STATE OF ALASKA

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF HEALTH CARE SERVICES

STATE MEDICAID HIT PLAN UPDATE (SMHPU)

VERSION 2.02

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1 EXECUTIVE OVERVIEW

The approach taken by Alaska Division of Health Care Services (DHCS) in preparing this State Medicaid Health Information Technology (HIT) Plan (SMHP) was to develop a plan with the intent to implement the Alaska Electronic Health Record (EHR) Incentive Program in January 2011. This allows Alaska's eligible providers the opportunity to review EHR products, find a match to meet the needs of their offices and hospital settings, and maximize payments available under the federal Provider Incentive Program. Alaska has closely followed the Final Rule, 42 Code of Federal Regulations (CFR) Parts 412, 413, 422, and 495 published July 13, 2010, implementing the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111–5), in the development of a plan that provides incentive payments for the adoption, implementation, and upgrade of certified EHR's and meaningful use of certified EHR technology.

In May 2009, Senate Bill 133 was signed into law requiring the Alaska Department of Health and Social Services (DHSS) to establish a Health Information Exchange (HIE) with a non-profit governing board that represents Alaska's various stakeholder communities. In November 2009, DHSS submitted a draft HIT Plan to the Office of the National Coordinator for Health Information Technology (ONC) detailing the development of an economical, sustainable HIE in Alaska. In March 2010, the DHSS entered into a cooperative agreement with the ONC to create an HIE in Alaska. In April 2010, DHSS contracted with the Alaska eHealth Network (AeHN) to be the non-profit governing board that will procure and manage Alaska's HIE.

The establishment of the non-profit governing board has established a foundation of collaboration and coordination that has brought a diverse group of stakeholders together to advance Alaska's HIE. Development of Alaska's HIE will result in the culmination of over ten years of statewide and regional health information exchanges and concepts created in the National Health Information Network (NHIN)and enhanced through ARRA stimulus. Currently AeHN is leading the evaluation process of qualified vendors to implement the state's HIE.

Alaska's HIT Coordinator participates on the governing board and other work groups to ensure efficiency and effectiveness of planning efforts. Outreach to educate providers on the Alaska's EHR Incentive Program is being coordinated with AeHN who is also the state's Regional Extension Center (REC). Education materials are being developed and made available through provider workshops and quarterly meetings to minimize duplication of efforts. Professional associations collaborating with AeHN include Alaska State Medical Association (ASMA); Alaska Hospital Association (AHA); Alaska Primary Care Association (APCA); Federally Qualified Health Centers (FQHCs); Alaska Native and Tribal Heath Network and Rural Health Clinics (RHCs).

DHCS completed its initial Medicaid Information Technology Architecture (MITA) State Self-Assessment (SS-A) in 2008 to support the current MMIS Replacement Project. The initial MITA SS-A did not include all of the elements to support development of this SMHP and as a result, a MMIS SS-A Update was conducted to revisit As Is and To Be business processes, assess MITA maturity levels according to MITA Framework 2.01 and develop a Technical Assessment and HIT Roadmap.

The approach taken during planning for Alaska's EHR Incentive Program administration was to review MITA business processes, and identify and integrate the EHR Incentive Program processes into Alaska's MITA business processes and existing day-to-day operations. In cases where processes did not exist, new processes were developed. Examples of these processes

would include Alaska's EHR Incentive Program eligibility determination, verification of member volume, attestation receipt and validation, and certain audit functions.

Alaska's SMHP will provide readers with an understanding of activities DHCS will employ over the next five years to implement section 4201 Medicaid provision of the ARRA, focusing on the implementation of the EHR Incentive Program. Subsequent sections of the SMHP provide a detailed description of the plan to implement and administer the Alaska's EHR Incentive Program, including Alaska's plans to:

- Establish, administer, and oversee the program;
- Obtain stakeholder input to assist with development and implementation of meaningful use definitions;
- Capture attestations and reporting data electronically;
- Disburse and monitor incentive payments;
- Update the State's electronic systems to improve functionality and interoperability;
- Pursue incentives to encourage adoption, implementation, or upgrade of certified EHRs and meaningful use by eligible professionals (EPs) within their practices and by eligible hospitals (EHs) throughout the state;
- Ensure Privacy and Security of electronic Protected Health Information (ePHI); and
- Prevent fraud and abuse

The ultimate goals for the State of Alaska are to ***improve access to health care and quality of health care for Alaskans***. The DHSS vision for the future of HIT is a multi-year vision that consists of existing and planned projects and initiatives that will significantly contribute to Alaska's health care transformation. By leveraging implementation of new technologies such as a modernized MMIS, extending web based access to providers and members, EHRs, and HIE networks, DHSS will do its part in supporting a health care system for Alaska that places individual Alaskans, their families and communities at the center of their health care experience and ultimately shift the focus from treatment to prevention.

1.1 SMHP Update Document Purpose

DHCS submitted and received approval for the State Medicaid Health Information Technology Plan (SMHP) in November 2011 and the related Implementation Advance Planning Document (IAPD) in March 2011. The Centers of Medicare & Medicaid Services (CMS) approved the Alaska EHR Incentive Payment Program to "go live" in March 2010.

At the time of original SMHP submission, DHCS chose to defer the planning and implementation activities necessary to develop the EHR Incentive Program Year 2 administration and business processes. This SMHP Update (SMHPU) will include the program description and related business processes to develop the second year of the EHR Incentive Program.

In addition over the course of the last seven months, DHCS and CMS have identified opportunities to refine the Adopt/Implement/Upgrade (A/I/U) to align with CMS direction or issues uncovered in operations.

Due to significant modifications in the organization structure of DHSS put into place since the February 2011 SMHP, an updated organization chart is included in Appendix F.

1.1.1 SMHP Update Audit Review

DHCS received input from CMS on February 28, 2012 relating to the State's SMHP Audit plans. This SMHP Update, version 2.1 addresses the changes and clarification requested in the CMS comments.

1.2 Background

The CMS has implemented through provisions of the ARRA that provide incentive payments to EPs, EHs, and critical access (CAHs) and acute care hospitals participating in Medicare and Medicaid programs that are meaningful users of certified EHR technology. The incentive payments are not a reimbursement, but are made to incent EPs and EHs to adopt, implement, or upgrade certified EHR technology. EPs and EHs participating in the Medicaid Provider Incentive Program may qualify in their first year of participation for an incentive payment by demonstrating any of the following: meaningful use in the first year of participation, or that they have adopted (that is, acquired and installed), implemented (that is, trained staff, deployed tools, exchanged data) or upgraded (that is, expanded functionality or interoperability) a certified EHR. Incentive payments may also be disbursed to providers who demonstrate meaningful use for an additional five years culminating in 2021.[1]

The ONC has issued a closely related Final Rule that specifies the Secretary's adoption of an initial set of standards, implementation specifications, and certification criteria for EHRs. Additionally, ONC will issue a separate notice of proposed rulemaking related to the certification of HIT.

Goals for the national program include: 1) enhance care coordination and patient safety; 2) reduce paperwork and improve efficiencies; 3) facilitate electronic information sharing across providers, payers, and state lines; and 4) enable data sharing using state HIE and the NHIN. Achieving these goals will improve health outcomes, facilitate access, simplify care, and reduce costs of healthcare nationwide.

DHCS will work closely with federal and state partners to ensure the Alaska EHR Incentive Payment Program fits into the overall strategic plan for the AeHN, thereby advancing national goals for HIE.

1.3 Current HIT Landscape in Alaska

1.3.1 Use of MITA Principles and Methodology

In 2008, Alaska DHCS completed a MITA SS-A using MITA Framework 2.0 the Plan for moving the MMIS forward to its envisioned To Be state. This work has been leveraged and integrated into the statewide HIT Landscape to promote statewide cost-effective and efficient use of HIT, where feasible. The same iterative MITA planning process was used, beginning with an environmental scan, to assess the As Is readiness of Alaska providers and identify gaps.

[1] CMS Office of Public Affairs: 202-690-6145. CMS Proposed Requirements for the Electronic Health Records (EHR) Medicaid Incentive Payment Program. December 30, 2009.

During the planning phase, business areas reviewed the regulatory requirements for submission of the SMHP published in the Final Rule at §495.332 and in CMS guidance for developing the SMHP published on April 29, 2010. The project team then reviewed each SMHP business process to determine if the standard MITA business process would apply to develop a concept of operations for the Alaska EHR Incentive Payment Program. As shown in Figure 1, all MITA business processes were reviewed and where feasible the approach adopted was to integrate the Alaska EHR Incentive Payment Program business process into DHCS's corresponding standard MITA business process.

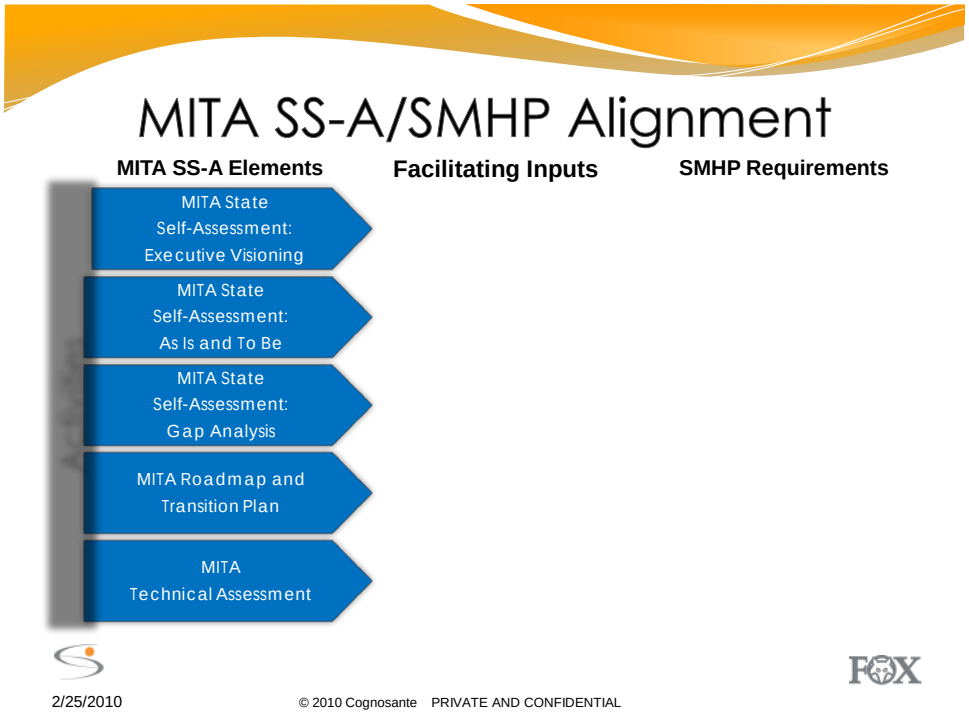


Figure 1 – MITA SS-A to SMHP Alignment

The 2009 MITA Technical Assessment will be reviewed following the identification of the Business and Technology gaps and functionality needs to fill the gaps. The Technology Assessment will be updated as necessary and Alaska EHR Incentive Payment Program HIT projects integrated into the MITA Roadmap.

1.3.2 Vision of HIT Future

The enactment of Senate Bill 133 established a vision for HIE and improved healthcare outcomes as a result of collaboration among medical providers in the state. The AeHN will implement a HIE network solution within the next 12 months; DHCS will put a modern, integrated MMIS in place shortly thereafter. Alaska continues to be a leader in telemedicine delivery, expanding the range of medical services to remote areas. These efforts are further supported by significant infrastructure investment in broadband access.

1.3.3 Provider Incentive Program Implementation

The Strategy to support the Provider Incentive Program will be divided into two phases. The first phase will support the year one requirement to accept provider registration from CMS National

Level Repository (NLR), accept provider attestation, ensure provider eligibility and distribute provider payments. The second phase will support the collection of provider meaningful use outcomes and measures in addition to the functions listed for phase 1.

DHCS intends to leverage the existing Medicaid Provider Enrollment Portal (PEP) by integrating a State Level Repository (SLR) portal to support the attestation, eligibility determination, provider payment calculation and the collection of basic meaningful use data.

2 CURRENT HIT LANDSCAPE ASSESSMENT – THE "AS IS" ENVIRONMENT

There are 22 hospitals in Alaska, 17 of which are located in rural areas (North Carolina Rural Health Research and Policy Analysis Center, Dec. 2008). The state has 13 hospitals currently identified by the Flex Monitoring Team as Critical Access Hospitals (April, 2009). There are 2 Rural Health Clinics in Alaska (Kaiser, 2010), and 26 Federally Qualified Health Centers provide services at 174 sites in the state (Kaiser, 2008). Most Alaskans have some form of health insurance coverage, although 17.7% of its residents lack any health insurance (Kaiser, 2006-2007.)

2.1 Current HIT Activities and Impact on Alaska Medicaid Members

2.1.1 Alaska Senate Bill 133 - Creation of Health Information Exchange System

The State of Alaska has enacted legislation that creates a secure electronic health HIE system that

- ensures confidentiality,
- improves health care quality, reduces medical error, increases care efficiency and advances delivery of health care service
- promotes wellness, disease prevention and management of chronic conditions by increasing the availability of personal health information,
- ensures information is available to make medical decisions when and where the service is provided,
- promotes a competitive marketplace and improved heat care outcomes,
- improves coordination of information and services through an effective infrastructure for the secure and authorized exchange and use of health care information.

2.1.2 Tri-State Children's Health Improvement Consortium (T-CHIC)

The State of Alaska is participating in T-CHIC as part of the Children's Health Insurance Program Reauthorization Act (CHIPRA) quality initiative in collaboration with Oregon and West Virginia. This program is expected to improve healthcare for Denali Kidcare patients through the evaluation and implementation of pediatric quality measures. The state will coordinate efforts with T-CHIC to integrate the T-CHIC quality measures into the EHR incentive program.

2.2 Current HIT Activities and Impact on Alaska EHR Incentive Payment Program

HIT is a broad concept that encompasses the use of electronic data and communication systems for compiling, maintaining and transmitting health information. The term "health information technology" is commonly used to refer to electronic health records (EHR), HIE, and related data collection, storage, and management applications. Alaska has a number of data and information management applications that are dependent on many of the same technologies as telemedicine/telehealth. The following section describes the current HIT activities in Alaska and their relationship to the EHR Incentive Payment Program.

2.2.1 Alaska eHealth Network (AeHN)

The AeHN is a 501(c) (3) Alaska non-profit corporation, organized and managed by Alaskans. The organization was originally formed in 2005 as the Alaska Regional Health Information Organization (RHIO) which was formed as a project under the Alaska Telehealth Advisory Council as a network of public and private organizations and businesses involved in healthcare, to work on adoption of EHR's and on HIE activities. The project was initially funded by a federal grant plus monetary support from strategic partners, including the Alaska Federal Health Care Partnership, the Alaska Native Tribal Health Consortium, Premera Blue Cross/Blue Shield, Providence Alaska Medical Center, and the Alaska Division of Health and Social Services. The Alaska RHIO was renamed AeHN in 2008.

Alaska DHSS contracted with the AeHN to be the nonprofit governing board to procure and manage Alaska's HIE grant program, and to assist the State in establishing HIE capability among health care providers and hospitals in Alaska.

Over the course of the last ten years, AeHN's predecessor organization, the Alaska Telehealth Advisory Council (ATAC, 1996-2005), and subsequently, AeHN and AeHN staff (2005-2010) have been actively engaged in the development of standardized HIE policies, procedures, participant agreements, provider agreements, data use agreements, and continued refinement of the business, technical and communications plan for HIE in Alaska. In addition, providers from across Alaska have been regularly engaged in ongoing forums, discussions and planning sessions for HIE through AeHN and AeHN's predecessor organization.

2.2.1.1 *Alaska Regional Extension Center*

On April 6th, the AeHN received $3,632,357, from the ARRA to establish one of 60 nationwide health information technology REC in addition to the contract to provide the nonprofit governing board to procure and manage the HIE as described in 2.2.1 above.. The Alaska REC will provide technical assistance to eligible doctors and hospitals that select and implement electronic record systems. The federal funding will allow AeHN to establish a HIT REC that will help Alaska's healthcare providers learn how to select and use EHRs, and obtain funding assistance for those who adopt EHR systems in coming years. DHCS will collaborate with the REC to share information collected in the Environmental Scan and ensure consistent messaging to providers. The REC has started to engage and enroll 1,000 or more eligible providers (for REC incentives) over the next two years. AeHN enrollment is open to all providers and other participants and REC services are available to all, however, REC incentive funding is limited to eligible providers

The REC plans to reach 1, 000 primary care providers and hospitals in two years in an effort to achieve widespread meaningful use of health Information Technology (IT) and to promote electronic health record utilization for every citizen by the year 2014.

2.2.1.2 *Alaska Regional Extension Center Activities (UPDATE – November 2011)*

The AeHN acting as Alaska's Regional REC has engaged in the following important activities supporting HIT efforts, targeting primary care physicians:

- Education and Outreach activities such as quarterly newsletter releases, website updates, media/press releases, and participation in professional association meetings.
- Coordination with other states through Communities of Practice (CoP) groups providing opportunities for sharing "best practices" for provider outreach.
- Webinars and presentations targeting HIE participation and EHR adoption.

AeHN acting as the REC has engaged over 200 Alaskan providers as of mid-August 2011.

As mentioned above, the National Indian Health Board (NIHB) was awarded a National REC grant in April 2010 and the Alaska Tribal Regional Health Center signed an agreement with the National REC in July 2011.

2.2.1.3 *National Indian Health Board National Regional Extension Center*

The NIHB received an award from the ONC to establish the operations of the American Indian/Alaska Native National Regional Extension Center (AI/AN National REC). The AI/AN National REC will assist Tribal health providers with achieving meaningful use of Electronic Health Records (EHRs).NIHB is expected to reach all Indian tribes to support EHR deployment and meaningful use implementation; an objective that could impact approximately 3,000 providers in 35 states at over 500 individual tribal provider sites. The Alaska Native Tribal Health Consortium (ANTHC) was an active participant in the development of the grant proposal.

2.2.1.4 *Tribal Regional Extension Center (REC)*

The NIHB and the Alaska Tribal Regional Health Center signed an agreement in July 2011 to support tribal health care providers in Alaska. By the end of July, the Tribal REC reported engagement of approximately 150 tribal providers.

2.2.1.5 *Health Information Exchange Acquisition*

AeHN has coordinated an effort to develop HIE product requirements, write a Request for Proposal (RFP), evaluate responses and select an HIE vendor for the state. This process included over 80 participants representing various provider and payor entities. Eight responses to the RFP were evaluated, 4 vendors were selected to deliver technical and workflow demonstrations based on specific pre-defined criteria.

AeHN is currently in the due diligence phase of the selection process. AeHN and the participants expect that a solution will be selected in October 2010 and a partial implementation will be complete within six to eight months of contract execution.

DHSS will participate in the statewide HIE. The MMIS will ultimately interface with the HIE to send requests for services and receive administrative and clinical data through the HIE. The clinical data received will be used by Medicaid to review services requiring prior approval and to validate quality improvement measures. The administrative data will aid in validating patient eligibility and validating that each enrolled Medicaid EHR Incentive Program eligible provider has met Medicaid patient threshold.

The AeHN has selected Orion Health as its statewide HIE technology provider. AeHN will work with Orion Health to deploy the technology using a hosted, software-as-a-service model. AeHN launched a pilot program in February 2011 with one hospital and two clinics participating in the exchange of authorized medical information. The pilot and associated user acceptance testing was completed in early September 2011. AeHN expects to begin connecting additional Alaska providers by December 2011.

2.2.2 Alaska Community Health Integrated Network (ACHIN)

In August 2008, a State of Alaska funding request was approved for a three year project to fund the initial phase of a project to build an integrated health information network across Alaska's Community Health Centers (CHC) for sharing of electronic health records. The Alaska Primary Care Association (APCA) has created the Alaska Community Health Integrated Network (ACHIN) project to implement health information technology resources that will serve safety net clinics across the state by building a Wide Area Network (WAN) to support centralized servers, software, videoconferencing, and telehealth applications. The health integrated network will initially include nine CHCs located throughout Alaska.

Over half of the CHCs participating in the project are active participants. The initial cost to join is based on the number of providers at each facility. Nextgen Health Information Systems is the selected vendor for this EMR and Practice Management (PM) project. For initial program funding individual CHCs and the APCA have allocated $2,668,450, with the balance of $2,500,000 coming from the State of Alaska.

ACHIN is working closely with AeHN and will connect its partners to the AeHN HIE when it becomes available.

2.2.3 Health Information Security and Privacy Collaboration (HISPC)

The privacy and security project is a component of the United States Department of Health and Human Services' strategy to identify variations in privacy and security practices and laws affecting electronic clinical health information exchange, develop best practices, and propose solutions to address identified challenges, and increase expertise about health information privacy and security protection in communities. States and territories selected to participate are charged with bringing together a broad range of stakeholders to develop consensus-based solutions to problematic variations in privacy and security business policies, practices and state

laws. The participating states include: Alaska, Arkansas, Colorado, Iowa, Illinois, Indiana, Kentucky, Massachusetts, Maine, Michigan, Minnesota, Mississippi, North Carolina, New York, Ohio, Oklahoma, Rhode Island, Utah, Washington, Wisconsin, West Virginia and Wyoming.

AeHN, Alaska's representative for the Health Information Security and Privacy Collaboration (HISPC) has developed common policies for privacy and security that have been adopted as national models. Phase III allowed other states to review the work started by the participants and develop a national set of privacy and security documents including an Inter-organizational Agreement, a Confidentiality Agreement and policies addressing each. This HISPC initiative was completed on schedule and provided a framework for the development of the AeHN HIE.

AeHN has developed a set of key messages important to health information stakeholders regarding the benefits of EHR and HIE. Of these messages, one set focuses on the Privacy and Security:

- Increase Patient Privacy and Security in exchanging Medical Records: The following safeguards will ensure greater privacy and security: Patient's personal medical information will be shared through the network only with their permission.
- Prior to releasing any personal information, the identity of anyone using the EHR system will be carefully confirmed to prevent unauthorized access or cases of mistaken identity.
- Patients will have Internet access to review their own health and medical history via a secure account.
- Patients will be able to review who has accessed their personal medical information through the Personal Health Record.
- Employers will not have access to the secure network used to exchange information between healthcare providers.
- Special selected categories of the medical record will be protected from exchange.

The messages and policies developed during the HISPC project have been incorporated into the AeHN RFP for HIE.

2.2.4 Alaska Electronic Health Record Alliance (AEHRA)

The AEHRA was organized in January of 2005. The Board of Directors includes representatives from the community, physicians, insurance companies, Premera Blue Cross, Aetna and medical associations including the Alaska Physicians and Surgeons, the Alaska Chapter of the American College of Physicians, and the Alaska State Medical Association.

The group was formed to support the development of affordable, interoperable electronic health records for non-public sector healthcare providers in Alaska. This network will tie together diverse practices, hospitals, and decision support systems to improve clinical practices within the state of Alaska. The goals of the Alliance are to assist physicians and mid-level providers in incorporating EHRs into their clinical practices by providing support, information, and resources. The ultimate vision includes developing an interoperable network of EHRs for providers in Alaska with the ability to connect to a nationwide, interoperable network.

Through a collaborative effort with AeHN and AEHRA a private firm was contracted to conduct a statewide survey of Alaska physicians and clinic managers to determine the following:

- Current physician usage of EHRs;
- Identification of the EHR systems in use in the State;
- Interest by non-users in adopting EHRs; and

- Identification of barriers to adoption.

The information from the survey was used to support selected Alaska providers who adopted and tested several recommended EHRs. The survey was the first step in the AEHRA's program, which was aimed at supporting the mutual goal of the Alliance and survey funders to develop a statewide EHR exchange network. The survey was funded by the Rasmuson Foundation through a grant to AeHN, and with contract management by ANTHC. Additional funding was provided by Providence Health System Alaska and the AEHRA. The database of Alaska licensed physicians was provided by the Alaska State Medical Association. In addition, the Alaska Medical Group Management Association emailed the survey link to their members, who are clinic managers, for them to take the survey online. An email notice was sent to those physicians in the database with available email addresses.

The survey was made available to 1401 physicians and 180 clinic managers using the ASMA medical license database and the Alaska Medical Group Management Association's membership.

Total completed surveys:

Physicians:	378	85.9%
Clinic Managers:	62	14.1%
TOTAL:	440	100%

Statewide participation was widespread; physicians and clinic managers from 29 communities completed the survey.

After the survey of Alaska providers, an eight-month evaluation process involving a 15-member statewide taskforce consisting of physicians and clinic managers, EHR vendors were evaluated based on their products, pricing, reputation, and interoperability.

