changes that will be implemented by January 1, 2018 to accommodate any 2017-18 rule changes recently release since the last update. Included in this A-SMHP annual update will be status of the transition of Medicaid to the use of Regional Care Organizations (RCOs), and Alabama’s HIE One Health Record..

Alabama State Medicaid Agency (A-SMA) agency continues to positively influence health outcomes of Alabama Medicaid enrollees in several ways, including:

- a. Transitioning from fee-for-service health care delivery to managed health care delivery through a TBD managed care approach to improve management and coordination. The Alabama RCOs were set to begin operations on 10/1/2018, but after further consideration, Alabama decided to terminate the RCO initiative. Alabama is

¹ As noted in the initial Alabama State Medicaid HIT Plan (A-SMHP), Alabama has branded its Health Information Exchange as One Health Record[®].

currently developing an alternative MCO model focusing on the existing Patient Health Home networks.

- b. Alabama continues to move forward with the implementation of the Integrated Care Networks (ICN) which is focused on managed care for A-SMA's long-term care population.
- c. Transitioning to paying for performance and value-based purchasing
- d. Identifying sub-populations with specific needs
- e. Supporting patient outreach and health education campaigns
- f. Public reporting to enhance competition
- g. Providing MU provider education, outreach, technical assistance in EHR utilization
- h. Creating infrastructure and processes to leverage clinical quality metrics and population health analytics.

On-going Implementation of One Health Record, A-HIE to support A-SMA to improve health outcomes and achieve other program goals by providing the infrastructure to:

- Enhance communication between providers/hospitals and patients through practical, efficient and effective HIT interfaces and tools,
- Enhance community-based care through infrastructure for care coordination and integration,
- Enhance safety net hospitals' efficiency and effectiveness through the use of certified EHRs and connectivity to One Health Record® to reduce hospital-acquired/healthcare-associated infections, hospital-based errors and adverse events, and preventable re-hospitalizations,
- Provide useful data for the RCOs, health officials, and other stakeholders to address the needs of priority populations, reduce disparities, and support payment reform.
- Enhance the ability to use measures of quality and performance.

The specific provisions addressed in this A-SMHP are as follows:

- Implementation of those provisions of the MU program 2017 program year became effective 8/2/1 for EHs and EPs, specifically changes to meaningful use objectives and measures and CQM reporting. The specific changes will be discussed in Section 4.
- Alabama's 2017 SMHP Addendum outlining Alabama's implementation the Stage 3 portion of 2015-17 Modifications Rule, OPPTS Rule, and any changes attributable to the Medicare QPP/MACRA/MIPS were approved by CMS on February 13, 2017. On March 23, 2017, CMS approved Alabama's MU screens to address 2015-17 modifications and Stage 33 final Rule published on October 23, 2016. .
- Update of the "To Be" section of the SMHP to incorporate. The details of the One Health Record® implementation and any changes in the HIE strategic vision .

An HIT-IAPD update will be submitted to support:

- The ongoing administration and operations of Alabama’s MU EHR Incentive Payment Program, including post-payment audit functions, and the projected program spending through September 30, 2020. The HIT-I-APD will primarily focus on addressing efforts and actions by the Alabama State Medicaid Agency (ASMA) that will be implemented beginning October 1, 2018.
- The management and oversight of the SLR activities. The current contract with HealthTech Solutions (HTS) expires on July 31, 2018 Alabama is presently preparing to extend this contract for a third year beginning on August 1, 2018.
- Continued funding for ongoing EHR Incentive Program staff and contract support, including vendor supported post-payment audit functions and collection and utilization of clinical quality measures (eCQM’s), and analytics.
- Funding to support both on-boarding and HIE architecture for Medicaid providers that an Eligible Hospital or Eligible Professional needs to connect to for purposes of demonstrating Meaningful Use. This includes Medicaid provider types such as behavioral health providers, substance abuse treatment providers, long term care providers, correctional health providers, pharmacies, laboratories, emergency service providers, and community-based Medicaid providers, as described and outlined in SMD 16-003, dated February 29, 2016.
- Continued funding for the on-going implementation and promotion of Alabama’s HIE, One Health Record® to support health information exchange and public health reporting.
- Funding to support the initiatives for the electronic data submission and collection of clinical qualities measures to support population health analysis to support improved care outcomes and alternative payment models.
- Funding to support connectivity for patient Admission, Discharge, and Transfer (ADT) notifications for regional and emergency management care coordination.
- Funding to support on-boarding activities and infrastructure improvements to the connect Alabama’s Prescription Drug Monitoring Program as specialized registry to the State HIE, One Health Record.

1.2 SCOPE

Section 4201 of the ARRA provides 90% FFP HIT Administrative match for four activities to be executed under the direction of the State Medicaid Agency (SMA):

- *Administer the incentive payments* to eligible professionals and hospitals;
- *Conduct adequate oversight of the program*, including tracking meaningful use by providers; and
- *Pursue initiatives to encourage the adoption of certified EHR technology* to promote health care quality, the exchange of health care information the collection and utilization of electronic clinical quality measures (eCQM) for population health analytics.
- *Pursue implementation strategies to expand and facilitate the connections between EP's and other Medicaid providers* to promote their use of EHR/HIE technologies for the purpose of meeting the MU objectives.

In addition, new guidelines have been published to support connecting interoperable systems, EHR & HIE, infrastructure, and connectivity among other Medicaid provider to allow EP's and EH's to demonstrate meaningful use and meet program objectives.

Alabama's updated SMHP continues to provide the state's plan related to:

- State Level Registry (SLR) management of registration, attestation and submission of quality measures, as well as managing the registration, reporting and payment for eligible professionals (EPs) and eligible hospitals (EHs) for participation in the Medicaid Meaning Use (MU) Incentive Payments Program. This requires that the SLR IT infrastructure support the administration of the incentive payments (100% FFP), including identification and attestation of EPs and EHs for the continuation of MU Modified Stage 2, Stage 3 payments and updates as it pertains to QPP/MACRA/MIPS Final Rule released on August 2, 2017.
- Maintenance and upgrade of Alabama's connection to CMS's Registration and Attestation System as needed.
- Automation of the provider appeal functions for EPs and EHs.
- Capacity to address MU measurement reporting, including collecting and using eCQM's
- Ongoing support for the development and dissemination of educational and engagement communication materials regarding the EHR Incentive Program and/or EHR Adoption/Meaningful Use. In November 2017, A-SMA extended its MU Technical Assistance & Outreach contract to Management and Medicaid Consulting Services, LLC (MMCS) for a third year.
- Ongoing support for environmental scans, gap analyses, provider needs assessments and multi-state collaborative efforts related to MU.
- Integration of the data from the Registry System into the MMIS provider history.
- Conduction of adequate oversight of the Medicaid MU Incentive Payments Program, which requires IT and human resources (employees and contractors) support (90% FFP for systems and administration) for:

- Any evaluation of the EHR Incentive Program and costs related to ongoing quality assurance activities, SMHP updates, I-APDs and federally required reporting.
- Automation of a risk-based auditing approach with a focus on provider eligibility, patient volume, , certified EHR technology and MU audit/oversight activities, including auditing contractor(s), in-house activities, and systems costs for interfaces to verify provider identity/eligibility (e.g., provider enrollment, license verification, sanctions, patient volume).
- Medicaid’s funding of One Health Record® under MU when used to support the Medicaid MU Incentive Payments Program, with continued focus on the connectivity for PHI exchange and utilization among Medicaid providers and their networks, health homes, reporting the public health meaningful use objectives, and technical assistance for Medicaid providers to achieve MU.
- On-going support of an enhanced enterprise data warehouse repository and data analysis capability, including access through One Health Record®, Alabama’s Health Information Exchange (A-HIE) that will be used across state agencies with appropriate cost allocations.
- Pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information (90% FFP for systems and administration).
 - Medicaid’s portion of One Health Record® that impacts an EP or EH’s ability to effectively and efficiently use a certified EHR to promote health care quality and the exchange of health care information, including the ongoing management of activities when used for services that are not MU focused (such as therapies or nursing home care) or when they are used by providers who relate to EPs/EHs receiving EHR Incentive Payments but are not an EP or EH. This would include the Master Patient Index, Record Locator Service, secure messaging, gateways, provider directories, development of privacy and governance policies and procedures, interfaces for data (e.g., home health) important to successful health information exchange for Medicaid providers, clinical summary, electronic reporting of structured laboratory data and enabling e-Prescribing. One Health Record® provides a state query gateway to the eHealth Exchange and provides HISP services in support of DIRECT secure messaging. Alabama One Health Record® will act as the “hub” for the exchange of information intra- and inter-state, allowing providers to meet MU requirements.
 - One Health Record® remains under the governance of the Medicaid Agency and costs continues to be a “fair-share” approach until full implementation is complete. cost allocated A-SMA is refining its “fair share” methodology for cost allocation due to the decision to discontinue the RCO implementation.

Alabama Medicaid will not be the sole funding source, but Alabama Medicaid will be responsible for its fair share “in accordance with benefits received.” Medicaid, Medicare (administered by Blue Cross-Blue Shield of Alabama (BCBSA), CHIP (administered by BCBSA) and BCBSA— the primary payers and managers of care

delivered in the state — , along with other secondary payers will receive the benefits. The approach provides an integrated, long-term sustainable governance structure and consumers have one web-based “door” to Alabama health care through One Health Record® <http://onehealthrecord.alabama.gov/>. Alabama is engaging secondary payers, such as Bright Health, as well as other ACO entities to further support the long-term sustainability for One Health Record.

The end goal is to reform Medicaid through incremental, but critical system wide changes identified within this A-SMHP. Due to Alabama’s extensive Medicaid population and expanded provider network, the infrastructure MUST work for Medicaid in order to work for the rest of the payers in the State.

Timeframe

This updated A-SMHP addresses the activities and responsibilities of the A-SMA related to continuing MU Modified Stage 2, Stage 3, and QPP/MACRA/MIPS in response to regulatory changes effective August 2017. .

The initial A-SMHP and I-APD provided the basis for funding for the Medicaid’s MU-HIT program, which included the A-HIE One Health Record®. Therefore, this A-SMHP re-iterates the inclusion of the areas identified above in Section 1.2 under Scope and an updated I-APD was submitted on June 27, 2018 in support of this A-SMHP. Alabama intends to update the A-SMHP at minimum annually.

1.3 REQUIRED VS OPTIONAL CONTENT

The A-SMHP has addressed all appropriate required and optional questions in the following sections using the format provided by CMS to assure consistency and ease in review. In line with CMS’s State Medicaid Director letter, Alabama intends to leverage existing efforts to achieve the vision of interoperable information technology for health care. The priorities for the State are enormous, complex and inter-dependent in a time of immense budget constraints and policy transformational activities, both federally mandated and optional. The major focus of this A-SMHP is to address the continuation of Modified Stage 2, Stage 3, and any QPP/MACRA/MIPS changes, MU-HIT program support activities, and One Health Record, Alabama’s HIE,. Previous A-SMHP updates identified and addressed the integration of mental health, senior services and public health infrastructure to assure more accurate and appropriate Medicaid payment and Medicaid eligibility, as well as MMIS development needed to manage the growing Medicaid population. All of these changes will have momentous impacts on Medicaid.

1.4 STAKEHOLDER ENGAGEMENT

Medicaid continues to engaged stakeholders within and outside the State and Federal government in the development of a common vision of how Medicaid's provider incentive program will operate in concert with the larger health system and statewide efforts. With Medicaid Commissioner Stephanie McGee Azar as the chair of the A-HIE One Health Record® Advisory Commission and the Medicaid Agency as the Executive Sponsor for the A-SMHP., t. Used for both the A-HIE S/OP and the A-SMHP, the One Health Record® has been able to engage and retain engagement with Governor-appointed leaders for providers, advocates, Regional Extension Center (RECs) and Universities engaged in health-IT education.

Alabama continues to provide “boots-on-the-ground” MU Technical Assistance for both EP MU program retention and HIE connectivity, and to develop and update its on-line capabilities to assure all possible EHs and EPs understand and have easy access to register and attest for meaningful use. These capabilities/tools were outlined and submitted previously with the April 2016 update.

This A-SMHP update includes changes to accommodate the approved 2017 SMHP addendum for the Stage 3 portion of the 2015-17 modifications rule, and potential changes pertaining QPP/MACRA/MIPS Final Rule issued in August 2017. The 2017 SMHP Addendum, was approved by CMS on February 13, 2017. As part of that 2017 SMHP Addendum, Alabama submitted the updated MU screens for the final rule of 2015-17 modifications, the MACRA/MIPS final rule on November 14, 2016, and the OPPI rule released on October 14, 2016, These updated screens were approved by CMS on March 23, 2017.

Alabama also submitted a request to CMS to extend the 2016 tail-period to June 30, 2017 to address changes reflected in these latest rule changes and to accommodate our issues with our SLR re-procurement. Alabama received CMS approval to extend Alabama's PY 2016 tail period for AIU on March 3, 2017 and for MU on February 2, 2017.

Alabama Medicaid continues to provide leadership on other inter-state issues through the the State Health Policy Consortium on Behavioral Health. Alabama is State HIE activities with a team of public and private providers and stakeholders. Alabama is represented on various national workgroups regarding critical issues, including mental health. In addition, Alabama continues to participate in the National Governor Association (NGA), Southern Governor Association, and National Association of Medicaid Directors (NAMD). It further serves in a leadership role in other national activities, including the AHRQ Medicaid Medical Directors Learning Network. In March 2018, Alabama One Health Record became a member of the State Health Information Exchange Collaborative (SHIEC) and as a member of the SHIEC PCDH Governance Council.

2. SMHP SECTION A: ALABAMA'S "AS IS" HEALTH-IT LANDSCAPE

2.0 INTRODUCTION TO "AS IS" HEALTH-IT LANDSCAPE

Standard:

Alabama sought to use a consistent approach to determine the health-IT landscape, including readiness of providers for meaningful use. The baseline provided in the initial A-SMHP confirmed that Alabama providers had limited experience with electronic health records (EHRs) and no health information exchange capability. The functionality required to exchange information in a meaningful way did not exist.

In the last annual update in April 2016, Alabama provided an updated 2015 environmental scan which demonstrated the progress Alabama had made in implementing Health IT infrastructure. The high noted were:

- There were 80+ different EHRs in Alabama EP-type locations.
- Many providers have low technical capabilities in underserved areas.
- Hospitals are much further along because they have more financial resources, greater technical staffing and experience and have a better understanding of the value.
 - 88% of those represented utilize EHR systems for practice management and reporting
 - 51% of those represented share PHI data with others; 49% do not share PHI/data.
 - Of those who share PHI data, 66% use Direct, 24% use other means.
 - 63% of those represented know about One Health Record, only 10% use the HIE for sharing.

State IT Requirements: Although Alabama's state IT infrastructure requirements for networking and internet services are established through the Office of Information Technology's Information Services Division, there does not exist a defined statewide architecture.

One Health Record®:

During FY 2016, Alabama's State HIE, One Health Record technology platform was re-procured in accordance with state law. The new HIE contract was awarded to Cognosante and so a transition from Truven to Cognosante began in July 2016 and continued through June 2017.

In May 2017, both the State HIE One Health Record, and Meaningful Use EHR Incentive programs were combined under Medicaid's the Health Information Technology Division. Gary D. Parker, now serves as the Division Director, and administers both programs.

2.01 As of September 30, 2017, One Health Record® has 107 facility connections throughout the state.

Alabama continues to update its ongoing analysis of readiness by geographic area provided the state with possible gateways beyond for the remaining of One Health Record® implementation, including the technical capability to support DIRECT and CONNECT. One Health Record® provides secure messaging, a provider directory, DIRECT support and patient index (MPI) so providers statewide will be able to participate in the Medicaid incentive program and use health information in a meaningful way.

While many design, development and implementation activities have taken place and public and private support for One Health Record® has been favorable throughout the process, there remain significant implementation and operational realities in the “as is” health-IT environment.

- The rate of adoption and participation by providers and hospitals continues to be low. However, recent upgrades to the Admission, Discharge, and Transfer notification functions have created a new interest to make connections among provider networks associate with niche health plans, ACO’s, MIPS participants. We continue to advertise the value of connectivity to One Health Record® as we moved toward 2018 with Meaningful Use Stage 3. The Stage 3 Final Rule for QPP issued in August 2017 better aligns with the next phase of One Health Record® implementation in support of eCQM reporting and exchange..
- Medicaid’s RCO initiative for service delivery transformation was terminated in August 2017. Medicaid is currently formulating an alternative approach to “pivot” the service delivery transformation that better aligns with CMS’s rules regarding managed care. The exact of the HIE is still undetermined at this point, but health information exchange will continue to be an underpinning infrastructure of Medicaid’s coordinated care system. While the recent focus of One Health Record® is very Medicaid centric, the “fair share” funding from private entities is essential and required in order to access Medicaid funding. The “value” beyond Medicaid is still a challenge to validate with the private market, but with new interest from niche health plans and ACO’s , new opportunities in the cloistered populations are now presenting themselves One Health Record will continue efforts to create a HIE utilization “tipping point” with use of DIRECT connectivity and ADT alerting requirements among hospitals, health plans, ACO’s and Medicaid’s own health home network to be have sizable percentage of those connected by September 30, 2020.

2.02 EHR Adoption/EHR Incentive Program Meaningful Use:

1d: Implementation Activities

Implementation Activities	Date
Registration Implementation	4/14/2011
AIU Attestation Implementation	4/14/2011
Payments Implementation	4/14/2011
Audits Implementation	10/1/2011
MU Attestation	4/1/2012-
AIU Recruitment	12/1/2015
MU Attestation – Modified Stage 2	8/1/2016
MU Attestation – Optional Stage 3	12/1/2017

Alabama Medicaid has disbursed over \$185 million to almost 2334 EPs and 89 EHs.

The focus for 2011 was AIU and the focus for 2012 was attesting for MU Stage 1. The process has moved to providers' readiness for use of their certified EHR in a meaningful way as well as connectivity to One Health Record®.

In 2013 and 2014, the focus continued on increasing attestations beyond AIU, streamlining MU processes, and provider utilization of their certified HER in a meaningful way.

In 2015, the MU Outreach included a focus on increasing the MU Stage 1 participation, with Medicaid seeing the AIU-to-MU migration rise as shown in the table below:

In 2016-17, the MU Outreach and Technical Assistance focused on maximizing our AIU participation, with Medicaid seeing an additional 311 AIU attestations. For both 2015 and 2016, AIU total participants were 489, which represents a 26% increase in year one participants.

	YEAR 1 TO 2 RETURN	Year 1	Year 2	Return Percentage	CMS MAP Percentage as of Jan 2017	Percentage Not Returning	Volume
AIU to MU ONLY							
	Paid	2334	887	39%	31%		
	Invoice in Process	0	6				
	Subtotal	2334	715	39%			
	Submitted	0	17				
	Total	2344	732	39%		61%	1134
	YEAR 2 TO 3 RETURN	Year 2	Year 3	Return Percentage	CMS MAP Percentage as of June 2017	Percentage Not Returning	Volume
MU	Paid	709	324	46%	38%		

YEAR 2 to YEAR 3	Invoice in Process	6	13				
	Subtotal	715	337	47%			
	Submitted	17	14				
	Total	732	351	48%		52%	381
	YEAR 3 TO 4 RETURN	Year 3	Year 4	Return Percentage	CMS MAP Percentage as of Jan 2017	Percentage Not Returning	Volume
MU	Paid	324	108	33%	0%		
YEAR 3 to YEAR 4	Invoice in Process	13	7				
	Subtotal	337	115	34%			
	Submitted	14	28				
	Total	351	143	41%		59%	208
	YEAR 4 TO 5 RETURN	Year 2	Year 3	Return Percentage	CMS MAP Percentage as of Jan 2017	Percentage Not Returning	Volume
MU	Paid			46%	38%		
YEAR 2 to YEAR 3	Invoice in Process						
	Subtotal			47%			
	Submitted						
	Total			48%		52%	381
	YEAR 5 TO 6 RETURN	Year 3	Year 4	Return Percentage	CMS MAP Percentage as of June 2017	Percentage Not Returning	Volume
MU	Paid			43%	%		
YEAR 3 to YEAR 4	Invoice in Process						
	Subtotal			43%			
	Submitted						
	Total			43%		57%	321

1e: EP Registered Providers

EP Registered Providers	Alabama Medicaid EP registered Providers who have met MU (9/30/2017)	Alabama Medicaid EP registered Providers met MU in 2016
2334	1392	486

1f: EP/EH Meaningful Use

	Meaningful Use Alabama EPs/EHs (documented registration with Alabama SLR) as of 9/30/2017	Signed DURSA with One Health Record® and have validated operational connectivity as of December 31, 2017:
EPs	2334	295
EHs	95	7

Provider Outreach: In 2014, Alabama began moving forward on implementation of a statewide initiative to engaged potential eligible providers to adopt electronic health record adoption and enroll in the Electronic Health Record Incentive payment program.

In November 2015, Alabama moved ahead with implementing the MU EP recruitment and technical assistance. The current strategy focused on bringing new 489 new EP’s into the program before the program year 2016 tail period ended on June 30, 2017.

A-SMA continues to support a partnered website with the A-HIE, One Health Record® (<http://onehealthrecord.alabama.gov/>), that links to federal and state sites, and contains information and answers to providers’ questions concerning MU. Stakeholder information regarding certified EHRs and MU requirements are provided by CMS and then forwarded to One Health Record by the State,

Structured Lab: The incentive program year 2017 for the meaningful use of certified EHR technology does not includes an measure for incorporation of structured lab results into EHRs. For an EP, EH, or critical access hospital to meet Stage 3 meaningful use requirements in 2018, more than 40% of all clinical lab tests results ordered for patients admitted to its inpatient or emergency department during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.

Alabama is partnering with University of Alabama-Birmingham (UAB) is a pilot project to secure and implement a process to collect lab results from both LabCorp and Quest Labs for the A-SMA patient population. The data feeds will comprise of a single 5-year data (2012-2017) dump to A-SMA and the monthly updates thereafter.

After evaluation of the pilot, A-SMA expects to procure the services of a third-party vendor to connect Alabama’s independent labs through a single collection gateway, and then send the lab results data, to A-SMA data repository, via One Health Record and/or other health IT platform. The data will then for used for qualitative analysis to identify areas for improve care coordination and outcomes. Alabama has approximately 110 independent labs in the State.

Patient Summary Report: The MU Incentive Program includes measures for patient care summaries :

- The core measure set for Modified Stage 2 and Stage 3 meaningful use requires that EPs, EHs and CAHs must demonstrate perform at least one test of the certified EHR’s capability to electronically exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results) among providers of care and patient authorized entities.
- The menu set measures for Modified Stage 2 and Stage 3 of meaningful use requires that EPs, EHs or CAHs that transition patients to another setting or provider must produce a summary of care record for more than 50% of transitions of care and referrals.

As part of the initial ONC S/OP and CMS A-SMHP S process, an environmental scan was conducted in 2010 to assess current capabilities Alabama updated the environmental scan with another survey in November of 2015 and provided the results of that update in the previous update approved on August 29, 2016 . As noted earlier, Alabama TA and Outreach netted 179 new participating EP’s for PY 2015, and 311 new EP’s for PY 2016. This represents a 26% increase growth in our MU program since PY 2014. .

Of those providers responding to the 2015 updated scan survey, almost 41% (409/1,001) indicated they have a Medicaid patient volume of 30% or higher. However, when asked whether or not the practice was planning to apply for Meaningful Use Incentive Payments, the blended responses were 13% yes, 64% unsure and 23% no. However, taking account percentage increase the PY 2015-16 attestations submitted, we estimate the percentage of providers who have a Medicaid patient volume of 30% or higher to be approximately 60% (470)

Since the implementation of the EHR Incentive Programs, adoption of Certified EHRs had increased substantially by physicians. The update ONC data, published May 2016, still shows EHR adoption rates by Alabama office based providers, with Certified EHRs exceeding the national rate at 80% vs 78%.

Table 1i: Electronic Care Summaries

Program Priority	Status as of December 2015	Target for December 2016	Status as of December 2017	Target for December 2018	Target for December 2019
% of hospitals sharing electronic care summaries with unaffiliated hospitals and providers	71%	80%	91%	98%	100%

E-Prescribing: Alabama had previously used SureScripts data to determine the baseline of physicians which utilize e-Prescribing in the state. According to data compiled by SureScripts, the percent of retail community pharmacies enabled to e-Prescribe and actively e-Prescribing on the SureScripts Network in Alabama grew from 64% in December 2008 to 96% in April, 2014. In addition, new prescription requests were 625,353 (86.3% of all e-Prescribing requests on the SureScripts Network for the State of Alabama) vs. 40,108,996 (80.8% of all e-Prescribing requests nationwide).

The total number of e-Prescribers grew from just under 1534 in March, 2011 to 6,394 in April, 2014. According to data compiled by SureScripts, as of August 2011 29.4% of office-based physicians in Alabama sent an electronic prescription on the SureScripts network using an EHR compared to 37.6% nationwide. By April 2014, this percentage increased to 64%, more than 100% during this period.

Medicaid continues to sponsor an e-Prescribing initiative to provide connectivity to SureScripts through a Medicaid Agency sponsored web-interface.

Secure Messaging: As of July 1, 2017, there were 8,347 patient queries and 9,013 Direct messages. Alabama Medicaid has established a tool within One Health Record® for provider-to-provider secure messaging. The Web portal features Direct Secure Messaging (DSM) or DIRECT exchange and will facilitate both the 2017 MU Modified Stage II and 2018 Stage 3 requirement for securely exchanging summary of care documents among Alabama hospital and office-based providers (Provider Priority Area 3) during transitions of care, and care coordination, or with referrals from one provider to another.

2.1 WHAT IS THE CURRENT EXTENT OF EHR ADOPTION BY PRACTITIONERS AND BY HOSPITALS?

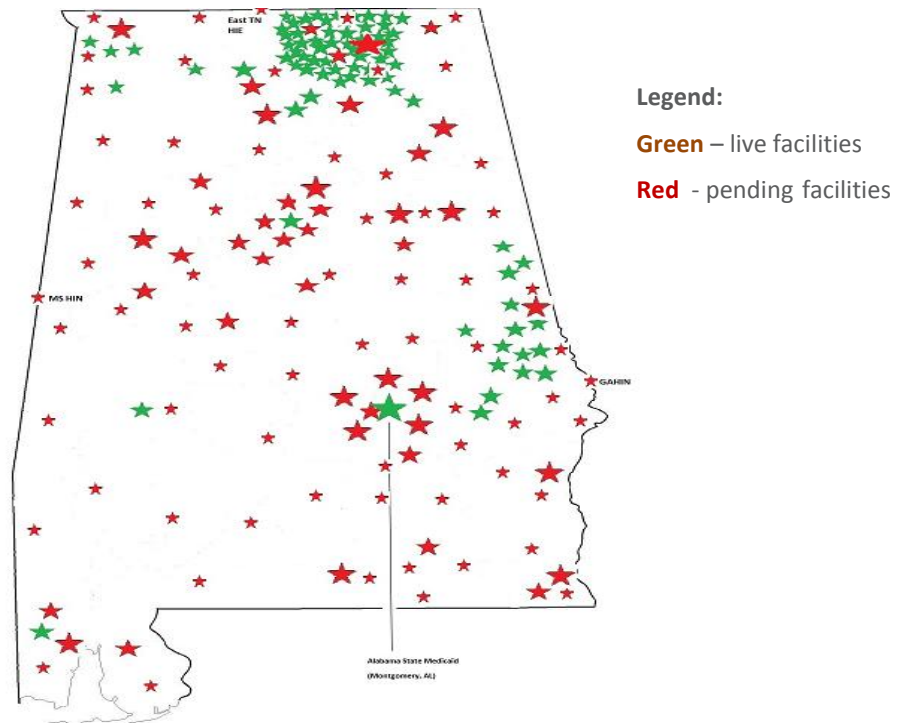
The current extent of EHR adoption by both practitioners has increased by approximately 33% as indicated in the surge of AIU attestation during 2016. Hospitals have remained steady over the same period as outlined in Table 1a.

As noted in the previous SMHP updates, Alabama's State Level Registry (SLR) has been in operation since April 2011. In Spring 2016, Alabama re-bid its SLR platform, with HealthTech Solutions being awarded the new contract. After allowing for a transition, Alabama opened MU PY 2015 on September 15, 2016. Alabama closed PY 2016 on November 14, 2017, thereby allowing a 60-day attestation period for PY 2015.

On December 5, 2016, Alabama began accepting 2016 AIU attestations, and on January 2, 2017, Alabama began accepting both MU and AIU attestations for PY 2016. The delay Alabama experienced in transition to its new SLR created a situation where we had overlapping backlogs for both 2015 and 2016 attestations, thereby creating a need to extend the PY 2016 attestation period for both AIU and MU. Alabama received approval from CMS, the latest approval on March, 3, 2017 to extend the PY 2016 submission deadline to June 30, 2017.

A-SMA intensified outreach activities in Alabama to register any new and remaining EP's before the end of PY 2016. This combined effort resulted in 490 new program participants. Also, for PY 2016, we accepted 811 attestations, which was a 45% increase over PY 2014 totals. The Outreach and TA metrics are highlighted in Table 2 below.

Table 2: Provider EHR/HIE Outreach 2016-8 (1/1/2016 – 9/30/2018)



Outreach Type	Occurrences- Approximate	Outreach Events
PI Director, Health IT Staff, & Medicaid Staff	24	Outreach projects in all counties to engage providers in adopting Health IT technology and MU Technical Assistance

Outreach Type	Occurrences-Approximate	Outreach Events
Phone contacts	1500	–Average 50 calls per month per staff person
Site visits	8 by MU Staff;	8 for MU Staff; augment with additional visits by Health IT Director
Incoming Phone Calls	750	Average 25 calls//staff person
Emails	6240	Average 100 emails/week/ staff person
MMCS (MU Outreach Contractor)	4-10	Weekly schedule sites visits for recruiting & PI TA
Off Site Working Seminars	7	Health IT Director and Medicaid Staff

As of 12/31/2017, the metrics for EHR activities in Alabama are as follows:

Figure 1a: Total Registration and Attestation Submissions

Registered (Active)	5939
Registered (Inactive)	10125
Submitted Attestation	4927
Not Submitted (Still in process)	63

Figure 2: Submissions by Type

Physicians	3613
Nurse Practitioners	781
Dentists	247
Physicians' Assistants	16
Certified Nurse Midwives	19
Dual Eligible Hospitals	245
Children's Hospital	<u>6</u>
Total	4927

Figure 3: Registration and Attestation Submissions by Location through 12/31/2017

For all program years s 2011-16 the state established the deadline for EP registration and attestation for a payments March 31 so that between January and March of the following calendar year, EPs registered and attested for an incentive payment associated with the corresponding calendar year.

For program years 2014-16 Alabama submitted to CMS an request to extend those tails periods due circumstances surrounding the 2014 MU Flex Rule changes and our SLR re-procurement. CMS approved those requests.

In the previously submitted and approved SMHP, A-SMA included the 2014 and 2015 SMHP Addendums to incorporate the 2014 MU Flex Rule changes and the 2015-17 Modified Stage 2 and Stage 3 Final Rule. Both of these Addendums were approved by CMS on January 16, 2015, and .

on February 5, 2015 respectively. The screen shots for the 2015-16 SLR changes were also approved by CMS in February 2016.

A-SMA released the RFP in April 2016. After the RFP evaluations were complete, A-SMA selected HealthTech Solutions (HTS) as the new SLR contractor. Alabama sent the new contract to CMS for review and CMS approved the contract in a letter dated August 29, 2016. C Alabama begin accepting 2015 EP registrations and attestations on September 15, 2018. Prior to the procurement delays, Alabama had established a 2015 tail period ending on 9/30/2016, but CMS approved Alabama request to extend the tail-period deadline until November 1, 2016.

On February 1, 2017, A-SMA submitted to CMS the 2017 SMHP addendum to outline A-SMA's implementation of Stage 3 portion of 2015-17 Modifications Rule, the OPPS rule, and any changes associated with Medicare Quality Payment Program under MACRA/MIPS. A-SMA submitted additional information to CMS on 2/10/2017. CMS approved Alabama's SMHP 2017 Addendum on February 13, 2107. On February 1, 2017 A-SMA also submitted to CMS the updated MU SLR screens as requested to identify the changes to accommodate the final rule 2015-2017 Modifications and Stage published on 10/16/2015, the OPPS rule published 11/14/2016, and the MACRA/MIPS Final rule, publish on 10/14/2016. CMS approved Alabama MU screens via e-mail dated March 23, 2017.

In February 2016, Alabama asked for and received CMS approval to extend our PY 2016 MU tail period deadline for both EP's and EH's to 6/30/206. In March 2016, Alabama submitted a request to CMS to extend the 2016 AIU tail period to June 30, 2016 for EP's and EH's. C

As of 12/31/2016, a total of 2020 providers (1932 EPs and 88 EHs) were approved for AIU payments for a total amount of \$103,602,932.15 (\$62,916,248.15 to EHs and \$40,686,684 to EPs). Another 1,565 (1,406 EP and 159 EH) were approved for MU payments of \$72,489,883 (\$12,005,0186, to EPs and \$62, 916,248. to EHs).

As of 12/31/2017, a total of 2,266 providers (2178 EPs and 88 EHs) were approved for AIU payments for a total amount of \$103,602,932.15 (\$62,916,248.15 to EHs and \$45,885,851 to

EPs). Another 1809 (1614 EP and 195 EH) were approved for MU payments of \$76,614,142.21 (\$13,889,025 to EPs and \$62,725,117.21 to EHs).

Table 2a: EPs Met MU 2015 and 2016

EP Registered Providers	Alabama registered have met 12/31/2017	Medicaid Providers MU as of	EP who registered use in previous year (12/31/2016)
2266	1614		1406

As outlined in the last A-SMHP dated 4/16/2016 , Alabama did continue with its plan for advancement of One Health Record® in efforts on fulfilling the needs of Medicaid Managed Care providers in both meeting their meaningful use reporting requirements and assisting in the care management of Medicaid enrollees. The State completed a Regional Pilot around East Alabama Medical Center to demonstrate and measure success by enabling providers the capability to . : (1) send and receive full clinical data through their EHRs to One Health Record®; (2) have the ability to log into the One Health Record® portal and review and/or print patient records; (3) have the capability to receive ADT alerts on patients; (4) send, read and receive referrals, notes, test results, and images to another member of One Health Record®; (5) automate reporting of immunizations, labs, and syndromic data to Public Health; and (6) track patient utilization of services and care coordination.

In December 2015 the North Alabama Regional HIE (previously addressed as Huntsville Regional HIE), completed it's connectivity to One Health Record®. This accomplishment did demonstrate the opportunity to continue to explore the issues related to connecting to private HIE implementations to support the meaningful use of health information exchange.

In February 2016, Alabama received CMS approval for an RFP to re-bid the State HIE platform. Alabama awarded the new HIE contract to group led by Cognosante. In July 2016, Alabama transition to the new HIE platform and CMS approved the contract in a letter date February 2017.

Beginning in July 2016 and continuing into early 2017, Alabama transitioned its HIE platform from Truven-Care Evolution to Cognosante-Intersystems platform. During the transition period, the North Alabama Regional HIE dissolved and several other providers, including East Alabama Medical Center and Jackson Hospital, both of which were State HIE pilots, did not return as participants of One Health Record. At the end of the transition, the total number of Hospitals participating in the State HIE dropped from 13 to 7.

In May of 2017, former Health IT Coordinator Paul Brannon retired, and Gary D. Parker assumed responsibility of the State HIE program. A re-assessment was done on the HIE implementation approach and a new outreach and provider engagement strategy was developed.

In November 2017, ASMA merged all its Health IT programs and activities in a single Health IT Division under the leadership of Division Director Gary D. Parker. The state will renewed its focus on increasing the State HIE utilization by addressing the high value points of health information exchange, population health analytics, and the role One Health Record has care coordination and community based.

This renewed effort has led to a resurgence in HIE participants and interest in connectivity to utilize the One Health Record services for ADT alerting, CCD referrals, and patient care coordination.

In January 2018, the Alabama Department of Public Health (ADPH) and One Health Record began on-boarding their 72 EHR locations by leveraging a single hub connection between their cloud-based EHR and One Health Record. We are taking the same single hub implementation approach with the Alabama Department of Rehabilitation for their. The state is using single hub connectivity with EHR vendors such as Greenway and Athena Health to onboard our Medicaid providers for the purposes of achieving meaningful use and MIPS.

For the remainder of FFY 2018, the state is focused on expanding the ADT alerting & notifications from our largest hospital systems and EHR hub connectivity.

The state has formed a Hospital CIO Advisory Team to lead on the efforts of HL7 ADT implementation among their peers and expansion of eHealth exchange framework as the 21 Century Cures Act takes effect. This Advisory team will also assist in pushing our efforts to establish HIE connections with Social Security Administration, Veteran's Administration, as well our participation in Strategic Healthcare Information Exchange Collaborative's (SHIEC) Patient Centered Data Home (PCDH) project.

For FFY 2019 and 2020 , the state will continue to seek Medicaid funding to expand One Health Record's® HL7 implementation of capabilities related to ADT alerts and public health for lab, immunization registry, cancer registry, syndromic surveillance reporting, and the Prescription Drug Monitoring Program (PDMP) registration and queries, These capabilities will include the integration of data integrity processes in these specialized registries and other data registries to support the analytics of eCQM's and population health.

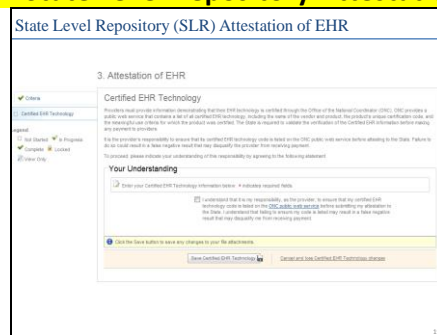
Also for FFY 2019 and 2020, the state will seek funding to procure a process to collect lab results data for the independent labs across Alabama on the ASMA recipients. A data registry will be established to augment recipient health record in One Health Record, support program population health analytics, and the ASMA managed care initiatives for alternate payment models on care delivery. The state will also continue to build out EHR hub connections

How recent is this data? The most recent data is derived from our Outreach efforts as of December 2017.. The One Health Record data is current as of December 2017. Regional Care Organizations were discontinued as of August 1, 2017 and new alternative is being formulated at this time. . In previously submitted A-SMHP’s, the data covered information during the 2010-13 program years. The 2015 Health IT Survey was attached in the previously submitted SMHP update.. Alabama is considering an update to environmental scan in 2019 Annual SMHP update.

2.1.1 Does it provide specificity about the types of EHRs in use by the State’s providers?

Through the MU registration process, EPs and EHs provide the certified EHR for AIU and MU. There are currently 81 different identified EHR systems throughout Alabama. A copy of the attestation of EHR screens for 2017 were submitted and approved by CMS in Alabama 2017 addendum. The screen shot below is the current entry for Healthtech Solutions SLR, who was awarded the contract in August 2016.

Figure 4: State Level Repository Attestation of EHR



2.1.2 Is it specific to just Medicaid or an assessment of overall statewide use of EHRs? As stated in the previously submitted A-SMHP updates, some of the data is specific for Medicaid, however other data — such as the updated 2015 Health IT Survey data — is broader than Medicaid.

2.1.3 Does the SMA have data or estimates on eligible providers broken out by types of provider? The AIU and MU submission data is categorized according to provider type.

Does the SMA have data on EHR adoption by types of provider (e.g. children’s hospitals, acute care hospitals, pediatricians, nurse practitioners, etc.)? See above in Figure 2 on page 27. Alabama has 4 critical care hospitals: St. Vincent’s Blount, Red Bay Hospital, Washington County Infirmary and Choctaw General Hospital. I. The State has a Children’s Hospital, which has received its incentive payment for all three years ending in 2016. , as well as a Women’s and Children’s Hospital that both qualify as children’s hospitals, which

has also completed the MU program. The Modified Stage 2 changes effective in 2015 that resulted from the 2015-16 Modified MU Stage 2 and Final Rule Stage 3 did not affect Alabama's Children's Hospital. Alabama has multiple acute care hospitals.

2.2 TO WHAT EXTENT DOES BROADBAND INTERNET ACCESS POSE A CHALLENGE TO HIT/E IN THE STATE'S RURAL AREAS? DID THE STATE RECEIVE ANY BROADBAND GRANTS?

As described in the previous SMHP, The Connecting ALABAMA multi-year, NITA funded initiative promoted the availability and adoption of broadband Internet access throughout the state of Alabama. Connecting ALABAMA, was a 12-region statewide investment in Alabama's broad band infrastructure. The regions were identified in last SMHP update.

In January 2016, Alabama re-energized its support to expand its broadband initiative with renewed outreach efforts and private partnerships, however, in April 2017, the state reduced its efforts in the project.

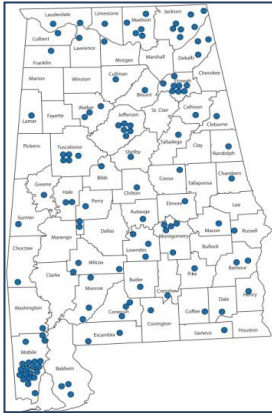
The state continues to focus with partners such as the Global Partnership of TeleHealth, Alabama Partnership for Telehealth, and the Southeast Telehealth Resource Council. This partnership has expanded the outreach has moved forward. University of Alabama-Birmingham received grants to promote Telemedicine activities in the State in February 2018.

In support those efforts and in addition to expanding access to care, the State HIE, One Health Record, is working closely with the Alabama Department of Public Health (ADPH) in their state-wide cloud-based EHR implementation and on-boarding to the State HIE.

When completed in June 2018, county health locations in our most rural locations with host telemedicine session, utilize electronic health records from our rural populations, and use the HIE to make referrals to and share CCD's with the Hospitals and other providers.

2.3 DOES THE STATE HAVE FEDERALLY-QUALIFIED HEALTH CENTER NETWORKS THAT HAVE RECEIVED OR ARE RECEIVING HIT/EHR FUNDING FROM THE HEALTH RESOURCES SERVICES ADMINISTRATION (HRSA)? PLEASE DESCRIBE.

Figure 8:
Alabama FQHCs ®



Through 2015, the FQHC’s and the Alabama Primary Health Care Association continues its leadership in several initiatives that support Alabama’s HIT vision including EHR deployment, utilizations, data aggregation, and populations health analytics. FQHCs are high volume providers in the State. It is anticipated that linkages will occur between the FQHCs either on an individual basis or through regionalization of their efforts and the statewide One Health Record®.

In June 2010, Whatley Health Services in Tuscaloosa, Alabama also received \$645,875 as part of the announced \$83.9 million in grant funding to help networks of health centers adopt EHRs and other HIT systems. The funds are part of the \$2 billion allotted under ARRA to HRSA to expand health care services to low-income and uninsured individuals through its health center program.

As of December 2017, , no further HRSA HIT/HER fund disbursements are known.

2.4 DOES THE STATE HAVE VETERANS ADMINISTRATION OR INDIAN HEALTH SERVICE CLINICAL FACILITIES THAT ARE OPERATING EHRs? PLEASE DESCRIBE.

As of date of this A-SMHP submission, no data is currently being shared with VA, DoD or IHS. In January 2018, the State HIE, One Health Record began to move forward to making connections to the VA through their eHealth exchange DSM service as well as the V-LER program.

The VA facilities in Alabama are provided in Table 2e.

Table 2e: VA Facilities in Alabama

Veterans Health Administration - VISN 7: VA Southeast Network			
Station ID	Facility	Address	Phone
521GG	Bessemer Clinic	975 9th Avenue, SW-Suite 400, UAB West Medical Center West Bessemer, AL 32055	205-428-3495
521	Birmingham VA Medical Center	700 S. 19th Street Birmingham, AL 35233	(205) 933-8101 (866) 487-4243
0302	Birmingham Vet Center	1201 2nd Avenue So, Birmingham, AL 35233	(205)-212-3122
619A4	Central Alabama Veterans Health Care System East Campus	2400 Hospital Road Tuskegee, AL 36083-5001	(334) 727-0550 (800) 214-8387
619	Central Alabama Veterans Health Care System West Campus	215 Perry Hill Road Montgomery, AL 36109-3798	(334) 272-4670 (800) 214-8387

Veterans Health Administration - VISN 7: VA Southeast Network			
Station ID	Facility	Address	Phone
619GB	Dothan Clinic	2020 Alexander Drive Dothan, AL 36301	334-673-4166
619GB	Dothan Mental Health Center	3753 Ross Clark Cir Ste 4 Dothan, AL 36303	(334) 678-1903
521GC	Florence Shoals Area Clinic	422 DD Cox Blvd. Sheffield, AL 35660	256-381-9055
619	Ft. Rucker (VA Wiregrass) Outpatient Clinic	301 Andrews Avenue Fort Rucker, AL 36362	334-503-7831/7836
521GD	Gadsden Clinic	206 Rescia Ave Gadsden, AL 35906	256-413-7154
521GA	Huntsville Clinic	301 Governor's Drive, S.W. Huntsville, AL 35801	256 535-3100
521GF	Jasper Clinic	3400 Highway 78 East - Suite #215 Jasper, AL 35501	205-221-7384
521GB	Madison/Decatur Clinic	8075 Madison Blvd., Suite 101 Madison, AL 35758	256-772-6220
334	Montgomery Vet Center	215 Perry Hill Road, Bldg. 6, 2nd Floor Montgomery, AL 36109	334-272-4670
521GE	Oxford Clinic	96 Ali Way Creekside South Oxford, AL 36203	256-832-4141
679	Tuscaloosa VA Medical Center	3701 Loop Road, East Tuscaloosa, AL 35404	(205) 554-2000 (888) 269-3045
Veterans Health Administration - VISN 16: South Central VA Health Care Network			
Station ID	Facility	Address	Phone
520-2	Mobile Outpatient Clinic	1504 Springhill Ave , AL 36604 Mobile, AL 36604	251-219-3900
0313	Mobile Vet Center	2577 Government Blvd. Mobile, AL 36606	(251)-478-5906
520GA	VA Gulf Coast Health Care System - Mobile Outpatient Clinic	1504 Springhill Ave. Mobile, AL 36604	251-219-3900
Veterans Benefits Administration - Southern Area Office			
Station ID	Facility	Address	Phone
334	Montgomery Regional Office	345 Perry Hill Rd. Montgomery, AL 36109	1-800-827-1000

The DoD facilities in Alabama are provided in Table 3.

Table 3: Department of Defense Facilities in Alabama

Branch	Location
Army	<u>Fort McClellan</u> <u>Anniston Army Depot</u> <u>Redstone Arsenal</u> <u>Fort Rucker</u>
Air Force	<u>Gunter Annex</u> <u>Maxwell AFB</u>
Coast Guard	<u>Group Mobile</u> <u>Marine Safety Office Mobile</u> <u>Aviation Training Center Mobile</u>

Alabama Medicaid has a long standing working relationship with the Native American Nations in Alabama; however, there are no IHS facilities in Alabama. There is a tribal clinic, the Poarch Band of Creek Indians at Atmore, Alabama, which is on the roadmap as the state connects with the clinics and hospitals around Mobile (south Alabama). Alabama has a traditional working relationship with the Poarch Band of Creek Indians. This tribe is a historical Medicaid provider enrolled as an FQHC and as a medical home provider. Outreach efforts are planned to keep tribal leaders aware of health-IT activities. Information regarding the tribal clinic is provided in Table 4.

Table 4: Tribal Clinic in Alabama

Tribal Clinic	Address	Phone
Poarch Band of Creek Indians:	5811 Jack Springs Road, Atmore, AL 36502	(251) 368-9136

Future plans to incorporate connectivity to such federal entities require that they must sign an agreement with EHealth Exchange in order to be able to exchange data with federal agencies; therefore One Health Record® has designed the Alabama agreements to align with DURSA. A copy of the Alabama DURSA was previously submitted as Attachment 8.23 to the May 12, 2014 A-SMHP.

2.5 WHAT STAKEHOLDERS ARE ENGAGED IN ANY EXISTING HIT/E ACTIVITIES AND HOW WOULD THE EXTENT OF THEIR INVOLVEMENT BE CHARACTERIZED?

A core principle for Alabama throughout the development of the continuing A-SMHP has been the engagement of a broad set of stakeholders as indicated in the HIT-MU and HIE efforts

Presentations: As previously outline in last SMHP update, Alabama continues their HIT/E outreach to the various stakeholders throughout the state and nationally by the HIT Director and

key staff. More recently opportunities have include various CMS Communities of Practice (CoP) ACO organizations

- *Commission and Work Groups:* As noted in the previous SMHP, The Alabama One Health Record® Advisory Commission is the State stakeholder entity that was engaged in the HIE implementation. In January 2018, the Alabama One Health Record CIO Advisory Board was created replace the original Commission and to provide guidance regarding the valued implementations and HIE participant on-boarding of Hospitals, care networks, and other health care integrated systems. This board last met on February 28, 2018 and meets quarterly. The Board created four (4) work groups to address he challenges with expanding: 1) Admission, Discharge, and Transfer (ADT) notifications, 2) Expansion connections through eHealth Exchange, 3) Public Health Registry reporting, and 4) Provider Directory capability expansion. These work groups meet every month. The activities of the new board are released on the One Health Record® website.
- *Involvement of Educational Institutions:* The state continues to coordinate and collaborate with the State educational institutions, but there are no existing contracts at this time.

2.6 DOES THE SMA HAVE HIT/E RELATIONSHIPS WITH OTHER ENTITIES? IF SO, WHAT IS THE NATURE (GOVERNANCE, FISCAL, GEOGRAPHIC SCOPE, ETC) OF THESE ACTIVITIES?

Governance: One Health Record® continues to be governed under the authority and auspices of the Alabama State Medicaid Agency. As noted above, the new Alabama One Health Record CIO Advisory Board was created to continue the work of the original Commission. The Board has created four additional work groups as outlined in 2.5 above. During the FFY 2019 & 2020, the Board will also provide solutions, support and collaboration regarding the development of long-term governance, finance, and sustainability plans.

In May 2017, the State discontinued using a and merged the State HIE program into A-SMA Health IT Division. The Medicaid team includes state employees Gary Parker, Director Health Information Technology, (100% Medicaid), and staff support for the Promoting Interoperability (PI) Program and new efforts in PI eCQM data collection and utilization. At present Janice Miles, Holly Jarnagin, , Connie Simington, Adeline Jackson, , , Melissa Bryant. (all 100% Medicaid) all function as support staff. PI post payment t Program auditing, PI population health analytics, and additional support for One Health Record® is handled through Medicaid contracted support.

Finance: As One Health Record® remains a part of A-SMA; Medicaid funding is an integral part of the financing mechanism for One Health Record®, which provides the infrastructure for providers to meet PI.. A-SMA first submitted an I-APD in early 2012 which was approved to support components of the A-SMHP related to:

- Medicaid portion of contracted support from ; GDH Government Services (policy and procedure consulting, auditing, implementation and operational support of the SLR, MU, and HIE); GDH Government Services (development support for eCQM project);

Management & Medical Consulting Services, (MMCS) (MU Outreach and EP Technical Assistance). The contracts with GDH and MMCS will continue for FFY 2019 & 2020.

- The Medicaid portion of One Health Record® technical and human resources. Medicaid contracts have been added to support both HITECH-HIT-MU and HITECH-HIT-HIE.
- Data repository, eCQM utilization, and analytic capabilities
- Alabama Department of Public Health project support for PI.

As stated in the previous SMHP-U dated April , the state completed “proof of concept” Regional Pilot for FFY 2014-16 with mixed results. The “fair share” value proposed to the participating stakeholders was never realized, and many of those participants chose not to re-engage their HIE connectivity during the platform transition period during the 4th quarter of FFY 2016. The focus will continue to be on Medicaid’s engagement and outreach because the HIE value is still yet to be established for the stakeholders to consider “fair share” contributions. The previous contributions were made in a good faith effort by the stakeholders to give One Health Record* sufficient time to provide value, but the regional “proof of concept, was not effective in establishing a “value” as had been first anticipated.

With the completion of the Regional Pilot in February 1, 2016, Alabama temporarily stopped all connectivity efforts until the after July 1 2016 because of the HIE contract re-bid.

As stated in the previously updated SMHP the State continued HIE implementations in FFY 2017 and 2018 with “fair share” contributions totaling \$1.8M. .

For FFY 2019 & 2020, the State will continue to provide the “fair share” contributions, with the plans to expand the stakeholder pool for those contributions beginning 4th quarter of FFY 2019.

A longer term cost allocation methodology for multiple stakeholders is currently being developed for funding beyond FFY 2020 to cover the estimated annual \$4 to \$5 million operational costs. This revised approach will include a combination of per-member-per-month (PMPM) fees based on HIE utilization of various ACO populations served, value-added services such as SSDI submissions, as well as annual fees for HIE services access, such as DIRECT and Admission, Discharge, and Transfer notifications. This proposed sustainability plan is expected to become effective in FFY 2020

Geographic: A-SMA participates in the CMS HITECH State’s only calls for Regions 4 and 6. A-SMA is a member of OSHERA popHealth Steering Committee, and . In March 2018, Alabama One Health Record joined State Health Information Exchange Collaborative (SHIECO as a Southeast Region member and will become participants in the Patient-Centered Data Home (PCDH) connecting to the Midwest Gateway hosted by Missouri Healthconnection.

Technical Infrastructure: One Health Record®, which is part of the MMIS system of systems, is the gateway for individual or group entities (primary providers, pharmacies, EMTs, hospitals, clinics, organized health systems, payers, consumers for Personal Health Records (PHRs) and government institutions), within the state to connect with other state HIEs and Medicaid agencies, federal agencies, and the EHealth Exchange. Direct secure messaging went live January 2012. Query exchange went live April 2012.

The technical infrastructure provides secure messaging, a Master Patient Index, a secure provider web site, privacy/security controls, Record Locator Service, gateways, health information technology infrastructure, provider directory, capacity to enable e-Prescribing, electronic reporting of structured laboratory data, clinical summary exchange,(ADT) notifications, and interfaces for data (e.g., laboratory) important to Medicaid providers to be fully successful in the health information exchange (HIE) environment.

The contract for the HIE technical infrastructure was re-bid in March 2016. The new contract awarded in July 2016.

Technical and Business Operations: The focus of the One Health Record® Business and Technical Operations is on implementation of One Health Record®, which is needed to support providers in promoting, obtaining and retaining interoperability incentives and support the state in carrying out its oversight responsibilities. A major cross-cutting area led by the Business and Technical Operations Workgroup was the coordination with Medicaid and the State Medicaid HIT Plan (SMHP). All Medicaid required sign-off was accomplished as part of the formal SMHP development process.

Policy and Legal: In order to identify and determine whether the Alabama laws or standards conflict with one another, conflict with federal law or regulations or create a barrier to MU, the state worked with other states, including the SERCH and Xerox User Group members, and conducted a survey of Alabama's border states (FL, GA, MS and TN) to determine where common ground exists and to identify where Alabama policy changes may need to be pursued.

Communications and Marketing: The state's goal is to utilize EHR utilization and One Health Record® to support Medicaid's service delivery transformation through Medicaid's managed care services. . The RCO initiative was discontinued in August 2017, and Alabama began new managed care initiative in September 2017 using their established Patient-Center-Medical-Home (PCMH) as a foundation of community care. Alabama is moving forward with the LTC managed care approach, called Integrated Care Networks, (ICN) with the release of an RFP in April 2018.. . Facilitating Medicaid and Medicare provider exchange, provider network hub connectivity, promoting interoperability, and care coordination (ADT's) are the state's main priorities. The One Health Record® website, new Outreach and TA contractor (MMCS), and joint collaboration with the Alabama Department of Public Health (ADPH), HIE CIO Advisory Board, and Alabama Department of Rehab Services – Children Rehab Services (ADRS-CRS) will continue to be important mechanisms for ongoing communication, outreach, and education.

The Health IT communications, which include both PI and One Health Record®, are comprehensive and include PI opportunities and requirements as well as the role of One Health Record® to support the exchange of information in a meaningful ways. The comprehensive Communication and Marketing plan addresses core messaging audiences that were identified, including but not limited to EHs, EPs, physicians, laboratory/x-ray entities, pharmacies, providers of ancillary services, other providers, rural health clinics, patients/consumers, payers, purchasers, state agencies, health professional school, general public and the federal and state government. The Alabama Medicaid website for One Health Record®, <http://www.onehealthrecord.alabama.gov/>, as well as the Agency website,

www.medicaid.alabama.gov, provides information, pages, and links to documents and information specifically relating to promoting interoperability, <http://onehealthrecord.alabama.gov/providers.aspx>. The goal is a consistent, focused message by all the partners/stakeholders working with providers to promote interoperability.

In March 2018, Alabama One Health Record joined the State Health Information Exchange Collaborative (SHIEC) and as a member of the of Patient Centered Data Home (PCDH) governance council, will participate in the PCDH by connecting to the Midwest gateway, via Missouri Health Connection HIE. Alabama will leverage the marketing opportunities presented by SHIEC to communicate its message into national and regional areas.

2.7 SPECIFICALLY, IF THERE ARE HEALTH INFORMATION EXCHANGE ORGANIZATIONS IN THE STATE, WHAT IS THEIR GOVERNANCE STRUCTURE AND IS THE SMA INVOLVED? ** HOW EXTENSIVE IS THEIR GEOGRAPHIC REACH AND SCOPE OF PARTICIPATION?

Geographic Reach: The only statewide health information exchange that will exist in Alabama will be One Health Record®. However, as stated above, the State HIE is expanding its geographic reach through its membership in SHIEC through PCDH project, eHealth Exchange (Georgia, VA, SSA), and in newly formed ISC HealthShare Collaborative for HIE-to-HIE clinical exchange.

Medicaid, as a key member of the One Health Record® HIE CIO Advisory Board provides a patient-centered hub that connects through gateways to the state agencies, provider systems and small community providers. One Health Record® provides bi-directional and direct connectivity to those providers not part of a health system. Further, One Health Record® will support MU reporting of public health measures, and ADT alerting..

As stated in the previous update, Alabama One Health Record® connected to North Alabama HIE (NAHIE). The RHIO ceased operations in September 2016 due to interoperability changes. Upon NAHIE dissolution, the state re-established HIE connectivity with former NAHIE hospital members as individual implementations by December 31, 2017.

As of 12/31/2017, 434 of the 2224 (19%) eligible Medicaid Promoting Interoperability (PI) EPs and 8 of the 88 (9%) EHs have been successfully connected to the One Health Record®. In addition, as of 4/30/2018, 451 of the 2224 PI Alabama EPs and 14 of the 88 EHs have signed a DURSA with One Health Record® and have validated operational connectivity. All have met promoting interoperability requirements..

The establishment of the statewide HIE aligns with the federal IT principles as it:

- Puts “individuals first” by creating immediate access to critical health information for patients, providers, and payers at the point of care;
- Allows the state to be a worthy steward of the country’s money and trust through facilitating administrative efficiencies and clinical effectiveness, including reduction of medical errors, avoidance of duplicative procedures and better coordination of care by linking public and private, physicians, clinics, labs and medical facilities;
- Supports health-IT benefits for all by allowing health care providers to share information about their patients in order to aid clinical decision making;
- Is outcomes focused in that it supports Medicaid/Medicare financial incentives to encourage providers to utilize EHRs and to promote interoperability;
- Builds boldly upon what works through the efforts led by the Alabama Dept of Public Health and Alabama Department of Rehabilitation Services;. and
- Encourages innovation as providers will need to have their own certified EHR in order to fully utilize the benefits of One Health Record® but will be also be able to use the secure messaging/DIRECT capability, ADT alerts, and bi-directional query exchange.

One Health Record® Governance Structure and A-SMA Involvement:

One Health Record® Leadership	FFY 17 (9/30/17)		
	Name	Medicaid	PH
Director, State HIE	Gary D. Parker	100%	
Administrative Manager		100%	
ASMA Commissioner	Stephanie Azar, Medicaid Commissioner	Part of Medicaid Director Duties	
ASMA CIO	Mason Tanaka	CIO Duties	
State HIE CIO Advisory Board	9 Member Board – Urban & Rural Hospitals, Children’s Hospital.	Advisory Role	

In the previously approved SMHP’s, Alabama outlined the historical chronology of the significant Health IT activities since Medicaid became the SDE for ONC cooperative grant and subsequent funding through the HIT-MU funding beginning FFY 2010-2016. The division is responsible for the HIT-PI program administration, State HIE Implementation, eCQM data collection processes and corresponding Health IT budgets for A-SMA.

In May 2017, Medicaid re-united the HIE and MU programs and Staff back into Agency’s Health Information Technology Division, with Gary D. Parker serving as the Division Director. Medicaid developed strategies to leverage the established, successful former MU technical assistance and outreach framework to promote interoperability and information exchange value cases.

In September 2017, Mason Tanaka replaced Marty Redden as Medicaid’s CIO and the Agency’s executive leadership of Information Systems, which includes the Health IT division.

A-SMA staff are, under the HITECH Medicaid PI , “conducting adequate oversight of the Medicaid PI Program, which requires IT and human resources (employees and contractors) support (90% FFP for systems and administration) for: Medicaid’s “fair share” of One Health Record® when used for oversight of the Medicaid PI Programs, including the following: ongoing management of the Master Patient Index; provider help-line and web site; privacy/security controls; provider needs assessments; provider outreach; Record Locater Service; secure messaging; gateways; health information technology infrastructure; provider directories; development of privacy and governance policies and procedures; interfaces for data (e.g., laboratory) important to Medicaid providers to be fully successful in health information exchange (HIE) environment; procurement of technical assistance for Medicaid providers to achieve MU; electronic reporting of structured laboratory data, clinical summary exchange, and enabling e-Prescribing. A-SMA staff are providing planning and preparation support under Promoting Interoperability for the future of One Health Record®.

Finance: As HITECH PI Administration, which includes One Health Record®, remains a part of A-SMA; Medicaid funding is an integral part of the financing mechanism for One Health Record®, which provides the infrastructure for providers to promote interoperability. Medicaid staff and contractors working on MU have had joint training sessions with outreach/TA contractor MMCS staff and co-ordinate on activities almost daily. Due to the Medicaid volume and impact on providers, Medicaid is a core factor in all of them. Medicaid is the starting place for all policy decisions with appropriate cost allocations for funding.

The A-SMA has implemented financial policies, procedures and controls to maintain compliance with generally accepted accounting principles and all relevant OMB circulars.

2.8 PLEASE DESCRIBE THE ROLE OF THE MMIS IN THE SMA’S CURRENT HIT/E ENVIRONMENT. HAS THE STATE COORDINATED THEIR HIT PLAN WITH THEIR MITA TRANSITION PLANS AND IF SO, BRIEFLY DESCRIBE HOW.

Alabama is transforming the way the state purchases and oversees Medicaid. It is simultaneously addressing both the evolution of health and the innovations within health care delivery. The relationship between the activities through MMIS-MITA and Alabama’s State Medicaid’s HIT Plan (A-SMHP) as the means to provide the technical infrastructure for the transformation is evident in timing, as well as impact. A-SMA has made it a priority to align the work so the needs of the Alabama Medicaid managed care efforts can be met through the infrastructure of one (HIE) as well as for timely and appropriately promotion of interoperability. A-SMA MITA 3.0 assessment includes the evolution of the A-SMA MMIS modularity process and inclusion of infrastructure to promote interoperability of systems in health care exchange.

One of the major initiatives in Alabama is the transition of Medicaid from fee-for-service to managed care through their patient center medical homes. The RCO project was discontinued in August 2017. . Continuing into 2018 a major focus of One Health Record® efforts has been to provide critical health information technology infrastructure to support the developing care networks and the Medicaid providers who will be a part of these new networks.

As noted earlier in this SMHP update, the regional pilot “proof-of-concept” was not successful or as effective as had been anticipated.

As stated in the last SMHP update, when the pilot was completed in January 2016, the state continued to focus on the expansion of connectivity to all remaining Hospitals (approximately 82) within the State by the end of FFY 2018. The expansion required direct collaborating with RCO networked hospitals, but as the uncertainty of the RCO implementation became more pronounced, the value case for hospital HIE connectivity became difficult, with hospitals taking a “wait and see” position.

The state continues to expand the effort for e-Clinical Quality Measures (e-CQMs). A-SMA has been an active OSEHRA contributor to the on-going expansion of popHealth® application development. With new open source capabilities, Medicaid is exploring the immediate use case value to support the MU attestation and audit capabilities, clinical DSS for both the sil evolving Medicaid managed care program and care coordination quality.

Beginning in 3rd quarter FFY 2016, various eCQM implementation utilization pilots were completed and demonstrated the initial use case to access data created in Certified EHR system file formats (CCDA & QRDA). While these pilots proved successful and demonstrate the capability of eCQM file submission from EHR systems, Alabama continues to work the development of population health applications, which include 2015 certification for the popHealth MU measure application tool.

The State is expecting to continue to develop the popHealth tool for other e use case applications for eCQM analysis in latter FFY 2018-9 and expand the population health data sets in FFY 2019-20 to monitor and support A-SMA’s PI, and HIE, and ACO programs.

The infrastructure for the One Health Record® will continue to be leveraged to the extent possible for quality reporting and care management efforts of EP-like and EH Medicaid providers and state staff.

With the release of SMD #16-006, dated 3/31/2016 and the current MITA 3.0 assessment, the MITA-MMIS infrastructure is also being considered for non-MU eligible providers with the goal of a uniform way of improving care management and fully utilizing the e-CQMs for quality oversight and payment reform.

In January 2018, A-SMA began pursuing opportunities to support the further adoption of Health IT in accordance with the recent release of SMD #16-003, dated 2/29/2016. This pursuit encompasses the development and implementation to various EHR gateway hubs for HIE connectivity, based on the “hub-and-spoke” approach, for Medicaid providers to exchange PHI. Greenway, Athena Health, eMDs, Amazing Charts, Medisoft, and Methasoft are the current vendors engaged at this time. Alabama will provide updates to the success of this effort in the next update.

2.9 WHAT STATE ACTIVITIES ARE CURRENTLY UNDERWAY OR IN THE PLANNING PHASE TO FACILITATE HIE AND EHR ADOPTION? WHAT ROLE DOES THE SMA PLAY? WHO ELSE IS CURRENTLY

INVOLVED? FOR EXAMPLE, HOW ARE THE REGIONAL EXTENSION CENTERS (RECs) ASSISTING MEDICAID ELIGIBLE PROVIDERS TO IMPLEMENT EHR SYSTEMS AND ACHIEVE MEANINGFUL USE?

Alabama One Health Record® has completed Phase 1, which included connections to the Medicaid MMIS and CHIP claims and eligibility systems. The core One Health Record® technical infrastructure, which includes DIRECT secure messaging and robust query exchange, is up and operational. Alabama One Health Record® has completed Phase 2 with connections first Early Innovators completed as well as the Regional “proof-of-concept”. All of these project milestones included onboarding of the substantial Medicaid PI providers statewide to One Health Record®, which requires administrative support for coordination and administration to accomplish those tasks. Alabama completed its HIE platform transition in 1st quarter FFY 2017, coupled with an updated assessment of the state HIE adoption in the 4th quarter of FFY 2017. For Phase 3, Alabama will follow a new outreach and marketing plan that focuses implementation tracks that emphasize value of care coordination.

In addition, Alabama’s complete SMHP and prior A-S/Ops (no longer updated) have provided and continue to provide detail on how One Health Record® was the only HIE in the state; it is statewide and the means for eligible providers (EPs) and eligible hospitals (EHs) to meet meaningful use modified stage two and stage 3. Previous copies of both documents on file at CMS.

As stated earlier, NAHIE is not longer an operational RHIO. Previous NAHIE members were re-connected to One Health Record® in July-October 2016. One Health Record® still remains as the only State-wide HIE in Alabama.

As stated above, A-SMA is using the HIE functionality and the PI program to demonstrate and support PHI exchange. One Health Record® continues to help Alabama’s EP’s and EH’s meet various MU measures because One Health Record® is Stage 3 certified, a production participant on the eHealth Exchange, and a member of Sequoia Project.)). Therefore, A-SMA is leveraging both programs to support and increase participation in both. This increases sustainability of the HIE as well.

One Health Record® is the infrastructure that will support connectivity to public health for the public health objective; it has both secure messaging (DIRECT) and query capacity to allow EPs/EHs/ to transport CCDAs; it is a certified by MU system; it has a DURSA agreement that complies with all federal and state privacy and security requirements, and it is a node on Healthway (the first state to do so). In addition, the state is increasing its efforts to address health data utilization, care coordination with and is exchanging information with Georgia and other states, assuring inter-state, as well as intra-state exchange of data to promote interoperability in a meaningful way. Alabama went live with 2015-16 Modified Stage 2 on

September 15, 2016, while changes for PY 2017 were completed with a “go live” of December 22, 2017.

As indicated in every update to the A-SMHP, the state is pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information (90% FFP for systems and administration). Alabama Medicaid will not be the sole funding source as indicated in response to Section 2.6. Alabama Medicaid will be responsible for its fair share “in accordance with benefits received.” The benefits received will be to Medicaid, Medicare (administered by Blue Cross-Blue Shield of Alabama (BCBSA)), CHIP (administered by BCBSA) and A-SMA’s Managed Care Organization’s ,who are the payers in the state and manage almost all of the care delivered in the state. For FFY 2019 & 2020, the beneficiaries are expected to expand to include payers in provider risk management, such as worker’s compensation and medical malpractice

One Health Record® impacts an EP or EH’s ability to effectively and efficiently use a certified EHR to promote health care quality and the exchange of health care information, including the ongoing management of the following activities when they are used for services that are not a MU focus (such as therapies or nursing home care) but promote interoperability, or when they are used by providers who relate to EPs/EHs receiving EHR Incentive Payments but are not an EP or EH. These activities include the Master Patient Index, Record Locator Service, secure messaging, gateways, provider directories, ADT notifications, CCDA exchange/queries, patient portal, development of privacy and governance policies and procedures, interfaces for data (e.g., home health) important to Medicaid providers to be fully successful in HIE environment, clinical summary, electronic reporting of structured laboratory data, enabling e-Prescribing, and queries into the state’s Prescription Drug Monitoring Program (PDMP) database. One Health Record® is under the governance of the Medicaid Agency and costs are allocated between Medicaid and the other stakeholders for the development of A-HIE is on a “fair share” basis going forward; however, the original design, development and implementation were totally funded through ONC grant funding.