Greenway and e-MD were selected as the top EHR vendors. These two vendor's products and services were deemed best-suited for Alaska's providers, with particular emphasis on those in the smaller 1 – 10 size clinics. The selection task force scored e-MDs and Greenway Medical Technologies the highest in the selection process based on a number of factors. Their recommendation was approved by AEHRA Board that then publicized the selection to Alaskan providers. The endorsed vendors scored well in the following areas:

- Affordability
- e-Prescribing capability and functionality
- Certification Commission for Health Information Technology (CCHIT) Certification
- Top rankings in American Academy of Family Physicians and American College of Physicians Surveys and consistently high scores from vendor analyst, KLAS
- Guarantee to interface with State HIE system, when selected
- Inclusion of a practice management system
- Small to mid-size practice specialty
- 93.3% satisfaction rating from Alaska physicians in 2009

These two endorsed providers are offering Alaska providers access to preferred pricing and pre-negotiated contracts to simplify the EHR selection process. Some of the Alaska provider advantages include:

- 30% discount on software solution

- 50% discount on hospital interfaces
- Pre-negotiated contracts (reduced legal fees)
- Access to EHR selection tools and ARRA info

Since being selected by AEHRA, e-MDs and Greenway have entered into contracts with 16 provider organizations through September of 2010 and continue to provide information to other providers about their solutions.

AEHRA continues to work closely with the AeHN REC in outreach and education activities for providers.

2.3 New HRSA Grants

The Health Resources and Services Administration (HRSA) announced a number of new health IT related grants in September of 2011. Alaska was awarded over $1.1 million in three award announcements.

2.3.1 Rural Health Information Technology Grants

Three Alaskan rural health networks will receive grants to support their adoption of HIT and certified EHRs. The funding announced in early September 2011, will also help participating eligible providers qualify for Medicare and Medicaid EHR incentive payments, administered by CMS. Each of the grantee organizations will receive funds to purchase equipment, install broadband networks and provide training for staff.

Table 1 – Rural HIT Grants

Organization	Location	Amount
Alaska Native Tribal Health Consortium	Anchorage, Alaska	$300,000
Alaska State Hospital & Nursing Home Association	Juneau, Alaska	$300,000
Tanana Chiefs Conference	Fairbanks, Alaska	$300,000

2.3.2 Community Health Center Planning Grants

HRSA distributed additional Patient Protection and Affordable Care Act (PPACA) funds for organizations to become community health centers in September 2011. The funding will help these organizations plan for the development of a comprehensive primary care health center, so that they can provide care for some of Alaska's most vulnerable populations and potentially create more high-quality jobs in the future for their communities. These awards fund community-based entities seeking to provide a more comprehensive range of primary health care services and or expand their services to a larger community.

Table 2 - Alaska's Community Health Center Planning Grants

City of Seward	Seward, Alaska	$80,000
Kodiak Area Native Association	Kodiak, Alaska	$80,000

2.3.3 Community Health Center Medical Home Grants

HRSA announced that 904 community health centers nationwide received funds to support an initiative that focuses on enhancing the quality and coordination of healthcare services through the patient-centered medical home.
These funds made available under the PPACA is considered supplemental funding that will provide upfront assistance to existing health centers as they try to achieve recognition as a patient-centered medical home. Activities include care planning, support for team-based models of service delivery and system upgrades.

Table 3 - Community Health Center Medical Home Grants

Anchorage Neighborhood Health Center	Anchorage, Alaska	$35,000
Bethel Family Clinic	Bethel, Alaska	$35,000
Bristol Bay Area Health Corporation	Dillingham, Alaska	$35,000
Interior Community Health Center	Fairbanks, Alaska	$35,000
Council of Athabascan Tribal Government	Fort Yukon, Alaska	$35,000
Southeast Alaska Regional Health Consort	Juneau, Alaska	$35,000
Manillaq Association	Kotzebue, Alaska	$35,000
Bristol Bay Borough	Naknek, Alaska	$35,000
Seldovia Village Tribe	Seldovia, Alaska	$35,000
Peninsula Community Health Services of Alaska, Inc.	Soldotna, Alaska	$35,000
Sunshine Community Health Center, Inc.	Talkeetna, Alaska	$35,000
Iliuliuk Family and Health Services, Inc.	Unalaska, Alaska	$35,000

2.4 Telecommunications.

2.4.1 United States Department of Agriculture (USDA) Community Connect

The Community Connect program, sponsored by the United States Department of Agriculture (USDA) provides grants to establish broadband service in rural communities. The grants may be used to deploy broadband transmission service to residents, businesses and critical community facilities such as police and first responders. They also may be used to construct and operate community centers that provide free broadband access to community residents. USDA Rural Development funding of $1,000,000 was awarded to Copper Valley Telephone Coop., Inc. to provide broadband services to Tatitlek, Alaska. Tatitlek is a traditional Alutiiq coastal village, with 96 percent of the population being Alaska Native. The Chugachmiut federally qualified health center (FQHC) and community center in Tatitlek will receive free high-speed Internet access for two years under this program. A microwave technology broadband system has been developed replacing the current satellite technology that was used and will result in a more cost-efficient and greater bandwidth capability for the Chugachmiut Clinic and the Tatitlek Community Center.

2.4.2 Federal Communications Commission Pilot Project (FCC)

The Federal Communication Commission (FCC) contract was filed by the ANTHC on behalf of the AeHN. A three-year, $10.4 million contract was awarded. The objective of the FCC contract is to unify separate electronic healthcare networks that are being developed throughout the state to supply rural health providers with connectivity to urban referral providers both in Alaska and in the Lower 48. This coordinated network will facilitate the exchange of critical health information between health providers. It will also support telemedicine services, as well as video conferencing and Voice-over-Internet applications.

The FCC contract is currently midway through the second year of a three-year contract. Funding through this source of revenue requires a 15-percent match for each year of the contract. The ANTHC has submitted a proposal for 2008 that includes funding for 231 facilities statewide. A contract was established with GCI and Structures to design an infrastructure under Phase 1 of the project which was completed in October 2009. Phase 2 of the project is to procure and deploy equipment for the implementation of the statewide infrastructure. Phase 2 efforts began in September 2010.

2.4.3 Universal Services Administrative Company/Universal Services Fund

The Universal Service Administrative Company (USAC) is an independent, not-for-profit corporation designated as the administrator of the federal Universal Service Fund (USF) by the Federal Communications Commission. The USF helps provide communities across the country with affordable telecommunications services through four programs that include the High Cost Program, Low-Income Program, Rural Health Care Program, and the Schools and Libraries Program.

The High Cost Program ensures that consumers in all regions of the nation have access to and pay rates for telecommunications services that are reasonably comparable to those services provided in urban areas. The Low Income Program is designed to ensure that quality telecommunications services are available to low-income customers at just, reasonable, and affordable rates. The Rural Health Care Program is designed to provide reduced rates to rural health-care providers (HCPs) for telecommunications services and Internet access charges

related to the use of telemedicine and telehealth. The Schools and Libraries Program commonly known as the "E-Rate Program," provides discounts to assist most schools and libraries in the United States to obtain affordable telecommunications and Internet access.

AeHN and its partners are closely coordinating the activities of the Rural Health Care Pilot Project with the Universal Service Fund to ensure sustainability of the completed healthcare infrastructure, particularly as related to rural healthcare facilities throughout the state.

2.4.4 Broadband Internet Access in Alaska

In January of 2010, the US Department of Agriculture's Rural Utilities Services ("RUS") awarded $88 million in federal broadband stimulus funding to GCI. The loan/grant will extend terrestrial broadband service for the first time to Bristol Bay and the Yukon-Kuskokwim Delta, an area roughly the size of the state of North Dakota. Completion of the project consists of two distinct efforts.

2.4.4.1 *Terra-Southwest Project*

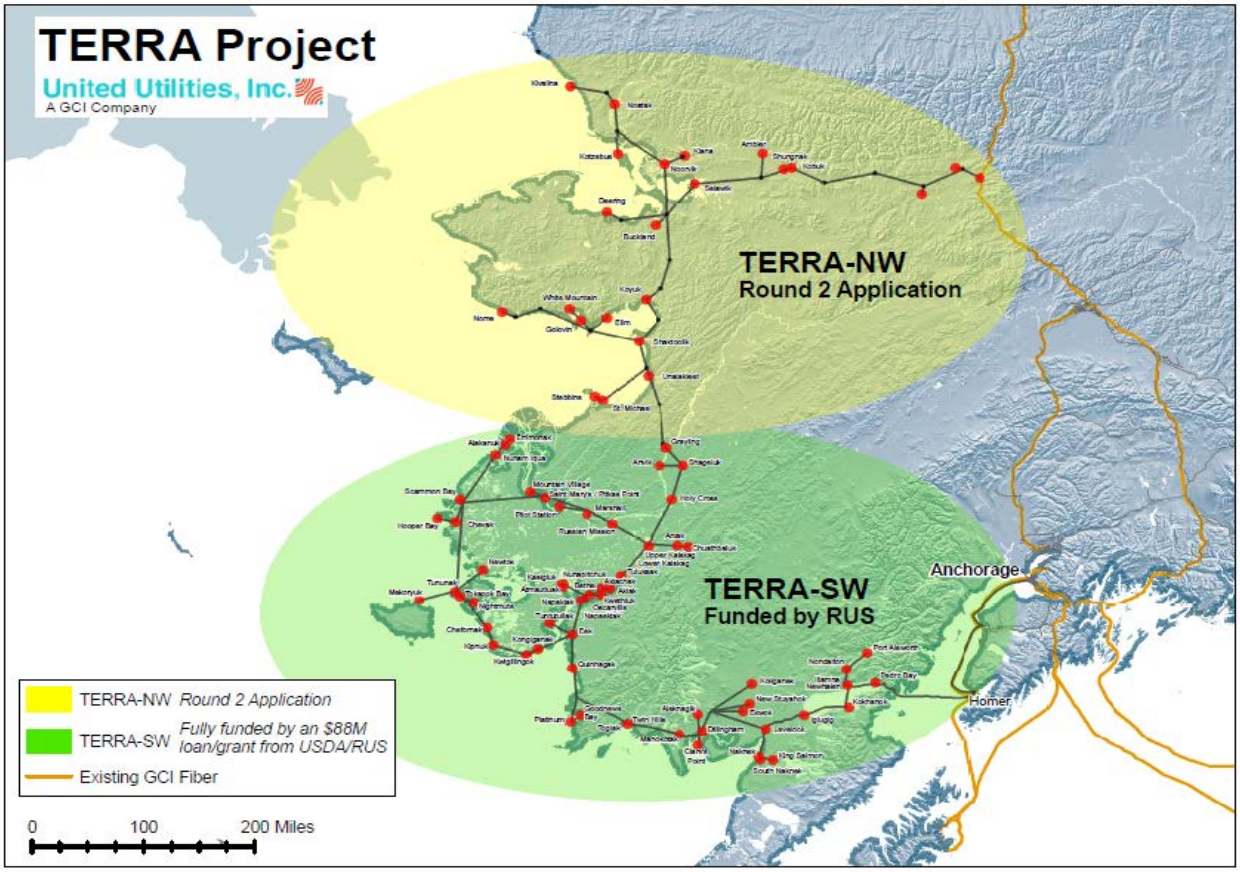
The Terra-Southwest ("TERRA-SW") Project, will serve 9,089 households and 748 businesses in 65 covered communities. A key benefit of the project is that it will serve public/non-profit/private community anchor institutions and entities, such as regional health care providers. The project provides an upgrade in capacity of the existing broadband regional microwave network, deployment of a broadband fiber optic/microwave regional network extending broadband services and will link Bristol Bay to the internet backbone in Anchorage. GCI is also in the process of constructing Alaska's first truly statewide mobile wireless network, which will seamlessly link urban and rural Alaska for the first time in the state's history.

2.4.4.2 *Terra-Northwest Project (Proposed)*

When funded, the TERRA-Northwest ("TERRA-NW") Project will deliver end-to-end middle mile terrestrial broadband service, for the first time, from the Internet backbone in Anchorage to the almost 4000 households and 300 business in 20 rural Tribal communities scattered across more than 8000 square miles in the Norton Sound and Kotzebue regions (the PFSAs), some of the most remote and economically and socially disadvantaged rural regions of the United States. The Project will dramatically expand communications options for all residential and commercial end-users; support private/public economic development efforts; improve crucial telemedicine and distance learning services; and enhance the operations of government, tribal, and non-profit entities. United Utilities, has applied for $108,213,247 in grant funding and an additional $46,377,107 in loan funding. Award of the grant and loan request for the Broadband Initiatives Program is anticipated to be announced in early October 2010.

See TERRA Project Map below.

Figure 2 – TERRA Project Map



2.5 Tri-State Children's Health Improvement Consortium(T-CHIC)

Alaska, in partnership with Oregon and West Virginia, received $2,231,890 for the first year of a five year grant that will total $11,277,361. Alaska, will receive approximately $750,000 per year for five years. The demonstration will test the combined impact of patient-centered care delivery models and health information technology in improving the quality of children's health care. The three States will work together to develop and validate quality measures, improve infrastructure for electronic or personal health records utilizing health information exchanges, and implement and evaluate medical home and care coordination models.

The first nine months of the grant is dedicated to planning followed by implementation and evaluation. Alaska's T-CHIC leadership, HIT Coordinator and Medicaid Staff will work closely to collaborate on various activities. Alaska, Oregon and West Virginia share the demographic quality of having a large proportion of their populations residing in rural areas that are disproportionately low-income.

2.6 Beacon Community Grant

Alaska submitted an application for a grant to address connectivity of telehealth and telehome with EHR's to provide a complete picture of coordinated care for use by providers. No Beacon grants have been awarded in Alaska at this time.

2.7 Federally Qualified Health Clinics and Rural Health Clinics

DHCS anticipates that FQHCs and Rural Health Clinics (RHCs) will continue to be active participants in the development of the state's HIE and HIT solutions.

The FQHC's are active in the Alaska Primary Care Association (APCA). The APCA provides outreach and education to FQHCs and RHCs and is able to provide Information Technology technical assistance and training to its members. APCA supports and serves all of Alaska's safety net providers, working to provide access to care for communities that have little or no resources.

FQHC and RHCs in Alaska also receive technical assistance from the DHSS Health Planning and Systems Development unit.

2.8 Veterans Administration and Department of Defense

The Veteran's Administration (VA) has used EHR technology for more than seven years. In 2003, the VA was the largest single medical system in the United States, providing care to over 4 million veterans, employing 180,000 medical personnel and operating 163 hospitals, over 800 clinics, and 135 nursing homes. About a quarter of the nation's population is potentially eligible for VA benefits and services because they are veterans, family members, or survivors of veterans. In response to this significant demand the VA has developed Veterans Health Information Systems and Technology Architecture (VistA) the largely internal EHR to be an open-source, highly integrated, and interoperable EHR system.

The system includes remote viewing of patient medical records and system alerts for routine screening, and critical care information. In addition, the VA has developed, a patient centered tool "HealtheVet" that has been implemented and is expanding to include more features to allow veterans to have secured messaging access to medical professionals, request prescription refills online and schedule appointments and view medical records. The Veterans Administration has also developed VistA Imaging, a coordinated system for communicating with PACS (radiology imaging) systems and for integrating others types of image-based information, such as EKGs, pathology slides, and scanned documents, into the VistA electronic medical records system. The Alaska VA Healthcare System (AVAHS) purchases care from other providers in the community. These records are imaged and made available through the VistA electronic medical records system.

These systems are deployed in 5 clinics in Alaska serving approximately 26,000 enrolled members accounting for over 15,000 visits in 2009.

The Department of Defense (DOD) has its own EHR deployed in Alaska. The 673d Medical Group is a DOD/VA Joint Venture medical facility located in Anchorage at the Elmendorf Air Force base (Joint Base Elmendorf Richardson) with 60 inpatient beds. DOD and VA are working to be able to share a "Virtual Lifetime Electronic Record" (VLER) that includes limited information and is currently difficult to obtain. Opportunities to improve this situation exist both in Alaska and across the nation.

A key barrier for the VA and DOD to HIE participation was noted in a report mandated by the Affordable Care Act (Section 5104) submitted to Congress September 2010. "There is a need for improvements in health information technology, building on a long history of innovation and practice that sets the Indian Health Service (IHS) (and ANTHC), VA, Department of Homeland Security (US Coast Guard) and DOD in Alaska apart as leaders in telemedicine. However, the interconnectivity necessary for coordination

of care through electronic health information exchange is lacking. Historically, Federal agencies have not had coordinated mechanisms for paying for participation in integrated health information systems nor have they developed clear policies that will permit participation." Report to Congress of the Interagency Access to Health Care in Alaska Task Force, p 4.

The VA and DOD participate in the AeHN HIE project, serving on its governance board and providing staff resources for workgroups. Alaska has been closely monitoring the NHIN activities and has volunteered to participate in NHIN trials as part of the HIE build out.

2.9 Alaska Health Information Exchange (HIE) Governance

This section will identify the health information exchange organization in Alaska, the governance structure; and the State Medicaid Agency (SMA) involvement. The section will also address the extent of the geographic reach and scope of participation.

The Alaska HIE Governance Model describes a health information organization that is consistent with federal and state guidance. The Alaska HIE complies with Alaska not-for-profit regulations and is a qualified 501(c)(3) entity with a Board of Directors made up of key stakeholders from the community and healthcare leaders. Organization by-laws define the governance and set organizational policy.

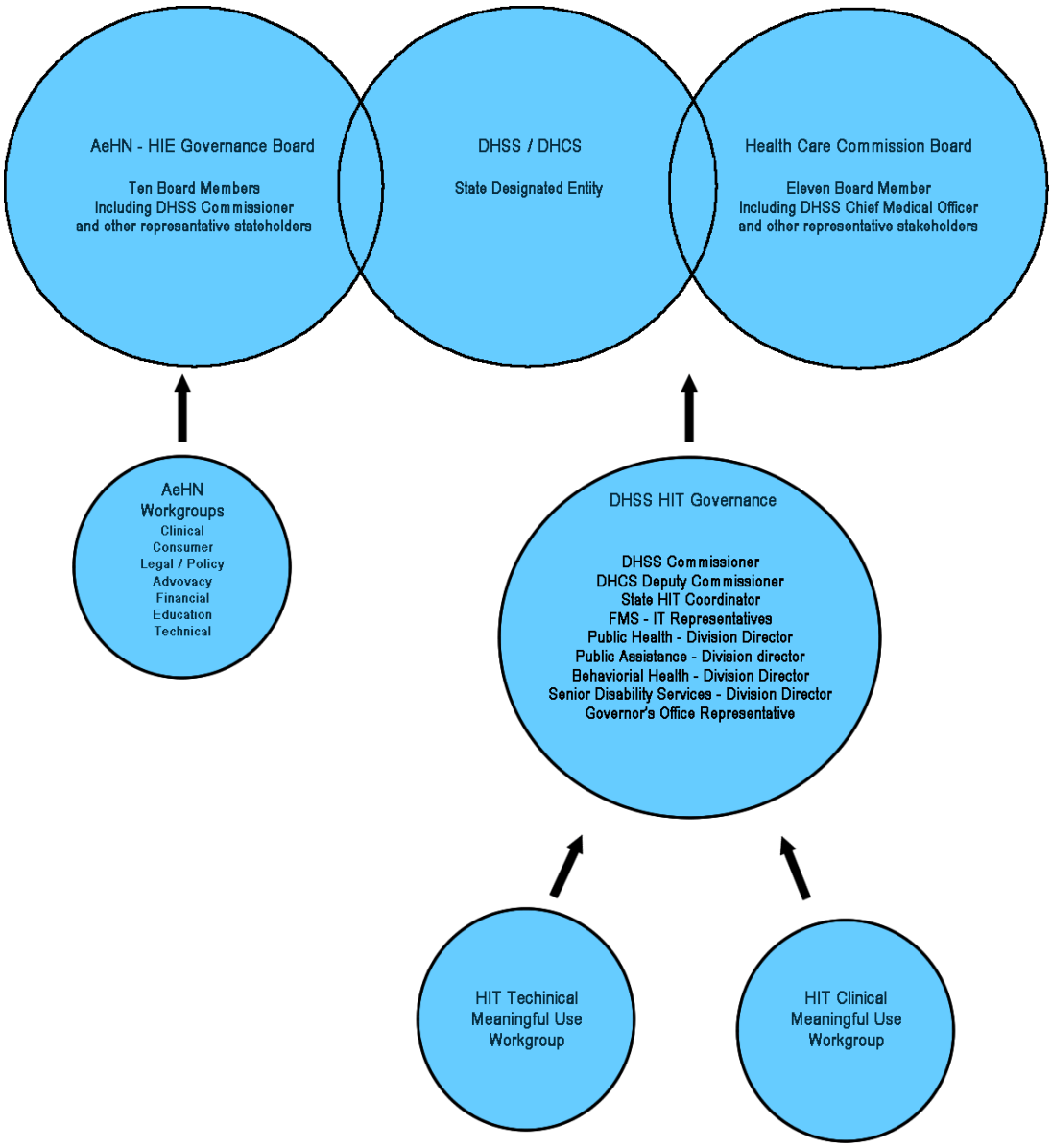
The Board establishes protocols for decision-making, communicating with the Alaska HIE executive management, and solicits feedback from its advisory workgroups. The Board has reviewed and ratified the operational structure illustrated in the Figure 2 below.

The SMA is located within DHSS and as such is an integral part of the Alaska HIE governance model. In addition, DHSS convenes a monthly HIT Status meeting to review progress on each of the HIT projects. This discussion includes representation from the DHSS Divisions as well as the AeHN, and other contracted project managers.

The Alaska HIE solution will when fully implemented allow all medical providers and their patients to have access to relevant patient records. Alaska anticipates that this single central HIE infrastructure will support the state's medical provider and patient population for the foreseeable future.

The relationship among the State Designated Entity (SDE), Alaska Health Care Commission (AHCC), AeHN and DHSS are depicted in the graphic in Figure 3 below.

Figure 3 – Alaska State Designated Entity Organization Structure



2.10 AeHN Board

AeHN Board positions are filled by volunteers from the stakeholder groups as shown in the figure below. Board representation is defined by Alaska Senate Bill 133. The DHSS Commissioner is responsible for ensuring the Alaska HIE board meets Senate Bill (SB)133 requirements. The Commissioner, or a DHSS Commissioner appointed representative, is a voting member of the board.

Table 4 – AeHN Board of Directors

Board Members	Affiliation	Officers	SB 133 Required Areas
Paul Sherry	Alaska Native Tribal Health Consortium	President	Alaska Tribal Health Organizations
Jerome List, MD	Alaska EHR Alliance	Vice President	
J. Patrick Luby	American Associate of Retired Persons (AARP) Alaska	Secretary	Health Care Consumers
Garth Hamblin	Bartlett Regional Hospital	Treasurer	Hospitals and Nursing Home Facilities
Jeff Davis	Premera Blue Cross Blue Shield of Alaska		Health Care Insurers
Jan Harris	University of Alaska		Liaison to the Board of Regents of the University of Alaska
Marilyn Kasmar	Alaska Primary Care Association		Private Medical Providers Community Based Primary Care providers
Thomas Nighswander, MD, Asst. Regional Dean	WWAMI Program		Health care providers
Al Parrish	Providence Health System Alaska		Hospitals and Nursing Home Facilities
Karen Perdue	Alaska State Hospital and Nursing Home Association		Hospitals and Nursing Home Facilities
Alex Spector	Alaska VA Healthcare System		Federal Health Care Providers
William Streur	Alaska Department of Health & Social Services		Commissioner DHSS
Jim Yarmin	Yarmin Investments		Health care consumers

2.11 Alaska Health Care Commission

In addition to SB 133 the AHCC was established in December 2008 under Administrative Order 246 (A.O. 246) to address growing concerns over the condition of Alaska's healthcare system and to serve as the state health planning and coordinating body. In January 2010 the AHCC, in accordance with A.O. 246, provided a five year (2010 – 2014) strategic plan on transforming healthcare in Alaska. The AHCC was chartered to provide recommendations to the governor and the legislature on a comprehensive statewide health care policy and foster the development of a statewide plan to address quality, accessibility and availability of healthcare for all citizens of the state. New Commission members were appointed September 14, 2010.

The AHCC has established the following areas of focus for 2011:

- Health Care Costs
- Patient-Centered Medical Homes
- Payment Reform

- Price & Quality Transparency
- Health Status
- Health Information Infrastructure
- Service Areas: Long Term Care; Trauma System
- Federal Health Care Reform

An AHCC member participates in the DHSS Clinical Work Group(CWG) established to develop strategies to manage and evaluate clinical data that may be available through use of EHR and HIE.

The AHCC has developed a set of proposed performance measures that will allow the State to establish a baseline and subsequently measure progress in key focus areas.