With the ending of the ONC grant funding, Alabama no longer operates with the Alabama Health Information Exchange Strategic/Operational Plan (AHIE S/OP). The A-SMHP now serves as the strategic and operational (90% FFP for systems and administration with an appropriate cost-allocation plan for the design, development, implementation and operations that are not Medicaid related and do not serve Medicaid enrollees). The A-SMHP continues to be dependent upon and provide opportunities for each other. One Health Record® will provide a state CONNECT gateway to the eHealth Exchange and provide HISP services in support of DIRECT secure messaging. Alabama One Health Record® acts as the “hub” for the exchange of information intra- and inter-state, allowing providers to meet MU requirements. Until One Health Record® went “live” in April 2012; the means for secure messaging and provider directories between EPs, EHs and other entities in the health care system did not exist. In the previous update, an A-HIE survey of 35% Medicaid-enrolled responses indicated current use of electronic health records and thus have the potential to take advantage of secure messaging with other providers through the One Health Record®. The November 2015 Health IT survey shows that percentage now at 67%. (2516/3755).

One Health Record®, which is part of the MMIS system of systems, is the State primary gateway for individual or group entities (primary providers, pharmacies, EMTs, hospitals, clinics, organized health systems, payers, consumers for Personal Health Records (PHRs) and government institutions), within the state to connect with other state HIEs and Medicaid agencies, federal agencies, and the EHealth Exchange.

Alabama is working diligently to address both the readiness of providers to exchange information and the readiness of providers to use IT in a meaningful way so that Alabama providers can access the full meaningful use incentive payments and avoid any potential future penalties. Alabama has refined both the HIE Readiness Assessment and Interoperability Services Guided to adjust and gauge provider health-IT maturity levels and determine the next steps required to connect and exchange information using One Health Record® or any other approved HIE, such as and including GaHIN and Missouri Health Connection. .

- In addition to the activities identified previously and in prior A-SMHP submission, the Medicaid Agency completed the following actions:
- Modified current strategies for promoting interoperability Outreach and TA which included a renewal of the support contract with Management & Medical Consulting Services, LLC (MMCS).
- Expanded collaboration on to improve PI data quality and project support activities with ADPH for their specialized registries, particularly Immunization, Cancer, and the PDMP.
- Developed a new eQIM environment using the OSHERA's popHealth® application platform for PI program support.
-
- Implemented ADT notifications for A-SMA providers in the Patient Centered Medical Home Networks.
- Development and implementation of Medicaid/CHIP patient portal.
- Completed the transition to a new Alabama One Health Record HIE technology platform.

2.10 EXPLAIN THE SMA'S RELATIONSHIP TO THE STATE HIT COORDINATOR AND HOW THE ACTIVITIES PLANNED UNDER THE ONC-FUNDED HIE COOPERATIVE AGREEMENT AND THE REGIONAL EXTENSION CENTERS (AND LOCAL EXTENSION CENTERS, IF APPLICABLE) WOULD HELP SUPPORT THE ADMINISTRATION OF THE EHR INCENTIVE PROGRAM.

State HIT Coordinator:

The HIT Coordinator in Alabama was discontinued on July 1, 2017. Gary D. Parker, who reports directly to Medicaid CIO Mason Tanaka, is A-SMA's Director of Health Information Technology and is responsible for all HITECH activities including the One Health Record and the Promoting

Interoperability programs. Mr. Parker and staff provide the tools and capability for EPs and EHs to obtain EHR Incentive payments and HIE implementation.

REC: As identified in prior A-SMHP updates, Alabama REC continues to be active among their membership in supporting A-SMA Health IT initiatives of HITECH PI and HIE. .

2.11 WHAT OTHER ACTIVITIES DOES THE SMA CURRENTLY HAS UNDERWAY THAT WILL LIKELY INFLUENCE THE DIRECTION OF THE EHR INCENTIVE PROGRAM OVER THE NEXT FIVE YEARS?

Alabama, like most states, continues to simultaneously manage multiple initiatives to reduce costs and transform health care. The most recent of these is the transition to managed care and data warehousing for population health analytics. Each initiative is dependent on health-IT to support the changes enrollees and providers will encounter. The success of the EHR Incentive Program will create the potential for success in the delivery system and payment reforms. The coverage and payment changes create a demand for the meaningful use of health information from new and existing data sources, including EHRs and One Health Record®. Three significant areas follow:

One Health Record® Technical Infrastructure: The One Health Record® infrastructure is being enhanced specifically with PI requirements in mind, such as connectivity to Alabama Department of Public Health (ADPH) for purposes of reporting the EHR Incentive Program lab, immunization and cancer registry, and bio-surveillance. The core technical components to assure trusted information sharing include a Master Patient Index (MPI), provider directory, XDS Registry/Repository, HL7 3.0, CCD, Fast Interoperable Health Resource (FIHR), PIX/PDQ, XCA/XCPD, auditing and logging, clinical viewer and DIRECT/CONNECT 5.0+ capabilities. . In June 2016, Alabama awarded the One Health Record HIE services contract to Cognosante.

Health Home for Individuals Chronic Patient 1st, Medicaid's current Primary Care Case Management under a 1915(b) waiver was amended and a health home for individuals with chronic conditions State Plan Amendment (SPA) has been approved by CMS. Medicaid staffs are working across initiatives to align MU measurement and health-IT infrastructure. The Patient 1st Networks and Primary Medicaid Providers (PMPs) are priority for implementation and considerations for their relationship to the Phase One gateways is currently under discussion. The requirement that health home initiatives utilize health-IT makes the engagement of providers in One Health Record® and PI critical.

On April 1, 2015 Alabama expanded the Health Home program to include an additional 250,000 Medicaid recipients with chronic health conditions access to enhanced care coordination and other services to improve their overall health. The Health Home program is set up to add an additional level of support to Patient 1st Primary Medical Providers (PMPs) by intensively coordinating the care of patients who have or who are at risk of having certain chronic conditions: asthma, diabetes, cancer, COPD, HIV, mental health conditions, substance use disorders, transplants, sickle cell, BMI over 25, heart disease and hepatitis C.

The Networks will play a critical role in the A-SMA managed care transition and will continue to provide population health management by furnishing preventive services and information; systematic data analysis to target enrollees and providers for outreach, education, and intervention; monitoring system access to care, services, and treatment including linkage to a medical home; monitoring and building provider capacity; monitoring quality and effectiveness of interventions to the population; supporting the medical home through education and outreach to recipients and providers, and facilitating quality improvement activities that educate, support, and monitor providers regarding evidence based care for best practice/National Standards of Care. All of these components are dependent on adequate health-IT, data collection infrastructure and the utilizations of eCQM's.

The state is still considering options to engage pharmacies, including reimbursement methodologies, because the role of pharmacies in the successful operation of e-Prescribing is significant, as well as the PDMP program for prescription drug queries to support efforts to confront the opioid use.

The state is developing a process to integrate lab test results from the Alabama's independent labs into the recipient service programs for population health analysis and care management.

Regional Care Organizations (RCOs): As previously stated, Medicaid cancelled the RCO implementation in August 2018. Medicaid is re-designing the managed care implementation and is currently in discussions with CMS on the A-SMA alternative approach to RCO's. Medicaid managed care is a critical component of the health care delivery transformation on Alabama's Medicaid Program and the resulting ACO participants are dependent on the One Health Record® system to provide the infrastructure to support the needed exchange of information and payment reform strategies. A-SMA is seeking to positively influence health outcomes of Alabama Medicaid enrollees through transitioning from fee-for-service health care delivery to managed health care delivery through their patient centered medical home (PCMH) to improve management and coordination. Alabama received CMS approval of their 1115 Waiver application in February 9, 2016.

Focusing renewed efforts on the PCMH and their providers will provide access to meaningful, reliable, actionable patient information in order to effectively and efficiently provide care; The focus of One Health Record® is very Medicaid centric, but "fair share" funding from private entities is required in order to access Medicaid funding. The "value" beyond Medicaid has to be validated to the private market. Their commitment is to the "promise" of value, rather than actual current value. This validation of the "promise" of value is materializing into actual value for our ACO clinics through improved care coordination provided by ADT notifications. "No Wrong Door": Alabama Medicaid received a grant from the Administration for Community Living (ACL) in October 2015. The \$2.36 million grant over three years will streamline access to long term services through CARES (Central Alabama Recipient Eligibility System), the state's joint eligibility system for public services and supports.

The goal is to enable people to make informed decisions based on the full range of available services. In addition A-SMA is taking concrete steps to fully incorporate a person-centered planning approach into everything they do. Person-centered planning is directed by the individual seeking services and shifts the role of agency staff from merely determining what services an individual qualifies for to assisting them in identifying and accessing a mix of paid and unpaid services based on their strengths, goals, preferences and needs.

The grant is part of an ongoing partnership with the Centers for Medicare & Medicaid Services (CMS) and the Veterans Health Administration (VHA) to support state efforts to advance system-wide changes that make it easier for people to remain living in their own homes and communities.

This grant , in conjunction with the Health Home SPA and managed care transition, will allow A-SMA to develop opportunities to expand our HIE access capabilities to our patients and consumers to support the meaningful use of PHI in improving outcomes.

Alabama Department of Public Health: A-SMA provided PI (formerly MU) TA and Outreach resources to enable their enrollment and receipt of PY 2016 EHR incentive payments. This effort was rewarded with ADPH implementation of a cloud-based CEHRT by December 2017. ADPH onboarding of their 72 facilities for bi-directional exchange, referrals, telemedicine activities, and ADT notifications will be completed and live by June 30, 2018.

2.12 HAVE THERE BEEN ANY RECENT CHANGES (OF A SIGNIFICANT DEGREE) TO STATE LAWS OR REGULATIONS THAT MIGHT AFFECT THE IMPLEMENTATION OF THE EHR INCENTIVE PROGRAM? PLEASE DESCRIBE.

In the 2015 Legislative session, the RCO patient population was expanded include the long term care populations beginning in October 2018. In accordance with this expansion, in April 2018, Medicaid released its RFP for their Integrated Care Networks (ICN) to incorporate their long term care populations into a managed care program. With the 2/29/2016 SMD #16-003, A-SMA will begin looking at ways to help EP's share transitions of care and improve care coordination with other LTC providers and their facilities in promoting interoperability and achieving meaningful use for Stage 3.

A-SMA and the One Health Record® Legal and Policy workgroup continues to outline the policies and procedures for the operation of One Health Record®, which went “live” in April 2012. Since authority already exists for PI and One Health Record®, there is no need for state legislative action at this time

2.13 ARE THERE ANY HIT/E ACTIVITIES THAT CROSS STATE BORDERS? IS THERE SIGNIFICANT CROSSING OF STATE LINES FOR ACCESSING HEALTH CARE SERVICES BY MEDICAID BENEFICIARIES? PLEASE DESCRIBE.

The A-SMA continues to coordinate with Border States to address the matter of Medicaid recipients crossing State lines to access health care services

- *One Health Record® Interstate- e-Health Exchange*: Alabama became a full participant on the eHealth Exchange, formerly known as the eHealth Exchange (formerly NHIN), in September 2012. Alabama was one of the first five State HIEs to become a certified eHealth Exchange participant and continues to be part of the e-Health Exchange and a member of the Sequoia.
- *SHIEC*: In March 2018, One Health Record became member of the State Health Information Exchange Collaborative (SHIEC) and the SHIEC Patient Centered Data Home (PCDH) project, with a connection established to the Midwest gateway by December 2018. Alabama is connected, via eHealth Exchange, with Georgia (GaHIN). One Health record is expected to complete connections with SSA (for SSDI records) by September 30, 2018, and with VA (both VLER and Direct) by March 2019. In June 2018, Alabama will be connecting to Missouri Health Connection for clinical document exchange, as an expansion to the SHIEC PCDH.
- *HITECH Conference*: A-SMA staff.
- *ONC Conference*: A-SMA staff
- *Open Source Electronic Health Record Alliance (OSEHRA)*: A-SMA joined the group in January 2015 to contribute to the development to solidify and enhance the popHealth® PI application for CCD/QRDA analysis. A-SMA served as chair of the Data Accessibility and Extraction Work group whose objective is to identify opportunities and capabilities to leverage eCQM's collected and contained in EHR systems. The group was merged into the development workgroup[in September 2016.
- *Community of Practice Calls*: A-SMA staff and contractors participate in the Meaningful Use, Audits, Performance Measures, Financial, I-APD/SMHP and Eligible Hospital as well as the eCQM Workshop.
- *HITECH All States Calls*: A-SMA continues to participate in the calls where the state has gained insights and guidance on matters related to the continued administration of the MU program, including Monitoring EHR Incentive Programs, Program Changes through implementation of each Stage, Auditing, eCQM use cases, HIT I-APD, CMS-37, and CMS-64 and HITECH Funding Used for HIE Development. Staff has participated in webinars on Micro-strategy Reports and GUI Training. The All States calls have provided opportunities for the state to better understand Medicaid Directors Letters, and learn best practices and tools, including research on provider readiness for the EHR Incentive Programs and the EHR Certification Number.
- *AHRQ Medicaid Medical Directors Learning Network*: Alabama's Medicaid Medical Directors, Dr. Robert Moon, a One Health Record® workgroup member, is a member of the national Medicaid Medical Directors Learning Network which provides a forum for clinical leaders of the State Medicaid programs to discuss their most pressing needs as policymakers. Two of those focus areas are MU, current and going forward, and health homes for individuals with chronic conditions. These are also priorities for A-SMA.
- *Medicaid Enterprise Systems Conference*: A-SMA Staff (MMIS & PI, HIE)

2.14 WHAT IS THE CURRENT INTEROPERABILITY STATUS OF THE STATE IMMUNIZATION REGISTRY AND PUBLIC HEALTH SURVEILLANCE REPORTING DATABASE(S)?

Alabama Department of Public Health (ADPH) is a key participant in One Health Record®.

ADPH's CHIP data and EPSDT screening data is included in One Health Record®. ADPH continues to work with the One Health Record®, to allow Alabama providers to access and report public health (PH) immunization registry data, report lab, cancer and bio-surveillance data for purposes of PI through One Health Record®. For FFY 2019 & 2020, One Health Record will put additional effort in this area to focus on data analytics, infrastructure upgrades, and Prescription Drug Monitoring Program (PDMP) HIE connectivity for opioid queries. As stated in the previous update, an expanded work effort in this area with the focus on ADPH PI data collection and measure reporting to their PI specialized registries resumed in January 2017.

Phase III will include the continuation for the improving the data quality for Immunization and Cancer reporting by all EP's & EH's, as well as inclusion of the PDMP as specialized registry for HIE queries.

ADPH runs the county health departments in 65 of the 67 counties in Alabama. In December 2017, these local agencies begin to implement a CureMD CEHRT EHR systems. Implementation will be completed by June 30, 2018. (The two counties that operate independently, Jefferson and Mobile, do have CEHRT). ADPH EHR interoperable systems, will improve eCQM collection, and bi-directional health information exchange, with One Health Record®. In addition, the Department continues with its modern laboratory information system through A-SMHP efforts. The state envisions single point ADPH registry access will become a part of One Health Record®, which will greatly assist epidemiological studies and improve data quality.

2.15 IF THE STATE WAS AWARDED AN HIT-RELATED GRANT, SUCH AS A TRANSFORMATION GRANT OR A CHIPRA HIT GRANT, PLEASE INCLUDE A BRIEF DESCRIPTION.

A description was provided in the initial A-SMHP regarding the Alabama Medicaid Transformation Grant (MTG), which provided the process and structure for the current One Health Record® design, development and implementation. Q-Tool, which was developed as a part of the MTG, was terminated as of 9/30/11. It is no longer needed with advent of the One Health Record®.

The state has built on, and benefited from, the many years state and stakeholders worked under the MTG. The credibility established related to transparency, stakeholder engagement, patient involvement and resource commitment through the MTG process and outcomes have allowed the participants to build trust in each other and the process to move into uncharted territory.

3. SMHP SECTION B: ALABAMA'S "TO BE" LANDSCAPE

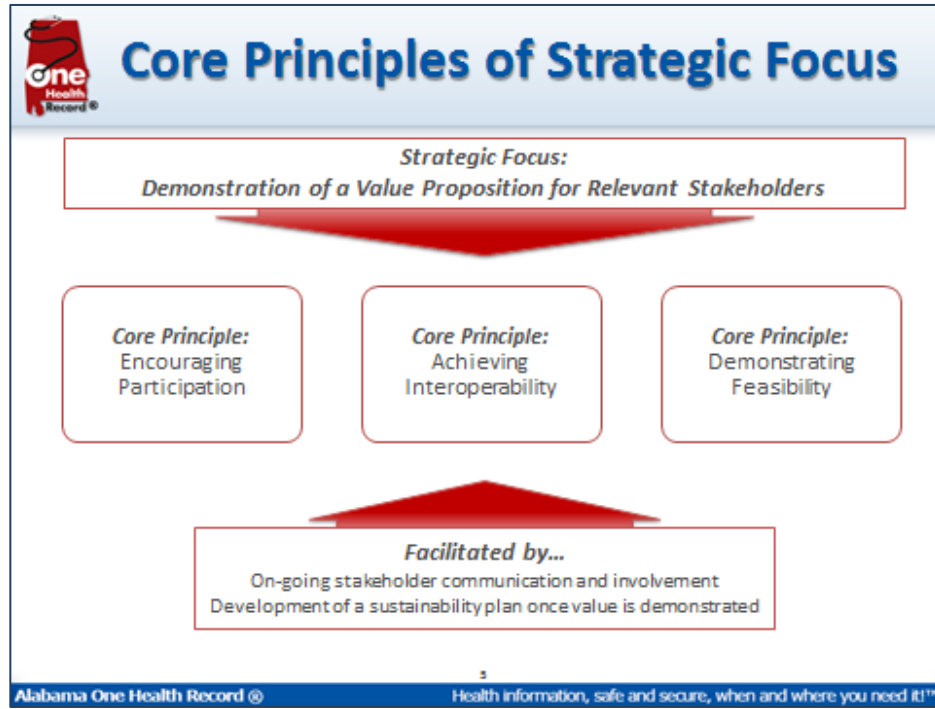
- 3.1** LOOKING FORWARD TO THE NEXT FIVE YEARS, WHAT SPECIFIC HIT/E GOALS AND OBJECTIVES DOES THE SMA EXPECT TO ACHIEVE? BE AS SPECIFIC AS POSSIBLE; E.G., THE PERCENTAGE OF ELIGIBLE PROVIDERS ADOPTING AND MEANINGFULLY USING CERTIFIED EHR TECHNOLOGY, THE EXTENT OF ACCESS TO HIE, ETC.

“To Be” Future State of Statewide Exchange of Health Information and health-IT: The state continues with the approach to provide an “individuals first”, health-IT infrastructure that provides “benefits for all”, is “outcomes focused”, “builds boldly on what works” and “encourages innovation”. The goal is to align with federal health care objectives (better health, better care, lower costs) and federal health-IT principles through a transparent multi-stakeholder process. The goal is to assure trusted information sharing that is based on national standards and provides the technical components to meet the gaps in HIE capabilities for MU, including but not limited to provider directories, identify management, secure messaging, electronic clinical quality measures (eCQM’s) and consumer engagement regarding their health care plans.

One Health Record® plans to be independently sustainable by 2021. We are currently exploring possible means of funding including provider subscription fees and providing access to payers on a subscription basis as allowed by law. In addition, A-SMA intends to contact all providers in the state with the goal of connecting at least 75% of all providers to One Health Record®.

The core principles for the current Medicaid statewide HIT strategy remain as depicted in the following Figure 10b.

Figure 7: Core HIT Strategy Principles



There continue to be several components of the statewide strategy. Due to the Medicaid managed care transition, including changes to patient volume calculation methodology for providers, and other major impacts on providers, Medicaid is a core factor in all of them. Medicaid is the starting place for all policy decisions with appropriate cost allocations for funding. The other key purchasers are Medicare through Alabama Blue Cross Blue Shield (A-BCBS), CHIP through A-BCBS and Alabama State Employees through A-BCBS.

“To Be” Promoting Interoperability :

- *Internal Medicaid Agency:*
 - *Standard:* One clear internal state government goal is to effectively and efficiently purchase and manage the Medicaid Program. There are three specific objectives to support the goal. The first is to integrate the activities of the PI Program organizationally into the broader Medicaid Agency. To this point, the Program Integrity (PI) Division provides the procedural structure to manage the audit, appeal and recoupment functions in coordination with the A-SMA. In addition, HIT-PI is currently included and very involved with MITA staff during the update to the MITA 3.0 Self-Assessment.

The second goal is to provide actionable, near-real time information to providers, state staff, the federal government, consumers and stakeholders. The supporting

objective focuses on promoting “interoperability” and improved care coordination among the provider networks through various Health IT protocols so EHR clinical information can be integrated as part of the enhanced data repository/warehouse with analytic capabilities. On this framework, expanded Analytical tools can access and analyze these new and currently available data sources..

The third objective focuses on educational outreach to providers and stakeholders for the “long-term” investment value in the health IT infrastructure and the importance of patient care continuity in provider work flows and data integrity in their patient medical information.

- *Methodology and Process:* A-SMA will follow a strategy to expand on three specific re-assessed and modified for 2018-2020; 1) Support Medicaid’s managed care initiative , and 2) Demonstrate both the immediate and long-term value of Health IT and information exchange to other purchasers and participants, 3) Expand the geographical integration of interoperability to include regional and national networks
 - Expansion of HL7 capabilities, of One Health Record® to supplement the standard Continuity of Care Document Architecture, including ADT, notes, lab results, prescription drugs, immunizations, cancer, orders, HL7 3.0, and Fast Interoperable Healthcare Resource (FHIR).
 - Connecting and “on-boarding” the Medicaid member Hospitals (80) and their integrated provider networks to One Health Record® by 9/30/2020 for both ADT notifications and bi-directional query exchange.
 - Expansion of data collection processes from EHR’s generated CCDA & QRDA files to support A-SMA’s PI program in utilization of popHealth® PI attestation & audit data, their Population Health Analytics program and managed care QA.
 - Expand the State Health Information Exchange Collaborative (SHIEC) Patient Centered Data Home (PCDH) network in Southeast Region for both national and regional ADT notifications, CCD query exchange, disaster planning and recovery.
 - Expand eHealth Exchange gateway connectivity to include SSA for the purpose of applicant medical record query and exchange for SSDI applications.

- Expand eHealth Exchange gateway connectivity to include the VA for data exchange with the Medicaid providers serving patients who utilize the state VA hospitals.
- Promote interoperability among Medicaid providers by connecting and onboarding their CEHRT's to One Health Record® through the development of single EHR vendor Hub interfaces.

To continue with this geographic strategy, Alabama will use the lessons learned to move ahead to expand the implementation of connectivity of the remaining Alabama hospitals, provider networks, ACO, and others beginning in 3rdth quarter of 2018,.

A-SMA and One Health Record will work in multiple geographical regions simultaneously rather than a single geographic region

The modified approach will have the following criteria:

- The presence of an existing network of care coordinators through the Primary Care Network (PCN), Health Home program, or Integrated Care Network (ICN) ..
- Hospitals and associated provider networks or a set of referring providers and clinics that cover outpatient services including pediatrics and family care, urgent care clinics, pharmacies, private clinics, skilled nursing facilities (SNF) and FQHC's.
- Engagement of other care participants, such as mental health centers, ACO's, and labs, who demonstrate the capability to utilize One Health Record®.

- *Promoting Interoperability (PI) :*

- *Standard:* The overarching goal for A-SMA is three-fold; 1) To retain all EP's that are program participants to complete the program before the Program ends in 2021; 2) To assure that any eligible EP and/or EH in Alabama, receives their appropriate EHR incentive payments; and 3) to move EPs further along the PI continuum, to expand the utilization of One Health Record® services for care coordination, and to increase eCQM usage and analysis in improving health care outcomes. This emphasis in 2016 and 2017 has seen our AIU-to-MU migration rates increase as shown below as of 12/31/2017.

As of 12/31/2017, a total of 2,266 providers (2178 EPs and 88 EHs) were approved for AIU payments for a total amount of \$103,602,932.15 (\$62,916,248.15 to EHs and \$45,885,851 to EPs). Another 1809 (1614 EP and 195 EH) were approved for MU payments of \$76,614,142.21 (\$13,889,025 to EPs and \$62,725,117.21 to EHs).

Methodology: Alabama intends to continue this positive trend of PI program procession but recognizes the eventual peaking as the 2016 participation window closed. The focus shifts from attesting for PI Stage III and interoperable PHI exchange. . The process moves to providers' readiness for use of their certified EHR in promoting interoperability with connectivity to potential ACO's, MCO's and other provider networks and by leveraging One Health Record®. Therefore, the state will continue to establish metrics to evaluate measures related to assuring providers are aware of the opportunities and requirements and that proper oversight and accountability is in place

Table 20: PI of Health Information Metrics and Goals

Program Priority	Report in last SMHP Update		Report January 2015		Report January 2016
	Status as of December 2015	Target for December 2016	Status as of December 2016	Target for December 2017	Status as of December 2017
Public Health agencies receiving ELR data produced by EHRs or other electronic sources. Data are received using HL7 2.5.1 LOINC or SNOMED Yes/No or %	Yes	Yes	Yes	Yes=100%	Yes
Immunization registries receiving electronic immunization data produced by EHRs. Data are received in HL7 2.5.1 formats using CVX code Yes/No or %	Yes	Yes	Yes	Yes=100%	Yes
Public health agencies receiving electronic syndromic surveillance hospital data produced by EHRs in HL7 2.5.1 formats (using CDC reference guide)Yes/No or %	No	Yes	No	Yes=100%	No

Program Priority	Report in last SMHP Update		Report January 2015		Report January 2016
	Status as of December 2015	Target for December 2016	Status as of December 2016	Target for December 2017	Status as of December 2017
Public Health agencies receiving electronic syndromic surveillance ambulatory data produced by EHRs in HL7 2.5.1 Yes/No or %	No	Yes	No	Yes=100%	No
Public Health Agencies receiving electronic Cancer data produced by EHR's in HL7 2.5.1 Yes/NO or %	No	Yes	Yes	Yes=100%	Yes

- Process:* The current goal is to retain a significant portion of the , and Stage 2 & Stage 3 EPs while promoting the value of interoperable exchange with and expanded HITECH Outreach and TA . Alabama continues to maintain successful EP retention in the PI program and has accomplished 98% (88 of 89) program completion for EHs. Alabama’s remaining EH will complete the program in the PY 2018.
- One Health Record®:*

 - Standard:* The breakthrough goal for the state of Alabama for Medicaid continues to be that “all Alabama Medicaid providers use One Health Record® for interoperable exchange of health information. An ongoing analysis of readiness by geographic area has provided the state with possible gateways for One Health Record® implementation, including the technical capability to support DIRECT and query. One Health Record® provides secure messaging, ADT alerting, provider directory, DIRECT support and a patient index (MPI) so providers statewide will be able to participate in the Medicaid incentive program and use health information in a meaningful way. One Health Record® provides the statewide infrastructure needed for the actual exchange of information in order for providers to promote interoperability meet meaningful use requirements and deliver care more efficiently and effectively.

- *Methodology:* Interoperability challenges have been less problematic since 2017. The metrics goal for the next 3 years remains at 60% of all Alabama Medicaid Hospitals and provider network e providers attesting for Stage 3, QPP, or MIPS by promoting interoperability, care coordination, and PHI exchange through One Health Record®.
- *Process:* An HIT-I-APD will be submitted in June 2018 to address specific activities to support MU Stage 3 and to promoting interoperable PHI exchange and seamless data access:
 - Funding for costs associated with the Medicaid specific staffing, contracted personnel support, systems, and activities supporting One Health Record® planning, preparation and on-boarding. One Health Record® has connections to the Medicaid MMIS and CHIP claims and eligibility systems. The core One Health Record® technical infrastructure, which includes DIRECT secure messaging, robust query exchange, and ADT alerting is up and operational. The emphasis is on use and it is important that there is onboarding of a substantial number of Medicaid MU providers in multiple geographic areas to One Health Record®. This activity will continue through 2018-2020 Funding for Public Health (PH) to interface with One Health Record® for bio-surveillance, immunization and cancer registries, and labs to support EHR Incentive Payment program PI submissions, and improving the data quality and integrity for registry information. The interface requirements are those of the federal implementation guidelines and require no additional functionality for the EPs or EHS. Funding for PH's Prescription Drug Monitoring Program (PDMP) to interface with One Health Record® for drug queries from EHR systems or provider portal.

Funding for onboarding of EP-types and EHS to One Health Record® for purposes of reporting to PH for PI is also included. The proposed requirements for One Health Record® connection to ADPH and for One Health Record® connection to EP-types and EHS for purposes of Medicaid MU reporting include the following:

- EHS and EPs can onboard for one or multiple PH connections and can onboard for PH prior to completing a full onboarding of all One

Health Record® services unless this requires a change in the core services already operational.

- An improved web site that ADPH and One Health Record® can view and download project status for each provider who has contacted the vendor regarding on boarding connectivity to ADPH through One Health Record®.
- Analytic reporting on status of each provider project maintained through the life cycle of the provider testing and operation, including verification of One Health Record® receipt from provider and transmission to either Biosense or ADPH, depending on effort.
-
- National transport and content standards with an automatic upgrade to national standard upgrades.
- One Health Record® administration shall determine when and if the four PH categories of records shall be stored in One Health Record® for more than a time limited period and gateway for direct reporting to the PH registries via One Health Record®.
- Provide an electronic means for EP's and EH's or their vendors to submit completed facility guides that include required information for each site(s)/location(s), including the EPs names, NPI and State Medical License numbers for each facility. Provide access to ADPH on these data elements in an electronic format that can be consumed by A-DPH.
- Obtain from One Health Record® administration verification of signed appropriate legal documentation regarding access, data security and visibility prior to activation of link. One Health Record® administration is responsible for collection and retention of legal documents from providers, vendor, ADPH as appropriate.
- Support connectivity for EP's and EH's connectivity to both ADPH SOAP WSDL's; test and production. Maintain a testing and a production environment.

- Support the capability to receive and retain an ADPH acknowledgement of receipt and acceptance or rejection of the messages sent to ADPH. Additionally, support the capability to send that acknowledgement back to EPs and EHs.
 - Trouble shoots ability during test and production phases, including if file/records are missing.
 - Create and maintain technical capacity for DIRECT secure messaging for ADPH for purposes of reporting immunizations, labs, bio-surveillance, cancer, and PDMP registry information.
 - Support the quality assurance of the reported EP & EH registry data and other eQIM registry data, such as vital and death statistics for population health analytics.
- *Eligibility:*
 - *Standard:* The Alabama Medicaid eligibility system (CARES) is now operational, effective, and federally compliant, and consumer centric effective.
 - *Methodology and Process:* The update of A-SMA's eligibility determination system is an enhancement of the Children's Health Insurance program (CHIP) system to support Modified Adjusted Gross Income (MAGI) determination according to the requirements of the Affordable Care Act (ACA) and the Medicaid final policy rule. Alabama acquired information technology services in-house to support the State as it works to build an eligibility system for the State's Medicaid and CHIP programs, while exploring the possibility of expanding to other HHS programs in the State of Alabama such as TANF, SNAP at a later phase in the project. CMS has approved enhanced Federal funding for the services through the period ending on December 30, 2021.

The project is will continue with additional implementation modules to be completed to address changes addressed in all four (4) phases.

3.2 WHAT WILL A-SMA'S IT SYSTEM ARCHITECTURE (POTENTIALLY INCLUDING THE MMIS) LOOK LIKE IN FIVE YEARS TO SUPPORT ACHIEVING THE SMA'S LONG TERM GOALS AND OBJECTIVES? INTERNET PORTALS? ENTERPRISE SERVICE BUS? MASTER PATIENT INDEX? RECORD LOCATOR SERVICE?

Alabama’s One Health Record® system functionality is basically the same in 2019 with adaptations to accommodate health-IT, health care and health care delivery changes. The difference is that the “vision” is “reality”. Alabama continues to build off the eHealth Exchange model, One Health Record® is envisioned as the gateway for individual or group entities (primary providers, pharmacies, EMTs, hospitals, clinics, organized health systems, payers, consumers for Personal Health Records (PHRs) and government institutions), within the state to connect with other state HIEs and Medicaid agencies, federal agencies, and the eHealth Exchange supporting DIRECT, ADT alerts, and query.

“To Be” Future State Functionality and Systems Architecture:

- *“To Be” Future State of PI Identification, Validation, Payment, Audit and Appeals HIT:* To improve the continuity of data/information, relationships and management through efficient, effective and interoperable IT technical infrastructure and business and technical business operations, Alabama has contracted with an outside vendor for the Promoting Interoperability Program at the state level. The web-based approach provides a system to capture and track provider applications, evaluate eligibility, and collect attestations, in order to make timely incentive payments to qualifying providers (EPs and EHs) for the adoption, implementation or upgrade of certified EHR systems. The system interfaces with the CMS Registration and Attestation System. As stated in the last update, the state re-bid its Alabama SLR contract. The contract was awarded on July 1, 2016 and the new system became available on September 15, 2016. . The state intends to submit an I-APD in June 2018 to address funding for the FFYs 2019-20 for PI administration .

The following chart identifies the IT functionality required by year for PI . The IT systems are all part of the MMIS, although some are a part of the claims processing system and other functions and architecture are not.

Table 21: MU IT Functionality by Year

Feature	Detail
<p>Year 4 MU Modified Stage 2 Functionality (July 1, 2016 to accommodate Modified Stage 2 changes as a result of MU Final Rule) ****The functionality listed is based on the current SLR platform, which switch vendors . .</p>	
<p>Program Year 2015 Modified Stage 2 Meaningful Use Measures (EP and EH)</p>	<p>In addition to the functionality described above, a system re-design was utilized to increase EP’s and EH’s ease of use. Incorporates the data set of objectives and eCQMs for Modified Stage 2 as defined in the Final Rule into the SLR attestation process (EP and EH).</p>
<p>Re-designed workflow and drop-down functional directories;</p>	<p>A new stream-lined re-design of the system is the primary modification with increased configurable items document drop down list, prefilled checks, and that the attestation process is quicker and less cumbersome.</p>

Feature	Detail
format removes redundancy and increases ease of use.	
Year 5-6 MU Modified Stage 2 Functionality (December 1, 2016 to accommodate Modified Stage 2 changes as a result of MU Final Rule).	
Review, Sign, and Submit Attestation	Alabama implemented electronic signatures to improve system workflow and document retention.
Incorporated and Improved workflow with reduced documentation uploads	A new stream-lined work flow that reduce the number of manual save activity, less documentation on EP, and a single upload requirement on submission only.
System change prevent concurrent PY attestation submission.	Edits implemented only allow a single attestation to be submitted until D-18 from the previous year has been recorded in the SLR.
Year 7 Modified Stage 2 & Optional Stage 3 (December 1, 2018 to accommodate Modified Stage 2 Option Stage 3 changes as a result MACRA/MIPS Final Rule, including release OPPTS rule & QPP.	

2013-2016 Program Changes

Alabama submitted a description of EHR Incentive Program Changes for prior years in the previous SMHP dated April 15, 2016, which CMS approved on 8/29/2016.

SLR Contract Awarded

A-SMA awarded the SLR re-bid to HealthTech Solutions (HTS) effective August 1, 2016. And was in for accepting 2015 attestation on 9/15/2015.

2016 Tail Period Extension

Due to overlap in attestations submitted causes by SLR re-bid, A-SMA requested an extension ed for both AIU and MU 20165 Tail periods from March 31 to June 30, 2017 to allow 90 days for EPs and remaining EHs adequate time for 2016 payment year registration and attestation submissions. CMS approved both extensions in emails dated 2/2/2016 & 3/3/2016, respectively.

2017 Program changes

On February 1, 2017, A-SMA submitted to CMS the 2017 SMHP Addendum that identified how Alabama are implementing the Stage 3 portion of the 2015-2017 Modifications rule, the recently released OPPS rule, and any potential changes associated with the Medicare Quality Payment Program (QPP) [MACRA/MIPS].

2017 Tail Period Extensions

On March 9, 2018, A-SMA requested and received approval to extend the 2017 tail period 45 days until 11:59 pm on 5/15/2018.

- *“To Be” Future State of One Health Record® to Support the Exchange of Information for Promoting Interoperability*: The overarching goal of Alabama’s One Health Record® is the development and facilitation of technology that will enable providers to exchange health information. To this end, Alabama started at its simplest level, secure messaging. While Alabama providers are able to exchange information with an aligned hospital, the State does not have local, regional or statewide health information capacity at present. It is recognized that providers will need a pathway and a process to exchange information with other qualified organizations, state and national agencies, and/or providers, interstate and intrastate health information organizations, and other information sources to be determined.

One Health Record® is envisioned as the primary gateway for individual or group entities within the state to connect with other state HIEs, Integrated Health Networks, State HHS agencies, federal agencies, the eHealth Exchange, and other interoperable systems. To achieve that goal, Alabama continues to use a staged multi-track implementation that allows for each phase to be fully implemented and integrated with the prior phase. The purpose of a multi-track staged implementation is to allow for a period of time of response and flexibility and most importantly, provider engagement, education, technical assistance.

The web service offerings continues to include administrative and technical validation of the eligibility of the provider to participate [authentication], validation of their status as a provider and agreement to comply with the privacy and security rules of engagement through an agreement that aligns with the national DURSA agreement.

The state focuses on the hybrid technical design with the capability to collect information into a secure repository and enable access to providers for integration into their EHRs One Health Record® serves as the nexus of these gateways, capable of PHI

exchange among all HIE participants , and orchestrating interoperability according to business rules needed to deliver meaningful use functions.

By consolidating access, the state is able to share and minimize operational costs, increase user acceptance and participation, and maximize benefits to all stakeholders. The goal of One Health Record® is to allow providers to access clinical data via their native EHR interface or with a secure Web browser in order to meet the requirements of promoting interoperability.

One Health Record® complies with all national standards as defined in the HITECH Act, and the final Standards and Certification Criteria established by ONC to support the Final Rule on Meaningful Use, including all specified content, vocabulary and privacy and security standards. One Health Record® also utilizes standardized code sets and nomenclature. Encryption is a core privacy and security process and utilizes current standards. Other encryption is layered on as and when needed (e.g. encryption of data at rest). As additional encryption standards are defined and specified by standards bodies, Alabama will analyze, decide and make appropriate IT infrastructure updates to support new algorithms or security processes. These standards include any Federal Information Processing Standards (FIPS) that are announced by the National Institute of Standards and Technology (NIST).

The state continues to evaluate the capabilities and risks associated with various encryption approaches including the ability of the private sector to implement the proposed algorithms. It is expected that encryption and security standards will continue to evolve and that an ongoing function of the HIE will be to stay abreast of evolving privacy and security risks, standards, and approaches.

Transactions in the secure website will be recorded when electronic health information is routed (source, destination, message ID, date and time) created, modified, accessed, and deleted to include which actions were completed, by whom (ID or username), when (date and time), and from where (host address/name) for auditing purposes. For data integrity, The Secure Hash Algorithm (SHA-1), as specified by NIST, is used , to verify that electronic health information has not been altered in transit. Alabama will is planning to upgrade SHA-2 in near future.

In previous SMHP updates Alabama has provided updates to infrastructure and core functions. The infrastructure, core functionalities, and capabilities will remain constant and consistent through FFY 2018-2021. With the HIE transition that took place in July 2016, Alabama implemented the HL7 ADT notifications within the InterSystems HealthShare HIE platform and will continue to on-board state hospitals to support care coordination and payment reform transition for A-SMA.

In November 2017, A-SMA re-energized the One Health Record adoption strategy to focus its immediate efforts on the distribution of Hospital ADT notifications to ambulatory providers to improve care coordinator, patient referrals, and patient centered medical home networks among Medicaid providers.

Moving forward in FFY 2019 & 2020, in addition to the ADT notifications, One Health Record implementations will include:

EHR Hub development: Under the prescribed activities of SMD 16-003, A-SMA will be connecting Medicaid providers to One Health Record through “hub” interfaces. This will enable the HIE to make a single front-door gateway connection to EHR vendor “hub” web service. The A-SMA providers will then be on-boarded to the HIE, as each individual EHR installation’s “back door” is opened by the EHR vendor. Alabama is currently working with Greenway, Athena Health, Medisoft, eMDs, and others with a go-live beginning in 4th quarter of 2018. These connections will include all Medicaid provider types including patients served in both Mental Health and Children’s Rehab providers.

eHealth Exchange expansion: Alabama will be expanding its gateway connections to include SSA, VA, and other regional HIE’s for information exchange. This gateway connections will allow One Health Record to provide PHR’s to SSA for SSDI determination and connectivity to VA-VLER program for Alabama’s VA Hospitals.

ADPH: The State will continue to work with ADPH to expand the HIE reporting capability to the ADPH registries to promote interoperability. Alabama will also move forward to develop a gateway interface for PDMP-HIE integration access for provider queries and reporting. This effort includes on-boarding the 72 ADPH county health location to the HIE for CCD exchange and patient referrals to local facilities and Childrens’ Hospital, in addition to supporting the expansion of Telemedicine projects across the state.

SHIEC: As a new member in SHIEC, One Health Record will expand its role to include servicing as a possible Southeast Region gateway for the Patient Centered Data Home for regional and national ADT alerting, CCD exchange, and disaster preparedness. Alabama plans to partner with SHIEC to support expansion of HIE connectivity to utilize the PCDH initiative.

Disaster Preparedness: One Health Record will partner with Alabama’s Emergency Management Agency to develop a pilot implementation to provide PHI access and exchange EMS first responders through mobile devices.

Patient Portal: Alabama Department of Rehabilitation Services – Childrens’ Rehab will pilot One Health Record’s patient portal in a kickoff to the consumer engagement plan to outreach and education of the A-SMA recipient population on health care accountability and control.

Population Health eCQM’s: A-SMA and One Health Record will develop and implement a process to provide and collect HL7 lab results information on their Medicaid recipient population from the independent labs state-wide. This effort will require a procurement of a third-party vendor to develop and integrate the necessary interface to provide the

lab results to the HIE and A-SMA. Phase I implementation will begin in FFY 2019 with approximately 45 labs, with an estimated 110 labs connected by 9/30/2020.

- *“To Be” Future State of Other Health Information Technology to Support the Interoperability of Health Information:* With the RCO effort terminated, the state is re-finalizing its pivot approach in its major health care transformations. A-SMA is simultaneously developing health-IT to support these new changes, which encompass payment reform, changes in service delivery and care coordination for individuals with chronic illnesses and eligibility expansions. Some of the technical infrastructure that is a part of the Alabama health-IT structure going forward includes the One Health Record®, including enhancements for public health reporting of immunizations, labs, cancer and bio-surveillance, state enterprise wide data warehouse/repository with analytical capabilities, and an enhanced Medicaid eligibility system. Many of the technologies developed and implemented for One Health Record® are being will continue to be leveraged.

The following table provides some of the health-IT enhancements that the state is looking across Medicaid initiatives to reuse or develop.

Table 23: Cross Medicaid Initiative Health IT Enhancements

Health IT Enhancement
One Health Record® is the single-entry interface that allows constituents to access disparate programs/activities related to health care, including public health reporting and PDMP query.
Health IT infrastructure for cross-agency transfers and referrals relating to responsibility for regulating, enforcement and implementation.
State enterprise wide repository/warehouse with analytic capability, and eCQM data collection.
Standardized authorization and physical and technical security framework.
Identify management as a common service.
Shared common business intelligence, rules engines and reporting functionality.
Service-Oriented Architecture (SOA), where interactions are standardized through messaging protocols and Enterprise Service Bus (ESB) technologies.
MITA 3.0 Self –Assessment is completed and Health-IT enhancements are included in all phases where applicable.
Health IT infrastructure to serve as a SE gateway for disaster preparedness, patient ADT and emergency notifications, and resident evacuations on national, regional, and state landscapes.

3.3 The schematic for the data warehouse system architecture to support Medicaid MU How WILL MEDICAID PROVIDERS INTERFACE WITH THE SMA IT SYSTEM AS IT RELATES TO THE EHR INCENTIVE PROGRAM (REGISTRATION, REPORTING OF MU DATA, ETC.)?

The state has contracted with DXC (fiscal agent) for its claims and provider management MMIS system, but begin the process of going modular in FFY 2019. It is contracted with HealthTech Solutions (HTS) for its SLR. The new SLR contract began on 8/1/2016 is renewal through July 31, 2021.

For the EHR Incentive Program registration and reporting of PI data, the provider interfaces directly with the SLR. The One Health Record® website also plays a role as the site provides information regarding PI, a link to the SLR, a checklist for submitting a provider's SLR application, a Workbook for EPs, Workbook for EHS, and information that will help EPs/EHS, in determining their patient volume for eligible professionals and groups. The PI web site did undergo an update to reflect the MU program being re-named to "Promoting Interoperability" (PI).

"To Be" Future State: A-SMA will include changes that expand on the earlier modifications to the automated payment system and integration with the EHR Incentive payment history into the provider's payment history, and Stage 3. Payment information is produced in the SLR and transmitted to the FA; however, the actual payments are issued by the MMIS and are thereby captured in the provider's payment history.

3.4 GIVEN WHAT IS KNOWN ABOUT HIE GOVERNANCE STRUCTURES CURRENTLY IN PLACE, WHAT SHOULD BE IN PLACE BY 5 YEARS FROM NOW IN ORDER TO ACHIEVE THE SMA'S HIT/E GOALS AND OBJECTIVES? WHILE WE DO NOT EXPECT THE SMA TO KNOW THE SPECIFIC ORGANIZATION THAT WILL BE INVOLVED, ETC., WE WOULD APPRECIATE A DISCUSSION OF THIS IN THE CONTEXT OF WHAT IS MISSING TODAY THAT WOULD NEED TO BE IN PLACE FIVE YEARS FROM NOW TO ENSURE EHR ADOPTION AND MEANINGFUL USE OF EHR TECHNOLOGIES.

The development and governance of the A-HIE (One Health Record®) and PI (formerly MU) have always been under the auspices of A-SMA. As with many new initiatives, the Medicaid Agency designated a team to focus on PI and on the initial design, development and implementation of the state HIE technical, technical and business operations, governance, finance and legal/policy areas.

One Health Record® anticipates a permanent governance structure in place on October 1, 2020. If needed, legislation will be passed within the next two years to allow One Health Record® to become an independent entity. It is anticipated that it will have a director and a board consisting of representatives from major stake holders. It is also anticipated that current contract staff will migrate into full time employees of One Health Record® with this transition.

There is a single Medicaid Health IT division, lead by the Health IT Division Director, that addresses Health IT activity. Within the division, there are two Medicaid programs that specifically coordinate and address HIT activities. The Health IT-Promoting Interoperability

program manages the PI activities and HIT-PI staff, and the HIT-HIE program which manages One Health Record® activities and the A-HIE Staff. The State HIT Coordinator position was abolished in May 2017. Table 9 provides the key staff and consultants along with their roles.

Table 24: Key Staff/Consultants and Roles

Staff/Contract Support	Roles
Director, Health IT: Gary D. Parker	Provides leadership, direction, administration, and coordination for all Health IT activities and programs (HIE & PI) under the Medicaid Program.
PI Associate Director, Manager, Provider Audit: Janice Miles	Coordinates the efforts set forth by CMS for the Provider Audit and Outreach of PI program requirements for EPs/EHs technical assistance in the Medicaid system
Reporting/Data Analyst: vacant	Coordinates the multiple reporting, and data requirements analysis that must be met through the various health IT data sources and submissions.
HITPI Specialist: Melissa Bryant	Assists other HIT staff in day-to-day payment operations and review processes of PI .
HIT-PI Operations Manager : Holly Jarnagin	Coordinates the efforts by CMS for the implementation and adoption of PI criteria by EPs/EHs in the Medicaid system.
HIT-PI Specialist: Adline Jackson	Assists other HIT staff in day-to-day operations and auditing processes of MU.
HIT-PI Analyst Connie Simington	Assists other HIT Staff in Provider Post payment Audit activities.
HIT-PI Account Clerk -= Kristy Thomas	Assists other HIT Staff in Provider Post payment Audit activities.
Management & Medical Consulting Services (MMCS)	Provides PI & HIE Outreach/Education support and PI Technical Assistance
GDH Government Services (GDH)	Assists in the development and enhancement of eCQM applications/platforms, including popHealth®
GDH Government Services	PI SLR System Development, Operations and Program, Program Training, eCQM Analytics (popHealth®)platform development , HIE Project Support (program, operations, and marketing)

Since initial funding for One Health Record® came from the ONC Cooperative Agreement, the process to cost allocate back to Medicaid is still evolving. The initial A-SMHP and I-APD included discussion and a request for Medicaid cost allocation funding. The funding approval from CMS addressed the state’s request for funding relative to the SLR, but did not include the Medicaid share for human and technical resources for One Health Record® beyond staffing. The state re-submitted the cost allocation request as a part of an I-APD that was submitted in early 2012, and has been to updated as needed or required. The I-APD was approved as well as all of the following I-APD updates since 2012. The last update was submitted on 5/19/2016 and approved by CMS in a letter dated 8/29/2016. An update to the I-APD will be submitted in June 2018. All relevant contracts have been submitted to CMS for review and approved with the latest approval letter received in January 2018.

“To Be” Future State of the Alabama Health IT- Division: A-SMA has undergone another stage of organizational changes, including a name change to Health Information Technology Division. The Health IT Division and its activities (HIT-PI & HIE) are within A-SMA under the A-SMA’s Department of Information Technology.

3.5 WHAT SPECIFIC STEPS IS THE SMA PLANNING TO TAKE IN THE NEXT 12 MONTHS TO ENCOURAGE PROVIDER ADOPTION OF CERTIFIED EHR TECHNOLOGY?

The A-SMA will continue the multiple and diverse activities it has taken in the past to encourage provider/hospital adoption of certified EHR technology, including presentations within the state and focused efforts through our PI Outreach and TA contractor, MMCS. For those providers who were not eligible for a particular Program Year, Medicaid staff will have already worked with each provider to exhaust every effort to establish eligibility for the incentive program. A-SMA implemented an extensive new effort to identify and recruit all remaining EP’s into the program before 2016 payment attestation period ended. This effort saw our program participation increase by 42%.

Examples of prior efforts were submitted to and approved by CMS.

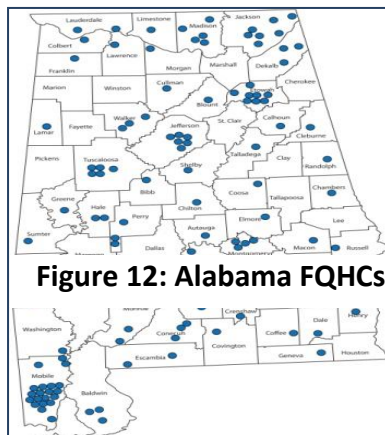
In addition and specifically related to the changes effective January 2018 Stage 3 PI, IPPS and QPP , A-SMA continues to provide outreach to providers via e-mail, website updates, webinars, and dissemination of information to provider and hospital associations. A-SMA continues provides training to the MMCS staff on the changes to the PI requirements and coordinating with MMCS to engage all providers promote interoperable exchange. . is routinely updated and reviewed for timeliness and accuracy..

Specifically, over the next 12 months, A-SMA will be concentrating its outreach and marketing to demonstrate seamless data interoperability to EP’s and EH by utilizing ADT alerting as value component in care coordination (locally, regionally, & nationally), EHR hub on-boarding for patient referrals and CCD exchange, and meeting exchange requirements for MIPS and MU measure reporting. This outreach will also include a follow-up of our 2016 SRA seminars in another set of seminars addressing data security, privacy and consent in July 2018.

3.6 ** IF THE STATE HAS FQHCS WITH HRSA HIT/EHR FUNDING, HOW WILL THOSE RESOURCES AND EXPERIENCES BE LEVERAGED BY THE SMA TO ENCOURAGE EHR ADOPTION?

As indicated in Section 2, The Alabama Primary Health Care Association (APHCA) that represents Federally Qualified Health Care Centers (FQHCs) throughout the state.

Through the APHCA leadership, a new initiative to on-board the APHCA data hub to One Health Record for public health reporting and data exchange is being planned to begin in 4th quarter of FFY 2018. It is anticipated that this linkages will occur with the FQHCs as a direct result to their regionalization oefforts and the statewide One Health Record®.



3.7 HOW WILL THE SMA ASSESS AND/OR PROVIDE TECHNICAL ASSISTANCE TO MEDICAID PROVIDERS AROUND ADOPTION AND MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY?

A-SMA continues with the numerous explicit strategies for continuing to assess Medicaid providers' adoption and promotion of interoperability through their use of certified EHR technology. For those providers who were not eligible for a particular Program Year, Medicaid staff work with each providers to exhaust every effort to establish eligibility for the incentive program. As an active participant in this process, once it is clear that the provider cannot meet the Medicaid encounter threshold to establish eligibility for the program year, each provider is already aware of their status. Therefore, every provider who is deemed ineligible for an incentive payment is aware before formal notification.

In addition and specifically related to the changes effective January 2018 related to Stage 3 MU, A-SMA will provide outreach to providers via MMCS, e-mail, website updates, webinars, and dissemination of information to provider and hospital associations. A-SMA is coordinating with MMCS to engage all program providers to promote interoperability. .

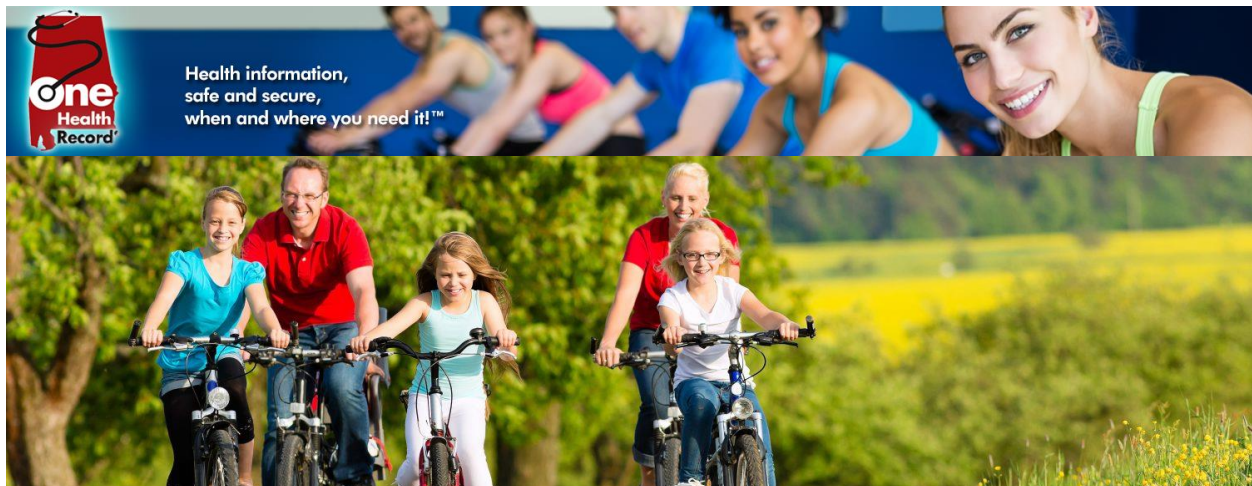
The state continues to implement plans for many technical assistance (TA) strategies through the PI Incentive Payment and One Health Record® implementation processes, MMCS, and state/contractor staff initiatives

Alabama continues to employ various of methods for providing technical assistance to and engaging the provider community as part of promoting interoperability and PHI exchange They include:

- Participation in numerous presentations to provider groups and associations, conferences and workshops throughout the state.
- The One Health Record® website (www.OneHealthRecord.alabama.gov) publishes information on a regular basis to educate providers about meaningful use of electronic health records and eligibility for the incentive payment program. The website was redesigned in late CY 2016 and is updated regularly. .

- New MU Outreach and TA contractor vendor, MMCS, continues to provide statewide “boots-on-the-ground” resources to retain EP’s into PI program through completion and educate EP’s about the value of data interoperability and exchange .

Figure 13: One Health Record® Website



- Specific information is provided about all aspects of the Promoting Interoperability program, including an e-mail address listerv and direct telephone contact number.

Figure 14: Promoting Interoperability



Promoting Interoperability (PI)

Health Information Technology (Health IT) is central to a reformed health care system because of its ability to provide vital health information at the point of service and to improve the quality of care for patients. The federal incentive payment program, presently known as “Promoting Interoperability (PI),” plays a key role by providing financial support to eligible hospitals and professionals as they make the transition from paper-based record systems to electronic medical records.

CMS Announcement of the New Name for EHR Incentive Programs

The deadline extension for submitting PY 2017 MU Attestations is May 15, 2018. [Click here](#) for more information.

Alabama State Level Registry (SLR)

- [Program Year 2017 Requirements for Meaningful Use Attestations](#) - 12/14/17
- [New Meaningful Use SLR eSignature Feature](#) - 5/23/17
- [Alabama State Level Registry \(SLR\) CMS Registration Retrieval](#)
- [Click here to view webinar held September 16, 2016 \(51 minutes\)](#)

If you have any questions or need assistance with the SLR, you may contact the SLR Help Desk using any one of the following methods listed below:

Phone: 1-844-288-4701, Option #1

Fax: (502) 219-9000

E-mail: helpdesk@thinkhts.com

If you need assistance in submitting your attestations, you may contact Medicaid's Technical Assistance Team.

Their contact information is:

Phone: 1-256-346-3611

E-mail: meganw@managementmed.com

Website: www.managementmed.com

Helpful Links

- [Promoting Interoperability \(PI\)](#) - *Official federal website for Medicare and Medicaid Electronic Health Records Incentive Program*
- [One Health Record](#) - *Alabama's Health Information Exchange*

Overview of MU Program

- Alabama’s State Level Registry, also includes a Provider Outreach Page that contains comprehensive and detailed information to assist with applying for the Incentive Payment Program, but links to related information at CMS and other HealthCare IT news.
- Webinars and program demonstrations are still conducted on an as-requested basis.
- Regular distribution of HIT related information on the state’s listserv.
- Alabama routinely reviews the database of providers that have started the attestation process and, after an extended period of time has elapsed, have not completed submission. The providers are contacted to determine the reason for the incomplete submission and technical assistance is offered to complete the attestation.
- Similar assistance is provided for those providers whose applications are pended during the review process. Providers are contacted via e-mail or directly by telephone to assist with the completion of the attestation.
- For those providers who are not eligible for a particular Program Year, Medicaid staff work with each provider to exhaust every effort to establish eligibility for the incentive program. As an active participant in this process, once it is clear that the provider cannot meet the Medicaid encounter threshold to establish eligibility for the program year, each provider is already aware of their status. Therefore, every provider who is deemed ineligible for an incentive payment is aware before formal notification.

“To Be” Future State for Assessing Adoption, Promoting Interoperability & TA Strategies: The State has initiated a targeted geographic approach to align with the Medicaid managed care program implementation, high volume ADT activity, and care coordination and referral to support the ADPH EHR implementation and telemedicine opportunities. . This approach is reinforced and is being implemented through our MU Outreach contractor, MMCS.

The state continues to prioritize groups of safety net and small providers to assure “no one is left behind”, including Patient 1st Primary Medicaid Providers (PMPs) and Networks, Medicaid/Medicare ACO network providers, FQHCs through APHCA, and providers serving the underserved in the Black Belt counties. A-SMA has also prioritized strategies and assessments focused on the following areas of interoperability and data exchange for meeting the PI program requirements: care coordination, referrals, and Care Summary Exchange. Information on the on-going efforts results of those efforts were presented in Section 2.0.

The A-SMA maintains its contract with the MMCS for TA and has included performance metrics and deliverables that are focused on assessing adoption and interoperability by EP-types and EHs, particularly rural hospitals and providers. In addition, A-SMA has established performance metrics for the program auditors to assure that as EPs and EHs move from AIU to Modified Stage 2, and Stage 3 that the PI program requirements are met.

3.8 HOW WILL THE SMA ASSURE THAT POPULATIONS WITH UNIQUE NEEDS, SUCH AS CHILDREN, ARE APPROPRIATELY ADDRESSED BY THE EHR INCENTIVE PROGRAM?

The underserved geographic areas and individuals with chronic conditions have been addressed in previous SMHP updates. . The scope of those activities has expanded to include issues with the opioid epidemic and children with special needs.

Children, who make up the largest portion of the Alabama Medicaid Program, are another population focus for One Health Record®. Alabama has a stand-alone CHIP program through the ADPH and administered by A-BCBS, both are participants on of One Health Record®. Pediatricians and family physicians, whose practices are extensively Medicaid, are represented on the One Health Record® Advisory Commission by Linda Lee, Executive Director, Alabama Chapter American Academy of Pediatrics, and Jeff Arrington, Executive Vice President, Alabama Academy of Family Practice Physicians.

“To Be” Future State for Children: One of the critical delivery systems for children is the Children’s Hospital of Alabama. The children’s hospital has received all of their EHR Incentive Payments and completed the program in PY 2016. . The state is also including the Home Health Networks in their implementation strategy to launch their manage care program related to health home for individuals with chronic conditions, including children.

The target date for the MCO implementation is October 1, 2018. One Health Record and Children’s Hospital are moving forward to establish HIE connectivity and resolve challenges related to patient matching of newly born children admitted for immediate care.

One Health Record is on-boarding 72 ADPH county health department for CCD exchange and patient referrals to both Children’s Hospital UAB, both in Birmingham, AL. These county health departments also serve as host sites for telemedicine activity.

While the focus for 2017-18 moved from PI Modified Stage 2 to Stage 3, and now include changes that have resulted from the IPPS and QPP (MACRA/MIPS), A-SMA is cognizant of the need to address the quality measures for the Modified Stage 2 and Stage 3. As stated in the last SMHP update, the state does not intend to require additional measures or mandate optional measures at this time, but is dependent on the results of the federal requirements; however, as the providers move forward, the option could be considered in the future. The evolving document provides a tool to assure quality measurement for all populations, including children and other underserved populations, is coordinated.

3.9 THE STATE INCLUDED IN A DESCRIPTION OF A HIT-RELATED GRANT AWARD (OR AWARDS) IN SECTION A, TO THE EXTENT KNOWN, HOW WILL THAT GRANT, OR GRANTS, BE LEVERAGED FOR IMPLEMENTING THE EHR INCENTIVE PROGRAM, E.G. ACTUAL GRANT PRODUCTS, KNOWLEDGE/LESSONS LEARNED, STAKEHOLDER RELATIONSHIPS, GOVERNANCE STRUCTURES, LEGAL/CONSENT POLICIES AND AGREEMENTS, ETC.?

“To Be” Future State Leveraging across Initiatives: The state has a commitment to utilize human and IT resources, policies and procedures, and technical and business operation processes across initiatives to enhance the benefits and reduce costs. Using the MITA framework and MMIS modularity, A-SMA seeks to approach issues functionally rather than by initiative, such as member, provider, contractor, operations, program and program integrity management. Examples of leveraging across initiatives were reported in previous sections.

- Section 1.2, which spoke to the use of Medicaid staff and contractors to support PI and One Health Record®, fully utilizing the FFP Health IT funding and the knowledge gained through the design, development and implementation process.
- Sections 2.1 and 2.6, which discussed the current One Health Record® A-SMA engagements and activities to leverage the health IT implementation.
-
- Section 3.2, which addressed the proposed leveraging of health-IT infrastructure across with FFP funding to promote interoperability. Going forward with FFY 2019 & 202, MMIS modularity, ADT expansion, regional HIE connections, and SSDI and other opportunities will be engaged in leveraging the State IT resources to support health care transitions involving Health IT.

3.10 DOES THE SMA ANTICIPATE THE NEED FOR NEW OR STATE LEGISLATION OR CHANGE TO EXISTING STATE LAWS IN ORDER TO IMPLEMENT THE EHR INCENTIVE PROGRAM AND/OR FACILITATE A SUCCESSFUL EHR INCENTIVE PROGRAM (E.G. STATE LAWS THAT MAY RESTRICT THE EXCHANGE OF CERTAIN KINDS OF HEALTH INFORMATION)? PLEASE DESCRIBE.

The state may or may not seek state legislation in the upcoming legislative session. The A-SMA, through a State Plan Amendment, expanded the definition of a physician to allow optometrists to be eligible as an EP and receive, upon meeting all the requirements, an EHR incentive payment.

One Health Record® anticipates possible passage of legislation in the next three years to allow One Health Record® to become an independent entity. It is anticipated that it will have a director and a board consisting of representatives from major stake holders. It is also anticipated that current contract staff will migrate into full time employees of One Health Record® with this transition.

Privacy and security issues are addressed through the One Health Record® Participation and Data Use and Reciprocal Support Agreement (DURSA) and a Business Associate Agreement between One Health Record® and participants, both of which are available to CMS upon request. Based on clarifications from SAMSHA, the state has also created a Qualified Service Organization Agreement (QSOA).

If an unanticipated issue arises that requires legislative action, the A-SMA will address the need at that time.

As a member and participant of State Health Information Exchange Collaborative (SHIEC), the Patient Center Data Home (PCDH) network, and the eHealth Exchange, the appropriate DURSA's and BAA are incorporated into the One Health Record legal and operation framework.

4. SMHP SECTION C: ACTIVITIES NECESSARY TO ADMINISTER AND OVERSEE THE EHR INCENTIVE PAYMENT PROGRAM

Standard: One of the stated priorities of the One Health Record® A-HIE Strategic and Operational Plans (S/Ops) is to “support the meaningful use of EHRs throughout the State and facilitate health care providers’ ability to qualify for Medicare and Medicaid incentive payments by aligning the S/OPs with the A-SMHP”. This remains a top priority as the state continues to move from concept to implementation for One Health Record®, from AIU to MU Stage 1 and from MU Stage 1 to MU Stage 2 and ultimately to Stage 3 of the promoting interoperability program.

Methodology: Alabama has put the patient in the center, built upon existing resources to create a bold vision that’s incrementally implemented to support both EP’s and EH’s health-IT needs so that they might qualify and receive MU incentive payments and foster innovation.

Process: A-SMA complies with all federal requirements and CMS guidance and is transitioning its focus from AIU and the more manual efforts required for implementation into MU and increased automation. It is evolving from an office that handled all components of the efforts for One Health Record® and MU into integrating some of the activities in their appropriate division within Medicaid, for example, incentive payments will be issued through the MMIS and captured in the provider payment history and A-SMA is initiating a pilot to submit eCQMs directly to the Medicaid agency.

There are four (4) components of the overall strategy to administer and oversee the EHR Incentive Payment Program:

- Pre-payment Processes, including provider eligibility assistance, registration and attestation;
- Payment Processes;
- Post-payment Processes, including processes for review and validation of meaningful use payments; and
- Statewide Infrastructure Assurance that the technical architecture is available to providers and consumers for private and secure messaging and exchange of information through DIRECT and/or CONNECT to other providers, public health and Medicaid for purposes of reporting on MU measures.

An addendum will be submitted once the Program Year 2018 system updates have been completed and screens can be submitted.

The State of Alabama has acquired a new vendor since the last SMHP submission. A contract with HealthTech Solutions, hereby referenced as HTS, went into effect on August 1, 2016 date. The new vendor was put into place and first utilized for Program Year 2015. The State recently finished accepting applications for Program Year 2017. The deadline for Program Year 2017 was approved by CMS and extended until 11:59 PM CT on May 15, 2018. An addendum was previously submitted and approved to outline the modifications made to the system for Program Year 2017, including both Modified Stage 2 and Optional Stage 3.

CQMs have not changed for Program Year 2015, but changes occurred PY 2017 which are discussed in the 2017 SMHP addendum, approved on 2/13/2017; the screens, previously submitted, were approved on 3/23/2017. The state has created and separated the confidential Promoting Interoperability (PI) Program Audit Requirements and Procedures and previously provided it to CMS as a separate, stand-alone document. The State's Audit Strategy has been updated to address Modified Stage 2 Objectives and measures and Stage 3 Objectives for Program Years 2017 and 2018 is provided in Section 5, which will be submitted separately

The state has developed multiple tools to enable eligible providers and hospitals to establish that they have satisfied the minimum requirements. Since the changes in the 2017 Program Year are primarily those associated with the Modified Stage 2 MU Objectives and an Optional Stage 3, none of the Eligibility or Certification tools are part of this update to the SMHP.

Pre-payment Processes: The high-level steps of pre-payment processes (Attachment 8.9) are:

- The provider or hospital successfully registers with the CMS Registration and Attestation System.
- After successful registration at the CMS Registration and Attestation System, notification is sent to the state via an electronic data transmission including notification if there are federal or state exclusions precluding payment to the provider or hospital. This file is known as a B-6.
- After 24 hours, the provider may commence the State Level registration and attestation process in the SLR.
- As the potential EP/EH completes the on-line SLR attestation (Attachment 8.8) the system applies checks and balances that will not allow the EP and/or EH to complete the registration process without submitting the requested documentation or answering all questions. As the following screen shots provided in Figure 26 indicate, certain documentation is required and must be attached as a part of the registration and attestation process. Screen shots of the entire process are provided in the previous submission of the last updated SMHP. .

- Upon receipt of a completed, submitted attestation, the state reviews the application to validate information provided and makes a decision to either reject or approve the provider’s application for an incentive payment.
The SLR system performs the following validation process and during the provider’s application process, any step that is not validated prevents the provider from continuing the attestation process until that step is performed satisfactorily.