AHCC Preliminary Health Care System proposed Performance Measures:

1. Increase Access

- Percent of Alaskans Uninsured
- Percent of Alaskans who have a specific source of on-going care
- Measure of insurance affordability (TBD)
- Indicator of workforce supply (TBD)

2. Control Costs

- Annual growth rate in total health system expenditures in Alaska
- Annual growth rate in Alaska's Medicaid expenditures
- Impact on Alaska's state budget: Annual change in spending and revenue; net savings
- Measure of provider revenue based on value rather than volume

3. Safe, High-Quality Care

- Percent of population receiving key preventive services
- Percent of Alaskans with chronic conditions controlled
- Percent reduction in gap between benchmark and actual levels of quality
- Percent reduction in gap between benchmark and actual levels of safety

4. Focus on Prevention

- Percent of Alaskan homes with safe water and wastewater systems
- Percent of Alaskans reporting health risks
- Percent of Alaskans who smoke cigarettes
- Percent of Alaskans who are obese or overweight
- Percent of Alaskans who are binge drinkers
- Percent of Alaskans with moderate to severe depression

- Death rate among Alaskans due to injury (intention and unintentional)

The AHCC has initiated a process to validate the measures and establish baseline percentages for each measure. The DHCS HIT Program Office expects to align program performance measure with the AHCC program measures where applicable.

2.12 Existing Alaska HIT and Data Resources

2.12.1 DHSS Health Technology Resources

Included in the sections below are the DHCS systems that are available to support Alaska's HIT efforts. Future Plans for the individual systems and their contribution to the expansion of HIT will be described in more detail in Section 7 *HIT Roadmap*.

2.12.1.1 *Medicaid Management Information System (MMIS)*

DHCS is rebuilding the state's Medicaid claims processing and payment system. The state's current MMIS is about 20 years old and is being replaced with more modern technology. In September 2007 the department awarded a contract to Affiliated Computer Services (ACS) for a new MMIS. The contract includes: design, development and implementation of a new claims payment system; a claims data warehouse information system; and operations of the new system for five years.

The new MMIS, known as Alaska Medicaid Health Enterprise, is scheduled to be in operation Spring of 2012. The system will be available to providers and members who participate in the medical assistance programs as well as the Fiscal Agent (FA) and state staff. Alaska Medicaid Health Enterprise is a sophisticated, Web-enabled solution for administering all Medicaid programs. It will have self-service features so users can access the system through a user-friendly Web portal. This progressive MMIS system will incorporate innovative features and advancements that provide the foundation for future growth and evolution of HIT and Alaska's Medicaid program.

The MMIS is the repository for Medicaid claims, members and provider information. DHCS envisions making this data available to the HIE to support provider billing, member eligibility and provider participation inquires. Prescription drug formularies, benefit package coverage and payment status information could also be leveraged directly through secure HIE transactions. These are but a few of the benefits of HIE participation that will contribute to cost control, as well as improved outcomes and satisfaction by providers and members with the MMIS and Medicaid administration.

Additional features of the new MMIS include an interface to the National Provider Identifier (NPI) database, enhanced secure web-based provider enrollment, maintenance, communication and tracking that is available for provider self-service; as well as a provider portal available to support administration of the EHR Incentive Payment Program, with a Patient Portal available to support patient access to EHRs.

2.12.1.2 *Alaska Automated Information Management System (AKAIMS)*

Alaska Automated Information Management System (AKAIMS): a state government administered web-based management information system and clinical documentation tool for the state's behavioral health provider grantees. AKAIMS provides an EHR function in addition to supporting state and federal data reporting requirements. Behavioral health providers with their own clinical information systems are able to interface electronically to a data repository to allow compliance with state and federal reporting requirements.

2.12.1.3 *Primary Care Information Management System (PCIMS)*

The Primary Care Management Information System (PCMIS) is a database that contains critical information managed by the Alaska Primary Care Office and other programs within DHSS. The PCMIS also supports the Directory of Health Care Sites in Alaska (http://www.hss.state.ak.us/directoryhealthcare/default.htm) as well as data describing services and staffing that is used to identify various primary care organizations and roles. As an example, PCMIS is used by Emergency Medical Service (EMS) staff to identify first responder agencies as well as grant information and tracking of purchases of emergency vehicles and equipment.

Recently, a web-based tool (AK COMMS) has been developed by the Emergency Medical Services Unit that will allow information in PCMIS to be updated. Ideally, a system like AK COMMS will replace PCMIS to provide web enabled functionality that will support online data entry and reporting system, access to the public to find services and contact information and provide a linkage between primary care agencies and facilities across the state to work in a more coordinated manner.

2.12.1.4 *MultiVue - Master Client Index (MCI)*

The DHSS Master Client Index (MCI) is a match and merge system that is made up of a variety of case management demographics operated by programs within DHSS. The software, purchased from Visionware, determines who individuals are, performs de-duplication of clients from a variety of system and helps determine individuals and families even if their name or address in not necessarily identical. This is done by ranking matches based on a variety of business rules. Individuals that might be a match but that cannot be determined without human intervention are manually resolved by a staff person.

For the past three years, the DHSS has utilized MultiVue to support the MCI. The MCI started with four core systems being initially bulk loaded. Additional systems have been matched and merged to produce a composite view of a person across all the participating source systems.

These systems included the:

- Permanent Fund Dividend system, managed by the Alaska Department of Revenue/Division of Permanent Fund Dividend (PFD). PFD was designated the most trusted data source, and has been configured as the preferred demographic for display purposes
- Eligibility Information System (EIS) managed by DHSS Division of Public Assistance (DPA). This system houses member eligibility history and is a key component of member demographic information for the Medicaid members.

- Juvenile Offender Management System (JOMIS) managed by DHSS Division of Juvenile Justice (DJJ); and
- Online Resource for the Children of Alaska system (ORCA) managed by the DHSS Office of Children's Services (OCS);
- Resource and Patient Management System (RPMS);
- Senior & Disability Services DS3
- Behavior Health AKAIMS

DHSS has identified that the existing MCI could serve as the master demographic view on future HSS projects, namely HIE and EHR. In order to support the requirements of DHSS in relation to the HIE and EHR projects, and maximize the State's investment in the MultiVue software, the existing MCI will be further enhanced by the addition of 3 new data sources VacTrAK, the Alaska Public Health Immunization registry, Vital Stats, the state's vital statistics record repository and MMIS Provider data.

Recently, a simple web application was developed to determine individuals who are or who once received services from any one of the DHSS programs in the index. Future MCI enhancements include developing reverse lookup capability from the MCI to the source systems that will gather additional data as needed such as case management contact information and the office or agency that is providing services.

2.12.1.5 *Division of Senior and Disabilities Services Data System (DS3)*

The DS3 is a collection of components contained within a single web-based data system that was developed in-house by Senior and Disabilities Services in an effort to manage the many programs that it oversees. This system provides user interfaces, processing logic, and role-based data access, all of which allows division staff to conduct and oversee day-to-day program activities. While DS3 is used to manage Medicaid programs it is also used to manage Adult Protective Services investigations, state-funded general relief programs, and other grant-funded programs that fall outside the scope of Medicaid. DS3 integrates many independent client-tracking tools into one. At this time the future of this software application is under review.

2.12.2 Alaska Public Health Technology Resources

Included in the sections below are the Alaska PH systems that are available to support Alaska's HIT efforts. Future Plans for the individual systems and their contribution to the expansion of HIT will be described in more detail in Section 7 *HIT Roadmap*.

2.12.2.1 *Lab Information Management System(LIMS)*

Alaska Division of Public Health (DPH) continues to develop the Lab Information Management System (LIMS)to collect and eventually share and distribute data from the state labs.. There are currently two separate LIMS databases one in Fairbanks and one in Anchorage. Separate lab databases are maintained due to bandwidth limitations between the two labs. The only data that is shared is patient and provider demographic information. DPH has leveraged a Centers for Disease Control and Prevention (CDC) grant to connect the two state labs to the CDC sending Health Level Seven International (HL7) standard transactions. Opportunities exist to

allow the labs to share more than patient demographic data. Ultimately the state labs would like to connect a consolidated LIMS system to the Alaska HIE product or alternatively connect each system to the HIE.

2.12.2.2 *VacTrAK*

VacTrAK is a consolidated immunization information system that has been developed in states over several years. It now includes about 3.9 million immunizations, is in the last stages of testing to be able to include immunizations from Public Health Nurses using RPMS. Due to the "infancy" of the system and the scope of the system, DPH has not been successful in acquiring grant awards to improve the product. DPH is participating in a forum with the VacTrAK vendor to identify opportunities to collaborate on solution alternatives.

VacTrAK contains both a graphical user interface and a database which is accessible through the internet. Vaccination records are stored and maintained at a central database, and physicians, nurses, and other medical personnel can view, edit, and update the records from any computer with an internet connection. For clinics with existing electronic systems, VacTrAK staff can establish a data exchange process that sends batch data directly to VacTrAK from an electronic medical record or from a practice management or billing system. As the State of Alaska issues immunization requirements for all children attending school or a licensed child care program, educational and day care administrators are able to access the records with read-only privileges in order to certify eligibility for enrollment

VacTrAK can accept a broad range of flat text files and HL7 messages. A minimal data set will be required for patient de-duplication. This feature positions the VacTrAK system to leverage the HIE when available.

2.12.2.3 *Vital Statistics*

AK Public Health Vital statistics does not currently have electronic transfer capability. An RFP is under development to procure a new vital statistics system that could include an HIE interface. It may be several years before the new system capabilities will be available.

2.12.2.4 *Resource and Patient Management System (RPMS)*

RPMS is an information management system administered by the U.S. Indian Health Service that includes clinical, business practice, and administrative information management applications and is in use in most health care facilities within the IHS delivery system. In addition to a number of organizations within the Alaska Tribal Health System, the Alaska Division of Public Health's Public Health Nursing Section uses RPMS as the EHR/HIE for the state's public health centers.

2.13 November 2011 Update - Current Interoperability Status of State Registries

The sections that follow will describe the current interoperability status of the State Immunization registry, the State Laboratory system and the Public Health Surveillance reporting capabilities in support of Meaningful Use of EHR technology.

2.13.1 Alaska Immunization Registry (VacTrAK)

The VacTrAK system implemented in Alaska supports the CDC requirements for immunization reporting and state-sponsored vaccine inventory control. Currently, providers have several options to satisfy immunization reporting requirements. Immunization records can be manually entered by the provider on a VacTrAK web portal. VacTrAK is capable of sending and receiving HL7 version 2.5.1 Standard messages for immunization records update from individual provider EHRs, history and state-sponsored vaccine inventory control. DPH is working with the vendor to identify specific requirements to support VacTrAK EHR integration and HIE integration.

2.13.2 Laboratory Information Management System (LIMS)

The Alaska LIMS system supports two state labs. There are currently two separate LIMS databases one in Fairbanks and one in Anchorage. Separate lab databases are maintained due to bandwidth limitations between the two labs. The only data that is shared is patient and provider demographic information. DPH has leveraged a CDC grant to connect the two state labs to the CDC sending HL7 standard transactions. DPH has developed a web-based interface to support the electronic submission of lab requests and results receipt. DPH is also working with the LIMS vendor to identify system modifications necessary to connect the LIMS systems to the HIE, to accept lab results and disseminate results. Business process modifications necessary to support these changes are also under development.

DPH is planning to incorporate HL7 data transmissions and leveraging Logical Observation Identifiers Names and Codes (LOINC®)for lab tests and Systematized Nomenclature of Medicine (SNOMED) for lab results as a mechanism to promote standardization and improve interoperability supports.

Additionally, current Alaska State Law is silent on the critical issues of exchanging lab results between authorized users.

2.13.3 AK STARS

The AK Stars system collects legislatively mandated reportable disease information from practitioners, hospitals and labs throughout the state. This web-based system also supports CDC requirements for National Electronic Telecommunications System for Surveillance/ National Notifiable Diseases Surveillance System (NETSS/NNDSS) transmission of reportable conditions and provides electronic lab reporting capabilities utilizing HL7 version 2.5.1 standard messages and appropriate LOINC and SNOMED codes.

The information is subsequently transmitted to CDC as required. Currently AK Stars uses the Public Health Information Network Messaging System (PHIN MS). The system securely sends and receives encrypted data over the Internet to public health information systems using Electronic Business Extensible Markup Language (ebXML) technology. LIMS has an electronic interface to AK Stars that regularly transmits reportable disease results. In addition, commercial labs, practitioners and hospitals are also able to submit state defined reportable diseases electronically to AK Stars.

2.14 State Medicaid HIT Plan Development

The SMHP was developed by leveraging content from a variety of sources describing the current activities and initiatives currently underway in the state, conducting interviews with key stakeholders and the HIT Program Office. A MITA SS-A update was conducted to document

and provide insight into current and future business process as well as document technical resources. These business processes are the basis for the on-going EHR Incentive Payment program operations. MITA business processes are identified and related to the activities necessary to support the program in subsequent sections of this document.

The team developing the SMHP participated in regular CMS and ONC sponsored teleconference opportunities, the Multi-State Collaborative monthly teleconference to understand the EHR Incentive Payment Program and the requirements of the SMHP.

2.15 MITA State Self-Assessment (SS-A)

2.15.1.1 *MITA SS-A Overview*

In July 2008, ACS completed an initial MITA SS-A to support the Alaska MMIS Replacement Project. While the initial MITA SS-A was completed using the MITA 2.0 Framework a number of required elements required for completion of Alaska's SMHP were not included. Subsequently, Alaska conducted a MITA SS-A Update to address the following three components:

1. An update of MITA Maturity determination based on the MITA 2.01 Framework;
2. Completion of a MITA technical assessment that includes a view of the current systems; and
3. Development of a To Be Roadmap and transition plan.

To complete the MITA SS-A Update and develop the required components of the SMHP identified above, DHCS contracted with FOX Systems to support the update activities. Using information from the initial MITA SS-A, FOX facilitated MITA SS-A Update sessions with subject matter experts for each of the eight (8) business areas. The MITA SS-A Update sessions revisited the As Is and To Be business processes and included a reassessment of MITA maturity levels. Additionally, FOX completed a Technical Assessment of the systems that are currently supporting the Alaska Medicaid Enterprise.

2.15.1.2 *MITA SS-A Vision and To Be Roadmap*

DHCS has identified the system changes needed to support the immediate need to implement the EHR Incentive Program within the PEP and Alaska State Accounting System (AKSAS) systems. DHCS is deferring some of its longer-term planning and benchmark development for HIT/HIE until 2011. DHCS participation with the AeHN HIE efforts, dialog with Alaska Public Health and T-CHIC collaborative is also underway. When details of these projects are fully understood, including a timeline for projects, this SMHP will be updated and a separate IAPD to request funding will be submitted.

The MITA SS-A Vision and To Be RoadMap as they are understood at this time are included in Section 6.

3 ENVIRONMENTAL "AS-IS" SCAN

Information from two separate surveys was used to determine the "As-Is" state of adoption by Medicaid eligible providers.

The first survey was conducted by the Alaska Electronic Health Record Alliance (AEHRA) and results were published in May of 2009. While these survey results were statistically significant and provided excellent information, it was focused primarily on licensed physicians and omitted a number of eligible providers such as Dentists, Nurse Practitioners and Certified Nurse-Midwives.

The second survey conducted by DHCS, to supplement the first survey, specifically targeted Medicaid providers including those providers omitted from the Alaska eHealth Record Association (AeHRA) effort. The DHCS survey was conducted in July-September of 2010. This section describes the survey process and results for both surveys

3.1 Summary of AEHRA Survey – May, 2009

In 2009, The AEHRA contracted with the Craciun Research Group (CRG) to conduct a survey to determine the following:

- Current physician usage of EHRs
- Identification of the EHR systems in use in the State
- Interest by non-users in adopting EHRs
- Identification of barriers to adoption

Information from the AEHRA survey was used in a pilot program with selected Alaska providers who are adopting and testing several recommended EHRs. The survey was the first step in the Alaska EHR Alliance's pilot program, which is aimed at promoting EHR adoption by educating providers on the benefits of EHR use. The survey was funded by the Rasmuson Foundation through a grant to AeHN, and with contract management by ANTHC. Additional funding was provided by Providence Health System Alaska and the AEHRA. The database of Alaska licensed physicians was provided by the ASMA.

3.1.1 Survey Strategy

The Alaska Medical Group Management Association initially emailed the survey link to their members, who are clinic managers, for them to take the survey online. An email notice was sent to those physicians in the database with available email addresses. The survey instrument (questionnaire) was designed for a multi-use approach. By design, the first survey instrument was intended to be part of a mail-out; the instrument was then re-designed to meet an online instrument format. Every effort was made to contact physicians and clinic managers in the medium that fit their work and personal preference. The survey was offered to participants in an exhaustive effort that included paper, fax, phone and email.

The specific process for contacting respondents included an initial invitation letter from Dr. Jerome List along with a paper version of the survey. The invitation was sent by mail to 1401 physicians Statewide in the ASMA's database of licensed physicians. Two postcard reminders were sent as follow-ups to physicians who had not initially responded. An email notice was sent to a smaller data base of physicians with available email addresses, plus three follow up email reminders to those who had not responded. Alaska Medical Group Management Association also sent out an email invitation to their 180 clinic manager members followed by two reminder emails. Follow-up phone calls were made to physicians and clinic managers per standard research practices of 2-3 times based upon contact interest and response.

3.1.2 Selection of AEHRA Survey Participants

The AEHRA survey was sent to a population of 1,401 physicians and 180 clinic managers. The respondents to the survey consisted of 378 physicians and 62 clinic managers representing 29 communities across the state for a total population of 440 respondents.

3.1.3 AEHRA Survey Limitations

Because of the self-administered nature of the survey, there are small inconsistencies in the number of answers to various questions. Some people skipped pertinent questions, and others answered questions that did not pertain to them.

Additionally, the AERHA Survey focused solely on physicians and clinic managers and did not include other Eligible Providers (EPs) such as Dentists, Nurse Practitioners and Certified Nurse-Midwives.

3.1.4 AEHRA Survey Analysis Summary

The AEHRA survey results are summarized in the table below.

Table 5 –AEHRA Survey Analysis

Survey Areas	Response Results
Use of EHRs and ePrescribing	A third of respondents, physicians/clinic managers, use ePrescribing. Half, 50% use an EHR including 40% who use practice management and 10% who do not. Note: This number cannot be ascribed to the total population of Alaska Physicians due to the self-selecting nature of the survey. However, at a minimum, 16% of Alaska physicians use an EHR and the figure is likely somewhere between that number and 50%.
Use of EHRs by Size and Type of Practice	26% of physicians in one-doctor practices have an EHR. Those with the largest clinics are most likely to have an EHR. 50% of Family Physicians, Internists, Pediatricians, and Ob/Gyn's use EHRs, whereas fewer, (41%) grouped in the "other" category of practice types, use them.
Brands of EHRs in Use in Alaska	No EHR holds a significant portion of the EHR market in Alaska. Centricity holds 11%; eClinicalWorks, 8%. There are approximately 55 EHRs in use.
EHR Connections	Most (74%) of the EHRs are integrated with a practice management system. Half are connected to labs and a third to one or more pharmacy. A third of the EHRs do not connect to any other entity.
Servers and Hardware	79% of the servers are located on site; 78% of EHR owners supplied

Survey Areas	Response Results
Non-Use of EHRs	Nearly half (47%) of the physicians not using an EHR have seriously considered buying one. 19% have considered but decided against it.

3.2 DHCS Survey

DHCS recently conducted an environmental scan of the Alaska Medicaid provider population to gather information to describe the current state of HIT adoption and use of electronic health records in provider offices and hospitals across the state. The HIT survey was conducted online. The assessment was conducted between June 28th and September 28, 2010. DHCS drafted an initial set of survey questions. These survey questions and responses are required by CMS for the "As-Is" Landscape Assessment, as well any Alaska-specific questions of interest. Early and effective definition of the required outcomes is critical to laying the foundation for a successful survey. Each question was evaluated as to its purpose and contribution to the SMHP and contribution to the understanding of the EHR "landscape" in Alaska. The questions were reviewed, modified as needed and approved by DHCS. The questions were further vetted with key stakeholders at AeHN and Alaska EHR Alliance.

3.2.1 DHCS Pre-Survey Outreach:

Outreach and educational information was provided to professional and hospital associations to make stakeholders aware of the opportunities provided by the ARRA Health Information Technology for Economic and Clinical Health (HITECH) Incentive Program.
DHCS identified several supports in the planning phases of the survey to develop survey interest and accuracy. A variety of communication mechanisms such as website postings, newsletters, presentations and email notices were applied to communicate the request to participate in the Medicaid survey. The July 2010 remittance advice notices contained an invitation to Medicaid providers to participate in the online survey. Associations were also requested to send letters of support, encouraging provider participation in the survey and Incentive Program. .

3.2.2 Provider Environmental Scan Development

The scan questions were developed based on the requirements in the Final Rule and the CMS template. The questions were refined and reviewed by a small group of stakeholders both internal and external to DHCS. DHSS Public Information Office reviewed and modified the communication notices, as well as participating in the review of the survey questions.
The scan was posted online, making it available for 12 weeks while the SMHP content was under development. Several communication activities (described in Section 3.2.1 above) were conducted over the course of the open period.
DHCS expected that the primary survey participants would be Medicaid providers that have an interest in the EHR Incentive Payment program.

3.2.3 Identified Interoperability Opportunities and Barriers

The top barriers (medium and major barrier categories combined) identified to adopting EHRs are Initial cost 84%, Practice disruption and the cost 85%, Uncertainty about which EHR to buy 65% and Privacy concerns 31%.

3.2.4 Environmental Scan Questions

Scan questions for both the DHCS EP and Hospital surveys are included in Appendix A and B respectively.

3.2.5 Environmental Scan Analysis

DHCS collected 270 scan responses over a period of 6 weeks from June 28, 2010 through September 28, 2010.

3.2.5.1 *Scan Limitations*

The goal to collect at least 547 scan responses was not achieved in this period of time. 95 responses were received online, 175 scan responses were submitted by the ANTHC, representing the physicians practicing in that group.

3.2.5.2 *Scan Results*

97% of the scan participants indicated that they plan to participate in the EHR incentive Payment program. 32 percent have an existing EHR, 67 percent are in a potential “adoption” phase, as they have purchased an EHR. Note that this high percentage is likely related to the EHR purchased by ANTHC for its practitioners.

Of the respondents, 59 percent are physicians, 16 percent of these reporting that they have an EHR and 78 percent reporting that they are in a potential “adoption” phase of EHR.

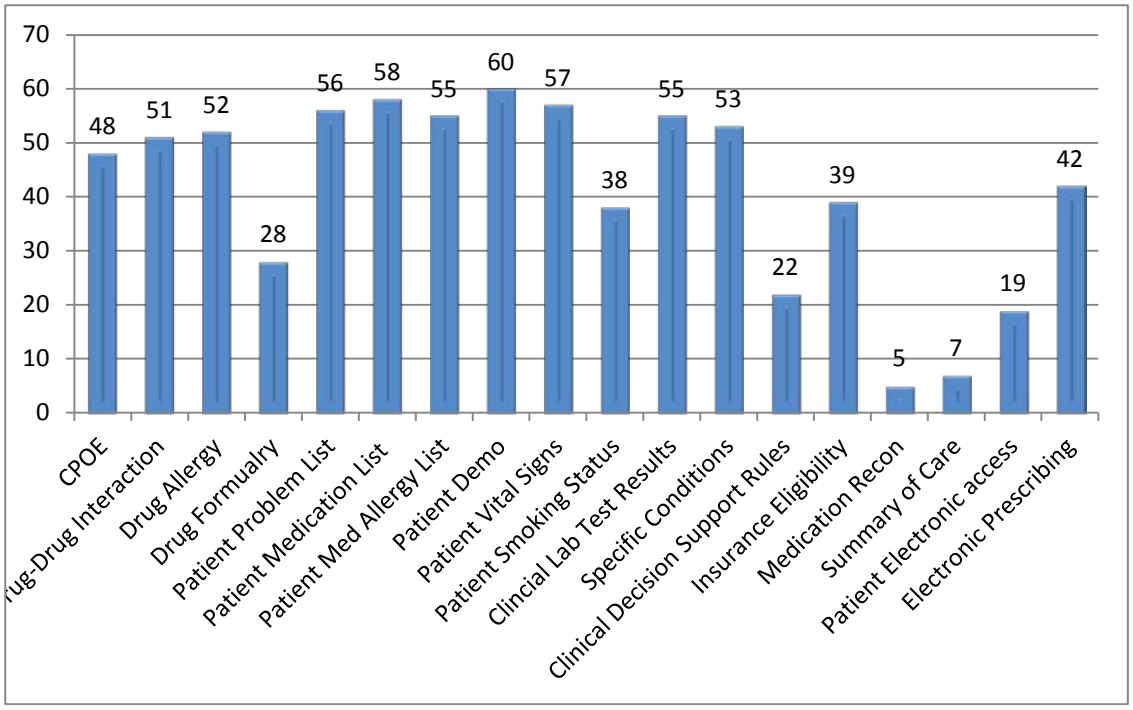
Table 6 – Environmental Scan Responses

Provider Type	Total Responses	Rank	Percentage
Physician – Individual	157	1	58.15%
Advanced Nurse Practitioner	53	2	19.63%
Hospital	12	4	4.44%
Dentist – Individual	9	5	3.33%
PC Agency	4	6	1.48%
Care Coordinator	3	7	1.11%
Nurse Midwife	2	8	0.74%
Care Coordination Agency	2	8	0.74%
Inpatient Psychiatric Hospital	1	10	0.37%
IHS Clinic	1	10	0.37%
SNF/ICF Facility	1	10	0.37%
Physician – Group	1	10	0.37%
Residential Supported Living	1	10	0.37%

Provider Type	Total Responses	Rank	Percentage
Arrangements			
Ambulatory Surgical Facility	1	10	0.37%
EPSDT Screener	1	10	0.37%
Not Medicaid	21	3	7.78%
Total	**270**		

The DHCS scan inquired about the functionality of the EHR systems in use. 51% percent of the features required by the final rule appear to be met within the existing systems and appear to be leveraged by respondents using those systems.

Figure 4 – Survey Responses to Meaningful Use Capabilities



Notably it was reported that only 3% have nurses and doctors that enter information directly into the EHR, however 65% of the respondents have purchased but not yet implemented their EHR system. This percentage may not be representative of the state as a whole, due to the large number of responses from ANTHC who reported they have purchased an EHR and are in the implementation process.

79% percent of the respondents are located in urban areas, primarily in Anchorage. This result could be significantly impacted by the impact of the ANTHC responses as a percentage of the total. However, most medical providers in Alaska are located in the few urban areas.
The map in the figure on the next page identifies the geographic distribution of the EHR Survey respondents that reported having an EHR.

Figure 5 – Alaska EHR Survey Respondents with EHR

99%percent of those responding to the survey reported they have broadband access. This result may be significantly influence by the high percentage of participants located in urban areas. Alaska is working to improve significant bandwidth issues in remote areas of the state. (See 2.4.4 Broadband Access for further information).

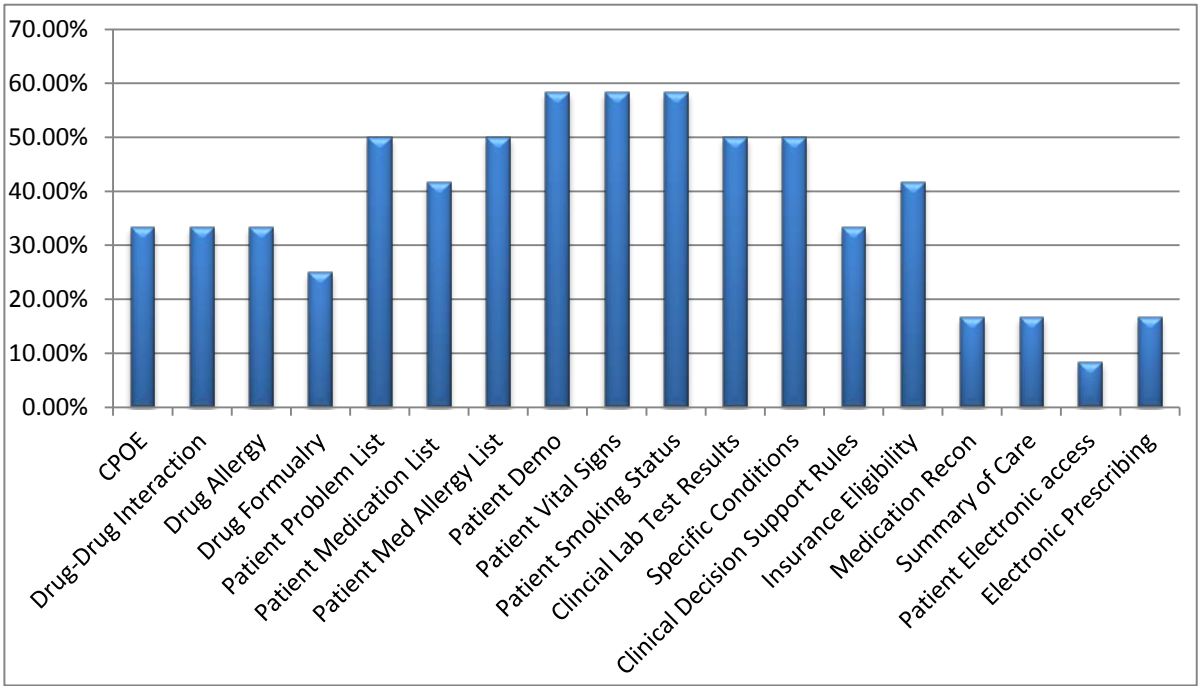
The AEHRA survey conducted in 2008 and updated in 2010 indicates that from 25 % - 30% of Alaska Physicians use an EHR.

Summary of Care, Patient Electronic access and e-Prescribing are notably among the least used/available functions within the EHRs of the respondents.

3.2.5.3 *Hospital Scan*

A separate survey instrument, targeting hospitals was developed. Of the 20 hospitals serving Medicaid patients in Alaska, 12 responded to the survey.15 hospitals were contacted directly to encourage their participation in the hospital survey.
The hospital survey revealed that 42 percent of responding hospitals have an existing EHR. The survey also indicated that 100 percent of those hospitals responding planned to participate in the EHR Incentive payment program.
92 percent of hospital survey respondents estimated that their Medicaid patient volume is greater than the 10% required for EHR Incentive Payment program participation.

Figure 6 – Hospital Reporting Usage of EHR Features



3.2.5.4 *Combined AEHRA and DHCS Scan Results*

Both the AEHRA and DHCS surveys inquired about EHR usage. All other survey questions varied sufficiently that the results of the two surveys could not be combined in a meaningful way.

Of the 448 respondents in the AEHRA survey 10 also participated in the DHCS survey, as determined by cross-referencing physical address and practice name information.

Of the 708 unduplicated responses, 307 or 43 percentage reported having an EHR system.

49 percent of those with an EHR system practice in a rural versus urban setting.

4 THE VISION OF HIT FUTURE – "TO BE" ENVIRONMENT

The DHSS vision for HIT demonstrates the agency' aspirations to develop improvements in delivery, cost containment and outcomes in healthcare management. As DHSS moves quickly to achieve its vision for HIT, there will likely be changes and unforeseen challenges that must be addressed. Alaska's vision for HIT establishes the foundational principles and approach and should be viewed as a living document that can guide DHSS on its journey to transforming health care in Alaska by achieving its vision for health information technology.

4.1 Participating Entities

Alaska has achieved broad participation in the development of its HIT strategy, legislation and implementation of solutions. The table below contains a listing of participants in the development of the HIE RFP and participation in the evaluation of proposals as well as vendor demonstrations.

Table 7 – Alaska HIT Participants

Alaska HIT Participants		
Alaska AARP	Central Peninsula Hospital	Providence Health & Services Alaska
Alaska Area Native Health Service	Cordova Community Medical Center	Providence Kodiak Island Medical Center
Alaska Ear, Nose and Throat	Department of Defense, Air Force	Providence Seward Hospital
Alaska EHR Alliance	Department of Defense, Army	Providence Valdez Medical Center
Alaska Federal Health Care Access Network	Eastern Aleutian Tribes	Samuel Simmonds Memorial Hospital
Alaska Federal Health Care Partnership	Fairbanks Memorial Hospital	Sitka Community Hospital
Alaska Native Medical Center	Hope Community Resources	South Peninsula Hospital
Alaska Native Tribal Health Consortium	IHS Alaska Area Office	Southcentral Foundation
Alaska Native Tribal Health Consortium	Ketchikan General Hospital	Southeast Alaska Regional Health Center
Alaska Primary Care Association	Ketchikan Indian Community Tribal Health Center	State of Alaska, DHSS
Alaska Primary Care Association	Kodiak Area Native Association	State of Alaska, Division of Public Health
Alaska Psychiatric Institute	Maniilaq Health Center	Tanana Chiefs Conference
Alaska State Hospital and Nursing Home Association	Mat-Su Regional Medical Center	Transportation Service Administration, Coast Guard
Alaska VA Healthcare System	Mt. Edgecumbe Hospital	University of Alaska
Anchorage Pediatrics, LLC	Norton Sound Regional Hospital	VA Healthcare System
Bartlett Regional Hospital	Peninsula Internal Medicine	Wrangell Medical Center
Bristol Bay Area Health Center	Petersburg Medical Center	Yukon-Kuskokwim Health Center
Central Peninsula General Hospital	Premera Blue Cross/Blue Shield	

4.2 Vision for HIT Environment

Like many states, health care in Alaska is at a cross roads. After many years of independent development around siloed programs and funding streams, delivery of care

has become more and more fragmented resulting in increasing costs, barriers to health care and decreasing quality outcomes of health care services provided.

Alaska's health care system is very complex, it contains many rules and regulations and is made up of many different types of organizations including government, quasi-government, non-profit, and private for-profit businesses. As a result, consumers and providers alike are frustrated and dissatisfied with the current state.

The DHSS recognizes that it plays a significant role in transforming health care in Alaska and has developed its vision for HIT to address many of the core challenges described above. In developing its vision for HIT for the future, DHSS has aligned its goals with that of the Alaska Health Care Commission that was created in 2009 to address growing concern over the condition of Alaska's health care system. Like DHSS, the Commission believes that access to good health care services, both physical and mental, is essential to all Alaskan's ability to actively participate in and contribute to their families, schools, places of employment, and communities.

The DHSS vision for HIT in the future is a multi-year vision and consists of existing and planned projects and initiatives that will significantly contribute to Alaska's health care transformation. By leveraging implementation of new technologies such as a modernized MMIS, that extends web based access to providers and members, EHRs, and HIE networks, DHSS will do its part in supporting a health care system for Alaska that places individual Alaskans, their families and communities at the center of their health care experience and ultimately shift the focus from treatment to prevention.

The ultimate goal of the state of Alaska is to improve access to health care and quality of health care for Alaskans. Specifically, the mission of the DHSS is to promote and protect the health and well-being of all Alaskans.

Alaska's vision for HIT also relies heavily on utilizing clinical information obtained through adoption, implementation and upgrade of certified EHR systems by providers and facilities and leveraging HIE technologies. Through the use of EHR systems, HIE and other technologies described in the following sections, DHSS is positioned well over the next three to five years to significantly impact the following shared goals, initially established by the Alaskan Health Care Commission in 2010-2014 Strategic Plan:

1. Improving access to health care services and affordable health insurance coverage;
2. Assure that health care services delivered in Alaska meet the highest quality and safety standards;
3. Reduce the rate of cost growth so that it is at least below the national average; and
4. Focus on prevention, not just clinical preventive services for individuals, but public health community-based policies and programs, to support improved health status and control costs by reducing the burden of preventable illness and injury.

The future of Alaska Health Information Technology includes the following six components and related strategies:

1. Simplified access to Health Care Information and Services for Beneficiaries

- Enhance secure web-based Beneficiary information, communication, outreach and tracking
- Provide enhanced provider on line search capabilities
- Improve service delivery through IVR (Interactive Voice Response) and VOIP (Voice Over Internet Protocol) technologies where possible
- Design and implement on line capabilities to enhance quality consumer directed access to care
- Development of strong Medical Home model delivery system
- Increase collaboration between all state payer and provider
- Streamline Point of Service functions (e.g. Smart Cards)
- Fully develop e-Prescribing functionality

2. Simplified interaction with the Health Care infrastructure for Providers

- Credentialing:
  - Single credentialing organization and standard forms for all payers for the State of Alaska
  - Adopt nationally recognized provider credentialing process
  - Interface to the NPI database

- Web-based Access:
  - Enhance secure web-based provider enrollment, maintenance, communication and tracking that is available for provider self-service
  - Provide online data submission with real-time claims tracking of approvals, denials, and other status reporting
  - Provide web based physician/provider quality and cost reporting
  - Provide a secure web-based care management systems options
  - Enhance web-based prior authorization function
  - Enhanced web-enabled claims processing functionality
  - Improve eligibility coordination and knowledge sharing between agencies and business partners

- Enhanced Technology Supports:
  - Streamline Point of Service functions (e.g. Smart Cards)
  - Support and accommodate electronic signatures
  - Provide for data interchange with Data Warehouse
  - Facilitate move to total electronic claims
  - Interface with future EHR and Personal Health Record (PHR) system functionalities
  - Fully develop e-Prescribing functionality

3. Improved Health Care outcomes measured by increased usage of performance criteria

- Create clear outcomes and expectations for providers to address pay for performance and quality of care
- Incentivize providers to use quality preventative care
- Utilizing HIE/HIT to improve health care Quality and Safety.
- Develop and expand innovative approaches to prevention.

- Develop a comprehensive statistical profile for delivery and utilization patterns

4. Evolving use of modern information technology to improve the delivery of Health Care and outcomes, identify administrative Efficiencies, coordination and optimization of care.

    - Administrative Efficiencies:
        - Improve contract administration
        - Provide automated federal reporting
        - Enhance automated reporting capabilities
        - Improve financial reporting capacity including data pulls, details, and definitions
        - Simplify and automate creation and management of edits and audits
        - Develop and Automate the Rate Setting process
        - Support and enhance capabilities to access federal rebate programs
        - Provide for data interchange with Data Warehouse
        - Develop and expand innovative approaches to prevention.
        - Reduce duplication of effort – regulatory vs. contract monitoring
        - Develop webcasts and other on line accessible training for MMIS users
        - Enhance web-based prior authorization function
        - Facilitate move to total electronic claims
        - Enhanced web-enabled claims processing functionality
        - Automate Third Party Liability (TPL) functionality
        - Fully develop e-Prescribing functionality
        - Enhance pre-payment and post-payment pattern analysis
        - Provide Contractor system supports (contract Mgmt system) to improve efficiency of contracting process

    - Coordination of Care
        - Develop enhanced interfaces to existing registries
        - Development of strong Medical Home model delivery system
        - Interface with future EHR and PHR system functionalities

    - Optimization of Care
        - Provide secure, web-based assessment tool for Waiver, Senior and disability functions
        - Improve service delivery through IVR (Interactive Voice Response) and VOIP (Voice Over Internet Protocol) technologies where possible
        - Provide clear and accurate EPSDT services and tracking
        - Explore health care literacy program to reduce Emergency Room (ER) use by Medicaid population
        - Implement Statewide HIE to improve episode of care management
        - Develop and expand innovative approaches to prevention.
        - Streamline Point of Service functions (e.g. Smart Cards)

5. Integrated medical service delivery model that includes high quality Medicaid providers

    - Encourage and promote retention of quality Medicaid providers
    - Explore health care literacy program to reduce ER use by Medicaid population
    - Implement Statewide HIE to improve episode of care management

- Improve eligibility coordination and knowledge sharing between agencies and business partners

6. Move from “client” focus to “family” or “community” based health care.

    - Development of strong Medical Home model delivery system

Alaska Information Technology Assets are described in Section 2. Thirteen existing Alaska HIT and Data Resources specific Projects planned over the next 3 to 5 years are included in Section 6 HIT Roadmap.

4.3 System Modifications to Support EHR Incentive Payment Program

DHCS has implemented the PEP to allow new Medicaid providers to enroll in a web-based secure environment.
The portal can be extended through a module SLR that is under development for the State of California and other states to support the EHR Incentive program.
DHCS expects to implement this portal solution and has identified minimal changes to leverage the solution in Alaska. DHCS does not intend to make system modifications to the existing Legacy MMIS. It may be necessary to identify and implement additional interface requirements for the new MMIS, Alaska Medicaid Health Enterprise, post-implementation to support SLR in a more automated and integrated manner.

Sections of the SLR Include:
Registration and Attestation

- Providers will be directed to the DHCS Provider portal to complete the registration and attestation process.
- Providers will enter additional data to complete registration
- Providers will be asked to attest to a number of items such as Medicaid patient volume, A/I/U, investment in EHR.
- Provider payments will be calculated by the SLR

The SLR features include:

- Secure provider log-in
- Self-service review and edit of providers’ demographic information
- Role-based screens for providers and Agency staff
- Facilitation of providers’ A/I/U or Meaningful Use (MU) attestation
- Submission of completed forms to State Medicaid entities
- Messaging to providers from State Medicaid entities
- Payment history log
- Initiation portal for providers’ appeals
- On-line help and a User Manual
- Routing and approval of provider registration information
- Inactivation of eligibility upon removal from program
- Review and approval of attestation information by Agency users
- Payment calculation
- Initiation of the payment cycle
- Management of appeals
- Review and reporting of quality metrics

4.4 Meaningful Use Data in Year 1

The implementation of the HIE in Alaska will provide an important vehicle to facilitate the standardization, exchange and outcome focus on the EHR data. In addition, the planned improvements in the Alaska Medicaid Data Warehouse will allow DHCS to consolidate and evaluate appropriate meaningful use data in the coming years.

Year one meaningful use data will be captured, and evaluated for the purposes of the providers meeting the eligibility requirements to attest to the ability to manage meaningful use data. These data elements will be managed in the SLR data store.

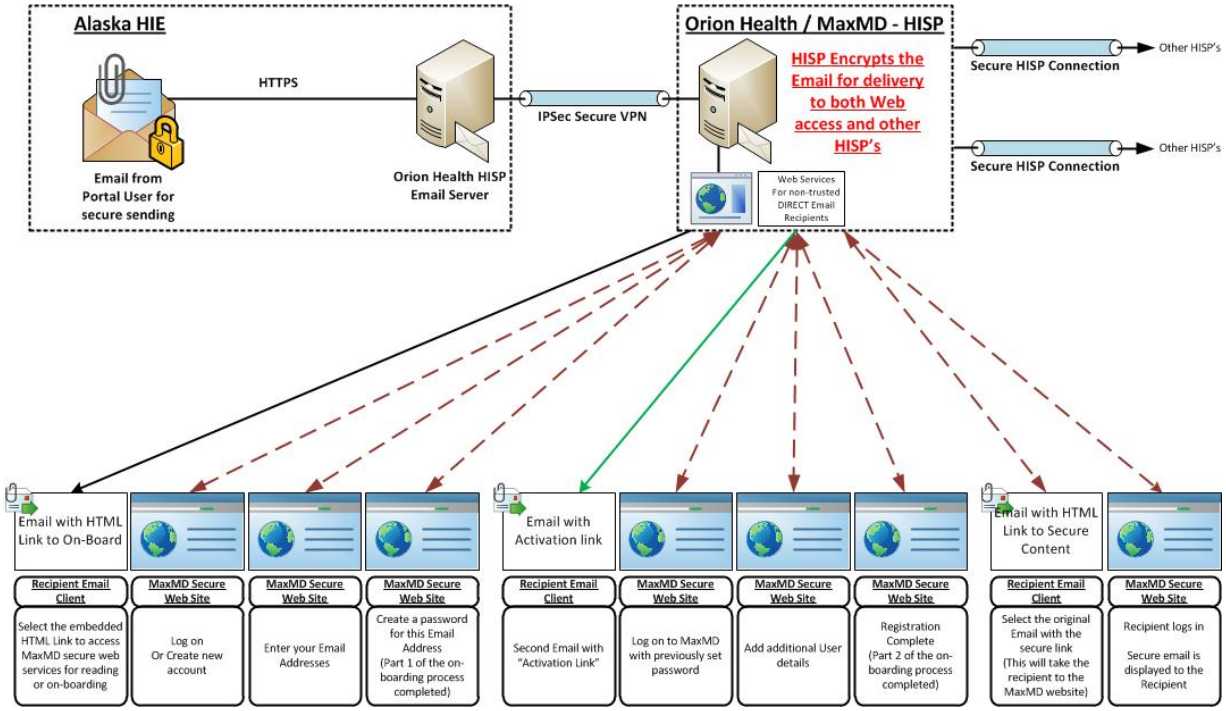
4.5 Data Sharing Components of Alaska HIT solutions

The Alaska HIE is expected to be the centerpiece of data sharing in Alaska. The Alaska HIE implementation will evolve over time as participation grows and Alaska HIT systems are integrated with the HIE. The sections below describe some of the essential components of the HIE infrastructure.

4.5.1 Direct Project Implementation

AeHN through its vendor Orion Health is working to provide means in which all participants in the continuum of care can communicate in a secure electronic environment across the state of Alaska. Important clinical history will be able to be sent to any location with Internet access regardless of whether they have an EHR or not. The Figure below depicts the Direct Project standards implementation in Alaska to support the simple distribution of clinical history and referral information.

Figure 7 – Direct Project Standard Implementation



The Air Force/DOD is participating in discussions to develop agreements to share Structured Continuity of Care documents (CCD) with the HIE beginning in November 2011 via Direct Project secure messaging standards. A significant portion of the population of Alaska is covered by DOD healthcare services. DOD frequently refers these patients to local resources in Anchorage and Fairbanks.

Discussions have started with commercial labs such as Quest, LabCorp and Peacehealth to determine their level of interest in HIE participation.

4.5.2 Alaska CyberAccess e-Precribing

DHSS is planning to implement an e-prescribing portal for Medicaid. This e-prescribing solution is called CyberAccess. The state plans to work with pharmacies around policies and procedures that will be developed for the new e-prescribing portal. Currently pilot sites are being identified by DHCS and a computer-based training around the portal is in development. Alaska plans to begin User Acceptance Testing (UAT) of CyberAccess in 2011. This implementation will encompass the basic core functionality of CyberAccess. There are expected to be approximately 4000 users of CyberAccess, comprising pharmacists, providers, state users, and ACS acting as the Alaska fiscal agent.

Access to CyberAccess will be controlled by user roles. These roles include Super User, Client User, User, Non-Prescribing User and Practice Administrator.

CyberAccess provides comprehensive patient medical history and functionality through a web-based, Health Insurance Portability and Accountability Act (HIPAA)-compliant Portal.

4.6 ALASKA Goals and Objectives

The general guidance provided by CMS tends to align well with those goals and priorities established by Alaska DHSS in its recent Executive Vision planning session. While DHSS is anticipating the advanced technical capabilities of a modern MMIS, its executive leadership has identified a number of business goals and objectives that will help guide their vision for HIT over the next 3-5 years and beyond.

As part of the visioning process, DHSS goals and objectives have organized by the eight (8) MITA business areas that make up the Medicaid Enterprise. For each of the business areas, MITA capabilities have been identified to help frame the desired vision. Additionally, we have identified where Alaska health care goals will be impacted by the pursuit and achievement of the more actionable objectives and actions.

Going forward, the ideas discussed in the Executive Visioning session can now be compared with other improvement opportunities, goals and objectives and should be reviewed routinely by DHSS Leadership.