The SLR has five (5) distinct steps in the state registration and attestation process:

- Account Creation
 - Step 1: Identification and Eligibility
 - Step 2: Medicaid Eligibility
 - Step 3:
 - MU – Meaningful Use of CEHRT
 - Step 4: Attestation Agreement to All Provisions
 - Step 5: Submission of Attestation

Table 14: SLR System Validation Process

Attestation Component	System Validation	State Action	Provider Action
Provider’s Credentials: Submit TIN and NPI	Confirms matching TIN/SSN and NPI are registered in the CMS Registration and Attestation System and are valid in Medicaid’s Provider Master File	None	Correct erroneous information and re-enter data to the CMS Registration and Attestation System. Provider may contact Medicaid’s Provider Enrollment Section for assistance.
Provider is not a hospital based physician.	Provider must attest through “checkmark” that he/she does not provide 90% or more of services in an inpatient hospital (21) or emergency room setting (23). Defined as services are provided in POS 21 or 23. Changes to the Stage 1 requirements effective January 1, 2013 related to the definition of hospital based physician have been addressed.	Provider is compared to the POS report maintained by the State and if POS 21 or 23 is greater than 75% and less than 90%, of <i>Medicaid</i> encounters, flag for post payment audit.	None
Professional License Number and Provider Status	SLR will validate the provider’s License Number on the Provider Master File & current status including:	None	If the provider receives an error message they must contact either the SLR Help Desk or the Medicaid

Attestation Component	System Validation	State Action	Provider Action
	<ul style="list-style-type: none"> • The PMF shows an active status • Does not show a “sanctioned” status • Does not show status of deceased 		Provider Enrollment section at the number provided on the screen.
<p>Medicaid Eligibility: Provider must meet patient volume of at least 20% Medicaid encounters for pediatricians and 30% for all other designated providers</p>	<p>Numerator and denominator information entered by provider must be at least 20% of pediatrician patient volume and 30% of all other providers’ total encounters.</p> <p>For patient volume, encounters are defined to include all services rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability, including zero-pay claims and encounters with patients in Title 21-funded Medicaid expansions, but not separate CHIPs. Since Alabama’s CHIP program is a stand-alone, those patients will not be counted</p> <p>The expanded definition of encounters from previous 12 months to previous 24 months were implemented to attestations submitted for program year 2013 forward.</p>	<p>All Medicaid encounters for the numerator will be validated by the agency. If the Medicaid claims reported by the provider are 15% higher than the Medicaid claims of record, the file will be flagged for post payment audit.</p> <p>If panel information is included and the information was not obtained from the Agency, AHIE will run reports from the following systems to confirm panel information: Patient First, Medicare Advantage, and Medicare dual eligible patients. If additional information causes the Medicaid patient volume to drop below 30% (20% for pediatricians), the provider is not eligible.</p>	<p>If provider does not meet minimum patient volumes percentage with Medicaid encounters, provider may obtain assistance from Medicaid and apply patient encounters from panel members in the following programs: Patient 1st, Medicare Advantage, Maternity program, or Medicare dual eligible patients. Providers will not be able to continue through the SLR until volume requirements are met.</p> <p>Alabama currently requires each provider to submit a workbook detailing how Medicaid encounters were determined and reports from an auditable source (such as a Practice Management System) to support the data submitted.</p>
Total Encounters	Medicaid Patient Volume/Total Patient Volume > or = 30%, 20% for pediatricians	The summary report from the provider’s practice management system is reviewed to	SLR System will not allow provider to proceed if volumes do not meet criteria.

Attestation Component	System Validation	State Action	Provider Action
		substantiate the total patient volume. Medicaid will select a statistically valid sample of provider denominator reports for further review and potential audit. (Also see Numerator data that is flagged for audit.)	Alabama currently requires each provider to submit a workbook detailing how Medicaid encounters were determined and reports from an auditable source (such as a Practice Management System) to support the data submitted.
Additional Medicaid Encounters	None	Same as State Actions under “Medicaid encounters” above	
Provider practices in an FQHC/RHC	None	Verification of an express statement from the provider of employment status on the attestation agreement and a letter from CMS identifying the FQHC/RHC status.	Check section of attestation agreement identifying that the EP is employed by an FQHC/RHC and submission of a letter from CMS confirming the status of the facility.
Medically Needy Patient Volumes	<p>Only applicable to providers attesting to practicing in an FQHC or RHC.</p> <p>Changes as a result of the MU Final Regulation have been incorporated effective 1/1/13.</p>	The summary report from the provider’s practice management system is reviewed to substantiate the Medically Needy patient volume.	Alabama currently requires each provider to submit a workbook detailing how Medicaid encounters were determined and reports from an auditable source (such as a Practice Management System) to support the data submitted.
Alabama Medicaid Volume Hospital Demographics Information	<p>The SLR system validates that the percentage of Medicaid patients is 10% or above.</p> <p>Changes as a result of the MU Final Regulation have been incorporated effective 1/1/13</p>	All information to establish eligibility for the program is based on the hospital’s annual cost report submitted to Medicare and to the Medicaid Agency. Staff compares the data submitted in the SLR to the hospital cost reports. If the data submitted does not	Correct attestation data and resubmit.

Attestation Component	System Validation	State Action	Provider Action
		match the data on the cost reports, staff will contact the hospital representative for clarification.	
The provider must attest to the meaningful use of CEHRT for the appropriate Stage.	Based upon the previously submitted attestation, the system calculates the appropriate MU Stage, Payment Year, Attestation Period (90 days or 1 Year), to which the provider may attest.	Vendor Letter containing the EHR description, version, and ONC certification or Product ID number.	Upload acceptable attestation document
The provider must submit certification number of provider's ONC certified EHR Technology	The system validates the certification number against the ONC Certified HIT Product List database.	Verify that the certification number submitted matches the EHR technology to which the provider attested. If the certification number does not match, contact the EP/EH representative for clarification and pend the application.	Submit correct certification number.
Provider must electronically sign the Attestation Agreement.		Review and confirm that: <ul style="list-style-type: none"> • Entries pre-populated from the SLR match information submitted by provider. • Electronic signature of EP of record or EH representative of record and current date is present. If any of the above conditions are not met, contact provider for a properly executed	No additional documentation as required since this is an electronic process now.

Attestation Component	System Validation	State Action	Provider Action
		document. Pend the attestation pending receipt of the correct document.	

For the EP validation process, the reviewer will review the following documents, which have been updated to accommodate changes as a result of the MU final regulation effective payment year 2013.

Table 15: EP SLR System Validation Process

Provider Place of Service (POS) Report EP Workbook Practice Management Summary Report Supporting Provider’s Denominator Other Documents that may be Submitted by Provider
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For the EH validation process, the following documents, which have been updated to accommodate changes as a result of the MU final regulation effective payment year 2013, will be reviewed by the reviewer.

Table 16: EH SLR System Validation Process

Cost Report Data submitted to Medicaid Internal Audits Section EH Workbook Attestation Agreement Other Documents that May Be Submitted by Provider:
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- Approval: The SLR contains verification steps for all requirements against which the reviewer reviews provider’s submission and related documentation to validate provider’s attestation to all eligibility requirements.
- In reviewing the aforementioned checklist or if the information submitted is inadequate or unclear, the application will be ‘unlocked,’ the account will be re-opened so the provider can resubmit the application with corrected or additional supporting data.
- Rejection: In reviewing the aforementioned checklist, a staff member finds the provider does not meet eligibility requirements set by the state. The provider is rejected.

- The state has the responsibility to audit providers who have received payment. Alabama has taken the option for CMS to audit the eligible hospitals based on the specifications and agreement presented prior to PY 2015.
- Those providers whose application was rejected may appeal the decision.

It is Alabama's intent to validate as much information as reasonable prior to issuance of a payment to minimize the need to recoup payments issued to ineligible. This review is balanced with the intent to minimize the burden on providers and to issue payments within 60 days of a successful submission of an application to the state and payment issued within 30 days of approval. A-SMA's conversion of the payment from manual invoices to issuance through the MMIS payment requires that payments are issued on the MMIS payment cycle, twice monthly. Preparation of the approved attestations for entry to the MMIS payment system has added time to the review cycle and, once submitted to the MMIS vendor, there is a minimum 10-day processing cycle for issuance of Electronic Fund Payments to providers.

In February, 2013, A-SMA amended the SLR contract to supplement A-SMA resources with operations staff to support review of EP attestations. Upon obtaining a new vendor on August 1, 2016, Alabama proceeded to use contract support staff in assisting Medicaid with SLR activities and verifications which are required in order for the state to issue complete timely and accurate incentive payments to Alabama providers. HTS provides an Alabama-specific SLR Provider Support Lead and Provider Support Specialists to process providers up to approval and payment and provide the appropriate reporting to the State. A-SMA retains responsibility for approval for payment and in rare instances rejection of an application. In addition, complex, ambiguous or questionable attestations are referred to A-SMA for further review. The Pre-Payment Validation Guidelines developed for this purpose are included in Attachment 8.19 in a previous A-SMHP. The guidelines are updated as program requirements change and the most recently updated version for Program Year 2017 Modified Stage 2 objectives and the optional Stage 3 objectives were approved by CMS and are provided in a previous Program Year 2017 Addendum.

A-SMA has augmented state resources, beginning August 2018, with 3 Agency state staff members to perform attestation review and will not continue to use contract resources for this purpose. Utilizing state resources results in fewer handoffs, a more cohesive administration of the program and retains institutional program knowledge within the agency.

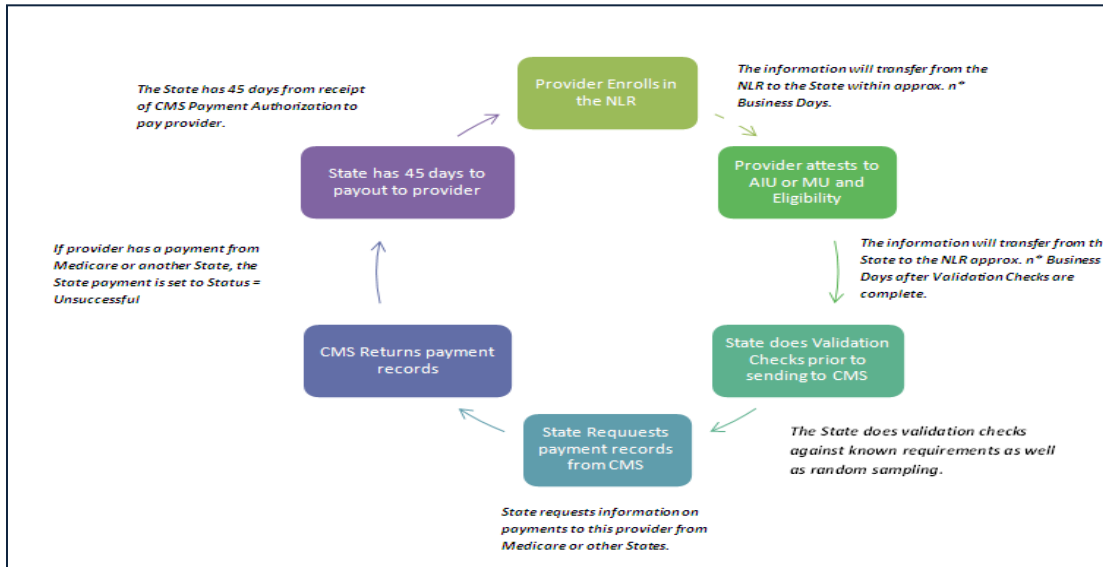
HTS does not review EH attestations due to the complexity and high dollar value of the EH incentive payments.

- In the past, Alabama has utilized the option to have CMS perform all hospital audits. However, since CMS no longer offers that assistance, the State of Alabama will begin auditing hospitals beginning with Program Year 2016. The specifics of this plan will be discussed in detail in our Audit Strategy, which is submitted separately. A-SMA hereby agrees that Alabama: Is bound by the audit and appeal findings;
- Will perform any necessary recouments arising from the audits;

- Will be liable for any FFP granted the state to pay EHs that, upon audit (and any subsequent appeal) are determined not to have been meaningful EHR users;

The following diagram is a high-level overview of the process for the meaningful use incentive program. This document has included the processes for attesting to and demonstrating AIU or Meaningful Use of EHR technologies. Figure 27 is the Process Overview.

Figure 27: Process Overview



Incomplete Registrations: There are two categories of incomplete registrations. There are registrations with exceptions due to stops and registrations/attestations that have been completed up to a certain point. The state monitors incomplete registrations and, if a registration remains incomplete, the state contacts the provider to inquire the reason and offer assistance. After further research, these “incomplete” applications have a final determination made upon discussing with the provider, such as either an approval or rejection. The outcome of the communication is documented in the SLR dashboard.

Payment Processes: Once determined eligible, the payment process (Attachment 8.9) was initiated by the A-SMA using spreadsheets and manual processes until the SLR Administrative Dashboard was fully functional in October 2011. At that time, it was the intent of the state to integrate the payment processes into the MMIS claims payment and financial systems through an amendment to its FA contract (DXC). However, after discussions with the FA liaison on the plan to move forward, it was determined that the process was not cost beneficial to A-SMA. Instead, the state was able to continue processing the payment data through the SLR, producing an invoice for the State’s Fiscal Office to produce paper checks. The State has completed the process of transitioning the payment processes to a web-based administrative interface within the SLR and is pursuing issuing payments through the FA’s electronic funds transfer (EFT) process. The State has received concurrence from CMS on this approach. The state has initiated an interim process with its FA of generating payment data from the SLR, sending the data to the FA; the FA enters the payment data to the MMIS and EFTs are generated on the FA’s biweekly

schedule with other Medicaid payments. This allows the incentive payments to be included in the provider claims history. In special circumstances in which the provider cannot be paid through the standard method of payment, the Check Write process, a paper check is still utilized.

Post-Payment Processes: The high-level steps of post-payment process, including processes for review and validation of meaningful use payments, (Attachment 8.12 and 8.15) are provided in Table 17:

Table 17: Post-Payment Process

Focus	Provider Selection	Method of Review
<p><i>The focus of the post payment audit are those areas that the agency is unable to validate during the pre-payment validation, including:</i></p> <ul style="list-style-type: none"> • <i>Place of Service for Non-Medicaid Encounters</i> • <i>Total Encounters by all payers</i> • <i>Certified EHR System is as reported</i> 	<p><i>The providers or hospitals selected for audit will be based upon the following categories:</i></p> <ul style="list-style-type: none"> • <i>A statistically valid sample or minimum of 10% Random Sample of all providers and all hospitals electing to receive incentive payments for AIU</i> • <i>All submissions identified as “flag for post payment audit</i> 	<p>The method of review/audit will include on-site visits by contracted staff.</p> <p>Alabama has taken the option for CMS to complete the EH audits and handle any subsequent appeals of whether a EH is a “meaningful user” on behalf of the state</p>

Statewide Infrastructure Assurance: In order to adequately oversee and efficiently manage the EHR Incentive Program as it moves to Stage 3 and beyond, the IT infrastructure needs to be available to state, providers and consumers for private and secure messaging and exchange of information. Through DIRECT secure messaging, query, and the One Health Record® provider directory, providers and the state can transfer clinical data, including information required for reporting and reviewing on MU quality measures, to other providers, Public Health and Medicaid.

The state is reviewing options for maximizing the technical infrastructure and technical and business operations for the required clinical quality measures for PI Stage 3, operation and implementation of Medicaid managed care transition where PI measures will be used for quality improvement, state program integrity activities and state oversight responsibilities yet to be determined. A potential consideration requiring further analysis is the option to use the infrastructure as a doorway to provide information to and receive information from consumers relative to the Promoting Interoperability (PI) Program.

Target Date	Description
1/1/2019	<ul style="list-style-type: none"> • EP Modified State 2 and and Stage 3 for Program Year 2018
1/1/2019	<ul style="list-style-type: none"> • EH Modified State 2 and Stage 3 for Program Year 2018.

With the implementation and use of a different vendor, HTS, new screenshots were submitted and addendums as necessary to show the new SLR platform's functionality in relation to the updated regulations. As of last, an addendum was approved for Program Year 2017 and included all applicable screenshots. This was submitted and approved by CMS. Program Year 2018 updates will be reflected in an upcoming addendum.

Prior SMHP Updates have included attachments that were approved by CMS and will not be resubmitted with this version.

4.1 HOW WILL THE SMA VERIFY THAT PROVIDERS ARE NOT SANCTIONED, ARE PROPERLY LICENSED/QUALIFIED PROVIDERS?

Standard: A-SMA requires and verifies Medicaid providers are properly licensed/qualified providers, have not been sanctioned, and comply with other Medicaid provider enrollment requirements related to ownership, control, relationship and criminal conviction before they are enrolled in the program. A-SMA issues provider contracts to physician applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the Alabama Medicaid Agency Administrative Code and the Alabama Medicaid Provider Manual. As per program integrity requirements, review is done at specified times as well as when provider behavior results in a review in compliance with federal Medicaid requirements.

Methodology: Alabama Medicaid provider eligibility status will be determined as a first step in the program registration process. Providers must be currently enrolled and eligible Alabama Medicaid providers in order to be eligible for MU through A-SMA. The SLR system currently provides files from the MMIS provider subsystem that enables the SLR system to verify the current provider status related to required ownership, control, relationship and criminal conviction information. While the CMS Registration and Attestation System audits against the national data bases, the Alabama system audits against the current Medicaid provider system to assure eligibility. If a provider is not eligible for "Active Medicaid Provider" status, has been suspended or denied for any reason, the SLR system will not allow the provider to create a user account. Alabama tracks against the exclusion information to the state from the CMS Registration and Attestation System. Alabama Medicaid cross-checks the OIG's website for list of excluded providers and maintains an updated list of providers excluded from participation in Alabama Medicaid. To further protect against payments for items and services furnished or ordered by excluded parties, all current providers and providers applying to participate in the Medicaid program are required (Alabama Medicaid Provider Manual, Chapter 7, Sections 7.3.1) to determine whether their employees and contractors are excluded individuals or entities.

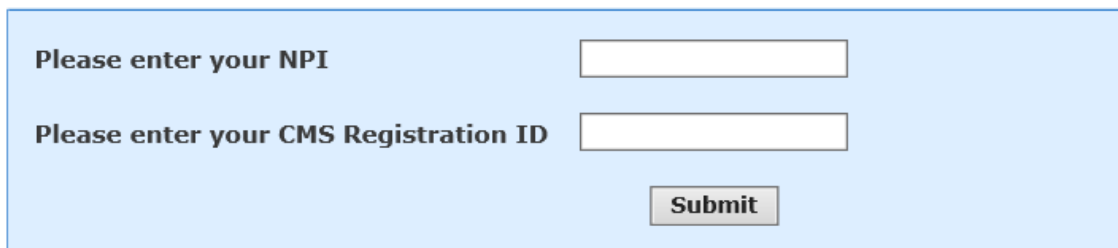
Initially, once the state reviewer completed the checklist, but prior to approval, A-SMA checked the provider against the list maintained by Program Integrity to determine whether the provider is under investigation, is under a recoupment status or has an action against him or pending. The automatic system validations for eligibility that are conducted throughout the attestation and

review precluded the need for this manual process and it was eliminated. Any change to the eligibility status to the provider is routinely and, on a real-time basis, updated in the Provider Master File.

Process: The process for approving issuance of Meaningful Use incentive payments has been provided earlier in Section 4. Alabama has partnered with HTS, , to implement the SLR through which eligible professionals and hospitals will establish their eligibility for incentive payments for meaningful use of electronic health record (EHR) technology and systems. The first phase of the EHR Incentive Program is a process that spans establishing eligibility to participate in the program with CMS at the national level, establishing eligibility to participate at the state level, attesting to the adoption, implementation or upgrade of a system certified by the CMS Office of the National Coordinator (ONC), meaningful use of the CEHRT for the period as required by the Provider’s MU Stage, and the state’s validation of that information for the purpose of authorizing issuance of the incentive payment.

The SLR account page establishes the provider’s identity. The information entered by the provider, National Provider Identifier (NPI) and CMS Registration ID , is compared to that entered into the CMS Registration and Attestation System. If the information is not found or does not match, an error message is returned and the provider must identify the source of the error and correct the problem at the CMS Registration and Attestation System.

Figure 28: SLR Account Page



The screenshot shows a light blue rectangular form with a thin blue border. Inside the form, there are two rows of text and input fields. The first row contains the text "Please enter your NPI" followed by a white rectangular input box. The second row contains the text "Please enter your CMS Registration ID" followed by another white rectangular input box. Below these two rows, centered horizontally, is a grey rectangular button with the word "Submit" written in black text.

The pre-payment review and validation process the state performs to exercise due diligence regarding licensure and sanctioning prior to issuing a payment to any provider or hospital (unless noted otherwise, the term provider will refer to an eligible professional or hospital) requires as a part of attestation that the provider confirm licensure and that no sanctions against the applicant are pending. The professional license number and provider status on the provider master file (PMF) will be validated by the SLR. The SLR confirms the provider’s NPI is registered in the CMS Registration and Attestation System and is valid in Medicaid’s Provider Master File Validation includes: PMF active is status and does not show a “sanctioned” status and does not show a status of deceased. If the provider receives an error message they must contact either the SLR Help Desk or the Medicaid Provider Enrollment section at the number provided on the screen. If there is a match, the following information is returned from the CMS Registration and Attestation System Record for an EP and EH:

Figure 29: EP

PMF Data for Provider: ARNOLD J TAURO			
IDs		General Information	
NPI	1558325308	Has Paid Claim	Yes
TIN	630903791	First Name	ARNOLD J
CCN		Middle Initial	
SSN	060905716	Last Name	TAURO
Alabama Medicaid Number	009971475	Business Name	ARNOLD J TAURO
License Number	25865	Address Line 1	200 HWY 280
Program		Address Line 2	
Taxonomy Number	208000000X	City, State, Zip	KELLYTON , AL, 35089-9710
CLIA Certification Type		County FIPS	19
Program Specific Provider Number		Phone Number	2562345021
Provider Type	31	Fax Number	2562345640
Duel Eligibility Indicator		Email Address	ped3@pacmd.com
Specialty Code	345	Enroll Status Code	(1) Active
		Hospital Bed Count	0
		Group Indicator	Y
		Dates	
		Enrollment Begin Date	4/1/2004 12:00:00 AM
		Enrollment End Date	2/14/2015 12:00:00 AM
		Create Date	11/15/2015 4:15:30 AM

Figure 30: EH

PMF Data for Provider: BAPTIST MEDICAL CTR SOUTH			
IDs		General Information	
NPI	1700977105	Has Paid Claim	Yes
TIN	203204949	First Name	
CCN		Middle Initial	
SSN		Last Name	
Alabama Medicaid Number	HOS0023H	Business Name	BAPTIST MEDICAL CTR SOUTH
License Number		Address Line 1	2105 E SOUTH BOULEVARD
Program		Address Line 2	
Taxonomy Number	282N00000X	City, State, Zip	MONTGOMERY , AL, 36116-2498
CLIA Certification Type		County FIPS	51
Program Specific Provider Number		Phone Number	3342882100
Provider Type	01	Fax Number	3342863368
Duel Eligibility Indicator		Email Address	
Specialty Code	010	Enroll Status Code	(1) Active
		Hospital Bed Count	454
		Group Indicator	N
		Dates	
		Enrollment Begin Date	7/1/1987 12:00:00 AM
		Enrollment End Date	12/31/2299 12:00:00 AM
		Create Date	11/27/2011 8:00:15 AM

4.2 HOW WILL THE SMA VERIFY WHETHER EPs ARE HOSPITAL-BASED OR NOT?

Standard: Hospital based as defined in the final regulation is an EP who furnishes 90 percent or more of his or her covered professional services in a hospital setting in the year preceding the payment year. The hospital-based exclusion is further defined as “90% or more of their covered professional services is in either an inpatient (POS 21) or emergency room (POS 23).

EPs can be excluded from the definition of hospital based if the EP can demonstrate that the EP funds the acquisition, implementation and maintenance of the Certified EHR technology, including supporting hardware and any interfaces necessary to meet MU without reimbursement from an EH or CAHA, and uses such Certified EHR Technology in the inpatient or emergency department of a hospital. EPs that can show they fund the acquisition, implementation and maintenance of the CEHRT can be determined to be non-hospital based.

Methodology: The SLR has a page that allows the provider to submit additional information that establishes the provider’s eligibility to participate in the program, including that the physician is *not* hospital based and that the provider has a valid Medicaid status. A setting is considered a hospital setting if it is a site of service that would be identified by the codes used in the HIPAA standard transactions as an inpatient hospital, or emergency room setting. The codes are: 21 for inpatient hospital and 23 for emergency room – hospital.

If an applicant is determined to be hospital based but wishes to be determined non-hospital based due to their funding of the acquisition, implementation and maintenance of CEHRT,

Alabama will utilize an administrative process to review the request based on the requirements and make a determination.

Process: The provider attests through “checkmark” that he/she does not provide 90% or more of services in an inpatient hospital (21) or emergency room setting (23). Provider is compared to the POS report maintained by the State and if POS 21 and/or 23 is greater than 75% and less than 90%, of *Medicaid* encounters, flag for post payment audit. The SLR system performs the validation process to confirm the provider’s credentials and status. The Agency will review Medicaid MMIS claims data reporting the number of Medicaid claims made during the representative period for which the physician is applying. If the percentage of claims showing POS 21 or 23 is above 75% and below 90%, the file is flagged for audit.

The state has created a Place of Service (POS) report generated from MMIS claims data. The report identifies the total number of POS 21 and 23 services thereby enabling the state to compare the number of hospital based services to total services. While this report is based on Medicaid claims data, it cannot be viewed determinative of the provider’s total patient services. Thus, the POS report is used as an indicator of the provider’s practice. If the POS report shows less than 75% of the provider’s service are hospital based, then the provider is likely to satisfy the requirement. If the POS report shows that the percentage is between 75 and 90, then the provider may be approved but is also flagged for a post-payment audit to confirm that the total services are actually less than 90%. If the report shows 90% or more, the provider’s total is likely to exceed 90% and the provider will be contacted to supply supporting documentation to prove eligibility. If the additional documentation cannot overcome the state’s conclusions, then the application will be denied and the provider advised of the appeal procedure.

If an applicant is determined to be hospital based but wishes to be determined non-hospital based due to their funding of the acquisition, implementation and maintenance of CEHRT, Alabama will first require the provider to submit appropriate supporting documentation and will consult with CMS prior to making a final determination.

4.3 HOW WILL THE SMA VERIFY THE OVERALL CONTENT OF PROVIDER ATTESTATIONS?

Standard: Alabama has implemented a thorough pre-payment validation of provider attestations to prevent improper Medicaid EHR Incentive payments and limit what must be done post-payment to address potential fraud, waste, and abuse.

Methodology: The overall process has been provided earlier in Section 4 with additional details related to licensure and location in Sections 4.1 and 4.2. A-SMA has also addressed the following in its pre-payment validation process either through SLR system edits and audits or review of documentation submitted by the EP or EH: practicing predominately in FQHC/RHC, EP/EH type, patient volume, certification of EHR and AIU. The focuses for the SLR system’s capability is to support a user-friendly application process and verification and completion of all required provider attestation data.

EP Process:

- *Provider Type:* Provider confirms HITECH provider type (pediatrician-20% threshold).

- *Patient Volume:* Medicaid Patient Volume/Total Patient Volume > or = 30%, 20% for pediatricians. The numerator and denominator Medicaid information entered by provider must be at least 20% of pediatrician patient volume and 30% of all other providers' total encounters. For purposes of determining patient volume effective payment year 2013, encounters include services rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability, including zero-pay claims and encounters with patients in Title 21-funded Medicaid expansions, but not separate CHIPs. Since Alabama's CHIP program is a stand-alone, those patients will not be counted.

The definition of encounters for Medicaid enrollees on a panel assigned to an EP has also expanded from previous 12 months to previous 24 months will be implemented to attestations submitted for program year 2013 forward; previous regulations and guidelines continued to apply to attestations through the 2012 grace period. A-SMA reviews the summary report from the provider's practice management system to substantiate the total patient volume. All Medicaid encounters for the numerator will be validated by the agency. A-SMA can generate a report from MMIS claims data that includes encounters, claims, services and number of recipients for every Medicaid provider by NPI for the 90-day period identified by the EP.

A-SMA continues to allow the use a representative period of 3 calendar months, beginning on the first (1st) of the month, rather than the exact 90-day period. This decision was based on administrative efficiency in ensuring consistency, accuracy or information, minimal confusion and easier manipulation and access of information from the MMIS. The report data is compared to the info submitted by the provider to determine the number of Medicaid encounters during the representative period.

Effective January 1, 2013, providers have the option to elect to use either a 90-day period in the previous calendar year, or in the 12 months immediately preceding the attestation. Alabama currently requires each provider to submit a workbook detailing how Medicaid encounters were determined and reports from an auditable source (such as a Practice Management System) to support the data submitted. Information on the State website, the SLR, and the workbook incorporate the expanded definition.

Attestations submitted for program year 2013 forward are allowed to include services rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability, including zero-pay claims and encounters with patients in Title 21-funded Medicaid expansions, but not separate CHIPs. Since Alabama's CHIP program is a stand-alone, those patients will not be counted. Zero-pay claims include claims: (1) denied because the Medicaid enrollee has maxed out the service limit, (2) denied because the service wasn't covered under the State's Medicaid program, (3) paid at \$0 because another payer's payment exceeded the Medicaid payment, and (4) denied because claim wasn't submitted timely.

An additional change that was accommodated effective payment year 2013 is the requirement for EP patient volumes that at least one of the clinical locations used has

certified EHR technology during the payment year for which the EP is attesting. Alabama will validate that at least one location used to establish EP's patient volume has certified EHR technology during the payment year.

If a provider submits managed care panel information that was not obtained from the Agency, A-SMA will obtain reports from the Patient 1st Program, in order to confirm panel information. If this additional information does not increase Medicaid patient volume to at least 30% (20% for pediatricians), the system creates a "STOP" and the provider is not able to complete the application. The provider may then contact A-SMA staff for assistance. SLR System will not allow provider to proceed if volumes do not meet criteria. If the provider must use patient encounters from the Maternity Program, or Medicare Advantage program, the provider must submit documentation substantiating the patient volume.

- *FQHC/RHC*: If a provider is attesting that he/she practices in an FQHC/RHC, the provider checks the status on the attestation agreement and A-SMA verifies the provider's employment in an FQHC/RHC through the state's MMIS claims system and Provider Master File. The EP must also submit CMS documentation that the facility is an FQHC or RHC and a letter from the FQHC or RHC board stating the provider meets the "practice predominantly" criteria as set forth by CMS.
- *Certified EHR Technology*: The provider must submit the certification number of the provider's ONC certified EHR Technology. The system validates the certification number against the ONC Certified HIT Product List database and AMA verify that the certification number submitted matches the EHR technology to which the provider attested. If the certification number does not match, A-SMA contacts the EP or EH representative for clarification. The provider can submit the correct certification number. In 2017, all Certified EHR Technology must meet 2014 ONC certification requirements however A-SMA implemented CMS enacted regulations that allow a provider to be able to attest to the use of other than a 2015 Edition CEHRT if the provider is not ready to attest to the optional Stage 3. The provider can continue to attest to a 2014 CEHRT, a 2014/2015 combination system, or a 2015 CEHRT if the provider is attesting to the Optional Stage 3 requirements for Program Year 2017 and 2018. The CMS approved addendum to the SMHP on 2/3/2017.
- *MU*: Effective payment year 2013, the SLR will accommodate the change in requirements that for EP patient volumes at least one of the clinical locations has certified EHR technology during the payment year for which the EP is attesting.

EH Process:

The SLR system validates that the percentage of Medicaid patients is 10% or above. All information to establish eligibility for the program is based on the hospital's annual cost report submitted to Medicare and to the Medicaid Agency. Staff compares the data submitted in the

SLR to the hospital cost reports. If the data submitted does not match the data on the cost reports, staff will contact the hospital representative for clarification.

As a final check, the attestation agreement is reviewed to confirm that the entries (7-10) match the information submitted in the SLR by the provider and is signed. If any of the above conditions are not met, A-SMA contacts the provider for a properly executed document and pends the attestation until receipt of the correct document.

Effective August 1, 2016 HTS , A-SMA contracted with HTS to provide staff and resources to directly support Medicaid in its administration of the Meaningful Use Electronic Health Record Incentive Program. As with the previous vendor, staff were contracted to conduct appropriate pre-payment reviews and payment/program reporting of EP attestations in accordance with A-SMA guidelines and submit recommendations to A-SMA for approval, rejection or further investigation by A-SMA. A-SMA staff perform secondary reviews attestations, apply policy decisions, determine whether the EP should be approved or rejected, and complete the payment process.

Figure 31: Pre-Payment Validation Checklist



Medicaid Approval Document

Provider Name, NPI		Medicaid ID	
Payee/Group, NPI		Medicaid ID	
HTS Reviewer		Date to AMA	
Program Year			
Complete the area below if the validation is returned to HTS.			
Date validation returned to HTS		Date	
Date validation returned to AMA for Approval		Date	
<p>During your review of the validations, please check below if an error or omission is discovered in one of the following categories:</p> <ol style="list-style-type: none"> Administrative error or omission such as erroneous information is entered into the validation field that does not affect the approval of the attestation. E.g. POS reported as 12% but MMIS data shows 28%. Critical error: The application of the validation guidelines is incorrect and the provider is not eligible. <p>Completely describe the error or omission (Administrative or Critical) in the Notes field.</p>			
Documents Submitted:			
	Yes	No	
Vendor Letter			SRA Compliance Form
EP Workbook			MU Dashboard Report
Practice Management Summary Report			Public Health Documentation
Screenshots: Drug/Drug & Drug Allergy Interactions & Drug Formulary			CQM Report
	Yes	No	
Attestation Component	Administrative Error or Omission	Critical Error or Omission	Notes
CEHRT CMS ID			CMS CEHRT ID: Vendor: Product: Version: Verified: HITECH/ONC CHPL Website
Place of Service 21 or 23			POS 21/POS 23 –
FQHC/RHC Status			Practice Predominantly Letter FQHC/RHC CMS letter
Needy Individual patient volume			
Medicaid Encounters (Numerator)			Representative Period: EP Workbook & PMS Report – date range matches Query, Provider Data, Variance
Total Encounters (Denominator)			Percentage with Query results/their denominator
Additional Medicaid Encounters (OB)			
MU Measures			Reporting Period Dates: Report Dates:

			Immunization Registry – Registration/Testing/Production – Date Name of Specialized Registry – Registration/Testing/Production – Date MU Requirements Met
CQMs			Reporting Period Dates: Report Dates: CQM Requirements Met
NOTES:			
RESPONSE:			
Recommendation for Approval			Recommendation for Rejection

Employee Name: Name

Date Completed: Date

Approved by: Name

Date Approved/Rejected: Date

The deployment of the administrative Dashboard in the SLR allows the State significantly more flexibility in reviewing, validating and approving attestations for payment. The State has the ability to process individual provider accounts and has real-time capabilities for certain functions. As a result, the state implemented a work flow process that permits provider attestations to be reviewed and approved and invoices submitted for payment on a bi-weekly basis, thereby reducing the delays required for the previous batch processing. For those providers that submit complete and acceptable documentation, payments can be processed in as little as three weeks (or 12-15 days) from submission. For those providers whose submissions are incomplete, the account can be pended and re-opened immediately allowing the provider to resubmit documentation. These SLR system enhancements have significantly improved the time frame for payment processing.