Table 8 – Alaska Healthcare Goals & Objectives by MITA Business Area

PROVIDER MANAGEMENT		
MITA Capabilities	**Alaska Health Care Goals**	**DHSS HIT Objective/Actions**
One-stop shop for enrollment & credentialing	*Reduce the rate of cost growth*	• Single credentialing organization and standard forms for all payers for the State of Alaska
Automated credential updates	*Improve Access*	• Encourage and promote retention of quality Medicaid providers
		• Enhance secure web-based provider enrollment, maintenance, communication and tracking
National enrollment data standards		• Interfaces to the NPI database
		• Adopt nationally recognized provider credentialing process
Provider network meets community needs		• Allow providers to update information online
Pay for performance & quality of care	*Highest Quality and Safety Standards*	• Create clear outcomes and expectations for providers to address pay for performance and quality of care

MEMBER MANAGEMENT		
MITA Capabilities	**Alaska Health Care Goals**	**DHSS HIT Objectives/Actions**
Patient empowerment/decisions	*Improve Access*	• Enhance secure web-based Beneficiary information, communication, outreach & tracking
		• Improve independent living time spans for aged and disabled
No wrong door		• Provide enhanced provider on-line search capabilities
		• Provide secure, web-based assessment tool for Waiver, Senior and disability functions
National enrollment data standards		• Provide online data submission with real-time claims tracking of approvals, denials, & other status
		• Improve service delivery through IVR (Interactive Voice Response) and VOIP (Voice Over Internet Protocol) technologies where possible
Access to quality care	*Highest Quality and Safety Standards*	• Provide web based physician/provider quality and cost reporting through tools such as HIE
Preventive care		• Provide clear and accurate EPSDT services and tracking

MEMBER MANAGEMENT		
MITA Capabilities	**Alaska Health Care Goals**	**DHSS HIT Objectives/Actions**
CARE MANAGEMENT		
MITA Capabilities	**Alaska Health Care Goals**	**DHSS HIT Objectives/Actions**
Medical Home		• Development of strong Medical Home model delivery system
Supports patient empowerment	*Focus on prevention*	• Develop enhanced interfaces to existing registries
		• Explore health care literacy program to reduce ER use by Medicaid population
Access to clinical data at point of care management	Improve Access	• Move from "client" focus to "family" or "community" based health care
Interoperable data sharing via HIE	Highest quality and safety standards	• Design and implement on line capabilities to enhance quality consumer directed access to care
		• Implement Statewide HIE to improve episode of care management
		• Provide a secure web-based care management system options
		• Utilize HIE/HIT to improve health care quality and safety

BUSINESS RELATIONSHIP MANAGEMENT		
MITA Capabilities	**Alaska Health Care Goals**	**DHSS HIT Objectives/Actions**
Collaboration of Medicaid with Public Health, Behavioral Health, local, other states and federal agencies	*Reduce the rate of cost growth & Improve access*	• Increase collaboration between all state payers and providers
		• Develop and expand translation services and resources
		• Improve eligibility coordination and knowledge sharing between agencies and business partners
		• Emphasize "Service Integration" among State program areas: Medicaid/Behavioral Health, Public Health, Seniors and Disabled Services
Secure, de-identified HIE nationally	*Improve access*	• Utilize HIE/HIT to improve health care quality and safety
Service level Agreements for HIE	*Highest quality and safety standards & Reduce the rate of cost growth*	• Improve contract administration
PROGRAM MANAGEMENT		
MITA Capabilities	**Alaska Health Care Goals**	**Alaska Objectives/Actions**
Instant access to accurate, timely clinical and	*Reduce the rate of cost growth, Focus on prevention and highest quality and safety standards*	• Provide automated federal reporting
		• Support and accommodate electronic signatures

administrative data via secure HIE		• Provide for data interchange with Data Warehouse
		• Improve financial reporting capacity including data pulls, details and definitions
		• Utilize HIE/HIT to identify administrative efficiencies, coordination and optimization
Dashboard decision support information		• Enhance automated reporting capabilities
Data supports strategic planning		• Support and enhance capabilities to access federal rebate programs
		• Develop and expand innovative approaches to prevention
		• Automate the rate setting process
Changes in eligibility, enrollment, benefit plan, and service rules are instantly implemented		• Simplify and automate creation and management of edits and audits
		• Streamline Point of Service functions (e.g. Smart Cards)
OPERATIONS MANAGEMENT		
MITA Capabilities	**Alaska Health Care Goals**	**DHSS HIT Objectives/Actions**
Streamline transaction processing through access to clinical data; use of HIE	*Reduce the rate of cost growth & highest quality and safety standards*	• Planning, assessment and compliance with ICD-10 and 5010 D.0. and 3.0
		• Automate Current Procedural Terminology (CPT) conversion and certify Multiple Chronic Conditions (MCC)
		• Facilitate move to total electronic claims
		• Enhanced web-enabled claims processing functionality
		• Interface with future EHR and PHR systems
		• Automate TPL functionality
		• Fully develop e-Prescribing functionality
		• Enhance web-based prior authorization functionality
Adopt MITA SOA to streamline system maintenance and enhancements, reuse components		• Expand availability of MMIS functionality as appropriate
		• Develop webcasts and other on line accessible training for MMIS users
PROGRAM INTEGRITY		
MITA Capabilities	**Alaska Health Care Goals**	**DHSS HIT Objectives/Actions**
Focus on preventing problems and rewarding quality	*Reduce the rate of cost growth*	• Enhance pre-payment and post-payment pattern analysis
Integrity, quality		• Enhance electronic access to

permeate all operations		information
Appropriate model for managed care	*Focus on preventions*	• Communicate warnings to pharmacists
Stay ahead of PERM		• Develop a comprehensive statistical profile for delivery and utilization patterns
CONTRACTOR MANAGEMENT		
MITA Capabilities	**Alaska Health Care Goals**	**DHSS HIT Objectives/Actions**
Integrate MITA Principles	*Reduce the rate of cost growth*	• Reduce duplication of effort – regulatory vs. contract monitoring
Promote SOA		• Reduce administrative burdens
Measure performance of Service Level Agreements		• Provide contractor system supports to improve efficiency of contracting process

4.7 HIT Data and Technical Standards

This section includes the set of data and technical standards to enhance data consistency and data sharing through common data-access mechanisms that are currently available and under development or consideration by Alaska HIT participants. It also includes the description of how the State will adopt national data standards for health and data exchange and open standards for technical solutions as they become available.

The Alaska HIE vendor is considering incorporating the standards in the following sections that will likely determine State integration standards.

4.7.1 Continuity of Care Document (CCD)

The CCD is a standard specification being developed jointly by American Society for Testing and Materials (ASTM) International, the Massachusetts Medical Society (MMS), the Health Information Management and Systems Society (HIMSS), the American Academy of Family Physicians (AAFP), and the American Academy of Pediatrics (AAP). It is intended to foster and improve continuity of patient care, to reduce medical errors, and to assure at least a minimum standard of health information transportability when a patient is referred or transferred to, or is otherwise seen by, another provider. http://www.continuityofcarerecord.org/

4.7.2 HL7

HL7 is a well-established standard for communication of medical information between computer systems. HL7's long standing encoding of messages is well-described in the HL7 manual available at http://www.hl7.org.

As previously mentioned the State's immunization registry and disease reporting repository currently support HL7 standard messages.

4.7.3 Secure Internet Messaging

Secure Internet messaging will be provided through Secure Socket Layer (SSL) encrypted SOAP (Simple Object Access Protocol). HL7 content will be sent within the "body" of a SOAP message with standard SOAP message headers and SOAP wrappers. The SOAP standard is defined at http://www.w3.org/TR/soap/.

4.7.4 XML

Extensible markup language (XML) will be used for ease of search and messaging – see Journal of the American Medical Informatics Association, Volume 13, Number 3, May/Jun 2006, p. 289+. “An XML-based System for Synthesis of Data from Disparate Database”.

4.7.5 Logical Observation Identifiers Names and Codes(LOINC)

The purpose of the LOINC® database is to assist in the electronic exchange and gathering of clinical results for clinical care, outcomes management, and research. Currently, most laboratories and clinical services use HL7 to send their results electronically from their reporting systems to their care systems. LOINC was identified by the HL7 Standards Development Organization as a preferred code set for laboratory test names in transactions between health care facilities, laboratories, laboratory testing devices, and public health authorities.

http://loinc.org/

4.7.6 SNOMED

SNOMED Clinical Terms (SNOMED CT) is a dynamic, scientifically validated clinical health care terminology and infrastructure that makes health care knowledge more usable and accessible. The SNOMED CT Core terminology provides a common language that enables a consistent way of capturing, sharing and aggregating health data across specialties and sites of care. SNOMED CT is comprehensive on its own, but also can map to other medical terminologies and classification systems already in use. This avoids duplicate data capture, while facilitating enhanced health reporting, billing and statistical analysis.
http://www.snomed.org/snomedct/index.html

4.7.7 National Council for Prescription Drug Program

The National Council for Prescription Drug Program (NCPDP) maintains standards for medication scripts, pharmaceutical rebates and drug billing units. The mission of NCPDP is to create and promote data interchange standards for the pharmacy services sector of the health care industry. http://www.ncpdp.org/frame_standards.htm

4.8 Secure Data Exchange

An HIE relies on systems using trusted data exchange standards. Orion Health uses the Rhapsody™ Integration Engine to manage electronic messaging, this solution leverages SSL and encryption and hashing algorithms. The Concerto™ Clinical Portal is responsible for the encryption of authentication information based upon Remote Authentication for Dial-In User Service (RADIUS) authentication protocol. This is a widely used protocol in network environments.

Data is also protected by managing user roles and permissions to access data by establishing “relationships” to patients. Further, the HIE does not allow modification of the data, the data is managed by the source.

4.9 Integration of Clinical and Administrative Data

This section contains a description of how the State will support integration of clinical and administrative data.

DHSS convened a clinical work group with representatives from DHCS and DPH to begin to consider the vision for the use of clinical data. The group also discussed current and future opportunities for the integration of clinical and administrative (generally MMIS) claims) data.

The clinical work group identified a number of goals for the use of meaningful use attestation, clinical quality measures and eventually clinical data made available to support program evaluation through the Alaska HIE infrastructure.

The goals have not been assigned a priority order which will somewhat be dependent upon the timing of certain system integration with the Alaska HIE infrastructure and the functionality provided by Orion Health.

Goal #1 – Alaska Registries should contribute to and benefit from the Alaska HIE.

Activities necessary to support this goal are:

- Identify and prioritize the Registries to participate in exchange
- The registries discussed included Immunization registry, Cancer Registry, Alaska Trauma Registry, Alaska Behavioral Risk Factor Surveillance System, Lead Electronic reporting and the disease reporting system AK Stars
- Collect as much registry information as possible in the Alaska HIE to reduce provider reporting burden and enhance the Alaska HIE business case

Goal #2 – Ensure that Medicaid providers can become Meaningful users

Activities necessary to support this goal are:

- Focus on providing features that support reporting immunizations, electronic lab results and automated disease reporting

Goal #3 – Improve Provider participation

Activities necessary to support this goal are:

- Identify overlapping program measures to reduce provider burden and confusion
- Develop “business case” to communicate provider benefits

Goal #4 – Improvement in Population Health Outcomes

Activities necessary to support this goal are:

- Define specific Target Population Health measures, many are aligned with the MU clinical quality measures, such as Diabetes prevention and monitoring, Heart Disease and Cancer monitoring, education and prevention

Goal #5– Patient Access to Alaska HIE to allow self-direction

Activities necessary to support this goal are:

- Implement and promote the use of a Patient Portal that should provide patient access to:
    - Immunization History

- Medical History
- Prescription List
- Health Education

The Clinical Workgroup is enthusiastic about the possibility of richer clinical data that will contribute to improvements in care; they are hopeful that there will be enough clinical data to demonstrate improvements in quality oversight and measurement initiatives. The group recognizes that the Alaska HIE will also provide an opportunity to develop measurements in a broader (non-Medicaid) population that has not been previously available.

4.10 HIT's Role in Health Outcome Improvements

DHSS expects that the availability of clinical data in the Alaska HIE and the ability to aggregate this data with the existing administrative (claims) data will provide substantial opportunity to evaluate and improve Medicaid program results. Understanding effective clinical results and the relationships to Medicaid program policy will increase the tools available to extend the reach of the limited program funding.

DHSS serves, children, seniors, the disabled, individuals with chronic conditions and vulnerable populations. DHSS recognizes that effectively managing care transitions and finding appropriate placement for these vulnerable populations will allow for the funding to target higher needs, rather than continued hospitalization or institutional support. Efficient data systems, including the Alaska HIE will facilitate timely and more accurate decisions based on accurate patient records, conditions, medications and treatment. In particular, Alaska Behavioral Health practitioners are very interested in gaining access to accurate prescription lists and medical records to improve treatment outcomes based on factual information.

At this time it is unknown precisely how many of the state's 22 hospitals will participate in the Alaska HIE; several have indicated an interest and one is participating in the pilot and user acceptance testing. In order to facilitate more effective institutional discharge planning, it will be important for the acute care, critical access and behavioral health facilities to participate in data exchange.

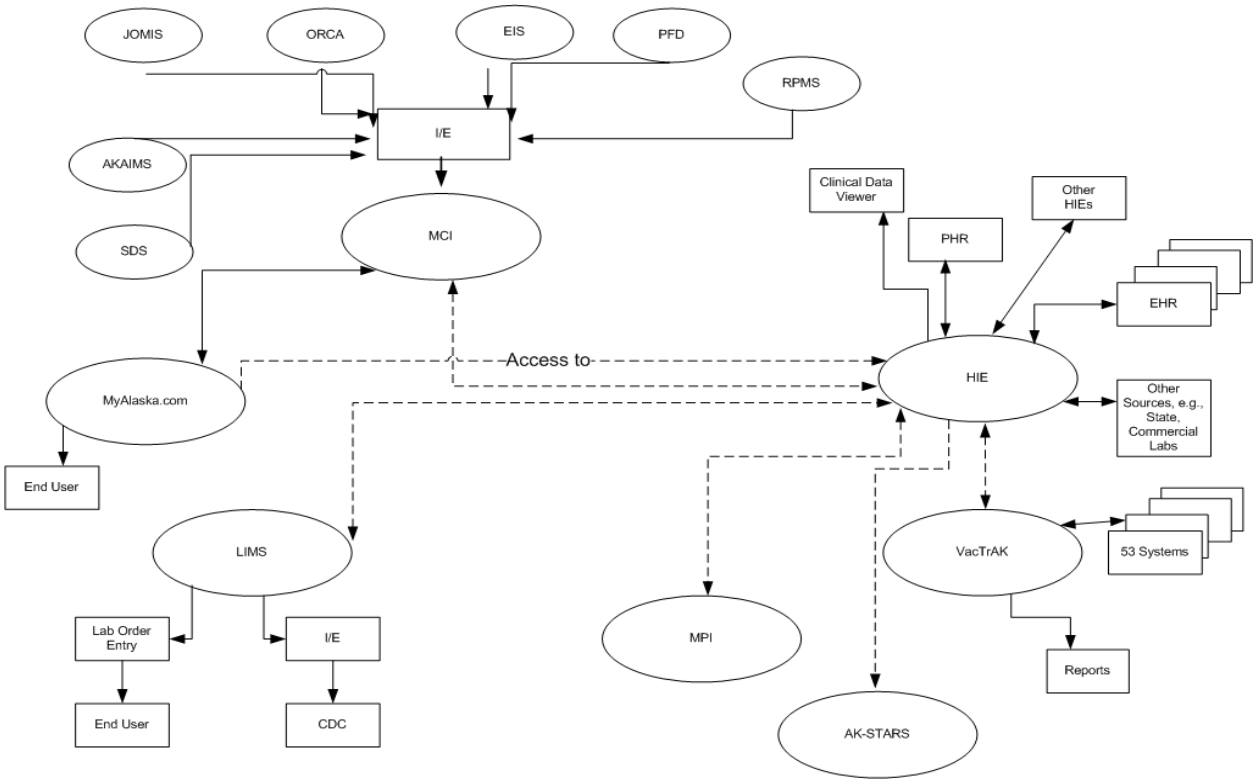
Alaskans will have the opportunity to participate in the Alaska HIE through the patient portal. myAlaska, an existing Alaska citizen portal is under consideration to support the authentication for the patient portal. It is anticipated that the patient portal will include an educational component that will focus on preventative care and chronic disease management. AeHN is considering the distribution of the Direct project solution to provide patients with the ability to send and receive secure messages to their caregivers. Patients will have access to immunization records, medical histories, problem lists and prescription records.

Alaska, per SB182 is an "opt-out" State; patients' records are included in the Alaska HIE unless they choose to opt-out of participation.

4.11 To Be Logical Architecture

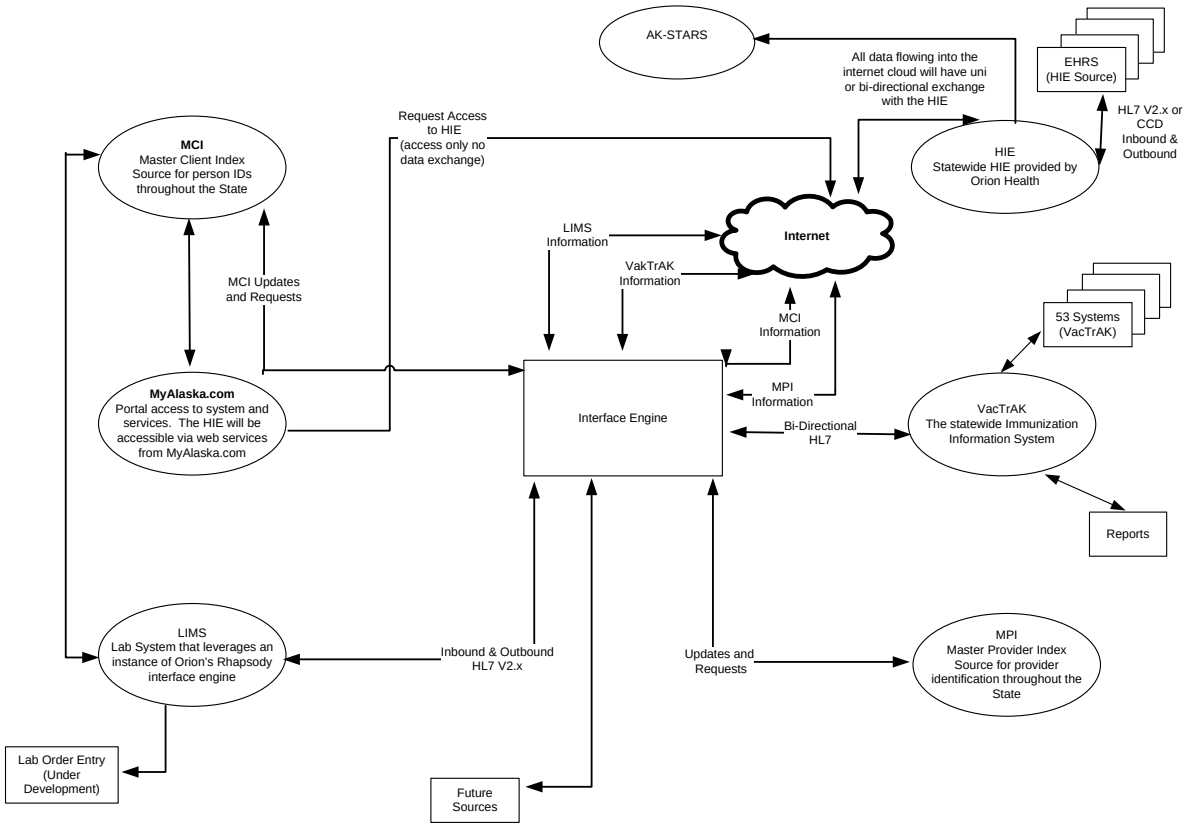
DHSS has identified the requirements and use cases for the integration of the first five state systems into an HIT infrastructure. These candidate systems and requirements were used to develop a Logical Architecture that would support the HIT integration needs for the foreseeable future.

Figure 8 – Anticipated Future State of HIT Integration



DHSS IT is working to develop the architectural design and project plans to implement this future state of integration by leveraging an Interface Engine supported logical architecture. The Figure below depicts the anticipated initial integration of the immunization registry (VacTrAK), the state lab system (LIMS) and the repository supporting state-defined reportable diseases (AK Stars) in addition to a state MCI and Master Provider Index (MPI) that will be made available to the HIE infrastructure via the interface engine. The state's new MMIS will also be a contributor to the MCI, MPI and may have a similar integration with the HIE infrastructure.

Figure 9 – Anticipated Logical Architecture



4.12 Alaska HIE Implementation

Section 4 of the SMHP submitted to CMS in November 2010 described the vision for the Alaska HIT Landscape. In the last ten months, AeHN, DHCS and other stakeholders have made significant progress in realizing the vision identified in that document.

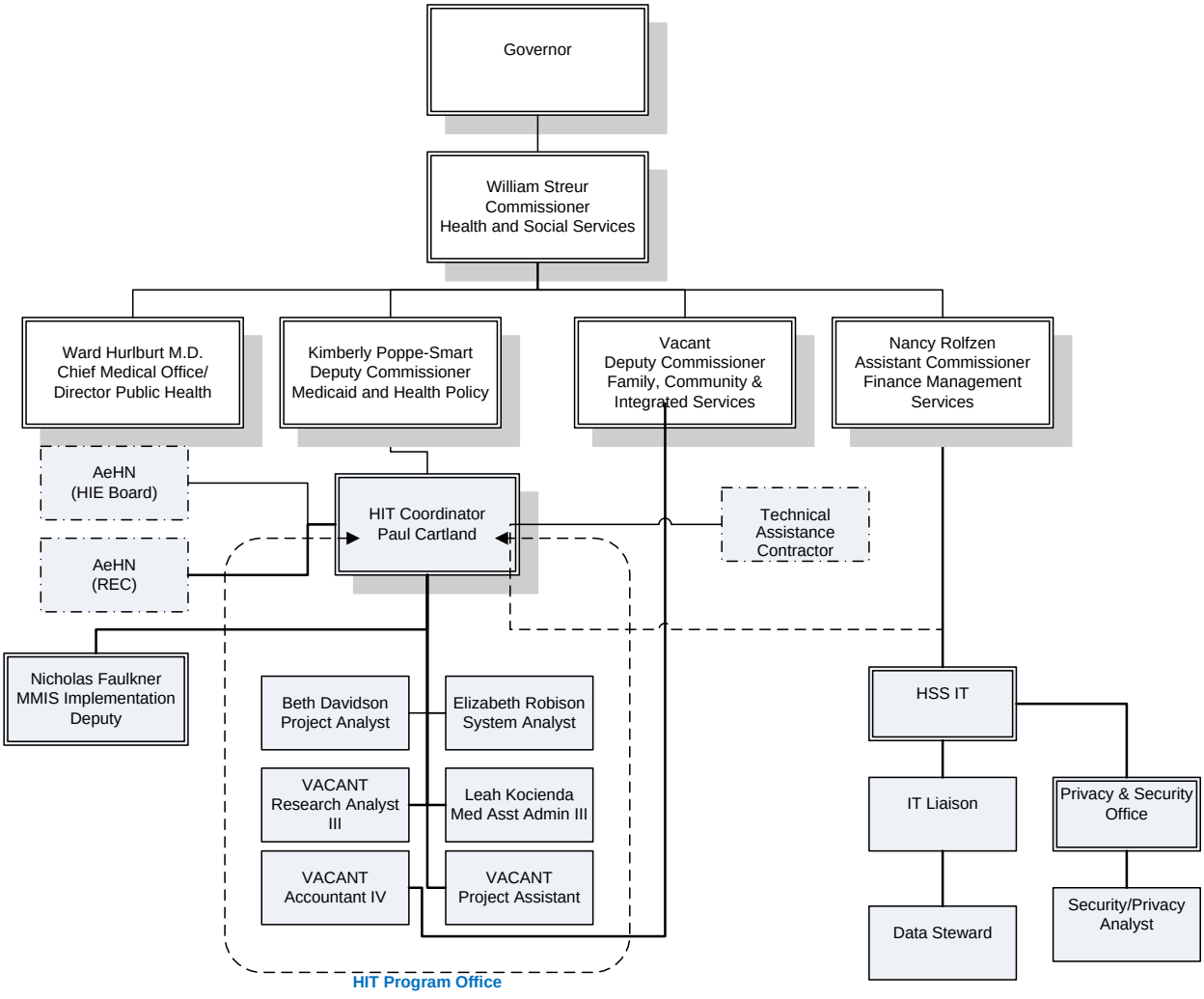
The HIE solution vendor Orion Health was selected, a contract was developed and a pilot implementation is underway with one hospitals and two clinics uploading data to the HIE infrastructure. The current pilot participants are: Fairbanks Memorial Hospital, Tanana Valley Clinic, and the Tanana Chiefs Conference (TCC), all of whom are now providing data transfers into the HIE infrastructure.

5 SPECIFIC ACTIONS NECESSARY TO IMPLEMENT THE ALASKA EHR INCENTIVE PAYMENT PROGRAM

This section includes a high level description of DHCS's Provider Incentive Program and specific actions necessary to implement the program, including a description of work groups and their purpose, goals and responsibilities, communications plan between work groups, and overview of results of regulatory and policy assessments.

5.1 Program Organization

Figure 10 – Program Organization



5.1.1 Concept of Operations

DHCS expects to manage the EHR Incentive Payment Program using resources located in the HIT Program Office within DHCS. This office will support the review and approval of Provider Incentive Program requests received from the NLR, monthly payment processing and required EHR Incentive Payment reporting. The office will also provide coordination and oversight of the DHSS Program Integrity (PI) unit performing the field audits of provider data.

The Office will leverage existing DHCS Medicaid business processes to manage the program such as provider enrollment, provider payment process, provider audits and state and federal reporting. These processes are identified in the SMHP by their MITA Reference names and numbers.

5.2 Communication Plans

MITA Reference: Perform Provider Outreach (PM07)

A procedure manual will be developed outlining the detailed procedures for communicating all facets of the EHR Incentive Program including eligibility, attestation, payment, recoupment, and appeals.

DHCS has developed a Communications Plan for informing providers, the public, external agencies, the media on progress made toward implementation of the EHR Incentive Program, and for sharing communications internally within the DHCS organization. The communication plan includes the following components:

1. A statement of objective, including a commitment to support the implementation of the provisions of the Recovery Act that provide incentive payments to EPs and EHs for the meaningful use of certified EHR technology.
2. A statement of strategies. Strategies include identification of EPs and EHs; education of EPs and EHs to adopt, implement, upgrade, and meaningfully use EHR technology; and provision of educational information for both providers and all interested stakeholders. Strategies will be implemented based on obtaining input via surveys, email input, training events, telephone, and meetings with medical professionals and organizations. Activities will be conducted through training events, presentations, and messages on the DHCS EHR web site, informative emails, articles, and news releases, partnering with various agencies, direct contact with EPs and EHs, to share information.
3. A statement about audiences. The key audiences are EPs and EHs, and affected stakeholders (interested parties, HIT work groups, consumers, vendors, and Alaska Medicaid members). The value of reaching out to EPs and EHs is to assist them with obtaining patient data and making the best possible healthcare decisions for their patients. Barriers that might be expected with EPs and EHs include cost, security/privacy issues, technical knowledge of providers, infrastructure issues, mindset, lack of knowledge, and time concerns. The value of reaching out to stakeholders is that the stakeholders will benefit from a multitude of health professionals being able to access health records needed to ensure informed and efficient delivery of appropriate care. Barriers that might be expected with stakeholders include lack of access, privacy issues, fear and perception of “government,” generational gaps, technical knowledge, literacy issues, language issues, cultural barriers, and lack of resources.

4. A summary statement. The summary statement includes the commitment of DHCS to distribute information in a timely manner to EPs, EHs, internal and external stakeholders, and interested parties. Ultimately, the key for a successful implementation of the ARRA Provider Incentive Program is for EPs and EHs to meaningfully use certified EHR technology to improve the healthcare outcomes for Alaskans.
5. Coordination with DHCS partners. DHCS will continue to coordinate outreach and education activities with its partner organizations such as AEHRA, AeHN, and ACHIN to ensure the broadest access to information for providers. This will include providing partners with website links, documents which can be included with partner outreach activities, and providing a speakers bureau for health summits.

DHCS will continue to refine the communication activities and the communication plan as the EHR Incentive Payment Program implementation plan is executed.

5.2.1 Policy Changes

MITA Reference: Develop and Maintain Program Policy (PG05)

No policy changes have been identified at this time. As the HIT Program Office further refines the program operations, policy changes may be required and will be addressed according to existing program policy maintenance procedures as needed. These policy updates, should they be required will be reported in a subsequent iteration of the SMHP.

5.2.1.1 *Recent Changes in State Laws or Regulations*

MITA Reference: Develop and Maintain Program Policy (PG05)

The DHSS Administrative Regulations Unit has identified the need to describe the state's participation in the EHR Incentive payment program within Alaska Administrative Code. These regulations will both refer to 45 CFR 170.102 - 45 CFR 170.306, "the Final Rule", as well as define provider participation requirements in Alaska.

The regulation additions have been developed and published for public comment under the title "Electronic Health Records Incentive Program 7AAC90" as required by state statute. The regulations will be in place prior to issuing incentive payments to providers.

A summary of the Regulatory changes are included in Appendix C.

5.2.1.1.1 Rule Changes – Update November 2011

The Alaska Administrative Code (AAC) changes required to support the EHR Incentive Payment Program were finalized subsequent to the distribution of incentive payments in April 2011.

DHCS is preparing an additional rule change to support group proxy details that were not in the original version and CMS clarification to practitioners that practice predominately in an FQHC.

The regulations will be updated to indicate that a practitioner may "practice predominantly" at a FQHC, RHC or FQHC look-alike if more than 50% of the provider's total patient encounters over a six month time period in the *previous calendar year to the payment year* were at a FQHC, RHC or FQHC look-alike.

The current regulation (included in Appendix C) reads:
(d) For purposes of this section, a provider practices predominantly at a federally qualified health center or rural health clinic if more than 50 percent of the provider's total patient encounters over a period of six months *in the most recent calendar year* occur at a federally qualified health center or rural health clinic.

5.2.1.2 *HIE/HIT Activities Crossing State Boundaries*

MITA Reference: Establish Business Relationship (BR01)

5.2.1.2.1 Pacific Northwest Health Policy Consortium

DHCS is participating in the Pacific Northwest Health Policy Consortium; the purpose of this group is to identify, discuss and resolve health information exchange issues among "neighboring" states in the Northwest United States. This group expects to meet several times in the fall of 2010 to develop a consistent practice to manage healthcare information "border" issues. The group further anticipates submitting a grant proposal to Research Triangle Institute (RTI) in December 2010. The State of Alaska will coordinate with other states as required to facilitate non-Alaska based Provider Incentive Program requests. Data agreements will be created as needed to allow for the validation of provider Medicaid patient percentage leveraging provider claim data.

5.2.1.2.2 Western State Consortium

The Pacific Northwest Health Policy Consortium was unsuccessful in its grant proposal. The group was renamed the Western States Consortium and a new proposal was submitted in August 2011. The group plans to work across multiple states to overcome policy challenges to the exchange of health information between states. Delegates from Oregon, California, Arizona, Hawaii, Utah, Nevada, Alaska, New Mexico and the Indian Health Service intend to focus on the practical and technical barriers to ensuring the privacy and security of interstate exchange, with a particular focus on using and possibly combining at a regional level, state-level provider directories and trust services, to promote privacy and security and facilitate interstate exchange.

5.2.2 Privacy Regulatory Changes

MITA Reference: Develop and Maintain Program Policy (PG05)

DHCS has not identified any required regulatory changes at this time.

5.3 Provider Contract Changes

MITA Reference: Establish Business Relationship (BR01)

DHCS has not identified any required provider contract changes at this time.

5.4 Provider Eligibility for Incentive Payments

MITA Reference: Enroll Provider (PM01)

Providers and hospitals eligible for the EHR Incentive Program are as follows:

- Physicians
- Pediatrician
- Nurse Practitioner
- Certified Nurse Midwife
- Dentist
- Acute Care hospital
- Children's Hospital

Providers and hospitals that are currently NOT eligible for the Alaska EHR Incentive Program include behavioral health (substance abuse and mental health) providers and facilities and long-term care providers and facilities. Note that some provider types that are eligible for the Medi***care*** program, such as chiropractors, are not eligible for the Medi***caid*** EHR Incentive Program.

5.4.1 Provider Eligibility Determination

The SLR will provide a number of validation steps to insure EHR Incentive payments are made to an eligible provider.

The SLR will validate that the provider is an enrolled Medicaid provider, based on NPI number and provider Taxpayer Identification Number (TIN). The SLR will validate that the enrolled provider is not currently sanctioned. The SLR will validate that the provider is a provider type that is eligible to participate in the EHR Incentive Payment Program. The SLR will leverage provider attestation for year one to determine if they are non-hospital based or practicing predominately in a FQHC or RHC. The SLR will assist the provider in calculating patient volume by collecting the number of Medicaid encounters and total encounters. Providers are also asked to indicate if they practice in multiple states, and to use encounter information for multiple states for both patient encounters and total encounters. The provider can alternately indicate the number of needy individuals to determine patient volume, if applicable.

The HIT Program Office will apply additional controls to ensure that the payments are made to an eligible provider. Prior to the monthly incentive payment issuance, the existing sanction process for provider enrollment will be repeated to avoid making payments to newly sanctioned or deceased providers. This process includes examination of the following resources to determine if each provider application appears on the lists:

- the USDHHS Office of the Inspector General (OIG) Exclusion list,
- the Excluded Parties List System (EPLS) a public service by General Services Administration (GSA) for the purpose of disseminating information on parties that are excluded from receiving Federal contracts, certain subcontracts, and certain Federal financial and nonfinancial assistance and benefits

The process also includes inspection of the provider credentials through the following resources:

Joint Commission on Accreditation of Health Care Organizations (JCAHO)certification is verified online at :

http://qualitycheck.org/consumer/searchQCR.aspx for appropriate provider types.

The Alaska occupational license issue and expiration date, verifying a current license, as well as identifying any action against the license is queried at:

http://www.commerce.state.ak.us/occ/pmed.htm

The current enrollment process leverages the occupational license validation process to ensure that providers do not have a criminal history. Prior to issuing a medical license in the State of Alaska the Medical licensing board performs a background check. Providers with a criminal history are not issued a license to practice in the State of Alaska.

The provider record will be reviewed to determine if the provider is associated with other NPI numbers that have received EHR Incentive Payments. The documentation submitted by the provider to evidence program eligibility will be reviewed. The provider claim data will be reviewed (as applicable) to verify that the provider is not hospital based.

5.4.1.1 *Provider Call Center Support*

MITA Reference: Manage Provider Communication (PM 04)

The Fiscal Agent (ACS) will use existing provider call center support processes to respond to Alaska EP and Eligible Hospital (EH) inquiries regarding the EHR Incentive Payment Program. The HIT Program Office will provide Frequently Asked Questions (FAQ's)and technical support to the ACS provider services unit to ensure uniform responses to provider inquiries. The ACS provider services staff will receive a training session on the EHR Incentive Payment Program that will address the basic provider questions and the implementation of the program in Alaska.

5.4.1.2 *Provider Eligibility Determination Assurances*

MITA Reference: Enroll Provider (PM01)

For ensuring that each EP and EH meets all provider enrollment eligibility criteria upon enrollment and re-enrollment to the EHR Incentive Program, the specifications and methodology for each criterion is described below:

5.4.1.3 *Eligible Provider Types*

Provider type eligibility will be based on the provider type and specialty associated with the provider in the MMIS system. The exception will be pediatricians. DHCS will verify pediatric licenses and board certifications through the American Board of Pediatrics web site or through the American Osteopathic Board of Pediatrics, depending on the physician's certification type.

Specifically, the Alaska EHR Incentive Program Registration component of the SLR web site will be limited to the following MMIS provider types:

Table 9 – Eligible Provider Types/Specialty Types

Eligible Entity per Final Rule	MMIS Provider Type	MMIS Specialty Type	Comment
Physician	20	All	

Eligible Entity per Final Rule	MMIS Provider Type	MMIS Specialty Type	Comment
Physician Assistant (practicing in a FQHC or RHC led by a Physician Assistant)	033	094	Medical Physician Assistant
Pediatrician	20 20	043 049	Pediatrics Allergy-Pediatric
Nurse Practitioner	34	All	
Certified Nurse Midwife	34	126	
Dentist	30	All	
Acute Care Hospital	001 and 005	see Comment	All Alaska Hospitals and types listed in Appendix D
Critical Access Hospital	001 and 005	see Comment	All Alaska Hospitals and types listed in Appendix D
Children's Hospital	001 and 005	see Comment	No Children's Hospitals within Alaska borders

Ineligible Provider Types: In contrast with the Medicare eligible provider definition, the following provider types will not be eligible for the Alaska EHR Incentive Payment Program:

- Podiatrist – Provider type 36
- Chiropractor – Provider type 25
- Optometrist – Provider type 35

Also ineligible by exclusion in the Final Rule are behavioral health practitioners and long-term care facilities that do not otherwise meet the definition of an EP or an EH (see §495.4 General definitions for Medicare eligibility; and §495.304 Medicaid Provider Scope and Eligibility).

5.4.1.4 *Methodology for EP Patient Volume*

DHCS has adopted the Final Rule CMS patient volume definition for the Alaska EHR Incentive Program. The following statements encapsulate the CMS Final Rule definition regarding patient volume:

- "… all EPs and the vast majority of hospitals will need to meet certain patient volume thresholds in order to be eligible for incentive payments. (The only exception to this rule is for children's hospitals, which have no patient volume threshold requirement)…
- …for the Alaska member volume, these thresholds are calculated using as the numerator the individual hospital's or EP's total number of Alaska member encounters in any representative continuous 90-day period in the preceding calendar year and the denominator is all patient encounters for the same individual professional or hospital over the same 90-day period."

- EPs practicing predominantly in an FQHC or RHC will be evaluated according to their "needy individual" patient volume. To be identified as a "needy individual," patients must meet one of following criteria: (1) received medical assistance from Alaska or the Children's Health Insurance Program; (2) Were furnished uncompensated care by the provider; or (3) Were furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.
- DHCS will allow clinics or group practices to use the practice or clinic patient volume and apply it to all EP's in their practice if the three conditions are met. (1) The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP; (2) there is an auditable data source to support the clinic's patient volume determination; and (3) so long as the practice and EPs decide to use one methodology in each year.
- The clinic or practice must use the entire practice's patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group/ clinic proxy in any participation year. If the EP works in both the clinic and outside the clinic (or with an outside group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice.
- DHCS will encourage providers to establish the group patient volume for an organization using the Medicaid group or clinic enrollment criteria (as identified in the Alaska MMIS) or by the Tax Identification Number of the group. There may be multiple groups or clinics within one given Tax Identification Number. Groups shall not include ancillary services such as nursing or pharmacy services in their Medicaid group patient volume. The group patient volume will be determined only by the eligible professional patient encounters.

- DHCS will validate the provider patient volume numerator by evaluating the number of Medicaid claims submitted by the provider during the 90 day period specified by the provider. It is expected that the numerator will be within ten percentage points of the number of members served in this period. DHCS does not have an independent source of validation for the EP denominator; these will be audited in post-payment audit. When EP's are participating in the Alaska HIE, the denominator is expected to be available through the HIE.
- DHCS will use the number of Medicaid discharges on the hospital cost reports to validate the numerator for EH's.

Table10 – Alaska Medicaid Patient Volumes

Eligible Hospital (EH) Type	Patient Volume over 90-day Period
Acute Care Hospital	10% Medicaid
Children's Hospital	No percentage requirement
Eligible Professional (EP) Type	**Patient Volume over 90-day Period**
Physicians (M.D., D.O.)	o 30% Medicaid o For Medical EPs practicing predominantly in FQHC/RHC – 30% Needy Individuals
Dentists	
Certified Nurse Midwifes	
Nurse Practitioners	
PAs in FQHC/RHC led by a Physician Assistant (PA)	
Pediatricians	o 30% Medicaid o If Pediatrician patient volume = 20-29%, the provider may qualify for 2/3 of incentive payment

5.4.1.5 *Verifying Hospital Patient Volume*

Acute care hospitals and Critical Access Hospitals will be asked to enter their Medicaid and total discharges for the prior federal fiscal year. Acute care, critical access and children's hospitals' Medicaid and total discharges are listed on the hospitals' cost reports. DHCS will use these numbers from the cost reports in order to verify the information entered by the hospitals. IHS hospitals do not submit cost reports. IHS hospitals will be asked to submit supporting documentation that contains this information.

5.4.1.6 *Ensure Providers are Licensed, Not Sanctioned*

MITA Reference: Enroll Provider (PM 01) and Disenroll Provider (PM 02)

DHCS's existing processes for checking provider licensure and sanctioning will be employed for the EHR Incentive Program. All providers are manually checked for sanctions before being enrolled in Alaska Medicaid. Once a month, CMS sends a file that is run against the provider file to check for any new sanctions. CMS also sends letters when new providers to the State are sanctioned. DHCS staff uses multiple local resources to identify new sanctions including some automated Alaska Occupation License verifications. Each of these sources will also be reviewed prior to completing any provider's enrollment in the EHR Incentive Program.

The group enrollment form captures the names of employees, contract employees, or any person with ownership or a controlling interest in the practice. Both the primary and secondary owners are checked against the sanction lists for all new provider enrollments.

Tribal provider who are working in a IHS facility are required to have an current occupations license in the State of Alaska, although Commissioned Officers of the US Public Health Services do not provide an Alaska occupational license, these providers must provide proof that they are licensed by another state or territory in the United States.

5.4.1.7 *Provider Attestation Process and Validation*

DHCS currently includes a PEP that allows providers to manage their enrollment and associated data electronically. This provider web portal will be modified to include a SLR module that will include the required elements of the EHR Incentive Program enrollment and attestation.

When providers register for the EHR Incentive Program, they will be asked to attest that they are not hospital based. DHCS will analyze claims for the reporting period with the provider's NPI in the rendering provider field, and look at the place of service for their claims. If the predominant place of service is at the inpatient hospital or ER, the provider will be considered hospital-based. DHCS will initially deny eligibility and advise the provider to ask for eligibility reconsideration if he/she can provide proof to the contrary.

DHCS has defined the attestation criteria for providers applying for an incentive payment to include each of the program eligibility criteria in the first year. In subsequent years as the providers will need to demonstrate their ability to "meaningfully" apply the capabilities of their EHR systems, DHCS will need to develop additional methods of verification.

5.4.1.8 *Allowed Attestation Grace Period*

DHCS will allow EPs to submit their EHR Incentive Payment program attestation up to 60 days beyond the calendar year. For example, EPs can select a 2011 90 day or greater period to demonstrate patient volume for program attestation until February 29, 2012.

DHCS will allow EHs to submit their EHR Incentive Payment program attestation up to 90 days beyond the 2011 Federal Fiscal Year (FFY) and up to 60 days beyond the 2012 and subsequent FFYs. EH's can select a 90 day or greater period in FFY 2011 to demonstrate Medicaid patient volume for program attestation until December 31, 2011. DHCS will allow EH's to select a 60 day or greater period in FFY 2012 to demonstrate Medicaid patient volume until November 30, 2012.

5.4.1.9 *Participation in National Level Repository (NLR)*

DHCS assumes that the NLR will be available to support the registration of Alaska Medicaid providers wishing to participate in the EHR Incentive Program. Providers will select one NPI number with which to register in the NLR and one TIN. DHCS further assumes that the NLR will transmit or make available transactions indicating that the provider had registered.

In the event that the NLR is not available at the inception of the implementation of the EHR Incentive Program, DHCS will compare the registration requests received prior to NLR

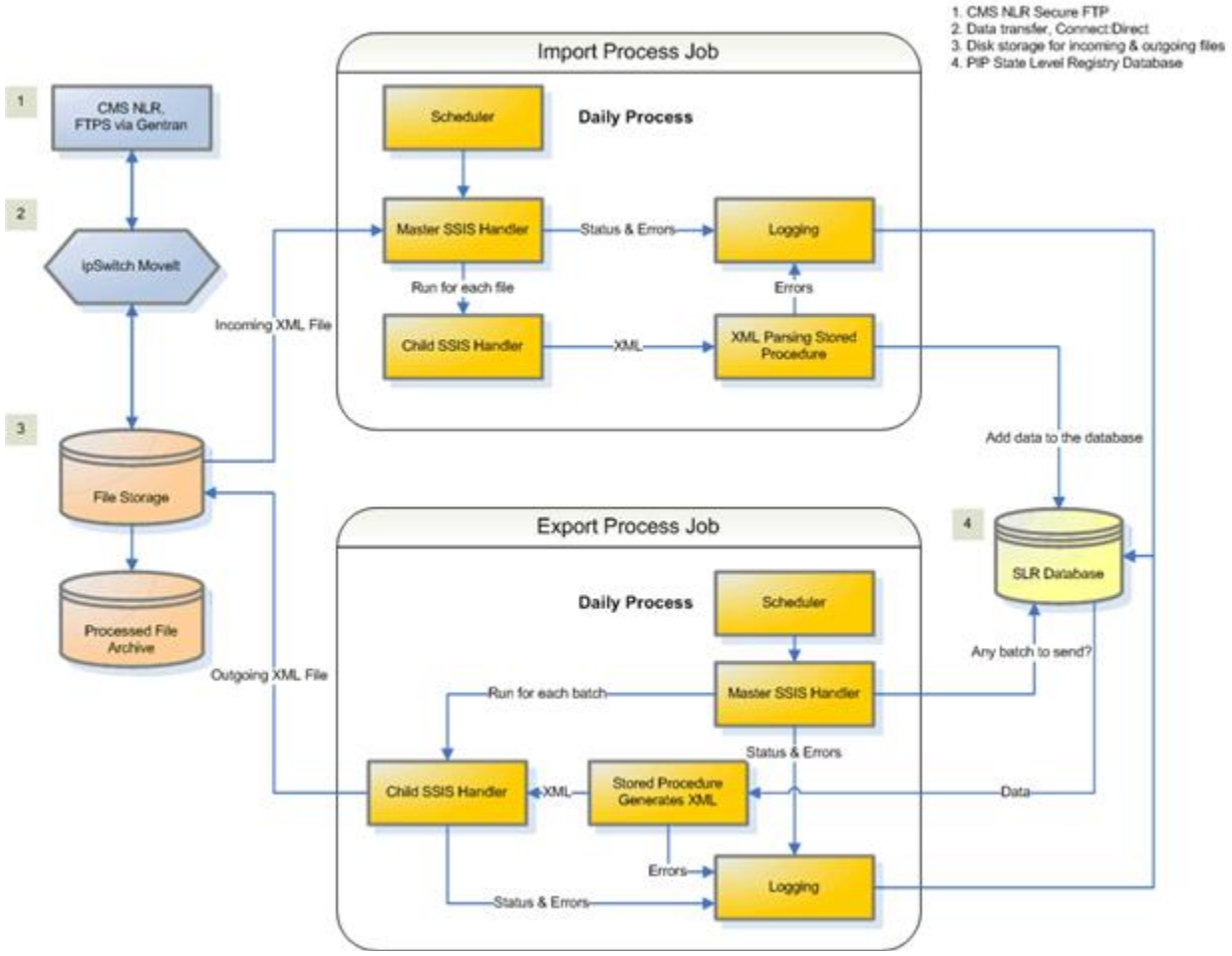
availability to the data in the NLR when it becomes available. If there are discrepancies, DHCS will utilize its existing internal process to validate the provider submission and recoup the EHR Incentive payment if necessary. DHCS will provide "retroactive" provider enrollment information to the NLR, in the event that the repository is not available at the inception of the program in Alaska.

DHCS will develop an electronic bi-directional interface with the NLR supporting the transactions supported by CMS. Specification details for this interface will be described in the IAPD supporting the EHR Incentive Program system changes.

Alaska has volunteered to be in the first group of states that will test the NLR interface.

The SLR will accept the registration data for Medicaid providers from the CMS NLR using Secure FTPS. The interface file is processed and loaded into the SLR as described in the following graphic:

Figure 11 – SLR/NLR Data Exchange



The SLR exchanges data with the CMS NLR through a secure FTPS protocol using Extract Transform Load (ETL) interfaces.

The SLR application accesses, edits and stores data in a SQL database. The SQL database receives incoming data from CMS through an import process and the SLR sends data back to CMS through an export process.

The import service accepts XML data coming from CMS using standardized schema. The incoming data exchange is accepted, validated and parsed to the SLR SQL database where it can be accessed by the SLR.

The export process follows a similar workflow. An export service extracts data from the SLR SQL database, validates and compiles the data into the XML. The XML file is sent through a secure FTPS protocol to CMS.

The import and export processes allow for CMS and the Alaska SLR to share pertinent provider information and payment information for the CMS provider incentive program

5.4.2 Provider Registration Process

5.4.2.1 *Provider Taxpayer Identification Number (TIN)*

MITA Reference: Manage Provider Information (PM06)

DHCS currently requires that all providers submit a valid TIN as a condition of Alaska Medicaid provider enrollment. Each EP or EH will be enrolled as an Alaska Medicaid provider and will therefore, without change in process or system modification, meet the requirement to supply a TIN.

The TIN will be used to identify the providers on Internal Revenue Service (IRS) Form 1099 and allow IRS reporting based on the appropriate TIN where providers have received an EHR Incentive payment from Alaska. Current business and system processes support the use of TIN to identify provider payments.

TINs are validated with the IRS annually. When DHCS submits a 1099 file to the IRS, the IRS will respond to DHCS with a letter including a list of incorrect TINs. DHCS follows up by contacting the provider for the correct information. If the provider does not respond, DHCS suspends provider payments until the correct TIN is submitted.

Assignment of Payment

It is understood that the National Plan and Provider Enumeration System (NPPES) registration system will require all providers to assign payment at the national level. The NLR Registration transaction to the State will include not only the EP's Personal TIN, but also the Payee TIN. DHCS plans to assign the payment at the state level, as the national level has no way to validate the payee TIN/EP TIN relationship. The TIN/EP relationship will be validated against existing relationships in the PEP system, which includes all Medicaid providers receiving payment from DHCS.

5.5 Meaningful Use Attestation

The SLR will be modified to accommodate Stage 1 Meaningful Use attestation. The design of the attestation solution will be modeled after the Medicare Attestation solution. Preliminary screenshots of the SLR modifications are presented in Appendix L.

EPs will complete the SLR MU attestation process indicating:

- The 15 Core Objectives including numerators and denominators as required
- The five selected of 10 Menu set objectives including one public health measure, indicating numerators and denominators as required
- The three of Core or Alternate Core Clinical Quality Measures, including numerator and denominator or exclusion for each
- Three of the 38 Menu set Clinical Quality Measures, including numerator and denominator for each

EHs will complete the SLR MU attestation process indicating:

- Each of 14 Core objectives, indicating numerator and denominator or exclusion where required
- The five selected of the10 menu set objectives indicating numerator and denominator or exclusion as required
- Each of 15 clinical quality measures including numerator and denominator or exclusion

The real time notification of MU doesn't occur until the provider saves the data. All saves are stored. The SLR will flag multiple entries for the same measure as an exception. The state will review and clear all exceptions prior to the SLR the D16 transaction submission. The state will flag providers that make frequent changes for audit.

DHCS expects several Alaskan EH's to be qualified for both Medicaid and Medicare incentive payments. As these dually eligible hospitals attest to Medicare Meaningful Use of certified EHR technology, DHCS will receive a C-5 transaction indicating that the hospital has meet the MU requirements.

EHs in their second year, will use the SLR to validate the EHR Certification Number and provide patient volume, average hospitals days and complete a second attestation.

EHs that are only eligible for, or choose only to apply for Medicaid EHR Incentive payments will attest to MU through the SLR as described above.

5.6 Processing Payments to Providers

MITA Reference: Prepare Provider EFT Check – (OM10)

Appropriate accounting expenditure entries will be created when DHCS staff enters payment requests into the AKSAS which is the state's accounting system. The staff will verify through the SLR that all supporting documentation has been submitted by the EP/EH and that all of the requirements for payment have been satisfied. The incentive payments are considered

supplemental payments. A specific funding code will be applied to provider incentive payments such that they can be tracked independently.