The following functionality is currently available:

- *Manage Providers*: allows the user to search for, view, and review the progress of providers' EHR Incentive submissions.
- *Manage Attestations*: allows the user to take action on or record information about a provider's attestation. Users can approve or reject attestations, view attachments, audit a completed attestation, take action on validation exceptions generated during an attestation, etc.
- *Verify Attestations*: allows the user to verify each provider's attestation application.

- *Approve Reject, or Unlock Attestations*: allows the user to approve attestations for payment, reject them, or unlock them to make modifications to the application and help the Provider resolve any issues.
- *Select Providers for Transmission*: allows the user to select providers that have no exceptions to be included in B7 or D16 data exchanges.
- *Audit Providers*: allows the user to perform Eligibility, Financial, and either Adopt, Implement, or Upgrade (AIU) or Meaningful Use audits on attestations. These audits are performed post-payment.
- *Adjust Financial Information*: allows the user to view and recoup or adjust payment information for providers.
- *Adjustments and Recoupments*: document these changes in the amounts paid to providers in SLR, including sending updates to CMS.
- *Appeals*: document and manage Appeals and communicate changes and results to CMS.
- *View Eligibility Queries*: allows the user to identify providers that are eligible, not eligible, or whether any providers had soft or hard stops on any of the attestation pages. For example, if required criteria documents were not attached, the attestation application would be ineligible.
- *Audit Queries*: queries are available that will display audited providers.
- *Run Reports*: allows the user to generate several reports to help to management of the project, such as NLR Applications Waiting on SLR, Providers with Volumes from Multiple States, Active Registrations Not Meeting Eligibility Threshold, etc.

The steps in the verification process have been incorporated into the SLR Administrative Dashboard and the reviewer updates the status in the SLR whether each provider meets each criterion. This verification is acceptance by the user that the appropriate update has been completed. This “Passed by User” is a literal value captured after the EP or representative of EH has verified that the information is correct. It is considered an accountability measure on the provider. The reviewer is also able to add Verification Items to alert other A-SMA staff to items that should be reviewed as part of the verification process, such as Pended items and whether the provider has been unresponsive to A-SMA efforts to request completion of the attestation.

The detailed description for each step is described and allows the reviewer to add notes, attachments as necessary and if the provider does not meet the criterion, that element is failed.

Figure 31c: SLR Administrative Dashboard Verification Screen

Verification History				
Item	Required	Description	Status	Exceptions
1	Yes	Place of Service	Passed by User	None
Last Updated: MNewboldAL 7/10/2013 1:51:57 PM				
2	Yes	FQHC/RHC Status	Passed by User	None
Last Updated: MNewboldAL 7/10/2013 1:52:22 PM				
3	Yes	Needy Individual Patient Volumes	Passed by User	None
Last Updated: MNewboldAL 7/10/2013 1:52:55 PM				
4	Yes	Medicaid Encounters (Numerator)	Unverified	None
Last Updated: acsopsAL 7/5/2013 1:22:12 PM				
5	Yes	Additional Medicaid Encounters (Numerator)	Failed by User	None
Last Updated: lbarber1 11/14/2013 11:33:56 PM				
6	Yes	Total Encounters (Denominator)	Passed by User	None
Last Updated: acsopsAL 7/15/2013 7:03:07 AM				
7	Yes	AIU Attestation Documents	Passed by User	None
Last Updated: acsopsAL 7/15/2013 7:06:13 AM				
8	Yes	Attestation Agreement	Passed by User	None

If the state elects to contact any provider for additional information; the reviewer may “Unlock” the application until the provider submits acceptable data. Once all elements are passed, the provider may be approved by the state.

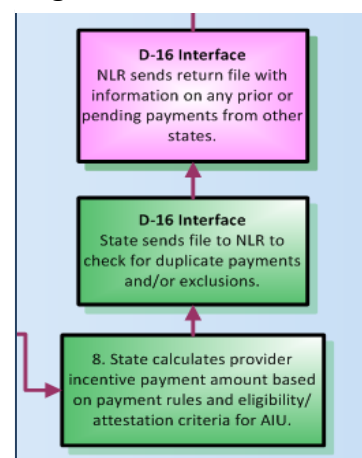
4.4 HOW WILL THE SMA COMMUNICATE TO ITS PROVIDERS REGARDING THEIR ELIGIBILITY, PAYMENTS, ETC.?

Standard: In addition to the attestation process communications indicated in 4.3, the state has established an additional notification for hospitals that are participating in both the Medicaid and Medicare Programs. EHs, unlike EPs, may participate in and receive EHR incentive payments under both Medicare and Medicaid EHR incentive programs during the same federal fiscal year. When applying under both programs during the first year of participation, it is important that the EH understands the differences in the two programs before deciding which program to apply to first. Under Medicaid, an EH may choose to receive its first payment based on the AIU option. AIU is not available to an EH under the Medicare program. A-SMA has created a communication tool to notify potential EHs prior to their selection of which program to apply to first.

A-SMA’s strategy for communicating the changes that have resulted from the final regulation for MU Stage 2 include providing information on the State website, the SLR and the workbook that are a part of the attestation process. In addition, provider outreach efforts include targeted e-mails, webinars and website updates; dissemination of information to provider associations; and for those providers who were not eligible for the previous program year, at the request of the providers Medicaid staff will continue to work with each provider to exhaust every effort to establish eligibility for the incentive program.

In order to help educate providers, A-SMA also makes available a workbook on the SLR portal that contains all the steps for

Figure 31: SLR interface



completing the incentive payment registration and attestation process. Prior to entering data into the actual SLR, eligible providers and hospitals must complete the workbook to assemble the information that will establish eligibility. The Agency requires that the workbook is loaded into the SLR with all other attestation documents. The EP workbook has been updated with the changes that resulted from the Stage 2 regulation that affected Stage 1 requirements.

A separate workbook is available for EPs and EHs. To improve the quality and accuracy of the information submitted and reduce the risk of potential errors, every EP and EH must submit the workbook as part of the attestation process. If the document is not uploaded, the provider is contacted with a request to submit the document. The attestation will then be pended so the workbook and any other additional documents can be submitted. A separate workbook has been developed for EHs submitting attestations for Program Years 2 and 3.

Providers confirm the Medicaid ID number of the designated Payee and, if there are more than one Medicaid IDs, they must select the Medicaid ID to receive payment. If the payment is to be made to the individual provider, it is made by a manual check and the provider is informed during the review process that they must submit a W-9 prior to payment. Providers may submit the W-9 by uploading it to the SLR portal.

Methodology: A-SMA has created a communication tool for potential EHs that include the following chart for hospitals participating in both the Medicare and Medicaid Programs. Once a provider incentive payment amount has been calculated based on CMS payment rules, A-SMA communicates the payment to the EP/EH.

Table 20: Hospitals Participating In Both Medicare and Medicaid

Payment Year	Medicaid Incentive Program Only	Medicaid 1 st , then Medicare in same FY	Medicare 1 st then Medicaid in same FY / Medicare 1 st , then Medicaid in a later FY
1 st payment yr.	AIU	AIU (Medicaid); MU, 90 day reporting period (Medicare)	MU, 90 day reporting period
2 nd payment yr.	Stage 1 MU, 90 day reporting period	Stage 1 MU, 12 month reporting period	Stage 1 MU, 12 month reporting period
3 rd payment yr.	Stage 1 MU, 12 month reporting period	Stage 1 MU, 12 month reporting period	Stage 1 or Stage 2 MU, 12 month reporting period depending upon program year.

*If the usual 12 month reporting period occurs in 2015, the reporting period is 90 days.


Process: All EHs are encouraged to carefully consider the requirements and limitations under both programs before making a decision on whether they will apply first to Medicare or Medicaid. An EH may apply under the Medicaid incentive program first in order to take advantage of the AIU option with the last year to AIU being for Program Year 2016. After approval and payment under the Medicaid AIU option, the EH may then attest under Medicare wherein it will still have to meet Medicare’s meaningful use requirements for the first year payment. This includes attesting to a 90-day reporting period for Stage 1 Meaningful Use (MU). Since the

Medicare incentive program does not have an AIU component for EH, an EH that chooses to participate in the Medicare EHR incentive program first, will have to be a meaningful user. This means the EH will have attested to a 90-day reporting period for Stage 1 MU. If during the same federal fiscal year the EH chooses to subsequently apply for a payment under the Medicaid program that EH will be “deemed” a meaningful user for the Medicaid program and the AIU option will not be available to that EH. Under this deeming scenario, the 90-day reporting period and MU data reported for Medicare will be carried over to Medicaid. The 4th column of the above table describes the effect of attesting under Medicare before applying to Medicaid.

A communication has been developed to notify EHs that if an attestation is made to Medicare first and there is no subsequent attestation to Medicaid until the following year that first Medicaid attestation will have to be based on a full year reporting period.

The A-SMA has also worked closely with the Alabama Hospital Association to educate eligible hospitals. To date, 89 Alabama EH hospitals have attested and only one has elected to attest to Medicare prior to attesting to Medicaid. In its effort to communicate to dual eligible EHs the significance of the proper sequence of attestation between Medicare and Medicaid, for the 2014 Program Year, Alabama has prepared the document below containing the current status of attestations for each EH and guidance for next steps to avoid issues with the proper sequence for attestations.

Figure 32: EH Guidance for Submission



ELIGIBLE HOSPITAL APPLICATION SUBMISSION PLAN 2013 - 2014

Based on recent changes by CMS to the CQM Reporting Requirements, this instruction document has been prepared by the Alabama Medicaid Agency and customized for the specific use of the Eligible Hospital (EH) named below. It is designed to identify and provide instructions on how the EH should prepare and submit its application for its next program and payment year based on the latest information in the EH's account in the State Level Registry (SLR). By following these instructions, the EH can minimize the chance of problems or delays in the review and approval of its application by Medicaid.

To assist Alabama hospitals with identifying Meaningful Use attestation time frames, we have identified the existing completed or in-process attestations for your hospital as well as the submission requirements for the next Payment Year for which your hospital is eligible for payment.

ELIGIBLE HOSPITAL IDENTIFICATION				
NAME: XYZ Hospital of Alabama			NPI: 1234567890	
ATTESTATION HISTORY				
PROGRAM YEAR	PAYMENT YEAR	ATTESTATION TYPE	STAGE	EHR REPORTING PERIOD
2011	1	AIU	-	N/A
2012	2	MU	Stage 1	90-Days
NEXT APPLICATION PROGRAM YEAR REQUIREMENTS				
IF SUBMISSION IS FOR PROGRAM YEAR...	YOUR PAYMENT YEAR IS...	APPLICATION TYPE	STAGE	EHR REPORTING PERIOD
2013*	3	MU	Stage 1	1-Year MU and 1-Year Electronic CQM Reporting Period
2014	3	MU	Stage 2	90-day Meaningful Use Reporting Period and 1-Year Electronic CQM Reporting

* → Our records show that your hospital has submitted an attestation to Medicare for Program Year 2013 and the file has been received by Medicaid. You are eligible to proceed with your 2013 Medicaid attestation. You have until 12/30/13 to submit your attestation for 2013.

Please read the attached documents and if you have questions or need additional guidance afterwards, please feel free to contact Alabama Medicaid Agency at (334) 353-3489 or (334) 353-3489.

4.5 WHAT METHODOLOGY WILL THE SMA USE TO CALCULATE PATIENT VOLUME?

Standard:

- EP Patient Volume:** Alabama is following the regulation established criteria for EPs who are not pediatricians or FQHCs/RHCs that the EPs have a minimum of 30 percent of all patient encounters attributable to Medicaid (20 percent for pediatricians) over any continuous, representative 90-day period within the most recent calendar year prior to reporting through payment year 2015. The denominator is all patient encounters for the same EP over the same 90-day period.

- Although Medicaid MCO use is not significant in Alabama, the Patient 1st Medical Home Program is a managed care model for purposes of calculating patient volume as authorized in the regulation: $\{[\text{Total (Medicaid) patients assigned to the provider but not seen in any representative continuous 90-day period in the preceding calendar year, with at least one encounter taking place during the calendar year preceding the start of the 90-day period}] + [\text{Unduplicated (Medicaid) encounters in the same 90-day period}]/[\text{Total patients assigned to the provider but not seen in that same 90-day period, with at least one encounter taking place during the calendar year preceding the start of the 90-day period}] + [\text{All unduplicated encounters in that same 90-day period}]\} * 100$

Effective payment year 2013, EPs have the option to elect to use either a 90-day period in the previous calendar year or 12 months of the calendar year in which the program year falls that the provider is attesting. In addition, an expanded definition of encounters has been implemented to attestations submitted for program year 2013 forward. Encounters includes services rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability, including zero-pay claims and encounters with patients in Title 21-funded Medicaid expansions, but not separate CHIPs. Since Alabama's CHIP program is a stand-alone, those patients will not be counted.

Zero-pay claims include claims: (1) denied because the Medicaid enrollee has maxed out the service limit, (2) denied because the service wasn't covered under the State's Medicaid program, (3) paid at \$0 because another payer's payment exceeded the Medicaid payment, and (4) denied because claim wasn't submitted timely.

- *FQHC/RHC Patient Volume:* EP practicing predominantly at an FQHC or an RHC when the clinical location for over 50 percent of his or her total patient encounters over a period of 6 months occurs at an FQHC or RHC. An EP meeting this definition would be allowed to count enrollees who are Medically Needy, including CHIP and uninsured as well as Medicaid in their patient volume thresholds.

The same changes that were implemented 1/1/13 for Medicaid patient volume are accommodated for "needy individuals" for purposes of FQHCs/RHCs patient volume. For example, Alabama took the option to allow EPs and EHs to calculate total Medicaid encounters for Medicaid patient volume for "90-day Representative Period" across last 12 months prior to the EPs or EHs attestation. The State took the same option for the "needy population" for the FQHC calculation.

- *EH Patient Volume:* The requirement is for 10% Medicaid hospital patient volume. Alabama has the also taken the option effective payment year 2013 to allow EHs to calculate total Medicaid encounters for Medicaid patient volume for "90-day Representative Period" across last 12 months prior to the EHs.

Methodology: Alabama is using the CMS specified definitions provided in the regulation. However, for the 90-day representative period, the A-SMA utilizes a 3-consecutive calendar month period. This significantly increases the efficiency and ease of accessing MMIS data, the

accuracy and consistency of the data. Effective payment year 2013, Providers have the option to elect to use either a 3 consecutive calendar month period in the previous calendar year or 12 months of the calendar year in which the program year falls that the provider is attesting. Alabama currently requires each provider to submit a workbook detailing how Medicaid encounters were determined and reports from an auditable source (such as a Practice Management System) to support the data submitted. The EP Workbook has been updated and information on the State website and the SLR will be revised to incorporate the expanded definition.

- *EH Patient Volume:* For purposes of calculating the 10% Medicaid hospital patient volume, Medicaid Patient Volume is determined by dividing the Total Medicaid Inpatient Discharges by the Total Hospital Inpatient Discharges; however, hospitals may also include Emergency Room/Department (ER) encounters in these numbers in order to achieve the minimum patient volume requirement. If ER encounters are used, the EH must designate the location in the Cost Report or the source documents for the hospital where these numbers can be found. Alabama includes general short-term hospitals, cancer hospitals, and critical access hospitals that meet the Medicaid patient volume criteria. Figure 33 represents the online EH workbook that captures the necessary data from the EH's cost report that must be submitted in the SLR. This online workbook also automatically calculates the EH incentive payment. The completed workbook must be saved and a copy uploaded to the SLR as an attachment as part of the EH's application.

Overview: This workbook is designed to help you collect information needed to complete the Eligibility components of the SLR. It is designed to gather detailed information regarding your hospital and create summarized data for entry into the SLR. You can also use this workbook to estimate your Alabama Medicaid eligibility based on your patient volumes.

General instructions for completing this workbook:

1. Each eligible hospital must complete all worksheets and retain a copy for the hospital records for a period of 6 years.
2. The information entered on the About You worksheet is entered on the About You page in the SLR. The information entered on the Discharges and Demographics worksheets are entered on the Confirm Medicaid Eligibility page in the SLR.
3. This workbook is designed for the eligible hospital only. Different worksheets are used for Eligible Professionals and Groups.
4. When you have completed using this workbook to enter your information into the State Level Registry (SLR), you must upload this completed workbook to the SLR. Do this at Step Two in the SLR. Note: If you use data from your General Ledger or other reports or business records for

Charity and Uncompensated Care, or Emergency Room encounters, you must also upload the pages that identify the report and contain this information.

5. To ensure reporting the correct data from your cost report, refer to workbook tab "Cost Report References" for assistance.

Update data from this worksheet in the About You Page of the SLR.

About You

The information you provide to the Alabama SLR is in addition to the information you provided when you registered with the NLR. This additional information is used by the State of Alabama to determine your eligibility to participate in Alabama's Medicaid Meaningful Use Incentive Payment Program.

Contact Person

Contact Person Phone Number

Contact Person E-mail Address:

Please provide the information below about the person completing the Worksheet

Name:

Phone:

Email:

NAME OF HOSPITAL:

Enter the data from this worksheet in the Confirm Eligibility Page of the SLR

Determining 10% Patient Volume

In order to be eligible for the Meaningful Use Incentive Payment Program, EHs must meet a minimum 10% Medicaid patient volume during a specified representative period.

You must specify a "**Representative Period**" from which you will obtain the necessary data to establish Medicaid eligibility. The designated Representative Period is the one year period covered by the hospital's most recently audited or filed cost report for the period ending anytime during the preceding federal fiscal year (FFY), or any continuous 90-day period (Alabama requires using 3 calendar months for this option) that begins on the first day of a month and also ends wholly within the preceding FFY. Alabama requires use of the cost report unless using the 90-day period is the only way to meet the minimum 10% Medicaid patient volume requirement.

Effective January 1, 2013, EH's may also choose any continuous 90-day period, which is 3 calendar months for Alabama, during the 12-month period immediately preceding the date of application.

Medicaid Patient Volume is determined by dividing the Total Medicaid Inpatient Discharges by the Total Hospital Inpatient Discharges; however, nursery/newborn days and swing beds must not be included in these totals. Hospitals may also include Emergency Room/Department (ER) encounters in these numbers in order to achieve the minimum patient volume requirement. If ER encounters are used, designate in the space provided below the location in the Cost Report or the hospital source documents where these numbers can be found. All data reported via the SLR or relied upon for that purpose must come from auditable sources. Alabama has designated the hospital's audited (or filed) cost report as the primary acceptable source document. See the workbook tab "Cost Report References" for identifying the appropriate cost report data.

Whenever other hospital Business Records are used, or any other documentation other than the cost report, to support or supplement documentation for data not included or readily identifiable in the cost report, the report or documentation must clearly show the name of the hospital and period from which the data is obtained. If not a report that automatically prints the identifying information on the report, that information may be hand-written on the report along with the name of the person preparing the report.

It is important to note that the supporting documentation for the reported data must be attached to the application in addition to this EH Workbook. When using cost report data, the appropriate pages from the cost report, with the specific numbers pointed out, must be attached. If the EH elects to use a 90-day representative period (3-calendar months) instead of the cost report period, it is imperative to identify and attach the source documentation for the reported data with the reported numbers specifically pointed out. If this documentation is not attached, the application will not be approved.

CAUTION! If the EH finds that a 90-day Representative Period must be used, the cost report information and documentation must also be submitted to show that it is insufficient to satisfy the Medicaid patient volume requirement and justifies the use of the 90-day period. If that cost report information is not included, the attestation will not be approved and the attestation will have to be Pended so that it can be resubmitted with the complete documentation.

Start Date Of Representative Period	
End Date of Representative Period	
<input type="checkbox"/> Using hospital cost report data and/or <input type="checkbox"/> Using other hospital business records	

Total Medicaid Inpatient Discharges <small>(S-3, Column 14, Line 12)</small>	0	+	Total Medicaid ER Encounters <small>(Designate CR location or data source below)</small>		=	Total Medicaid (Encounters)	0
Total Inpatient Discharges <small>S-3, Column 15, Line 12)</small>	0	+	Total ER Encounters <small>(Designate CR location or data source below)</small>		=	Total Patients (Encounters)	0
Medicaid Patient Volume							#DIV/0!
Source of ER Encounter Data (attach documentation)							

Average Length of Stay	=	Total Inpatient Bed Days	0	/	Total Discharges	0	=	#DIV/0!	Days
<p>(This number will be calculated based on entries in other fields.)</p> <p style="text-align: center;">Note: Nursery or newborn days, and swing beds, must NOT be included in the totals for inpatient bed days or discharges.</p>									

Incentive Payments	Percentage of Total Incentive
First Incentive Payment	50%
Second Incentive Payment	30%
Third Incentive Payment	20%
Total Incentive Payments	100%

- EP Patient Volume:* Pediatricians, who achieve a 20% volume, may qualify to receive a reduced payment amount. Encounter counts are based on the rendering (aka performing) provider, a supervising physician may add the encounters of a nurse-practitioner as part of the physician’s volume calculation. If an Eligible Provider practices at multiple sites, one or all sites can be used to compute patient volume. Through payment year 2012, an Eligible Provider must have at least 50% of all patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with the certified EHR technology. Effective payment year 2013, an EP must have the certified EHR technology at one of the locations during the EHR reporting period.

Related to “PA led,” Alabama follows the regulation definitions and make a determination from the current MMIS provider data on the eligibility of an Alabama PA: when a PA is the primary provider in a clinic (for example, when there is a part-time physician and full-time PA, the state would consider the PA as the primary provider); when a PA is a clinical or medical director at a clinical site of practice, or when a PA is an owner of an RHC.

Alabama allows clinics and group practices to use the practice or clinic Medicaid patient volume (or needy individual patient volume, insofar as it applies) and applies it to all EPs in their practice under three conditions: clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP; there is an auditable data source to support the clinic's patient volume determination; and the practice and EPs decide to use one methodology in each year. For “panel member” methodology effective payment year 2013, Alabama has taken the option to look-back for at least one Medicaid encounter in the last 24 months rather than 12 months prior to the 90-day representative period. Patient panel methodology requires at least one Medicaid encounter taking place in the 24 months prior to 90-day period.

An EP who works at multiple locations but does not have certified EHR technology available at all of them would have to have 50% of their total patient encounters at locations where certified EHR technology is available as the state must base all meaningful

use measures only on encounters that occurred at locations where certified EHR technology is available. At least one of the clinical locations used for EP patient volumes is required to have certified EHR technology during the payment year for which the EP is attesting. Alabama will validate the attestation that one location used to establish EP's patient volume has certified EHR technology during the payment year as a part of the post-payment audit.

The SLR requires the EP to identify the location of the EHR to which the attestation for the incentive payment is submitted. Effective payment year 2013, SLR functionality exists to accept multiple locations and allow providers to attest that 50% of encounters are at locations with certified EHR technology.

The patient volume methodology that is used by the state is provided by the state to potential EPs so they can determine their individual patient volume. The steps of the A-SMA methodology are provided in the following patient volume worksheet. Changes have been made to the worksheet for 2013 that address the changes to patient volume definition, look-back period, etc.

- *EH Patient Volume:* Since there is no Medicaid patient volume for Children's Hospitals, A-SMA made sure no unnecessary barriers were established that could delay participation by the children's hospital. The definition of a Children's Hospital has been revised to include 'any separately certified hospital, freestanding or hospital within a hospital that predominately treats individuals under 21 without a CMS certification number because they do not serve Medicare beneficiaries'. These hospitals will be issued an alternative number by CMS to enroll in the incentive program (Payment has already been received by Alabama's two children's hospital).

4.6 WHAT DATA SOURCES WILL THE SMA USE TO VERIFY PATIENT VOLUME FOR EPs AND ACUTE CARE HOSPITALS?

Standard: The data for the total patient volume (denominator) is not available within the Medicaid data base (MMIS). Total Patient Volume for EPs must be drawn from the provider's practice management system. Total Patient Volume for an EH is derived from the EH's cost report. For an FQHC/RHC EP, Medically Need patient totals are also obtained from the facility's practice management system.

Methodology:

- *EH Patient Volume:* All data reported or relied upon for these purposes must come from auditable sources. Alabama has designated the hospital's auditable cost report as the primary acceptable source document. Other hospital Business Records may be utilized to supplement documentation for data not included or readily identifiable in the cost report. The designated Representative Period is the one-year period covered by the hospital's most recently auditable cost report, or any continuous 90-day period that begins on the

first day of a month and also ends within the one year period covered by the most recent auditable cost report through payment year 2012. Effective payment year 2013, Providers will have the option to elect to use either a 90-day period in the previous calendar year or 12 months immediately preceding the attestation. Alabama currently requires each provider to submit a workbook detailing how Medicaid encounters were determined and reports from an auditable source (such as a Practice Management System) to support the data submitted. Information on the State website, the SLR, and the workbook have been revised to incorporate the expanded definition.

The hospital may choose whichever period allows it to meet the minimum 10% Medicaid patient volume requirement. In either case, the one-year period covered by the cost report must have ended at some time within the 12-month period preceding the start of the current federal fiscal year.

Medicaid Patient Volume is determined by dividing the Total Medicaid Inpatient Discharges by the Total Hospital Inpatient Discharges; however, hospitals may also include Emergency Room/Department (ER) encounters in these numbers in order to achieve the minimum patient volume requirement. If ER encounters are used, the EH must designate in the space provided below the location in the Cost Report or the source documents for each hospital where these numbers can be found.

- *EP Patient Volume:* All data entered in the SLR must be derived from an auditable data source and is subject to State verification and audit. Medicaid encounters will be verified by the State from its Medicaid Management Information System (MMIS) paid claims data. Non-Medicaid encounters must be drawn from Providers' practice management systems or other auditable data sources and will be subject to State audits.

"Encounter" is re-defined effective January 1, 2013, but the process remains the same; thus, providers must be sure of how they evaluate the data from their practice management systems and ensure that they are counting encounters only. The data source for patients within the Medicaid Maternity Care Program in which Providers are paid a global fee that covers all prenatal, delivery and post-partum services is the EP's practice management system. For patients for whom Medicaid paid Medicare Part B, the EP's practice management system is also the data source. Many times a Medicaid claim may not be submitted to the State's MMIS claims system for these patients so the EP must be able to identify Medicare patients who were also Medicaid recipients during the representative period from his/her practice management system. The list must contain the patient's Medicare number and dates of service. If the Part-B premium was paid and the encounter was not counted as a Medicaid encounter, then each unduplicated date of service will count as one encounter and added in the numerator only. If no premium was paid, the patient cannot be counted.

Individual Eligible Providers who find that they do not meet the patient volume requirement on their own and are members of a group practice may be able to use the encounters of the entire group to meet the requirement. The encounters for each

member of the group must be counted and added together for a group total. Encounters billed only under the group's NPI, and not to a rendering provider, may be added to the total (and must be counted in the same manner as for EPs described above).

- *FQHC Patient Volume:* Medically Needy patient volumes submitted must be supported by data from the provider's Practice Management System report or a cost report must be submitted to support the Medically Needy volumes. Changes as a result of the Stage 2 regulation for Stage 1 related to medically needy patient volumes has been incorporated into the A-SMA policy, SLR and business processes.

4.7 HOW WILL THE SMA VERIFY THAT EPs AT FQHC/RHCs MEET THE PRACTICES PREDOMINATELY REQUIREMENT?

Standard: An EP practices predominantly at an FQHC or an RHC when the clinical location for over 50 percent of his or her total patient encounters over a period of 6 months occurs at an FQHC or RHC through payment year 2012. Effective January 1, 2013, Alabama application will define "Practices Predominantly" to include within the most recent calendar year or within the 12-month period preceding attestation.

Methodology:

- Does the EP practice in a setting other than the FQHC/RHC? If not, standard is met.
- If the EP practices in a setting other than the FQHC/RHC, are over 50 percent of his/her total patient encounters over a period of 6 months at the FQHC/RHC or at other locations? If at the FQHC/RHC, standard is met. If not, it is not. If the EP practices at both a Federally Qualified Health Center (FQHC) and within his or her individual practice, certified EHR technology would have to be available at the location where the EP has at least 50 percent of their patient encounters.

Process: EPs must attest to their denominator and in attesting to the denominator of their total book of business, A-SMA requires that the EP state locations of practice, including FQHCs/RHCs and total population by location. The agency validates the provider's employment in an FQHC/RHC. Where the EP states he/she is full-time at the FQHC/RHC and the APHCA information confirms, the standard is met. (For auditing purposes, A-SMA may cross check the provider's enrollment history and claims data to determine if Medicaid has been billed by the provider outside the FQHC. If a discrepancy is found, further action will be pursued).

Where the EP is less-than full time, A-SMA will make a determination of "predominantly at an FQHC". If the EP is less than full time but the EP can reach the 30% standard using Medicaid enrollees only from non-FQHC/RHC locations, no further action is required and the EP is eligible. If the EP cannot reach the 30% standard with Medicaid encounters, then a determination of "predominantly at an FHQC/RHC" will be made. If there is a discrepancy of over a designated percent and volumes cause the Medicaid percentage to drop below 30% (20% for pediatrician), the provider is ineligible. Discrepancy cases will be flagged for post payment audit.

4.8 HOW WILL THE SMA VERIFY ADOPT, IMPLEMENT OR UPGRADE (AIU) OF CERTIFIED ELECTRONIC HEALTH RECORD TECHNOLOGY BY PROVIDERS?

Standard for Adopting, Implementing or Upgrading: providers may receive a first year of payment if they have installed and commenced utilization of certified EHR technology (as “a qualified electronic health record (as defined in section 3000(13) of the Public Health Service Act) that is certified pursuant to section 3001(c) (5) of such Act as meeting standards. There is no EHR reporting period for demonstrating adoption, implementation or upgrading certified EHR technology by Medicaid EPs and EHs, but the entity must be registered with the CMS Registration and Attestation System and select Alabama as the payment state. Since EPs/EHs can switch prior to payment, review of the CMS Registration and Attestation System prior to payment is completed through the state submitting a file to the CMS Registration and Attestation System for verification.

Methodology: EPs and EHs must attest to AIU and provide evidence that demonstrates actual purchase/acquisition and or installation. The EP or EH must submit the certification number of the provider’s ONC certified EHR Technology as a part of the registration and attestation process. The EP and EH must sign and attach the Attestation Agreement.

Process: The state validates that the appropriate documents are submitted for attestation against the following list: receipts for software EHR vendor, sales contract, agreement, and screenshot of the sign on the EHR, a copy of the agreement for upgrade, vendor letter, containing vendor name, version and certification number, and work plan (EH), cost report, invoice, or other reasonable documents. If there is no document or it is not one of the documents listed above, the state contacts the provider to request correct documents. If the document provided does not match the EHR system described, the state will contact the provider. In any of these situations, the state will pend the application for submission of appropriate documents.

The SLR system validates the certification number against the ONC Certified HIT Product List database. The system verifies that the certification number submitted matches the EHR technology to which the provider attested. If the certification number does not match, the provider is unable to proceed with the application. The state then contacts the EP or EH for clarification. The application pends in the meantime. Pended applications are reviewed periodically and the provider is sent follow-up e-mails and, if no response, telephone calls.

If the attestation agreement is present, CEHRT information exported from the SLR to the document matches information submitted by the provider, and the signature of EP of record or EH representative is present, the EP/EH is eligible for payment.

4.9 HOW WILL THE SMA VERIFY MEANINGFUL USE OF CERTIFIED ELECTRONIC HEALTH RECORD TECHNOLOGY FOR PROVIDERS’ SECOND PARTICIPATION YEAR?

Standards: In order to receive Medicaid incentive payments, providers will be required to demonstrate - and A-SMA will track and validate - meaningful use of CEHRT for all periods beyond the initial option to receive incentives for AIU. In support of Alabama Medicaid and other

provider’s effort to reach and maintain meaningful use status, Alabama One Health Record® AHIE S/OPs has made e-Prescribing, structured lab results and clinical exchanges core functionalities. One Health Record® went “live” April 2012.

In response to the regulatory changes for Stage 1 MU, A-SMA implemented January 1, 2013, the mandatory and optional changes into Alabama’s policy, SLR and business processes. This includes changes to the A-SMA audit protocol. The audit strategy is provided in detailed in Attachment 8.15.

Methodology: Starting in 2012, meaningful use objectives and clinical quality measure results were reported to the state by EPs and EHs to demonstrate that they have used EHR technology in a meaningful way.

The changes effective payment year 2013 related to the reporting of measures are provided in the following Table 20a.

Table 20a: Payment Year 2013 Changes to Reporting Measures for Objectives

Attestation Component	System Validation	State Action	Provider Action
Additional Alternate Measure for CPOE Objective	<p>A-SMA accommodated the additional optional measure for 2013 for the CPOE objective: More than 30% of the medication orders created by the EP or authorized providers of the EH’s or CAH’s inpatient or ER (POS 21 or 23) during the EHR reporting are recorded using CPOE.</p> <p>The current measure option will be retained: 30% of unique patients with at least one medication in their medication order entered using CPOE.</p>	<p>A-SMA:</p> <ul style="list-style-type: none"> • Information on the State website and SLR has been revised to incorporate the change to the objective. • Provider Outreach includes (1) e-mail, webinars, website updates, and dissemination of information to provider groups (provider and hospital associations), and (2) coordination of AL-REC to engage CAHs to achieve MU. 	<p>SLR: The SLR was revised to allow this objective as optional as of January 1, 2013, for 2013 onward.</p>
Additional e-Prescribing Exclusion	<p>Alabama has accommodated the required addition of an additional e-prescribing exclusion that may be claimed by any EP who does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP’s practice location at the start of his/her EHR reporting period.</p>	<p>A-SMA: Required for 2013 forward for EPs attesting to Stage 1 of MU.</p> <p>Information on the State website and SLR have been revised to incorporate the change.</p> <p>Provider Outreach includes e-mail, webinars, website updates, and dissemination of</p>	<p>SLR: The SLR has been revised to support this requirement for EPs attesting to Stage 1 of MU.</p>

Attestation Component	System Validation	State Action	Provider Action
		information to provider associations,	
Vital Signs Addition of Alternative Age Limitations	A-SMA has accommodated this optional measure for 2013 and made it mandatory 2014 that affect the age limitations on growth charts and blood pressure. More than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data.	<p>The definition for a second denominator has been added with the ability for the user to indicate which denominator they are using for reporting.</p> <ul style="list-style-type: none"> • Information on the State website and SLR were revised to incorporate the change. • Provider Outreach includes e-mail, webinars, website updates, and dissemination of information to provider groups (provider and hospital associations). • Coordination of AL-REC to engage CAHs to achieve MU. 	SLR: The SLR has been revised to support this option for 2013 only for EPs attesting to Stage 1 of MU.
Vital Signs Exclusions Change	<p>A-SMA has accommodated the following optional modifications to the exclusions for 2013 and make them mandatory 2014:</p> <ul style="list-style-type: none"> • Any EP who sees no patients 3 years or older is excluded from recording blood pressure • Any EP who believes that all three vital signs of height, weight and blood pressure have no relevance to his/her scope of practice is excluded from recording them • Any EP who believes that height and weight are relevant to his/her scope of practice, but blood pressure is not is excluded from recording blood pressure • Any EP, who believes that blood pressure is relevant to his /her scope of practice, but height and weight are, 	<p>A-SMA:</p> <ul style="list-style-type: none"> • Information on the State website and SLR has been revised to incorporate the change. • Provider Outreach includes e-mail, webinars, website updates, and dissemination of information to provider associations, 	SLR: The SLR has been revised to support this as optional for 2013 only for EPs attesting to Stage 1 of MU and makes it required for 2014.