Funds are dispersed as specified by the State Medicaid Agency business rules. Payments are routed as specified by the "pay to" instruction from the CMS NLR most recent registration transaction, to the EFT account or payee address on file for the payee TIN as identified in AKSAS.

Providers determined to be eligible for EHR Incentive Program payments will be identified and payments made on a monthly basis (e.g., all providers identified as eligible providers in March 2011 would receive their Year 1 payments in April 2011)

The Provider Number is used in AKSAS (the state accounting system) not the TIN or NPI. The NPI is tied to the Provider Number during provider enrollment in the Provider Enrollment Portal.

Providers determined to be ineligible for the EHR Incentive Program payments will be notified via email of the decision, the reason(s) for the decision, as well as the process for reconsideration.

5.6.1 Provider Registration and Payment Request

DHCS Plans to use the PIP system to accept provider registration, evaluate provider eligibility and record provider attestations. The table below outlines the Attestations to be captured for Eligible Providers.

Table 11 – Eligible Professional Attestations

During EHR Year 1 reporting period, the EP attests:	During EHR Years 2 through 6 reporting period, the EP attests:
The Physician Assistant attest that he/she is working in an FQHC or RHC so led by: a) a PA as the primary provider in the clinic, b) a PA as the clinical or medical director at a site of practice, or c) a PA as an owner of an RHC.	The Physician Assistant attest that he/she is working in an FQHC or RHC so led by: a) a PA as the primary provider in the clinic, b) a PA as the clinical or medical director at a site of practice, or c) a PA as an owner of an RHC.
The EP attests that he/she practices predominantly in an FQHC or RHC, if applicable	The EP attests that he/she practices predominantly in an FQHC or RHC, if applicable
The EP is a non-hospital based professional who furnishes 90% or more of his/her professional services in an inpatient hospital or emergency room setting, if he/she does not practice predominantly in an FQHC or RHC	The EP is a non-hospital based professional who furnishes 90% or more of his/her professional services in an inpatient hospital or emergency room setting, if he/she does not practice predominantly in an FQHC or RHC
The EP is not concurrently receiving an incentive payment under another Alaska ID number.	The EP is not concurrently receiving an incentive payment under another Alaska ID number.
The EP has adopted, implemented or upgraded (A/I/U) a certified EHR	The EP used certified EHR technology
The EHR product used is certified and EP entered a product certification number	The EHR product used is certified and EP entered a product certification number
The EP has confirmed assignment of his/her payment to another TIN and agrees to this assignment, if applicable	The EP has confirmed assignment of his/her payment to another TIN and agrees to this assignment, if applicable

During EHR Year 1 reporting period, the EP attests:	During EHR Years 2 through 6 reporting period, the EP attests:
The EP's percentage of Alaska encounters or Needy Individual (for EP's practicing predominantly in an FQHC/RHC) patient volume is equal to or greater than the allowed percentage of their specialty (See Appendix E)	The EP's percentage of Alaska encounters or Needy Individual (for EP's practicing predominantly in an FQHC/RHC) patient volume is equal to or greater than the allowed percentage of their specialty (See Appendix E)
The EP has specified the patient volume date range of at least 90 days	The EP has specified the patient volume date range of at least 90 days
	The EP has specified the EHR reporting period and provided the result of each applicable measure for all patients seen during the EHR reporting period for which a selected measure is applicable
	The EP has satisfied the required objectives and associated measures under §495.6(d) and §495.6(e), except §495.6(d)(10) "Report ambulatory clinical quality measures to the State"
	The EP attests to meeting the meaningful use criteria associated with his/her year of participation and applicable stage per the rule
	If applicable, the EP attests that the clinical quality measures not reported do not apply to any patients treated by the EP
The EP attests that all information is true and accurate per wording in the rule	The EP attests that all information is true and accurate per wording in the rule

For all calendar years, an EP who practices in multiple physical locations, not all of which have certified EHR technology available, the EP will demonstrate meaningful use using only the locations where the EP has certified EHR technology available.

In order to qualify for payment in year 1, the EP must attest to Adopting, Implementing or Upgrading to EHR technology as per §495.6, in years 2-6 the EP must meet the definition of §495.4 meaningful EHR user

The table below outlines Attestations for Hospitals and CAHs.

Table 12 – Eligible Hospitals and CAHs Attestations

Eligible Hospitals or CAHs eligible only for the Alaska EHR Incentive Payment Program, attesting to Adopt, Implement, or Upgrade in their first participation year attests that:	During 2011 reporting period, the eligible hospitals or CAHs attesting to Meaningful Use attests that:	During 2012 and subsequent reporting periods, the eligible hospitals or CAHs attesting to Meaningful Use attests that:
The EH or CAH adopted, implemented or upgraded (A/I/U) a certified EHR	The EH or CAH used certified EHR technology	The EH or CAH used certified EHR technology.

Eligible Hospitals or CAHs eligible only for the Alaska EHR Incentive Payment Program, attesting to Adopt, Implement, or Upgrade in their first participation year attests that:	During 2011 reporting period, the eligible hospitals or CAHs attesting to Meaningful Use attests that:	During 2012 and subsequent reporting periods, the eligible hospitals or CAHs attesting to Meaningful Use attests that:
	The EHR product used is certified and EH or CAH entered product certification number, vendor, product, and version	The EHR product used is certified and EH or CAH entered product certification number, vendor, product, and version
	The EH or CAH satisfied the required objectives and associated measures under §495.6(f) and §495.6(g).	The EH or CAH has satisfied the required objectives and associated measures under §495.6(f) and §495.6(g), except §495.6(f)(9) "Report hospital clinical quality measures to the State"
		The EH or CAH attests that the information submitted with respect to clinical quality measures was generated as output from an identified certified EHR technology
		The EH or CAH attests that the information was submitted to the knowledge and belief of the official submitting on behalf of the eligible hospital or CAH
		The EH or CAH attests that the information submitted includes information on all patients to whom the measure applies
		For EHs or CAHs that do not report one or more measures, the EH or CAH attests that the clinical quality measures not reported do not apply to any patients treated by the EH or CAH during the reporting period
		The EH or CAH attests numerators, denominators, and exclusions for each clinical quality measure result reported, providing separate information for each clinical quality measure including the numerators, denominators, and exclusions for all patients irrespective of third party payer or lack thereof; for Medicaid patients.
		The EH or CAH attests the beginning and end dates for

Eligible Hospitals or CAHs eligible only for the Alaska EHR Incentive Payment Program, attesting to Adopt, Implement, or Upgrade in their first participation year attests that:	During 2011 reporting period, the eligible hospitals or CAHs attesting to Meaningful Use attests that:	During 2012 and subsequent reporting periods, the eligible hospitals or CAHs attesting to Meaningful Use attests that:
		which the numerators, denominators, and exclusions apply
	The EH or CAH specified the EHR reporting period and provided the result of each applicable measure for all patients admitted to the inpatient or emergency department (POS 21 or 23) of the hospital during the EHR reporting period for which a selected measure is applicable	The EH or CAH specified the EHR reporting period and provided the result of each applicable measure for all patients admitted to the inpatient or emergency department (POS 21 or 23) of the hospital during the EHR reporting period for which a selected measure is applicable
The EH or CAH attests that all information is true and accurate per wording in the rule	The EH or CAH attests that all information is true and accurate per wording in the rule	The EH or CAH attests that all information is true and accurate per wording in the rule

5.6.2 National Registry Validation

DHCS will no longer duplicate CMS checks on National Death Registry or National Sanction list, per the Audit CoP presentation of 4/26/2011.

5.7 Alaska Tribal Hospitals and Clinics

CMS has previously issued guidance stating that health care facilities owned and operated by American Indian and Alaska Native tribes and tribal organizations ("tribal clinics") with funding authorized by the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended) must be reimbursed as Federally Qualified Health Center (FQHCs) in order to be considered as an FQHC for the purposes of the Medicaid EHR Incentive Program. In June 2011, CMS has revised this policy and will allow any such tribal clinics to be considered as FQHCs for the Medicaid EHR Incentive Program, regardless of their reimbursement arrangements, per CMS FAQ 10417.

Therefore EPs practicing predominantly in an FQHC, RHC **or** Tribal Clinic will be evaluated according to their “needy individual” patient volume. To be identified as a “needy individual,” patients must meet one of following criteria: (1) received medical assistance from Alaska or the Children’s Health Insurance Program; (2) Were furnished uncompensated care by the provider; or (3) Were furnished services at either no cost or reduced cost based on a sliding scale determined by the individual’s ability to pay.

5.7.1 Validation of Hospital Cost Report Data

DHCS will leverage Form CMS-2552-96 Hospital Cost Reports as submitted to verify the information entered into the SLR by the hospital.

5.7.2 Validation of Tribal Hospital Cost Report Data

Tribal hospitals submit a modified cost report to IHS for review and validation. DHCS will rely on these audited cost reports to support incentive payment calculations.

DHCS will need to calculate first Tribal hospital payment on the most recent cost reports (may be 2008 or 2009 but not 2010) and then when more recent data is available, recalculate and adjust the overall payment to the tribal hospital, consistent with the approach planned by Medicare to adjust hospital payments in the future as updated reports are available.

Tribal hospitals can include the charity services for which no federal funding was provided from auditable financial reports, or the most recent cost report.

5.8 Provider Payment Calculations

5.8.1.1 *Eligible Professionals (EP) Payment Calculation*

Each EP will receive the full payment of $21, 250 in their first year, with the exception of Pediatrician's qualifying with a 20% - 29% patient volume. In subsequent years, each EP will receive the full payment of $8,500, with the exception noted above.

Per §495.310, an EP may not begin receiving payments later than calendar year 2016. Payment after the first year may continue for a maximum of five years. EPs may receive payments on a non-consecutive, annual basis. No payments may be made after calendar year 2021. In no case shall a EP participate for longer than six years or receive payment in excess of the maximum $63,750. The SLR will ensure that payments are not made after 2021 and that the participation is limited to six years as well as the maximum payment amount.

EPs that meet the State definition of Pediatrician and carry between 20 percent and 29 percent Medicaid patient volume will have their payment reduced by one-third. The Pediatrician will not receive more than $14,167 in the first year and not more than $5,667 for subsequent years. The total allowable for six years will not exceed $42,500. All other requirements noted above for an EP remain the same.

Some providers may have difficulty producing data for a 90 day period due to capabilities of their software and other entity reporting requirements. DHCS will allow EPs to use a 90 day or greater period of time, up to one year if for calculating patient volume and meeting meaningful use requirements if this is practical and advantageous for the professional or group.

5.8.1.2 *Eligible Hospital (EH) Payment Calculation*

The Alaska EHR Incentive Program hospital aggregate incentive amount calculation will be a one-time, up front calculation using the equation outlined in the Final Rule, as follows:

(Overall EHR Amount) times (Medicaid Share) where Overall EHR Amount Equals {Sum over 4 year of [(Base Amount plus Discharge Related Amount Applicable for Each Year) times Transition Factor Applicable for Each Year]} times Medicaid Share Equals {(Medicaid inpatient-bed-days plus Medicaid managed care inpatient-bed-days) divided by [(total inpatient-bed days) times (estimated total charges minus charity care charges) divided by (estimated total charges)]}

An example hospital calculation spreadsheet is included in Appendix G.

Alaska intends to pay the aggregate hospital incentive payment amount over a period of three annual payments, contingent on the hospital's annual attestations and registrations for the annual Alaska Incentive payments. The reason for this approach is that most of Alaska's hospitals operate on a very thin margin and will need the money as soon as possible to offset their EHR system costs.

In the first year, if all conditions for payment are met, 50 percent of the aggregate amount will be paid to the EH. In the second year, if all conditions for payment are met, 40 percent of the aggregate amount will be paid to the EH. In the third year, if all conditions for payment are met, 10 percent of the aggregate amount will be paid to the EH. No Alaska EHs may begin receiving payments after 2016 and no payments may be made after calendar year 2021. Prior to 2015 payments can be made to an eligible hospital on a non-consecutive annual basis. The SLR supports these requirements.

5.8.1.2.1 Eligible Hospital (EH) Payment Calculation – Update November 2011

DHCS has clarified the EHR Incentive payment Hospital calculation based on guidance from CMS and system implementation experiences.

DHCS has clarified that the Years 1-4 are sequential years an example was 2006 -2009, however as more current cost reports are available for use in this calculation (2010 for example) Years 1-4 would include 2007 – 2010.

EH's have been directed to specifically exclude swing bed days and nursery days from the incentive payment calculation, including discharge calculations. The SLR supports the exclusion of these amounts from the incentive payment calculation.

Some hospitals and providers may have difficulty producing data for a 90 day period due to capabilities of their software and other entity reporting requirements. DHCS will allow hospitals and providers to select 90 days or greater, up to one year, as the time period for calculating patient volume and meeting meaningful use requirements. DHCS will allow hospitals to use a 90 day period if that is advantageous and practical for the provider or provider group.

5.8.2 Hospital Attestation Tip Sheet

The DHCS HIT Program Office has developed a tip sheet to guide EHs through the attestation process. The elements of the tip sheet are listed below.

Confirm Medicaid Eligibility for Eligible Hospitals

Acute Care and Critical Access Hospitals (CAH) must have:

- Medicaid discharges of at least 10% of all discharges to establish Medicaid patient volume,

- An average Length of Stay (LOS) of 25 days or less,
- A CMS Certification Number (CCN) that ends in 0001 – 0879 or 1300 – 1399 to be eligible to receive an incentive payment
- Children's Hospitals with a CCN that ends in 3300 – 3399 are automatically eligible

The hospital Medicaid patient volume is established by selecting a representative 90 day period or greater from the previous federal fiscal year. For purposes of calculating eligible hospital patient volume, a Medicaid encounter is defined as services rendered to an individual (1) per inpatient discharge, or (2) on any one day in the emergency room * where TXIX Medicaid or another State's Medicaid program paid for:

- Part or all of the service;
- Part or all of their premiums, co-payments, and/or cost-sharing;

*In order for emergency room encounters to count towards the patient volume the emergency department must be part of the hospital.

The hospital tip sheet is included in Appendix I which also lists the SLR element definitions.

As noted in section 5.7.3 Validation of Tribal Hospital Cost Report Data, the Tribal Hospitals will use modified cost reports. A Tribal Hospital Tip Sheet made available to assist Tribal hospitals completing attestation is included in Appendix J.

An updated Hospital Calculation worksheet is included in Appendix G. This update includes the line numbers from the hospital cost reports.

5.8.2.1 *Payments to Eligible Providers through Managed Care Plans*

This requirement does not apply, Alaska Medicaid programs do not have contracts with managed care entities.

5.8.3 Provider Payment Monitoring

This section will include the processes and **verification methods** in place to assure that:

- *No amounts higher than 100% of FFP will be claimed for reimbursement of expenditures for State payments to Medicaid eligible providers for the EHR incentive payment*

MITA Reference Draw and Report FFP (PG18)

In order to ensure that no amounts higher than 100 percent of federal financial participation (FFP) will be claimed for reimbursement, payments to EHR Incentive Program eligible providers will be reported on a separate line on the CMS 64 (Management and Administrative Reporting (MAR) 1060/1062 reports) report. This report will be reviewed for accuracy and deficiencies.

- *Payments are made directly to a Medicaid EP or Hospital or to an employer or facility to which such a provider has assigned payment) without any deduction or rebate.*

Payments will be made directly to an EP or EH or to an employer or facility to which the provider has assigned payment.

- *All assignments to an entity promoting the adoption of certified EHR are voluntary for the Medicaid EP*

- *Entities promoting the adoption of EHR technology doe not retain more than 5% of payments not related to or required for the operation of the technology*

The State has no current plans to create any "Designated Entities" for promoting the adoption of certified EHR technology.

- *Medicaid EP or eligible hospitals do not collected EHR payments from multiple states*

System controls will be implemented and tested in the AKSAS payment system to ensure appropriate payments and reporting. DHCS assumes that states will participate in the registration and payment reporting to the NLR. DHCS will interrogate the NLR based on unique provider NPI and TIN, prior to completing the payment process to ensure that EP or EH do not collect EHR payments from multiple states. This process will also ensure that EPs have not previously received Medicare payment for the same Program Year.

Process to ensure that existing fiscal relationships with providers to disburse incentive payments through Medicaid managed care plans does not result in payments that exceed 105% of the capitation rate

Alaska does not make payments to managed care plans.

- *Method to monitor the compliance of providers beginning the program with different requirements dependent upon the year*

Providers will be required to attest to the year of their participation that they have not requested to participate in the Medicare (for EPs) or any other State Provider Incentive Program. Communications with the CMS NLR will be used to validate this information prior to making the incentive payment. The SLR system will retain information on Alaska's payments to providers for prior years and will accept prior years' information from the NLR if providers change their state designation to Alaska.

- *Process to ensure that the Medicaid EHR incentive program payments are made for no more than six years and that no eligible provider or hospital begins receiving payments after 2016*

Provider participation in the EHR Incentive Program will be tracked in the SLR. The Provider's status relative to Program eligibility will be assessed with each annual payment request. The eligibility determination will include the interrogation of the NLR to assess previous payments based on unique provider NPI and TIN. DHCS will maintain in each participating Provider record the year in which payments are requested and the EHR Incentive Program requirements relative to the year of the request. Each eligible provider will be limited to a maximum of six payments. New provider EHR Incentive Program participation requests will not be allowed after December 31, 2016.

In addition, DHCS will submit program participation data to CMS including data for the number, type and practice location(s) of providers who qualified for an incentive payment on the basis of having adopted, implemented, or upgraded certified EHR technology or who qualified for an incentive payment on the basis of having meaningfully used such technology as well as aggregate de-identified data on meaningful use.

- *Description of the process and method used to calculate the net average allowable costs and verification that the payments do not exceed 85% of the net average allowable cost*

DHCS has removed references to the net allowable cost calculation method and application to the Incentive payment.

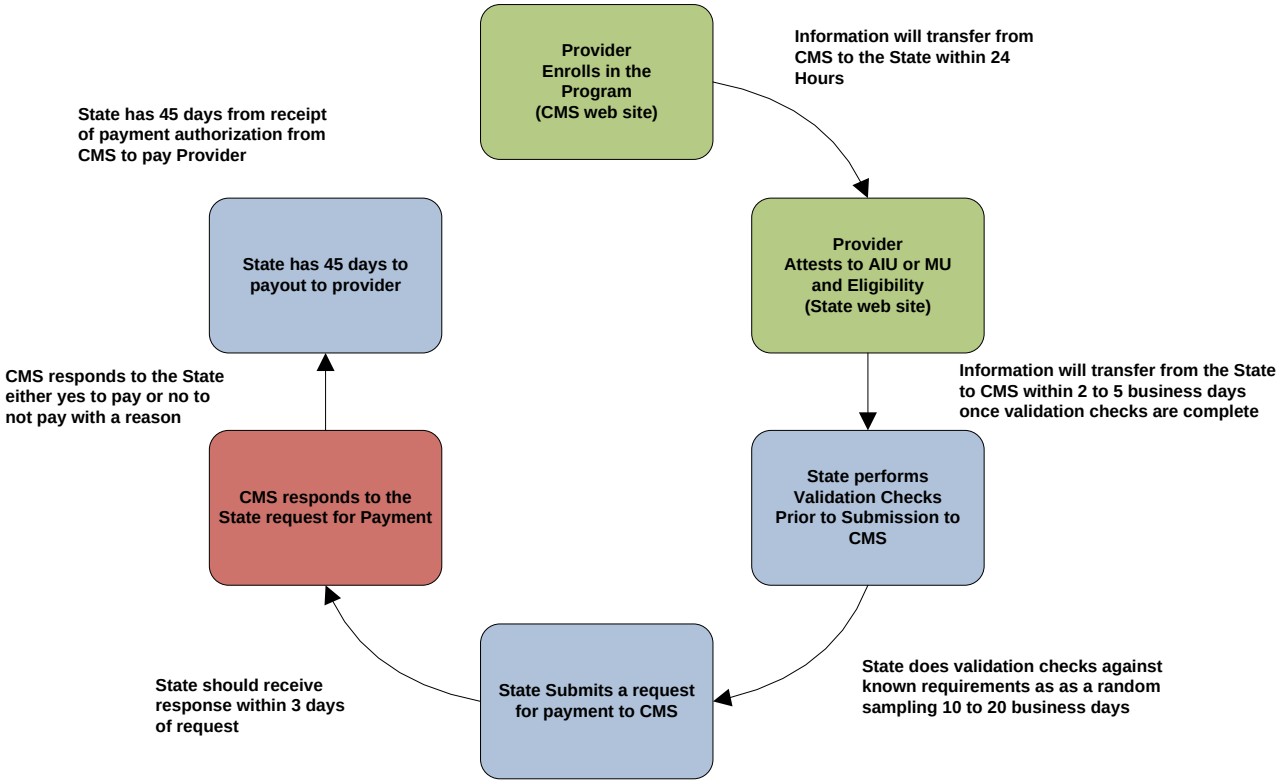
- *Description of the process, data and method used to calculate the hospital payment incentives*

Hospital Payment calculation is described in detail in Section 5.5.2.2

5.8.4 Provider Payment Timing

Payment calculations are described in Section 5.5.2

Figure 12 – Payment Cycle Example



Once a provider has enrolled in the NLR, DHCS assumes that the registration information will be transferred to the state within 24 hours; depending upon the time of day that the NLR registration takes place.

The provider will also enter additional information on the state's SLR enrollment site, such as making attestations, calculating patient volume and calculating net allowable costs. DHCS will take no action on an enrollment until the provider indicates it is complete.

At this point automated and manual validation checks are performed and a decision regarding enrollment is reached. This decision is transmitted to the NLR within 24 hours. The manual validation check can take up to 20 business days to complete.

The state calculates the payment amount, completes final sanction checks and transmits a request to pay to the NLR. A response approving the payment (and completing a validation for duplicate payments and OIG sanctions) is transmitted from NLR to the state.

The state makes the payment in the next monthly payment cycle.

5.8.5 Provider National Provider Identifier (NPI)

MITA Reference: Enroll Provider (PM01)

Providers that enroll in the Alaska Medicaid program are required to have an NPI number. Providers that are not enrolled with the state Medicaid program will not be considered for EHR incentive payments. Therefore all providers receiving payment will have a validated NPI.

5.8.6 Role of Contractors in the Alaska EHR Incentive Program Implementation

DHCS will rely on ACS, the Alaska Fiscal Agent to accept provider inquiries regarding the program; maintain the provider enrollment portal that supports provider registration, attestation and provider payment calculation.

5.9 Reporting Requirements

Basic reporting requirements have been defined for the SLR. There will be an Ad hoc reporting engine allowing users to create their own specific reports to fit their needs, determined by selections made by the user creating the report.

Examples of the planned reports for phase 1 of the SLR are included in the table below.

Table 13 – SLR Reports

Report Type	Report Description
Registration Report	provider registration information assisting the verification of EP's registered in the program
Eligibility Report	provider eligibility information assisting the verification and validation of an EP's status
Validation Report	shows the data that has been tracked to determine the validity of an EP's Registration, Eligibility, and Attestation information

Report Type	Report Description
Payment Reporting	who has been paid, when they were paid, how much they were paid, the Check of electronic transaction number of the payment, a distinct timeframe for viewing i.e. a month, quarter, or year. Who has completed their submission for payment, whether or not they have received that payment
NLR Report	showing all providers that have enrolled in the NLR, whether or not the providers that have enrolled in the NLR are currently enrolled in the SLR
A/I/U and MU report	showing if the provider has completed their A/I/U or MU attestation respectively, when it was completed (Date of completion).
Provider Report	showing providers that have entered information into the SLR application and have completed data entry, have not completed data entry, where they are in the process, this report can also be time sensitive i.e. a provider began their data entry but did not finish and have not returned to complete for longer than 60 days. This report can also be used as an outreach and education tool allowing outreach coordinators to reach out to those providers and assist them with completion.
Attestation Report	showing if a provider has completed their attestation, why or why not. It can also show whether or not the attestation was completed successfully why or why not.
Eligibility Report	showing if the provider has met the eligibility requirements set forth in the application. Report also has a mechanism that allows states to create a threshold range for providers i.e. if a provider is above 29% Medicaid volume yet below 29.9% Medicaid volume it can generate a letter which again can be used as an outreach tool to assist providers that may have missed some information that could get them to eligibility for the EHR incentive.
Forecasting Report	showing possible payments to providers and hospitals, the report allows states to forecast needs to provide incentive payments to those eligible to receive payments. The report can also determine average payment size. This is for Eligible Hospitals and Eligible Professionals.
Ineligibility Report	shows which providers have been deemed ineligible for incentive payments why they were deemed ineligible. This report can also generate a letter to the providers informing them of their status and the reason why

5.9.1 EHR Incentive Program Reporting

DHCS currently submits monthly reports to the CMS Region X Office regarding the number of providers and hospitals registering at the CMS site, registering and attesting at the SLR as well as the number and dollar amount of EHR Incentive Payments.