Attestation Component	System Validation	State Action	Provider Action
	not, is excluded from recording height and weight.		

The changes to the Core and Menu measures and CQMs identified in the Final Rule that were effective in Program Year 2014 were included in the SLR. The screen shots have been submitted to and approved by CMS and are included in Appendices 8.17 and 8.18 and include those corrections to CQMs issued by CMS on 9/26/2013.

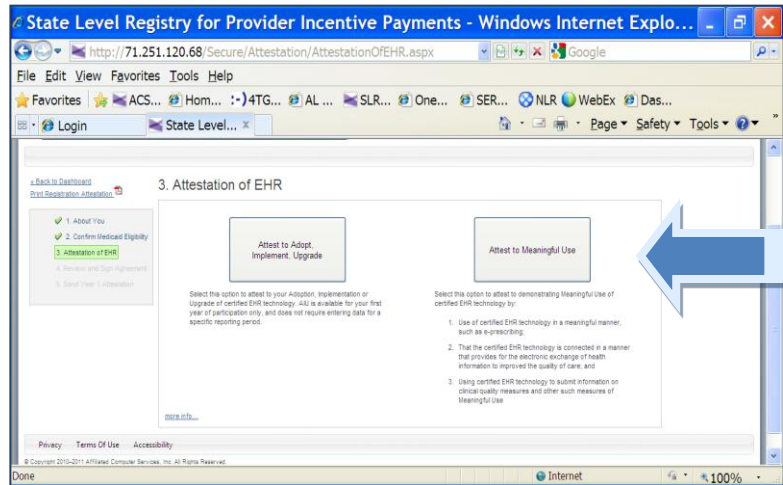


Figure 42: Screenshot to Attest to MU

A-SMA has engaged in a similar process for the changes to the core and menu measures effective in Program Year 2015. The screen shots, previously submitted to CMS by the State of Alaska, have been approved. Figure 42 demonstrates the opening screen. Screenshots for changes for Program Year 2016 and 2017 have been submitted and approved as of (date). Screenshots for changes for Program Year 2018 are incomplete at the time of this update and will be submitted when available. After the last submission that addressed 2015-2016 and Stage 3 changes, an addendum was submitted and approved for all Program Year 2017 updates. An addendum will again be submitted for Program Year 2018 but those modifications and system changes are not yet available at the time of this submission.

Process: CQMs are reported during the attestation process along with the meaningful use objectives. Providers enter the denominator, numerator and any applicable exclusion results directly into the attestation system. A-SMA will continue many of the steps of Payment Year 1 (for AIU) into the MU processes, but has added appropriate additional technical functionality and business processes to address the new parameters, including the EHR certification period and MU core objectives. A-SMA’s vendor (XEROX) went “live” with the MU phase in April 2012.

Alabama EPs and EHs will follow the same basic process for attesting for MU as was followed for AIU. However, EPs and EHs will be attesting to use of their certified EHR in a meaningful way. To allow providers to attest to core objectives, the SLR provides a screen that identifies the objective, provides exclusion criteria, and allows providers to exclude themselves from a measure when appropriate. All core objectives are provided on the left side of the screen with the

particular objective for attestation with measurement specification on the right side of the screen. Some objectives deal with functionality and others with use.

When an objective requires data from a patient record, the provider must attest to as to whether the data was extracted from all patient records or only from patient records maintained using certified EHR technology.

Other objectives require connectivity to public health, such as reporting of immunizations and syndromic surveillance. An updated screen shot of the attestation for reporting information to a public health immunization registry that accommodates the Stage 1 MU changes January 1, 2013, follows, and the screenshots for syndromic surveillance is provided in Attachment 8.13, which is included at the end of this document.

The menu objectives require reporting numerator and denominator using federally established specifications. The measure, specification, definitions and exclusions are provided by A-SMA and the provider can attest to exclusion or the actual numerator and denominator for each. A screen shot illustrating one of the menu measures follows.

Lastly, providers must report on EHR technology to report clinical quality measures. The state provides screens for the provider to attest to the selection of the 3 core or alternative and 3 additional objectives and related measures, data source, exclusions, population criteria, numerator and denominator.

For EHs for both the Medicare and Medicaid EHR incentive programs, CMS will collect the meaningful use measures; therefore, the Alabama SLR has the capacity to collect from CMS, retain, analyze and use the information for Medicaid purposes. A-SMA is able to access the MU data from the C5 file transmitted from CMS by hospitals eligible for both Medicare and Medicaid EHR incentive payments in order for the State to integrate the data into SLR data fields for EH MU Core and Measure and CQMs. A-SMA is thus able to use the data during the state's oversight processes. A-SMA accepts the C5 file as evidence of Medicare attestation approval all dual eligible EHs and uses that approval as acceptance of the EH's Meaningful Use of CEHRT.

All screenshots were submitted by Alaska as the lead representative of the SLR collaborative states that use the Xerox COTS platform. These were approved by CMS. A-SMA understands that the inclusion of the screenshots in the submission of the A-SMHP does not constitute submission of the screen shots.

4.10 WILL THE SMA BE PROPOSING ANY CHANGES TO THE MU DEFINITION AS PERMISSIBLE PER RULE-MAKING? IF SO, PLEASE PROVIDE DETAILS ON THE EXPECTED BENEFIT TO THE MEDICAID

POPULATION AS WELL AS HOW THE SMA ASSESSED THE ISSUE OF ADDITIONAL PROVIDER REPORTING AND FINANCIAL BURDEN.

A-SMA is not proposing any changes to the MU definitions at this time.

4.11 HOW WILL THE SMA VERIFY PROVIDERS' USE OF CERTIFIED ELECTRONIC TECHNOLOGY?

Standard: In order to receive a Medicaid incentive payment the EHR technology must be "certified" as "a qualified electronic health record that is certified pursuant to section 3001(c) (5) of such Act as meeting standards adopted under section 3004 of such Act that are applicable to the type of record involved (as determined by the Secretary), such as an ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals." The Recovery Act specifies 3 requirements: use of certified EHR in a meaningful manner (e.g., e-prescribing), use of certified EHR technology for electronic exchange of health information to improve quality of health care, and use of certified EHR technology to submit clinical quality measures(CQM) and other such measures selected by the Secretary. A-SMA will verify compliance with all three components for MU.

Methodology:

- *Pre-Payment:* A-SMA will validate the appropriate documentation is submitted for attestation. For Program Year 2015-2017, valid documentation is a vendor letter from the EHR vendor that includes the vendor, product, and version of the certified EHR.

- *Post-Payment:* The focus of the post payment audit is the areas that the agency is unable to validate during the pre-payment validation, including the certified EHR System is as reported and is used, the EHR is the data source for measurement, and the EP/EH is accurately reporting the measurements and results. The updated audit strategy is provided in Attachment 8.15.

Process: If documentation is not one of the documents identified above, or does not match the EHR system described by the EP/EH, the state will contact provider to request the submission of the correct documents and pend the application for submission of appropriate documentation. The provider must also submit the certification number of the provider's ONC certified EHR Technology. The SLR system validates the certification number against the ONC Certified HIT Product List database. Where an issue has been identified, the provider is flagged for post payment audit.

EPs and EHs will be selected on a 10-15% random sample. In addition, EPs or EHs whose submissions have been identified as “flag for post payment audit” will be automatically selected for audit.

4.12 HOW WILL THE SMA COLLECT PROVIDERS’ MEANINGFUL USE DATA, INCLUDING THE REPORTING OF CLINICAL QUALITY MEASURERS? DOES THE STATE ENVISION DIFFERENT APPROACHES FOR THE SHORT-TERM AND A DIFFERENT APPROACH FOR THE LONGER-TERM?

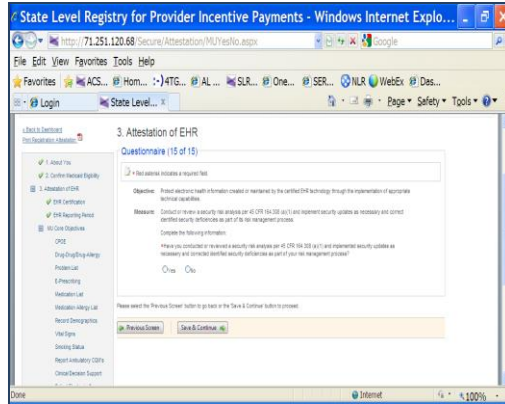
Standard: The initial reporting period for collection of meaningful use data is 90 days. During this period the provider must demonstrate meaningful use of certified EHR technology and the state is required to validate to CMS that providers meet all of the eligibility criteria to qualify for Medicaid incentive payments for the meaningful use of information, including the applicable patient volume thresholds, hospital-based requirements, and all other requirements. CQMs are reported during the attestation process along with the meaningful use core and menu objectives.

Methodology: As explained in great detail in Section 4.9, starting in January 2012, meaningful use objectives and clinical quality measure results will be reported to the state by EPs and EHs to demonstrate that they have used EHR technology in a meaningful way using the same attestation process and SLR as they used for AIU. Providers will enter the denominator, numerator and any applicable exclusion results directly into the attestation system to demonstrate meaningful use. For demonstration that they are meaningful users of Electronic Health Records (EHRs), EPs should use the EHR reporting period associated with that payment year. For the first payment year that an EP is demonstrating meaningful use, the reporting period is a continuous 90-day period within the calendar year through 2012. For subsequent years, the reporting period would be the full calendar year. However, the exceptions are 2014, 2015, 2016, and 2017 in which the reporting period is 90 days.

Process: The process is fully explained in 4.9. The requirement changes from AIU to MU resulted in a change in the attestation screen which states what the EPs and EHs must attest to for MU. Each provider must provide reports from his/her certified EHR technology (CEHRT) validating the denominator and numerator.

There are 15 components of the Attestation Questionnaire for MU, including as shown below attestation of capability to exchange information and complete a security risk assessment.

Figure 49: Screen Shots for Information Exchange and Security Risk Assessment



4.13 * HOW WILL THIS DATA COLLECTION AND ANALYSIS PROCESS ALIGN WITH THE COLLECTION OF OTHER CLINICAL QUALITY MEASURES DATA, SUCH AS CHIPRA?

Standards: A chart of all the quality measures by program, including MU, is was provided the last SMHP update.

Methodology: The attestation process for MU requires the reporting of the actual numerator and denominator. Some measures have denominators of unique patients regardless of whether the patient’s records are maintained using certified EHR Technology or not and other measures include in the denominator of only patients whose records are maintained using a certified EHR. Other measures require only a yes/no attestation.

The state has identified measures specifically for their Patient 1st Program and the approved A-SMA’s State Plan Amendment (SPA) for health homes for individuals with chronic illness measures align with MU in measure specifications. For example, Patient 1st measures for care coordination include the “reconciled medication list” and “timely transmission of transition care record”.

Process: Alabama is moving to more electronic information sharing so information can be available, accessible and integrated in the care team’s work flow as well as available at the point of care. The intent is to allow the managed care PCN team members and patients to communicate clearly, consistently and accurately about a patient’s health status and service delivery needs through the use of tools and resources which facilitate data exchange. It is the longer term goal of A-SMA through its PCN’s to provide timely and complete clinical information to health care providers at the point of care, including PMPs, and Network team members; specialty physicians; emergency physicians; hospitalists and other providers within acute care facilities; health care providers at skilled nursing facilities and rehabilitation centers. Through the use of One Health Record® capacity, PCNs and their network providers will be able to access imaging, laboratory and pathology and medications.

Alabama intends to leverage the EHR Incentive Program clinical quality measures for both the adult Medicaid measures (A-SMA is a grant awardee for the adult Medicaid measures) and the RCOs, which includes children and adults, including pregnant women and individuals with chronic

conditions. A-SMA's focus is currently on transitioning from claims based measurement to clinical measures based on data from the certified EHRs. In addition, A-SMA is moving to a Regional Care Organization (RCO) Medicaid delivery system and incorporating the efforts of Patient 1st into the planning and preparation for the RCOs. The A-SMA is currently in the planning and preparation stage related to e-CQMs. One Health Record[®] is expected to be the transport mechanism for the meaningful use e-CQM measures.

Although Alabama has a separate CHIP program, the state views standardization of data collection and measurement as a core principle for infrastructure development. In addition to gaining dual benefit from the reporting of these measures, the approach decreases provider burden. A-SMA intends to use the four clinical quality measures that overlap MU and CHIPRA proposed measures for children: Weight Assessment Counseling for Children and Adolescents, Chlamydia Screening for Women, Childhood Immunization Status and appropriate testing for children with pharyngitis. As indicated previously, the state has the same leadership involved in the various national efforts to benefit from lessons learned from federal initiatives, other states and private approaches.

4.14 WHAT IT, FISCAL AND COMMUNICATION SYSTEMS WILL BE USED TO IMPLEMENT THE EHR INCENTIVE PROGRAM?

Standards: The initial SMHP addressed the various IT, fiscal and communication systems used to implement the Alabama EHR Incentive Program as the SLR became operational in 2011. The expanded MMIS, using the MITA framework to incorporate all management information needs related to the Medicaid program built for and use by Medicaid enrollees, providers and administrators of the program but not exclusively or solely for Medicaid, includes a separate contract for the SLR (HTS as vendor), interfaces with the MMIS claims and provider systems (HP fiscal agent as vendor), and as of 2012 interfaces with One Health Record[®].

Methodology: To meet initial timelines, some processes were manual for the initial year. As of June 2013 meaningful use payments are processed through the A-SMA MMIS system and such are handled through the electronic fund transfer capabilities used for claims. There are still three scenarios that require incentive payments to be processed manually through the new state finance system. These scenarios deal with two state medical school entities and those instances when they payment is issued to an EP as an individual.

Process: A-SMA is now reviewing various approaches to collect clinical quality measures from meaningful use providers that incorporate an enterprise approach to data analytics. At this time a combination of the One Health Record[®] and the MMIS decision support system is being contemplated. A-SMA is also considering the viability of using the SLR to capture QRDA 1 measures. (Maturity Level 3-4).

4.15 WHAT IT SYSTEMS CHANGES ARE NEEDED BY THE SMA TO IMPLEMENT THE EHR INCENTIVE PROGRAM?

Standards: The initial A-SMHP provided the high-level overview of the year one IT system changes needed to implement the EHR incentive program for AIU. In addition to the systems currently in place for registration and attestation for AIU through the SLR, systems support is provided for the payment process. Changes to the SLR, will accommodate MU attestation, reporting and payment.

The system's structure, as indicated in the initial I-APD is to support provider eligibility, payment and allow the state to adequately provider financial and quality oversight. The changes to the SLR and the interface with the NLR required to address the changes to Stage 1 as a result of the final MU Stage 2 regulation were provided earlier in Table 2a and Table 6a. System changes for those provisions of the regulations that became effective in 2016 and 2017 as approved by CMS in the SMHP 2017 Addendum have been implemented. Any changes for PY 2018 will be completed and implemented by January 1, 2019.

Methodology: Screen shots for the attestation and reporting provided in previous sections indicate some of the IT changes required to support MU. Reporting requirements for ARRA and ongoing Medicaid are through the current financial reporting systems. The original I-APD for MU included funding for all components related to the MU system and the current vendor contract provisions include system updates for all anticipated program changes.

The ASM SLR interfaces with the CMS Registration and Attestation System in order to determine compliance with all of provider eligibility requirements, including:

- Appropriate provider type,
- Choice of Medicare vs. Medicaid for EPs,
- Choice of Alabama as the state of payment (information which will be provided through the CMS Registration and Attestation System),
- Use of certified EHR system (list of certified systems to be provided by CMS and cross-checked)
- Meets either the AIU or MU requirements.

The A-SMA SLR is able to retain documentation required by the state to validate the acquisition and installation or upgrade to a certified system in the initial implementation and activation.

Additional SLR functionality that is included and already operational:

- Web portal that allows EPs and EHs to complete the application process, view their information and track payment information. The web portal system pre-populates information from the CMS Registration and Attestation System, as well as receives and stores current Alabama MMIS provider enrollment. The system also addresses all requisite steps of the provider application process, including provider applicant eligibility determination, attestation, and payee determination; application submittal confirmation; Medicaid payment determination (including CMS Registration and Attestation System confirmation) and payment generation.
- Repository of all registration and attestation data and document up load.

- Capacity for certain authorized users (e.g. state staff) to enter notes at various stages of the process. (Secure email functionality directly from the system has not yet been enabled.)
- Print and download capability in an unalterable format.
- Application progress tracking and payment.

Process: The SLR (HTS) provides capacity to accommodate connectivity to the CMS Registration and Attestation System for registration, support the SLR registration, attestation and reporting, is able to validate and track EPs and EHs, and has the capacity to create invoices, make, track, report and audit payments and ongoing eligibility.

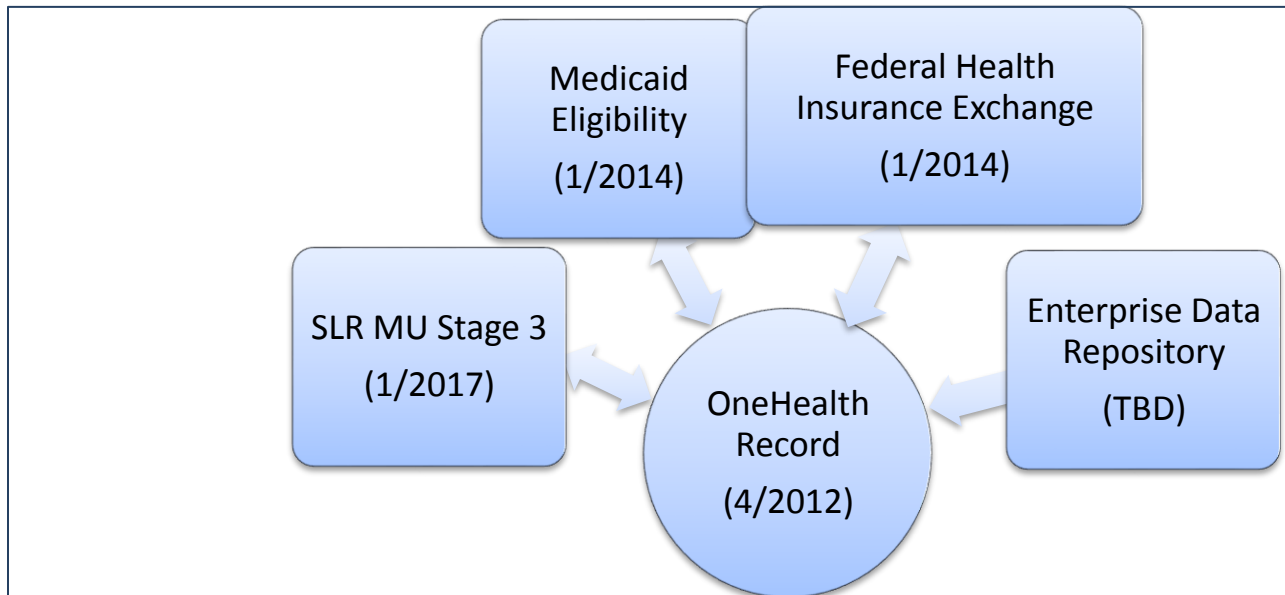
Additional activities, such as payment, require a combination of system and manual activities. For example, attestations approved for payment are extracted from the SLR system. The system then creates a payment listing for transmittal to the FA for payment through the MMIS. Upon completion of the payment, A-SMA retrieves the payment data from the MMIS, and the SLR is updated. A D-18 is sent to CMS.

Enhancements to the SLR were completed to go from AIU to MU. Additional enhancements are under consideration to more fully automate the overall process, including areas such as electronic signatures. An enterprise state data repository is also required to support the MU measurement oversight process. Finally, One Health Record® (A-HIE) is needed to support EHs and EPs in the exchange of clinical information and connectivity to public health for reporting immunizations and syndromic surveillance. An I-APD was submitted and approved that includes necessary changes to the SLR and funding for the Medicaid share of One Health Record® staff and appropriate system linkages to SLR.

4.16 WHAT IS THE SMA'S IT TIMEFRAME FOR SYSTEMS MODIFICATIONS?

The state will make system modifications as needed. The changes to the SLR for MU that are required for changes to Stage 1 as a result of the Stage 2 MU regulation were implemented prior to January 1, 2013. Those changes to the SLR that are effective for the 2014 Program Year were implemented January 1, 2014 for EH and April 1, 2014 for EP. One Health Record® went “live” in April 2012. The changes to the SLR required for the Flexibility Rule were implemented in September, 2014. As discussed above, the changes to the SLR for the 2015 and 2016 Program Years are dependent upon the successful completion of the procurement process for the SLR. Alabama Medicaid eligibility system will also “go live” prior to January 2014. The enterprise data repository does not have a specified date. Appropriate I-APDs will be submitted in the near future.

Figure 50: Health-IT System Development and Modifications



4.17 WHEN DOES THE SMA ANTICIPATE BEING READY TO TEST AN INTERFACE WITH THE CMS REGISTRATION AND ATTESTATION SYSTEM?

This was addressed in the initial A-SMHP. The interface was completed prior to implementation of the SLR for AIU. Alabama’s SLR effectively transfers data to and from the CMS Registration and Attestation System on an ongoing basis.

4.18 WHAT IS THE SMA’S PLAN FOR ACCEPTING THE REGISTRATION DATA FOR ITS MEDICAID PROVIDERS FROM THE CMS REGISTRATION AND ATTESTATION SYSTEM (E.G., MAINFRAME TO MAINFRAME INTERFACE OR ANOTHER MEANS)?

Standard: The interface between the CMS Registration and Attestation System and Alabama SLR is a mainframe to mainframe interface as indicated in the initial A-SMHP. There has been no change. All data elements from the CMS Registration and Attestation System are downloaded to the Alabama system including initial information related to provider eligibility as provided to CMS from the provider, including but not limited to sanction status, hospital-based status, practicing predominately in FQHC/RHC, eligible professional or institution type and EH MU Measure data.

Methodology: The CMS Registration and Attestation System will provide information about providers who have applied for the incentive program. After passing high level editing during the CMS Registration and Attestation System file processing most records will be loaded into the state system. The provider will access the state system and register to use the provider portal.

If the provider is not Alabama Medicaid enrolled, the provider will be required to do so prior to registering on the system.

Process: Enrolled providers who are not a Medicaid HITECH provider type on the MMIS enrollment file will not be able to access the enrollment system and will be directed to Medicaid via information on the provider portal and/or website. If the enrolled provider is a valid Medicaid provider type, he/she may access the state system.

The system home page has a status bar displaying the status of the provider applicant's record. The system uses the NPI associated with the logon ID to search for a match. If a match is found, the provider has been verified and may proceed to the next step. If no match is found, then the provider is given an error message indicating that there is no match for the record from the NLR. The provider is instructed to contact the CMS Registration and Attestation System.

The Provider enters the SLR and is able to view the CMS Registration and Attestation System information (NPI, provider name, business address/phone, personal TIN, payee TIN, payee address, Medicaid agency, Medicaid state, legal entity name, payee legal entity name, payee address, provider type and email address). Once the provider confirms the information, the provider will proceed. If the information is not confirmed, the record will suspend as incomplete and the EP/EH is directed to the CMS Registration and Attestation System to fix the information. If the provider type entered by the applicant does not match the provider type listed in the enrollment file, the provider information will be placed on a report for provider enrollment file maintenance.

The Medicaid EHR Incentive Program registration provides information on the date the information was originally created and updated, the name of the provider, TIN, NPI, business address, Medicaid/Medicare Program, phone number, contractor ID, hospital based (Y or N), hospital based percentage, FI/Carrier/MAC status, NPI status, OIG exclusions, death master file (Y or N), registration status, and registration status reason. The Medicaid EHR Incentive Program attestation section will provide data originally submitted by calendar year. Other SLR information includes payment information (payment summary Information, program year payment issue date, payment method, payment address, payment amount, withheld reason and EHR Incentive Program Status) and measurement information (program year status, submission of quality measures, cancellation date, number of measures met by participation year, stage reporting period and EHR certification number).

4.19 WHAT KIND OF WEBSITE WILL THE SMA HOST FOR MEDICAID PROVIDERS FOR ENROLLMENT, PROGRAM INFORMATION, ETC?

Standard: As indicated earlier in this document and in the initial A-SMHP, the Web portal allows EPs and EHs to complete the application process, view their information and track payment information. The website has been operational since April 2011 for AIU and is HIPAA compliant. It has been and will continue to be enhanced, to allow for future program changes.

Methodology: The web portal system pre-populates information from the CMS Registration and Attestation System, receives and stores current Alabama MMIS provider enrollment, addresses all requisite steps of the provider application process, including provider applicant eligibility determination, attestation, and payee determination; application submittal confirmation; Medicaid payment determination (including CMS Registration and Attestation System confirmation) and payment generation. The web portal has a login requirement and other appropriate privacy and security safeguards addressing access, authorization and authentication.

Process: Copies of the screenshots are provided in Attachment 8.10 and throughout the A-SMHP document in response to appropriate questions. The home page screenshot follows:

The One Health Record® home page provides a link to this site. A link also exists from the A-SMA home page assuring providers can find the site. The SLR portal also provides a link to the CMS Registration and Attestation System to ease provider's access. (See Figure 53.)

Figure 53: One Health Record® Website

One Health Record®
Health information, safe and secure, when and where you need it!™

[About Us](#) [Services](#) [Resources](#) [News](#) [For Health Providers](#) [Meaningful Use](#) [Information](#)

Welcome | Your Security and Privacy | Resources | How To Get Started

Our Progress... 2015

40 Facilities	4,221 Secure Messages	4,017 Query Transactions	6 Actively Connecting Hospitals	17 Actively Connecting Clinics
261 Individual Users			2 Connected Hospitals	

Copyright Alabama One Health Record®
[Home](#) | [Security and Privacy](#) | [Policies](#) | [Alabama.gov](#) | [Medicaid](#) | [Contact Us](#)

Figure 54: Medicaid Agency Home Page



4.20 DOES THE SMA ANTICIPATE MODIFICATIONS TO THE MMIS AND IF SO, WHEN DOES THE SMA ANTICIPATE THE MMIS-I-APD?

Standards: As addressed in Section 4.16, Alabama anticipates “modifications” to the “expanded” MMIS system as expansions to the MMIS system of systems to include One Health Record. The state has already received funding and approval for the updated Alabama Medicaid eligibility system.

Methodology: Current interfaces between the SLR and MMIS claims and provider management systems continue. Over time and to the degree possible, manual operations will be replaced by more automated processes but the current priority to inclusion of necessary functionality, ease and consistency for providers and standardization of activities to assure effective, efficient and timely operation.

Process: As indicated earlier in this updated A-SMHP, an I-APD has been submitted to fund changes related to the EHR Incentive Program, including Medicaid’s fair share of One Health Record® and the enterprise state data repository with analytical capabilities. A separate I-APD has already addressed the Medicaid eligibility system.

4.21 WHAT KINDS OF CALL CENTERS/HELP DESKS AND OTHER MEANS WILL BE ESTABLISHED TO ADDRESS EP AND HOSPITAL QUESTIONS REGARDING THE INCENTIVE PROGRAM?

Standard: From the beginning of the process, Stakeholder education and engagement have been core principals of the One Health Record® S/OPs and SMHP process. A priority has been involvement of providers and their associations in the planning so operational details, like call centers/help desks are not forgotten. A-SMA’s approach to addressing EP and EH questions regarding the incentive program has been multifaceted, including presentations at various stakeholder and provider regional and statewide meetings (AMGA, HIMSS, Academy of Pediatrics, etc.), educational information on the One Health Record® and A-SMA home pages with links to the SLR, information on the SLR website and linkage to the CMS “FAQ” website.

Methodology: A-SMA is responsible for the MU Incentive Activities as indicated in an earlier section. Full time staff is dedicated to the EHR Incentive Program and their contact information (e-mail and phone) is available on the websites. A-SMA’s vendor, HTS, provides a help desk staffed by a call center for providers.

Process: The first point of contact is the A-SMA for questions and information about the EHR Incentive Payment Program. A-SMA staff is available daily to address questions and assist providers in the process. Providers can and do call A-SMA staff daily regarding the program requirements, processes and individual issues and/or clarifications. A-SMA has taken a concrete approach of individually handling any issue identified to them by a provider to reduce any barriers to registration and payment. In addition, XEROX has established a call center with contact information posted on each page (telephone number and e-mail) and is a resource for providers as part of the contracted attestation review and validation services. There are escalation processes in place for systems issues and, if the inquiries are program related, they are sent to the A-SMA either via e-mail or phone.

A-SMA has sought to utilize current methods of communication to assure information is provided readily and consistently. For instance, One Health Record® has established an ongoing “newsletter”, which the state has also used for communicating information related to the EHR Incentive Program. When CMS has issued an alert of new FAQs, the state has forwarded the information on to interested parties.

4.22 WHAT WILL THE SMA ESTABLISH AS A PROVIDER APPEAL PROCESS RELATIVE TO: A) THE INCENTIVE PAYMENTS, B) PROVIDER ELIGIBILITY DETERMINATIONS, AND C) DEMONSTRATION

OF EFFORTS TO ADOPT, IMPLEMENT OR UPGRADE AND MEANINGFUL USE CERTIFIED EHR TECHNOLOGY?

Standard: Providers whose application for AIU or MU is rejected may appeal the decision (Attachment 8.9). EPs and EHs can protest a negative decision by the state related to participation eligibility, attestation decision and calculation of EHR Incentive Payment.

Alabama has taken the option to have CMS perform audits and handle any subsequent appeals of whether a EH is a “meaningful user” on behalf of the state. Via this updated A-SMHP, A-SMA hereby agrees that Alabama:

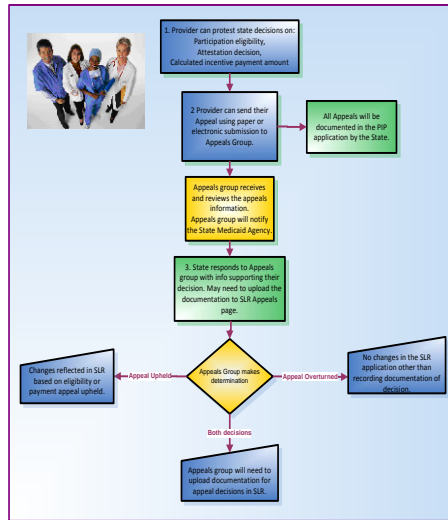
- Designates CMS to conduct all audits and any resulting appeals of eligible hospitals' meaningful use attestations;
- Is bound by the audit and appeal findings;
- Will perform any necessary recoupments arising from the audits;
- Will be liable for any FFP granted the state to pay EHs that, upon audit (and any subsequent appeal) are determined not to have been meaningful EHR users; and
- Acknowledges that the results of any adverse CMS audits would be subject to the CMS administrative appeals process and not the Alabama appeals process.

Methodology: EHR Incentive Payment appeals are treated like other appeals. If a provider disagrees with a Medicaid determination with regard to an appealable issue, the provider may request a dispute resolution meeting. The request can be submitted via paper or electronic. They are submitted to the Alabama Appeals Group and the appeal is documented in the PIP application by the state.

A provider's request for a resolution meeting shall clearly identify each specific issue and dispute, state the basis on which A-SMA's decision on each issue is believed to be erroneous, provide documentation or a summary supporting the provider's position, and state the name, mailing address, and telephone number of individuals who are expected to attend the dispute resolution meeting on the provider's behalf.

Process: When an appeals group receives an appeal, the group reviews the appeals information and notifies A-SMA. A-SMA then responds to the Appeals Group with the information supporting their decision and will upload documentation to the SLR Appeals page as appropriate. The Appeals Group makes a determination. If the appeal is upheld the appropriate changes are reflected in the SLR. If the appeal is overturned, there would be no changes in the SLR application other than recording documentation of the decision. In either case, the Appeals Group will upload the documentation for the appeal decision into the SLR. The workflow is illustrated in Figure 55.

Figure 55: Provider Appeal Process



4.23 WHAT WILL BE THE PROCESS TO ASSURE THAT ALL FEDERAL FUNDING, BOTH FOR THE 100 PERCENT INCENTIVE PAYMENTS, AS WELL AS THE 90 PERCENT HIT ADMINISTRATION MATCH, ARE ACCOUNTED FOR SEPARATELY FOR THE HITECH PROVISIONS AND NOT REPORTED IN A COMMINGLED MANNER WITH THE ENHANCED MMIS FFP?

Standard: As indicated in the initial A-SMHP, Alabama has instituted the financial reporting requirements under HITECH for all activities and has created within the state financial accounting processes, the separate coding required to track SMHP HIT funding from enhanced MMIS funding. There have been no changes.

Methodology: As CMS created a new line item on the 64/37, Alabama did the same for state budgetary reporting. In addition, all provider incentive payments are coded to match the federal specifications so only EPs and EHs are paid and the appropriate payment amount is reported to CMS for quarterly federal financial reporting. Alabama has assigned separate fund codes for tracking and accounting purposes (THE: health exchange TMU: meaningful use).

Process: A-SMA has appropriately billed for the 100 percent funding for EHR Incentive Payments issued to date. A-SMA has also appropriated drawn down funding for direct A-SMA staff working on the EHR Payment Program. A-SMA has not made full use of Medicaid funding that is available for the Medicaid share of One Health Record® and contract support. A-SMA will update the SMHP to address changes to the One Health Record® to accommodate efforts to onboard eligible EP types and rural EHs and accommodate quality measurement and reporting needs related to the transition of the state to Medicaid Regional Care Organizations (RCOs) in a follow-up SMHP submission.

Upon submission and approval of the all SMHP updates and related I-APDs, A-SMA will report on the appropriate lines of the CMS 37 and CMS 64 ARRA HITECH HIT-MU expenditures, ARRA HITECH HIT-HIE expenditures and the applicable MMIS. A-SMA will continue to submit relevant

contracts to CMS for review and approval prior to requesting funding for them in the federal reporting.

4.24 WHAT IS THE SMA’S ANTICIPATED FREQUENCY FOR MAKING THE EHR INCENTIVE PAYMENTS (E.G. MONTHLY, SEMI-MONTHLY, ETC.)?

Standard: A-SMA has paid EPs and EHs as their applications have been approved within a payment cycle.

Methodology: The state has established a timeline for EHR Incentive Payments and is communicating the timeline to providers to avoid end of year issues. The Meaningful Use Incentive Payment Program began on April 1, 2011 and will end on December 31, 2021. EPs may receive incentive payments for up to six years for a maximum amount of \$63,750. An EP must submit the first application no later than 2016.

Process: When an EP or EH completes all requirements and is eligible for an EHR Incentive Payment, the payment will be made at the next Medicaid payment cycle.

Incentive payments are currently issued through the FA MMIS via electronic funds transfer process generally on a biweekly basis unless special handling is required. The payment schedule (referred to as the Check Write Schedule) is updated annually, based on the state’s fiscal year, and is posted on the Alabama Medicaid Agency website under the “Providers” tab. In this was, the anticipated payment date is always available to the provider.

4.24(b) WHAT WILL BE THE PROCESS TO ASSURE THAT MEDICAID PROVIDER PAYMENTS ARE PAID DIRECTLY TO THE PROVIDER (OR AN EMPLOYER OR FACILITY TO WHICH THE PROVIDER HAS ASSIGNED PAYMENTS) WITHOUT ANY DEDUCTION OR REBATE?

Standard: The A-SMA does not take a reduction or rebate on EHR Incentive Payments.

Methodology: These payments are not considered claims based payments. Within the MMIS system, A-SMA set up new transaction codes so these payments are listed as separate line items on the provider’s respective remittance advice.

Process: A-SMA submits a provider payment form to the MMIS that is generated from the SLR. Once the payments are process, A-SMA receives a separate activity report which indicates to whom the payments were paid. The transactional codes used are exclusively designed for EHR Incentive Payments only. Any recoupments outside those specifically related to the EHR Incentive Payments exclude these transactional codes.

4.25 WHAT WILL BE THE PROCESS TO ASSURE THAT MEDICAID PROVIDER PAYMENTS GO TO AN ENTITY PROMOTING THE ADOPTION OF CERTIFIED EHR TECHNOLOGY, AS DESIGNATED BY THE STATE AND APPROVED BY THE US DHHS SECRETARY, ARE MADE ONLY IF PARTICIPATION IN SUCH A PAYMENT ARRANGEMENT IS VOLUNTARY BY THE EP AND THAT NO MORE THAN 5%

OF SUCH PAYMENTS IS RETAINED FOR COSTS UNRELATED TO THE EHR TECHNOLOGY ADOPTION?

Standard: As required in regulation and indicated in the initial A-SMHP, Alabama attests that payments to an entity promoting the adoption of certified EHR technology, as designated by the State, will only be made if participation in such a payment arrangement is voluntary for the Medicaid EP involved, and if such entity does not retain more than 5 percent of such assigned Medicaid incentive payments for costs not related to such technology. No change has occurred in this area.

Methodology: The provider file provides the person/facility to which the provider wishes payment to be issued and the payment process will issue the payment. The A-SMA provider TIN/NPI would be cross-referenced with the EHR number and/or the bill of sale, to verify the 5%.

Process: A-SMA has not had any requests related to this provision. If and when such does occur, the process will be done manually. The Medicaid provider would need to request in writing the designation of another entity TIN to receive the payment and that information would be included in the attestation signed by the provider. The attestation would state that designation is voluntary on part of the provider, the entity name, address (including e-mail address), and the amount. A-SMA will validate the credentials of the entity designated to determine if that entity is eligible for the payment, the amount is within the regulation requirements and then issue payment.

4.26 WHAT WILL BE THE PROCESS TO ASSURE THAT THERE ARE FISCAL ARRANGEMENTS WITH PROVIDERS TO DISBURSE INCENTIVE PAYMENTS THROUGH MEDICAID MANAGED CARE PLANS DOES NOT EXCEED 105 PERCENT OF THE CAPITATION RATE PER 42 CFR PART 438.6, AS WELL AS A METHODOLOGY FOR VERIFYING SUCH INFORMATION?

Standard: Alabama attests that disbursement of incentive payments through Medicaid MCOs will not exceed 105 percent of the capitation rate. Alabama is not a high concentration managed care state and A-SMA has no Medicaid MCO contracts to date.

Methodology: If and when Alabama enters into any Medicaid MCO risk based contract, the state will put into place a business process which will be manual in nature to assure that the total of the incentive payments through a MCO will not exceed 105 percent of the capitation rate.

Process: There has been no change in Section 4.26 since the initial A-SMHP was submitted to CMS. Alabama commits to assuring that the state will address the requirement when and if the state enters into Medicaid MCO risk contracts.

4.27 WHAT WILL BE THE PROCESS TO ASSURE THAT ALL HOSPITAL CALCULATIONS AND EP PAYMENT INCENTIVES (INCLUDING TRACKING EP'S 15% OF THE NET AVERAGE ALLOWABLE

COSTS OF CERTIFIED EHR TECHNOLOGY) ARE MADE CONSISTENT WITH THE STATUTE AND REGULATION?

This question is obsolete based on changes made by CMS to the process that no longer requires a separate state calculation and tracking is required related to the 14% of net average allowable costs of certified EHR technology.

4.28 WHAT WILL BE THE ROLE OF EXISTING SMA CONTRACTORS IN IMPLEMENTING THE EHR INCENTIVE PROGRAM – SUCH AS MMIS, PBM, FA, MANAGED CARE CONTRACTORS, ETC.?

Standard: As indicated in the initial A-SMHP and earlier in this document, the Alabama FA for MMIS and FA activities (DXC), the former Medicaid Transformation Grant contractor who is now the contractor for the SLR (Xerox- formerly ACS), and the One Health Record® contractor (Truven) were engaged in the implementation of the EHR Incentive Program as they all involved in critical components for which success is dependent. Both contracts for these services are in the procurement process and the outcome will determine the contractor going forward. Other contractors that remain involved and their roles have been identified previously and include GDH Government Services to provide support for program and policy, auditing, and data analytics.

Methodology: The FA manages the MMIS interfaces with SLR. The SLR contractor manages the SLR technical and technical and business operations. The One Health Record® contract will manage the interface with the SLR through the state “gateway”. Since the MMIS will be enhanced and expanded to accommodate all the HIT needs to support MU, an I-HIT-APD will be forthcoming.

Process: A-SMA has explicitly required coordination between contractors in their contracts with each of the vendors and consultants and specifies roles and responsibilities.

4.29 STATES SHOULD EXPLICITLY DESCRIBE WHAT THEIR ASSUMPTIONS ARE, AND WHERE THE PATH AND TIMING OF THEIR PLANS HAVE DEPENDENCIES BASED UPON: THE ROLE OF CMS (E.G. THE DEVELOPMENT AND SUPPORT OF THE CMS REGISTRATION AND ATTESTATION SYSTEM PROVIDER OUTREACH/HELP DESK SUPPORT); THE STATUS/AVAILABILITY OF CERTIFIED EHR TECHNOLOGY; THE ROLE, APPROVED PLANS AND STATUS OF THE RECs; THE ROLE APPROVED PLANS AND STATUS OF THE HIE COOPERATIVE AGREEMENTS; STATE-SPECIFIC READINESS FACTORS.

As indicated in the initial A-SMHP, there are multiple dependencies throughout A-SMHP. Time resources (human and financial) remain tight with numerous moving parts, several competing agendas (One Health Record®, Medicaid Eligibility System upgrade ICD-10, etc.) and significant cross-dependencies. (Eligibility information needed for population validation, connectivity between providers and with public health through One Health Record® for MU, etc.) The state

has committed to leveraging across programs and initiatives and has initiated business processes and personnel to assure that happens.

CMS central office continues to be extremely responsive and the dependency of the state on the continuation of ONC and CMS continued responsiveness cannot be understated. A quick approval of this updated A-SMHP is needed along with approval of the I-APD, which will be submitted immediately following the submission of this A-SMHP. The state will do everything it can to mitigate that risk and depends on the federal government to do the same.

5. SMHP SECTION D: ALABAMA'S AUDIT STRATEGY FOR MODIFIED STAGE 2 AND STAGE 3

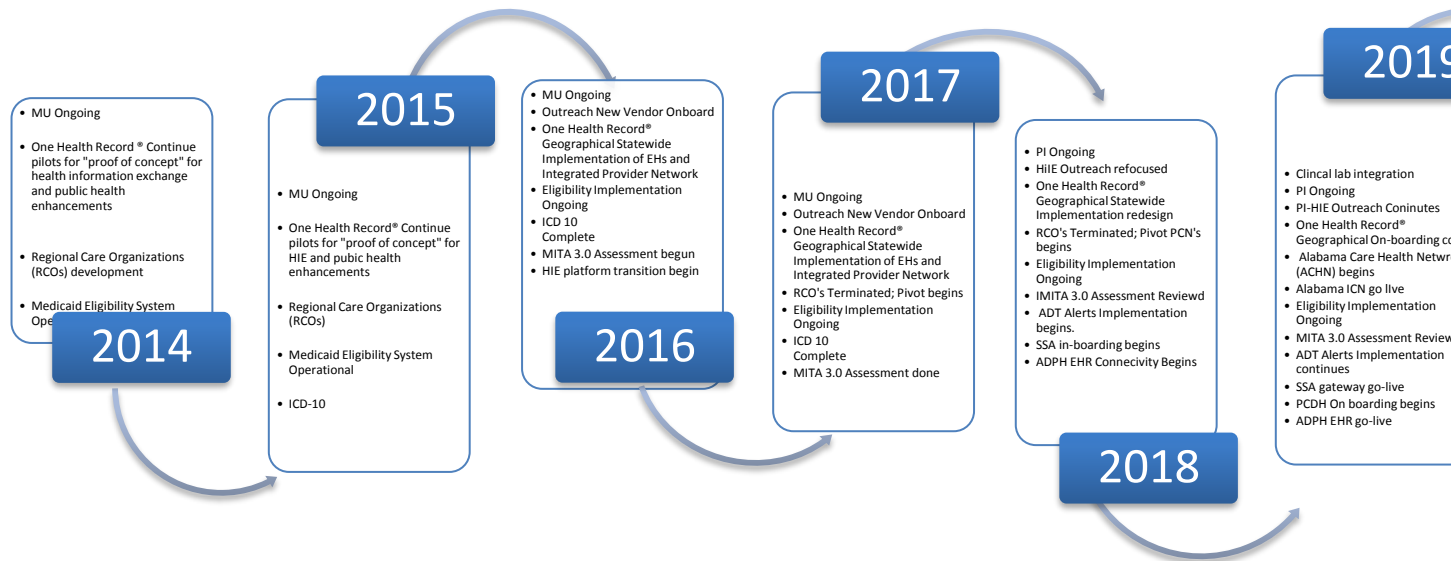
5.0 ALABAMA AUDIT STRATEGY

Alabama will submit the update of Audit Strategy for Stage 2 and Modified Stage 3 as a separate document in July 2018.

6. SMHP SECTION E: ALABAMA'S "ROADMAP"

PROVIDE CMS WITH A GRAPHICAL AS WELL AS NARRATIVE PATHWAY THAT CLEARLY SHOWS WHERE THE SMA IS STARTING FROM (AS-IS) TODAY, WHERE IT EXPECTED TO BE IN FIVE YEARS FROM NOW (TO-BE) AND HOW IT PLANS TO GET THERE.

Figure 58: Medicaid Health-IT Roadmap



Alabama is transforming the way the state purchases and oversees publicly funded health care, including Medicaid. It is simultaneously addressing both the evolution of health and the innovations within health care delivery. The relationship between the activities through the ONC State HIE Cooperative Agreement, including Alabama's State Strategic/Operational Plan (A-S/OP), and Alabama's State Medicaid's HIT Plan (A-SMHP) as the means to provide the technical infrastructure for the transformation was evident in timing, as well as impact, over the last few years.

The One Health Record® Commission and the A-SMA continue to make it a priority to align the work so the needs of both efforts have been met and the dependencies of infrastructure of one (HIE) for success in the other (MU) can be addressed timely and appropriately.

As the figure above indicates, the "target" in 2018 expands the assurance of meaningful exchange of health information to be in place as more providers and enrollees engage in the health care system .

- *2011:* The submission of the A-SMHP was the first step toward moving from concept to implementation and operation of critical health-IT functionality for which Medicaid is a core funder and major benefiter, but not sole participant. The state has been a leader in registering EPs and EHRs, completing pre-payment reviews and making significant payments for AIU in 2011. The state updated its environmental scan and identified areas of focus. The state and its vendor completed preparation for registration and attestation for MU starting 2012.

Simultaneously, using ONC State Cooperative Agreement funding, A-SMA staff have supported One Health Record® design and development of governance structure, legal/policy parameters, financing framework, technical and technical/business operations, and communication strategies to create the statewide infrastructure for the exchange of clinical information in a meaningful way. In working with the REC, the One Health Record® Commission workgroups, contracted support and A-SMA direct staff, the state has engaged and informed the multiple stakeholders which are impacted and have impact upon these proposals.

- *2012:* An I-APD was submitted in January 2012 to assure prior federal approval in order to move forward. An updated MITA assessment was also completed. The state updated its environmental scan and identified opportunities and potential risks to mitigate. CMS review of relevant contracts continued.

As indicated earlier in the document, the business processes and technical infrastructure were in place to move from AIU to MU, handle any potential appeals if they arose, integrate MU payment history into the MMIS provider history, and evolve from pre-payment reviews to pre and post-payment reviews and audits.

The state began development for a Medicaid eligibility system to accommodate the changes set forth in the Patient Protection and Accountable Care Act (ACA). One Health Record® statewide Health Information Exchange also went “live” in 2012. Five hospitals and a minimum number of FQHCs were targeted for One Health Record® early adoption in the second calendar quarter of 2012 to meet the needs of providers for meaningful use. One Health Record® supports both DIRECT and query, provides secure messaging, provider directories and identity management, and also the health information exchange technical infrastructure to support the exchange of information.

A-MSA targeted outreach in coordination with the REC and Tuskegee University. The Alabama REC provided “boots on the ground” outreach to the small practices and has signed up over 80% of their membership, which equates to approximately 700 physicians. A-SMA also became a participant in NHIN in 9/12.

One of the significant health care delivery efforts for Medicaid enrollees with chronic conditions went “live” in 2012. Alabama pursued the State Plan option to provide care management to individuals with chronic conditions to improve health, improve care and decrease costs. The new initiative, which is dependent upon and requires health-IT for the exchange of clinical information between the Patient 1st Primary Medicaid Providers (PMPs) and Networks and for quality reporting, positively impacts high cost and high utilizers of health care.

- 2013: Using ONC State Cooperative Agreement funding, One Health Record®:
 - Continued to address legal/policy parameters.
 - Established an initial financing framework for the “proof of concept” pilot.
 - Continued to provide technical capacity to support Direct secure messaging and query intrastate and interstate through a contract vendor. This includes a Master Patient Index, provider directory, XDS Registry/Repository, XCA/XCPD, auditing and logging, continuity of care viewer, and DIRECT/Query 3.0 capabilities.
 - Advanced technical/business operations through the connection of One Health Record® to three hospitals (Jackson, East Alabama Medical Center and the University of Alabama at Birmingham, Alabama) and one clinic (Jackson Clinic). Nine Clinical Care Documents have been placed in the HIE database and a few hundred Direct secure messages have been exchanged.
 - Implemented communication strategies to create the statewide infrastructure for the exchange of clinical information in a meaningful way. In working with the REC, the One Health Record® Commission and Commission workgroups contracted support and Medicaid Agency direct staff. The State has engaged and informed the multiple stakeholders which are affected and have impact upon these initiatives.

- One of the major initiatives in Alabama is the transition of Medicaid from fee-for-service to managed care through Regional Care Organizations (RCOs). Starting in 2013, a major focus of One Health Record® efforts has been to provide critical health information technology infrastructure to support the developing RCOs and the Medicaid providers who will be a part of the RCO networks.
- 2014: Eligibility using MAGI is active, MU is an ongoing operation, One Health Record® continues to support all of the efforts and ICD-10 has been postponed for a year. The state continues to update its environmental scan and MITA Self-Assessment to identify opportunities and potential risks to mitigate.

States and providers are facing considerable potential risks in light of the great abundance of work that needs to be completed efficiently, accurately, transparently and quickly. However, the potential for health and health care improvement is significant. The state is well positioned to meet the challenges and take full advantage of the opportunities.

- 2015: As the figure indicates, the “target” is 2015 for the assurance of critical health-IT functionality to be in place for the meaningful exchange of health information for which Medicaid is a core funder and major benefiter, but not sole participant.

Operationally, One Health Record® is still at the “proof of concept” stage; however, the core principles for Alabama’s One Health Record’s® strategic focus have been and continue to be:

- Encouraging provider participation, including continuing to leverage the REC activities.
- Achieving interoperability, which has been a struggle due to the current state of certified EHR adoption.
- Demonstrating feasibility through the initiation of a pilot.
- On-going stakeholder communication and involvement.
- Development of a longer term sustainability plan once value is demonstrated

One of the major initiatives in Alabama is the continuation from concept to implementation of Medicaid Regional Care Organizations (RCOs). A major focus of One Health Record® efforts has been to continue provide planning and preparation for critical health information technology infrastructure to support the developing RCOs and the Medicaid providers who will be a part of the RCO networks.

Enhancements have been made to One Health Record® website to be more user friendly and create more usable information. The following screenshots are representative of the enhancements.

- *2016-17*: As the figure indicated, 2016 & 2017 was to be a continuation of 2015 targets, with goals of expanding on the implementation of the health-IT functionality in place for increasing the meaningful exchange of health information. However, many of these objectives were stalled due to a HIE platform transition that 9 months to complete and the termination of the RCO initiative in August 2017. In September 2017, a revised Health IT strategy was completed and launched in November 2017. Medicaid continues to be a core funder and major benefiter, but not sole participant, as demonstrated by ADPH's increased involvement and improvement in the IMZ data quality & MU reporting initiatives.
- *2018*: As the figure indicates, 2018-19 will include be a continuation of 2017 targets, with goals of expanding on the implementation of the health-IT functionality in place for increasing the meaningful exchange of health information. Medicaid continues to be a core funder and major benefiter, but not sole participant, as demonstrated by ADPH's increased involvement and improvement in the IMZ data quality & PI reporting initiatives.

Operationally, One Health Record®, completed the regionalized “proof-of-concept”. Use case benefits and interoperability continue to be challenges. The core principles for Alabama’s One Health Record’s® strategic focus remain as modified in 2017, but strategic changes to the implementation will follow more of short-term value for long-term investment . The new emphasis of that focus will be:

- Recruiting provider participation for Health IT utilization for PHI exchange by leveraging ADT notifications in local markets to improve care coordination.
- Expanding patient “data” interoperability (access & extraction) to support the business case for population health analytics for manage care programs.
- Expand HIE connections to 50% (40) of the remaining hospitals and their integrated networks by the end FY 2020.
- On-going stakeholder communication and involvement.
- Development of a permanent governance and sustainability plan by 12/31/2019.
-
- Continuing into 2019-20, the major initiative in Alabama is the leverage ADT notifications and PHI exchange for care coordination in the implementation of the Alabama Care Health Network (ACHN) with a “go-live” date of 10/1/2019.

- Expand geographical reach of Alabama One Health Record by establishing itself a SE regional gateway for ADT alerts, disaster preparedness, and CCDA exchange.

• One Health Record® efforts will to continue provide and expand the planning and preparation for critical health information technology infrastructure to support the Medicaid providers who will be a part of the ACHN network.

Updates to One Health Record® website and enhancements to the PI pages have more user friendly and more timely, usable information.

Table 23: Updated A-SMHP Initial Table of Alabama Activities and Approaches Roadmap

Activity	Year	Approach
Technical Architecture		
Become consistent with HHS adopted interoperability standards	Initial Completed - Ongoing	One Health Record® and A-SMHP will monitor and apply HHS interoperability standards as they are developed. Technical infrastructure will deploy standard interface for connectivity to the statewide network. One Health Record® will adhere to the HHS standards when exchanging records with another entity on the eHealth Exchange.
Design, develop and implement the state MU Infrastructure as expanded MMIS	AIU Completed MU SLR Completed Ongoing	MMIS architecture built to interoperability, privacy and other Modified MU Stage 2 standards to allow interface with CMS Registration and Attestation System, provide the support required for provider identification, payment and oversight. Initial health-IT focus on payment for AIU. Immediately following, technical support for MU quality measurement reporting, oversight and payment completed. A-SMA is currently re-bidding SLR contract with a new go-live set for 8/1/2016.
Business and Technical Operations Activities/Approaches		
One Health Record® RFI	Completed	There were 21 responses to the RFI, which provided validation to the Technical Infrastructure’s workgroup proposed approach.
Initial One Health Record® S/OP, A-SMHP and I-HIT- APD	Completed	Alabama Strategic/Operational Plan no longer submitted to ONC effective 6/30/14. Strategy incorporated into in A-HIE operational policies where needed, and A-SMHP/I-HIT-IAPD.
PI	Completed, but Ongoing	Development and implementation of technical and business operations to support PI , ADT , VBP, and Population Health Analytics aligned with federal and other states.
Governance Activities/Approaches		

Activity	Year	Approach
One Health Record® Operating Commission Charter, By-Laws and Policies/Procedures	Ongoing	Revised and adopt using examples from other states and private organizations. Periodic review continues.
A-SMA Established	Completed	A-SMA established within the Medicaid Agency
Trigger Thresholds	On Hold	Establish threshold events including participation, financial; budget sustainability, functional and political events
HIT Oversight	On Hold	Adopt regulations for HIO oversight by A-SMA by FY 2020.
Finance Activities/Approaches		
Long-Term Sustainability for One Health Record® A-HIE	Completed by FY 2020.	Commission will advise legislature after plan development is completed and ACHN has been established & operational
Cost Benefit Analysis of statewide HIE	Completed, but Ongoing	Blue Cross/Blue Shield of Alabama conducted the analysis. Stakeholder discussions involving ACO and the ACHN and connected entities to review analysis
Business Case for Participation in One Health Record®	Completed, b	Alabama State University conducted this analysis.
Federal Reporting for MU and other ARRA activities (ONC funding)	Ongoing	A-SMA created a standardized approach to federal reporting through the Medicaid Agency and state A-SMA.
Federal funding	Ongoing	A-SMA identify and fully utilize federal funding through MU authority, Affordability Act authority, CHIPRA authority and ongoing MMIS authority. A-SMA submit additional I-HIT-APDs and I-MMIS-APDs to support public, mental health, structured lab integration, PDMP, and geographical PHI exchange activities.
Policy and Legal Activities and Approaches to Activities		
Legislative Requirements		
Establish a statewide policy framework that allows for incremental and continuous development of One Health Record®.	Ongoing	Determine the need for state law that is necessary. Draft such that changes to federal law that automatically trigger a mirror change in state law.
Establish Requirements for how One Health Record® & PI Infrastructure will comply with all applicable federal and state legal and policy requirements, with a continuing alignment to federal Medicare and Medicaid requirements. Federal regulations will be the floor and Alabama regulations will only be written if they deviate.	Ongoing	Research and identify federal regulations to compare to Alabama state legislation for conflicts, potential updates, or missing legislation. Compare the eHealth exchange business agreement and DURSA and identify potential areas of concern/follow-up for comparison with Alabama state law. Continue to refine Develop an Alabama specific DURSA and Business Agreement.

Activity	Year	Approach
		<p>Review Current Law & Regulations/laws to determine from “as is” to “to be” for both federal and state authority:</p> <ul style="list-style-type: none"> • missing and needs to be added • exists and no longer appropriate • exists and needs to continue • exists and needs to change but outside authority of state to change (federal law) <p>Areas of Focus:</p> <ul style="list-style-type: none"> • Privacy and Security: • Federal Law Compliance: HIPAA, FERPA, MH, Adolescent, Substance Treatment, HIV/AIDs, Other • Authorization & authentication • Insurance and “entity” status • Tax Law • Relationship to HISPC and to MITA efforts • Other
Identify policy issues and establish recommended policy	Ongoing	Medicaid Agency to develop with assistance from Legal and Policy Workgroup.
Privacy and Security		
Examine the federal privacy and security requirements for data security and integrity related to the exchange of health information	Completed, but Ongoing	Research and identify federal regulations to compare to Alabama state legislation for conflicts, potential updates, or missing legislation. ARRA, HIPAA Privacy Rule, HIPAA Security Rule, Confidentiality of Alcohol and Drug Abuse Patient Record Regulation)
Establish how levels of consumer access to information in the AHIE will be defined and how sensitive health information will be protected.	Ongoing	Consumers given choice regarding decisions about the collection, use and disclosure of their PHI. Policies developed that will ensure that consumers have a timely means to dispute the accuracy of HIE information.
Review Health Information Security and Privacy Collaboration (HISPC) work in the area relating to privacy and security	Completed	<ul style="list-style-type: none"> • There is no HISPC for Alabama. • Alabama Medicaid will investigate local policies.

Activity	Year	Approach
Development of Exchanges with Other States		
<p>Perform research to gain an understanding of other state policies regarding HIE to determine where common ground exists and to identify where Alabama policy changes may need to be pursued. Conduct a survey of states to determine which states have the most compatible technologies and policies in place. Examine pilot exchanges between states to determine the parameters for its operation and governing regulations.</p>	<p>Completed, but /Ongoing</p>	<p>Alabama Medicaid coordinates with the Strategic Health Information Exchange Collaborative (SHIEC) . Alabama Medicaid completed work with Missouri and Georgia to initiate interstate exchange.</p> <p>Alabama is a participant of eHealth Exchange and will expand connections as other states become participants in the e-Health Exchange. This is true for DIRECT as well. Alabama is expansion this gateway connection to include the SSA (SSDI) and VA (V-LER & Direct)</p>
Policy and Procedure Development		
<p>Identify recommended legal policies and procedures related to a statewide policy development process</p>	<p>Completed, but Ongoing</p>	<p>Legal and Policy Workgroup to identify.</p>
<p>Determine One Health Record® operational policies and procedures in relationship to University Education: medical education & informatics with AHIE participants & Stakeholders</p>	<p>Ongoing</p>	<p>Legal and Policy Workgroup in conjunction with Governance will identify and develop outline of issues.</p>
<p>Incorporate recommended legal policies and procedures</p>	<p>Ongoing</p>	<p>Alabama Medicaid Agency to receive issues from LRT and Legal and Policy Workgroup</p>
<p>Establish recommended priority policies</p>	<p>Completed-Annual Work plan Modifications – Ongoing</p>	<p>Alabama Medicaid Agency to develop and modify implementation framework</p>
Oversight and Risk Mitigation		
<p>Establish risk mitigation policies</p>	<p>Completed, but Ongoing</p>	<p>Legal and Policy Workgroup will identify and develop outline of issues.</p>
<p>Establish oversight and enforcement mechanisms</p>	<p>Ongoing</p>	<p>Will not require legislative change to accomplish.</p>
<p>Incorporate risk mitigation legal policies and procedures</p>	<p>Ongoing</p>	<p>Alabama Medicaid Agency to receive issues from LRT and Legal and Policy Workgroup</p>
Communication and Marketing		

Activity	Year	Approach
<p>Progress reports and details on AHIE system issued via association publications, HIE Web site;</p> <p>Establish and publicize mechanism for regular progress updates and feedback via Web site</p> <p>Creation of provider-specific “tool kit” for CEO/CIO use with hospital CEOs/boards/medical staff (e.g. fact sheets, FAQs, white paper, slide presentation, sample articles, emails, brochures); available via Web site Scheduled presentations to providers at their location, society and other state and regional meetings</p> <p>Physician outreach and education activities in coordination with REC</p> <p>Development of CME-based educational activities for physicians</p>	<p>2010 – 2017</p> <p>Ongoing</p>	<p>By audience: Providers, (Hospitals, Physician, Laboratory, X-ray, Pharmacy, Ancillary Services, Rural and Safety Net and Other); Healthcare Payers, Purchaser, State Agencies</p> <ul style="list-style-type: none"> • Branding/Logo Development – Year 1 • Web site first available – Year 1 • Established feedback/reporting mechanism – Year 1 • Dissemination of news articles for hospital publications for patients, physicians, community – Years 1-5 • Progress reports and details on AL HIE system issued via hospital association publications, HIE Web site; Years 1-5 • Development of White Paper – Year 1; update Years 2-5 • Presentations to physicians at hospital, society and other state and regional meetings – Years 1-5 • Creation of provider-specific “tool kit” for CEO/CIO use with provider CEOs, boards, medical staff (e.g. fact sheets, FAQs, white paper, slide presentation, sample articles, emails, brochures); available Web site. - Year 2 • Update toolkit – Years 5-6 • Development CME Activity for physicians – Year 2 (Physicians) • Dissemination of news articles for patient publications – Years 2-6 • MU Outreach and TA strategy for 2016-17 Provider Recruitment & Migration – years 5-6

6.1 WHAT ARE THE SMA’S EXPECTATIONS RE PROVIDER EHR TECHNOLOGY ADOPTION OVER TIME? ANNUAL BENCHMARKS BY PROVIDER.

As stated in the previous update, the state established a 10% targeted goal for final AIU participation for PY 2016. . The end of PY 2016 saw Alabama increase its percentage of AIU participants by 25% 479/1855 due to focus TA and outreach, with an overall increase of 54% (302/555) over our average year participation. The brought Alabama unique program participants to 2334 EP's.

Table 24: 2017 PI Incentive Payments; CY 2018

Volume		Average Payment	Paid/Budgeted Amount	Assumptions
2nd Quarter 2018				
EP Modified Stage 2 – Year 1	260	\$ 8,500.00	\$ 2,210,000.00	Averages 275/month to process
EP Modified Stage 2 – Year 2 and beyond	75	\$ 8,500.00	\$ 637,500.00	Assumes Migration to Stage 2 average per month.
2nd Quarter Total			\$ 3,485,000.00	
3rd Quarter 2018				
EP Modified Stage 2 – Year 1	260	\$ 8,500.00	\$ 2,210,000.00	Averages 275/month to process
EP Modified Stage 2 – Year 2 and beyond	75	\$ 8,500.00	\$ 637,500.00	Assumes Migration to Stage 2 average per month.
2nd Quarter Total			\$ 3,485,000.00	
4th Quarter 2018				
EP Modified Stage 2 – Year 1	260	\$ 8,500.00	\$ 2,210,000.00	Averages 275/month to process
EP Modified Stage 2 – Year 2 and beyond	75	\$ 8,500.00	\$ 637,500.00	Assumes Migration to Stage 2 average per month.
4th Quarter Total			\$ 3,485,000.00	
CY 2018 Totals			\$ 14,940,000.00	

6.2 DESCRIBE THE ANNUAL BENCHMARKS FOR EACH OF THE SMA'S GOALS THAT WILL SERVE AS CLEARLY MEASURABLE INDICATORS OF PROGRESS ALONG THIS SCENARIO.

An overarching principle for inclusion or exclusion of any outcome and/or performance measure is that the measure provide day-to-day operational usefulness and support the evaluation of the effort at the individual, population, initiative and statewide level from the perspective of consumers, providers, and purchasers/payers. Outcomes and/or performance benchmarks are

consistent for evaluation of “success” for MU. As stated in the previous SMHP update, Alabama identified 6 priority areas for MU: e-Prescribing, Lab Exchange and Care Summary Exchange Stage 1-to-Stage 3 migration, Public Health reporting and data quality, and eCQM’s analysis. IN 4th quarter 2016, A-SMA continued to focus

The metrics for those program priority areas are provided in the table below and provide the status as of December 2016. The performance progress measure/target for lab exchange is based on state collected data and compared to a baseline of no connection to the State Lab (Public Health), LabCorp and Quest (largest private providers). The performance progress measure/target for patient care summaries were originally established through the 30-60-90-120 day roadmap engagement with the One Health Record® vendor. These measures continued to support the progress and utilization of Health IT across Alabama.

Table 25d: Performance Progress Measures/Targets

Program Priority	Status as of December 20163	Target for December 2017	Status as of December 2017	Target for December 2018	Status as of December 2018
Public Health agencies receiving ELR data produced by EHRs or other electronic sources. Data are received using HL7 2.5.1 LOINC or SNOMED (Yes/No or %)	Yes	Yes	Yes	Yes=100%	Yes
Immunization registries receiving electronic immunization data produced by EHRs. Data are received in HL7 2.3.1 or 2.5.1 formats using CVX code (Yes/No or %)	Yes	Yes	Yes	Yes=100%	Yes
Public health agencies receiving electronic syndromic surveillance hospital data produced by EHRs in HL7 2.3.1 or 2.5.1 formats (using CDC reference guide) Yes/No or %	Yes	Yes	Yes	Yes=94%	Yes
Public Health agencies receiving electronic syndromic surveillance ambulatory data produced by EHRs in HL7 2.3.1 or 2.5.1 Yes/No or %	No	Yes	No	Yes=100%	Yes
% of hospitals sharing electronic care summaries with unaffiliated hospitals and providers	20%	80%	17%	60%	TBD%
% of ambulatory providers electronically sharing care summaries with other providers	15%	50%	15%	35%	TBD%

6.3 DISCUSS ANNUAL BENCHMARKS FOR AUDIT AND OVERSIGHT

Table 25e Annual Benchmarks for Audit and Oversight

2011 AIU Audit Metrics

Total number of EP AIU audits for Program Year 2011 to be completed.	344 (20% of 2011 Program Year Provider Participants)	Total number of EH AIU audits for program year 2011 to be completed.	18 (20% of 2011 Program Year Provider Participants)
Total number of EP AIU audits for program year 2011 conducted as of 12/31/2015	360(105% of total)	Total number of EH AIU audits for program year 2011 conducted as of 12/31/2016	AIU For EHs will begin in the last quarter of FFY 2014
Total number of EP AIU audits for program year 2011 requiring secondary post audit reviews	46 (12.7%)	Total number of EH AIU audits for program year 2011 requiring secondary post audit reviews	Unknown
Total number of EP AIU audits for program year 2011 corrective action plans	2 (.006%)	Total number of EH AIU audits for program year 2011 corrective action plans	Unknown

2012 AIU Audit Metrics

Total number of EP AIU audits for Program Year 2012 to be completed.	40	Total number of EH AIU audits for program year 2012 to be completed.	
Total number of EP AIU audits for program year 2012 conducted as of 12/31/2015	51 (127%)	Total number of EH AIU audits for program year 2012 conducted as of 12/31/2016	
Total number of EP AIU audits for program year 2012 requiring secondary post audit reviews	20 (39%)	Total number of EH AIU audits for program year 2012 requiring secondary post audit reviews	
Total number of EP AIU audits for program year 2012 corrective action plans	0	Total number of EH AIU audits for program year 2012 corrective action plans	

2012 MU Audit Metrics

Total number of EP MU audits for Program Year 2012 to be completed.	40	Total number of EH MU audits for program year 2012 to be completed.	
Total number of EP MU audits for program year 2012 conducted as of 12/31/2015	42 (105%)	Total number of EH MU audits for program year 2012 conducted as of 12/31/2016	
Total number of EP MU audits for program year 2012 requiring secondary post audit reviews	12 (29%)	Total number of EH MU audits for program year 2012	

		requiring secondary post audit reviews	
Total number of EP MU audits for program year 2012 corrective action plans	0	Total number of EH MU audits for program year 2012 corrective action plans	

2013 Audit Metrics

Total number of EP AIU audits for Program Year 2013 to be completed.	30
Total number of EP MU audits for Program Year 2013 to be completed.	30
Total number of EP MU audits for program year 2013 corrective action plans	
Total number of EP MU audits for program year 2013 corrective action plans	

7. ACKNOWLEDGEMENTS

The State of Alabama thanks the many stakeholders of Alabama One Health Record® Health Information Exchange and their workgroups for their ideas, expertise and time in the initial development of the Alabama Strategic Plan for Health Information Exchange (A-S/OP) and ongoing contributions to the Alabama State Medicaid HIT Plan (A-SMHP). The enormous amount of volunteer commitment has been extraordinary and has resulted in a concrete strategic vision that will meet the needs of the state, providers and consumers.