DHCS updates the CMS 37 and CMS 64 reports on a quarterly basis as required communicating the Administrative costs as well as payments associated with this program.

5.10 Coordination with Medicare to Prevent Duplicate Payments

DHCS assumes that the NLR will be available to support the registration of Alaska Medicaid providers wishing to participate in the EHR Incentive Program. DHCS will receive transactions from the NLR that will determine if providers eligible for both Medicaid and Medicare payments have already received Medicare payments.

Hospitals determined to have met Medicare Meaningful use requirements are also deemed to have met Medicaid Meaningful use requirements. DHCS assumes that the NLR will identify duplicate payments for Medicare or other states' Medicaid programs and will not transmit those requests to Alaska.

In the event that the NLR is not available at the inception of the implementation of the EHR Incentive Program, DHCS will compare the registration requests received prior to NLR availability to the data in the NLR once available. If there are discrepancies, DHCS will utilize its existing internal process to validate the provider submission and recoup the Incentive payment if necessary.

DHCS will develop an electronic bi-directional interface with the NLR. Specification details for the interface that support receipt of Medicare payment information will be described in the IAPD supporting the EHR Incentive Program system changes.

5.11 Program Integrity (PI) Monitoring

MITA Reference: Identify Candidate Case (PI01)

DHCS program integrity goals and objectives are included in Section 8 Audit Strategy.

5.11.1 Incentive Payment Recoupment

MITA Reference: PG15 – Perform Accounting Functions

In the event DHCS determines monies have been paid inappropriately, a current Recoupment process will be leveraged to recover the funds. An Accounts Receivable (AR) record will be created associated with the appropriate provider and the payment identified as an overpayment in AKSAS. Payments amounts may need to be collected and would be refunded to CMS via the appropriate CMS 64 adjustment. The existing practice allows DHCS to work out an acceptable repayment period dependent upon the provider circumstances and amount of the AR.

AR can be manually established in the MMIS against a provider's future payments or within AKSAS. All recoupments must be applied manually. These funds will be identified as EHR Incentive Program reversals and as such will reduce the amount of the Quarterly Provider Incentive Program Federal Fund draw.

5.11.2 Fraud and Abuse Prevention

MITA Reference: PI01 – Identify Candidate Case

MITA Reference: PI02 – Manage Candidate Case

Managing risk is an important component to the success of this implementation; particularly one of this scale. The SLR web portal provides the Agency with flexible but robust business logic that allows the Agency to customize when and where in the provider incentive program process to add checks for fraud and abuse to mitigate risk. At many points in the overall process, such as after the registration and eligibility processes, the data submitted validates against other databases to help ensure the legitimacy of the provider's account.

The DHCS PI unit supports the investigation of potential misuse, by providers and clients. The PI leverages a decision support system Java Surveillance Utilization Review System (JSURS) to identify providers that may be suspected of claims fraud or specific Medicaid program abuse. It is reasonable to examine these identified providers' participation in and documentation provided for the EHR Incentive Payment program for compliance. Any evidence of Medicaid Provider Fraud will be referred to the Medicaid Fraud Control Unit through the Program Integrity Section in accordance with established procedures.

Section 7.*Audit Strategy* describes the prepayment and post payment audit functions that may lead to the detection of fraud or abuse of the EHR Incentive Payment Program.

5.11.3 Provider Appeals

MITA Reference: PM05 – Manage Provider Grievance and Appeals

Provider "pre-appeal" situations could include disputed payment amounts, Medicaid patient volume percentage, evaluation of hospital based services for EP and hospital's qualification to participate. The pre-appeal process may be initiated by a phone call or through written notification of the discrepancy. In the pre-appeal process, the provider will have 10 business days to provide the additional information that supports their request, prior to their request being denied. If that information is not provided within the given time frame or the information is insufficient, the provider will be notified either by phone or via mail that the request is being denied. At this point, the provider can choose to proceed to a formal appeal process.

Prior to a formal audit being issued, DHCS will conduct a review process in which the provider will be notified in writing of any discrepancies. In the review, the provider would be allowed to submit any additional data that supports what they originally attested to.

Any discrepancies identified after the initial review processes completed by the HIT Program Office would trigger a formal audit that would be issued and conducted by the DHCS Program Integrity department.

DHCS will leverage existing administrative review processes in place to manage formal provider appeals. DHCS works to minimize the number of complaints that will require a formal appeals process by working closely with providers that have a complaint. Complaints are defined in Alaska as problems reported by providers that have been escalated to management level for resolution. Complaints are documented by the FA. The term "Appeals" are used only for providers. Structured protocols and documentation exist to move the communication up the complaint channel. Provider Appeal criteria are specific and called out by regulation. Grievances and appeals are filed with DHCS or the FA via fax and USPS. Requests for

documents are managed manually. Confidential documents are transferred by certified mail. Verification of information is handled and documented manually.

EHR Incentive payment appeals will first be handled by the Medical Assistance Administrator, a second level of Appeal will be handled by the Manager of the HIT Program Office

State regulations governing the program also address specific appeals rights afforded under this program. The regulations are included in Appendix C and Title 7 Alaska Administrative Code (AAC) Chapters 165.030 and 165.080.

5.12 Coordination with AeHN

DHCS will continue to work very closely with AeHN in their REC role to identify providers that, through the survey or other contact have indicated a need for assistance in EHR implementation, training or product identification. DHCS and AeHN have agreed that the REC staff will assist Medicaid providers in 1) determining potential EHR Incentive Program eligibility, 2)completing the CMS NLR registration (if necessary) and finally 3)completing the information requirements and attestation on the Alaska SLR. These efforts will allow potentially eligible Alaska Medicaid providers to participate in the EHR Incentive Payment program regardless of initial technical knowledge or experience. .AeHN intends to contact 100% of the state's medical providers over the course of the grant period.

AeHN will compile provider data using the ONC provided CRM database. Documentation collected by AeHN on provider EHR implementation status and attestation related to meeting meaningful use criteria will be accessible to DHCS. This collaboration will ensure the broadest outreach while maintaining efficiencies.

5.12.1 Federal Financial Participation (FFP)

DHCS will authorize the full amount of each Incentive payment due to the provider through the AKSAS system. EPs will be offered a choice of direct or assigned payments. In the case where the provider is a member of a group and chooses to assign the incentive payment to the group, these payments will be made to a group consistent with existing AKSAS capabilities. In the case where the provider who is a member of a group chooses to retain the incentive payment, the payment will be made directly to the provider through an existing process in the AKSAS.

This section will include a description of the process to assure that EHR Incentive payments 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 five percent of such payments is retained for costs unrelated to EHR technology adoption.

DHCS will use the existing AKSAS capabilities to make the EHR Incentive Program payments. An automated process will be leveraged to retain the voluntary payments to a state and federal designated entities promoting the adoption of Certified EHR technology. The providers will be offered the option to participate in the voluntary retention at the time they request their annual incentive payment.

5.13 DHCS EHR Outcome Evaluation

DHCS has not determined the specific processes and methods that will be applied to manage the Meaningful Use data criteria and health outcomes. DHCS intend to establish a Meaningful

Use Advisory Board (MUAB). The MUAB will be comprised of a variety of stakeholders including hospitals, representatives from various provider types, state agencies and tribal entities. Meaningful use methodology will follow the final rule, additional Federal guidelines and be further clarified to achieve the health improvement outcomes identified for Alaska.

5.14 State Alternative Methods

No alternative methods as allowed by the Final Rule are proposed by DHCS at this time.

5.14.1 Meaningful Use Criteria

Participants will have the option to submit directly or through the HIE when that functionality becomes available.

DHCS and DPH have agreed that public health meaningful use criteria will be consistent with the meaningful use criteria as identified in the Final Rule.

Alaska will support providers' capability for electronic reporting of immunizations to VacTrAK, the state's immunization registry. Participants will have the option to submit directly or through the Alaska HIE when that functionality becomes available.

5.14.2 Additional Meaningful Use Objectives

No Additional Meaningful Use Objectives are proposed by DHCS at this time

5.14.3 Patient Volume Calculation

Alaska plans to use the patient volume calculation as described in the final rule (see section 5.4.1.4) No state-specific adjustments are proposed.

5.15 Dependence upon Federal Initiatives

The current federal HIT initiatives, such as the State HIE Cooperative Agreement, the RECs, and broadband initiatives, were designed to set the foundation and provide an environment that would support adoption of EHRs and deployment of state and regional exchanges networks. DHCS is dependent on the success of these initiatives to provide the infrastructure that makes it feasible for individual providers to easily adopt and effectively utilize EHRs and electronic exchange to support and enhance patient care and essential business operations. DHCS is also dependent on the success of other federal initiatives, such as Health Resources and Services Administration (HRSA) grants, that support HIT innovation and testing projects that will provide lessons learned, best practices, and specific examples of how EHRs and electronic exchange can benefit both providers and patients.

DHCS is dependent upon CMS for the review and approval of this SMHP as well as the IAPD that will be submitted to request federal funding for the Alaska EHR Incentive Program system changes. DHCS also relies on CMS to create the NLR to provide operational support for provider participation in the program. DHCS is also anticipating additional CMS educational and technical support to assist states with implementation of the program so that monies can be deployed and meaningful use achieved on a broad basis as quickly as possible.

DHCS is dependent upon CMS and the ONC for the distribution of the Final Rule regarding the Provider Incentive Program and Meaningful Use criteria. DHCS is dependent upon ONC for the

certification requirements and certification of EHR systems so that Alaska Medicaid providers can adopt, implement, or upgrade to appropriate certified EHR systems.

5.16 Population and Public Health Measures Alaska Capabilities

5.16.1 Immunization

As described in section 2.3.1 above, the VacTrAK system supplies the State's immunization registry. Currently approximately 50% of the facilities that report immunization data to the registry use a form of electronic data submission. VacTrAK is capable of receiving HL7 version 2.3.1 or 2.5.1 messages. Eligible professionals will be able to submit electronic immunization records in support of Meaningful Use Attestation to receive the second EHR Incentive Payment.

5.16.2 LIMS

AeHN has commissioned a research group to facilitate a statewide evaluation for those organizations that cannot send and/or receive structured lab data, particularly those smaller lab entities in the state. Through targeted surveys, AeHN proposes to identify further the technical barriers for adoption of the exchange of structured lab results. Further strategies will be developed as a result of this work. AeHN has begun partnership discussions with the three largest lab vendors in Alaska, the results of which will also be incorporated into the recommendations.

The state's Technical Meaningful Use Workgroup has begun the planning and development of an interface between the state's LIMS and the HIE infrastructure.

5.16.3 Syndromic Disease Surveillance

At this time the State of Alaska does not have the ability to collect Syndromic Disease Surveillance data electronically. Eligible professionals and hospitals will not be able to submit Syndromic Disease Surveillance data in support of Meaningful Use Attestation to receive the second EHR Incentive Payment.

DHCS and DPH have collaborated to develop a matrix that describes that Public Health Meaningful Use measures and the manner in which a provider can meet these objectives in Alaska. The matrix is included below and is posted on the program website to assist providers in complying with MU objectives

Table 14 – EHR Incentive Payment Program Medicare and Medicaid Public Health Meaningful Use Measures

Short Description	Measure	Objective	Exclusions	ONC Standard	State System & Status	Alaska HIE Status
Immunization Registry **Eligible Professionals and Hospitals**	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP or eligible hospital submits such information have the capacity to received the information electronically).	Capability to submit electronic data to immunization registries of Immunization Information Systems and actual submission in accordance with applicable law and practice.	An EP, EH or CAH who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically	HL7 2.3.1 or 2.5.1	VacTrAK is able to accept either HL7 2.3.1 or 2.5.1	Alaska HIE will be able to accept HL7 transactions **Date TBD**
Reportable Lab results **HOSPITAL ONLY**	Performed at least one test of certified EHR technology's capacity to submit electronic data on reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an eligible hospital submits such information have the capacity to receive the information electronically).	Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice.	No public health agency to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically.	HL7 2.5.1	LIMS transmits reportable diseases to AKSTARS	Alaska HIE will be able to accept HL7 2.5.1 transactions **Date TBD**
Electronic syndromic surveillance data **Eligible Professionals and Hospitals**	Performed at least one test of certified EHR technology's capacity to submit electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP or eligible hospital submits such information have the capacity to receive the information electronically).	Capability to submit electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice.	An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically	HL7 2.3.1 or 2.5.1	AK Syndromic Surveillance is not able to accept electronic submission at this time	Alaska HIE will not be able to accept these transactions in 2012

5.17 Coordination with HIE

The Alaska HIE Infrastructure is the centerpiece of the HIT efforts in the State. The Medicaid EHR incentive program benefits the HIE expansion, encouraging additional providers to invest in certified EHR technology as the entire value proposition of HIE becomes more widely accepted. Likewise, the expansion of the HIE infrastructure and REC services has increased interest in the incentive payment program. The State HIT Coordinator has responsibility to guide both efforts establishing an effective collaboration point for the three Federal programs.

DHCS plans to leverage the Alaska HIE infrastructure to support the requirement to store clinical data by 2013.

5.18 HIT Performance Measures

Alaska is in the process of implementing the statewide HIE solution and engaging health care providers in HIT activities. In the sections below, the progress towards developing initial baseline statistics and reasonable annual performance measure targets are described. It is expected that the performance measures will be further refined and improved. Estimates will be more accurate as the HIT activities become more mature.

5.18.1 EHR Incentive Program Participation

DHCS will calculate the percentage of Medicaid providers participating in the EHR Incentive Payment Program by calculating the number of Medicaid providers that have received an incentive payment divided by the total number of Medicaid providers in eligible MMIS provider types. The baseline EHR Incentive Program participation was zero at December 31, 2010. Of the estimated 2,500 potentially eligible providers, the program estimates 500, or 20% will participate by December 2011.

5.18.2 HIE Participation

The Alaska HIE expects the largest adoption in the first three years after go-live, currently estimated for Fall 2011. Significant events that will positively impact HIE participation include:

- Approval to connect the Alaska HIE to the Nationwide Health Information Network (NwHIN), allowing VA and partial DOD patient data to be available for participating healthcare organization (Nov 2011)
- Acceptance of CCDs via a packaged HL7 message from participating healthcare organizations in lieu of separate HL7 messages for laboratory and radiology results, medication lists, etc. (Nov 2011);
- Solution to allow the IHS RPMS EHR to sending out HL7 messages (CCDs or otherwise) into the HIE (Dec 2011)

Given the positive HIE response in Fairbanks, Juneau, Kenai Peninsula and Mat-Su healthcare communities along with the Alaska Native Tribal Health Care/ Alaska Native Medical Center (ANTHC/ANMC) moving through the process to eventually connect, there is conservative confidence that by year 4 the HIE is in production, 70 percent of the healthcare organizations should be actively participating in the Alaska HIE. Providence Health Systems, one of the large

providers in Alaska is still managing the implementation of a large-scale EHR rollout. Although it appears this organization may be a late adopter, given one of the criteria for being an accountable care organization is participating in health information exchange, there is confidence they will participate in the HIE in years 2-3.

The remaining 30 percent of Alaska health care providers will be late adopters due to barriers such as:

- resource issues preventing acquisition of EHRs
- resistant to delivery practice changes
- risk averseness for privacy/security
- current incentives are perceived inadequate to adopt change

As the push messaging service using Direct Project standards is made available for all Alaska providers (Fall 2011), and shown to be successful, the adoption of other HIE services will no doubt receive a measurable improvement in activity. There may, however, have to be additional incentives to gain adoption and participation.

The statewide HIE implementation begins late in 2011. The baseline participation in the HIE is zero at July 2011. Of the estimated 9,000 healthcare providers in Alaska, 70% as noted above are targeted to become HIE participants. At December 31, 2011, the HIE anticipates an initial 200 providers will be exchanging data through the HIE.

The State Shared Services are anticipated to be available beginning in 2012. DHCS will calculate the number of providers with logins to shared services each month divided by the total number eligible to use shared services.

AeHN estimates that 28% of hospitals will participate in shared services year 1 and 100% of the 21 hospitals participating by year 2.

An estimated 8% of the estimated 4,100 providers eligible for REC services will be participating in year 1. As of mid-August approximately 200 providers have requested REC services from AeHN. The Alaska Tribal REC reports over 200 providers requesting their services.

AeHN currently estimates that 9% of providers eligible for REC services will be participating in year 2. Provider participation in HIE by MU requirement met benchmarks will be established once the Alaska HIE is implemented.

The HIT Program Office anticipates that 10% of the estimated 2,500 potentially eligible Medicaid providers will meet the MU criteria in Year 2. It is expected that most of the providers that were eligible to receive a year 1 A/I/U payment will be able to achieve meaningful use.

5.18.3 E-Prescribing

The HIT Program Office plans to conduct a second annual scan. The scan will address identify the various barriers to e-Prescribing. Understanding these barriers will allow the AHCC to explore recommendations of policies and programs which the legislature and the field have a readiness to support. Additional strategies will need to be developed to encourage non-participating pharmacies and providers to participate.

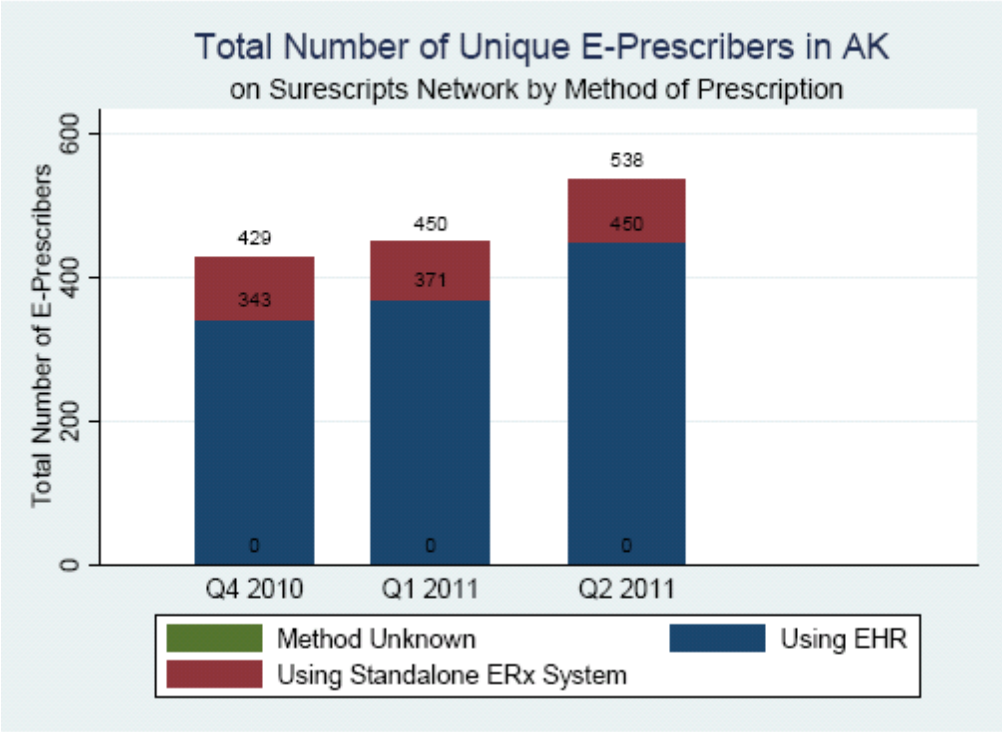
A readily available dataset regarding participation in e-prescribing participation across the nation is the Annual Surescripts report. In Alaska, a large percentage of providers who work in a hospital settings and e-prescribe within the hospital setting do not use an outside pharmacy. These prescriptions are not captured in Surescripts data, decreasing the overall precision of the Surescripts report as it applies to Alaskan e-prescribing participation. The data from the Surescripts report is limiting in that the data contained in Alaska's report doesn't contain all the necessary data to determine this specific performance measure; i.e. may have numerator but not denominator.

Surescripts data indicates that 8% of prescriptions are submitted electronically in 2009, the State estimates that 28% of prescriptions will be electronically requested by the end of Year 1 and 38% by the end of Year 2. Additionally, 27% of refill requests should be electronically submitted by the end of year 1 and 37% by the end of year 2.

Surescripts data available for 2010 indicates that 93% of pharmacies are participating in the Surescripts network; the same numbers of pharmacies are participating as reported in 2009.

The Surescripts data provided for 2010 does not indicate the number of prescriptions submitted electronically in 2010, however the number of total Surescripts e-prescribers has appears to have increased over 2009 and continues steady growth in early 2011 as depicted in Figure 8 below.

Figure 13 – Total Number of Unique e-Prescribers in Alaska



5.18.4 Electronic Lab Results

Currently, the State Lab does not have functionality available to allow for electronic receipt of request or distribution of results. The State Lab is working to implement a web portal to receive

requests and make results available to providers.. Many providers within Alaska use lab services such as Quest, LabCorp and Peacehealth. Many of the labs are receiving requests electronically but less are returning results electronically. The HIT Program Office has commissioned a survey to develop statistics around electronic exchange of lab data.

5.18.5 Electronic Immunization Record

The immunization program in Alaska has been diligent in its efforts to expand the number of providers submitting electronic immunization records. DPH targets the number of immunizations administered and recorded electronically by the end of year 1 is 50% of immunization record. This measure is calculated by the number of immunization administrations available electronically divided by the total need for vaccines. In addition DPH will track the number of providers entering immunization administrations each month divided by the total number of providers in the State to arrive at a percentage of providers participating in the immunization registry electronically.

5.18.6 Public Health Reporting

Public Health reporting includes the reports to State and local public health agencies submitted electronically for vital statistics and reportable diseases.

DPH estimates that 75% of reportable disease reports will be submitted via electronic means by the end of year 1 and 85% of reports submitted electronically by the end of year 2. Currently approximately 10% of the disease reports are via HL7 standard message to AK Stars and the others are handled by encrypted batch files sent to AK Stars.

5.18.7 Electronic exchange of Clinical Summaries

Providers will be able to share patient care summaries across unaffiliated organizations through the HIE using either Direct Project standards or through their EHR connection to the HIE.

This measure will be determined by the number of Clinical summaries in the HIE divided by the total number of encounters documented.

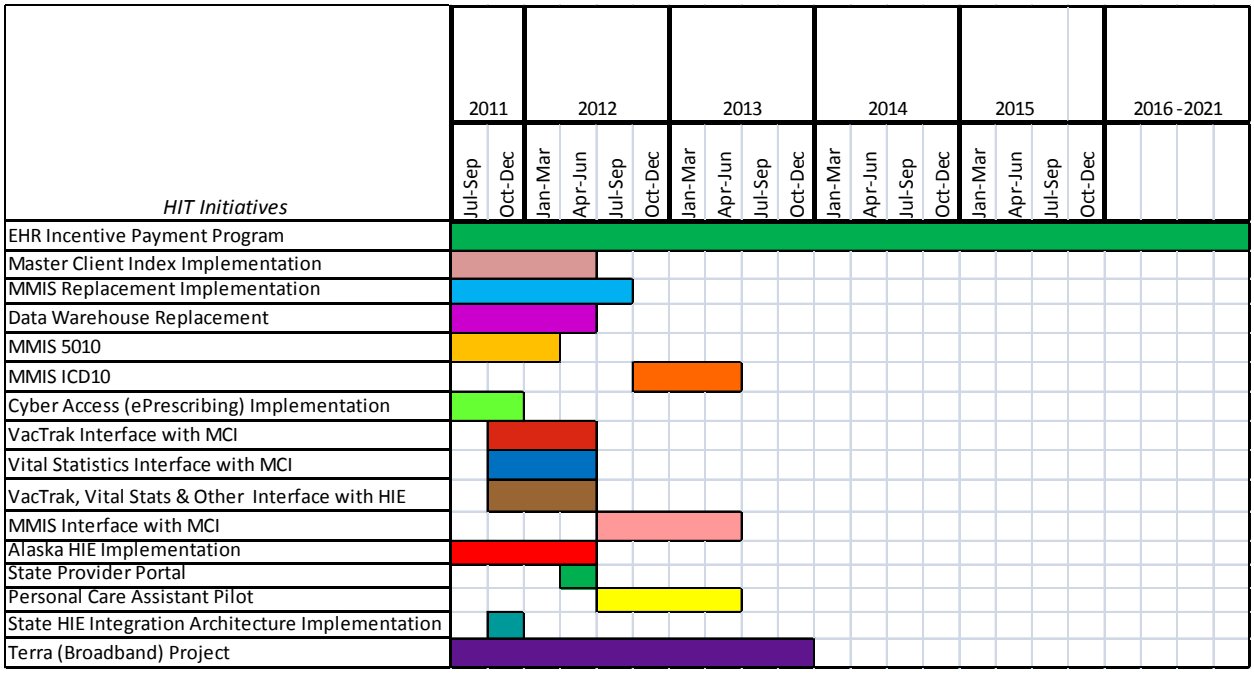
AeHN expects that 10% of patient care summaries will be available electronically by the end of year 2.

6 HIT ROADMAP

6.1 Alaska Vision for Moving from "As Is" to "To Be" HIT Landscape

This section will include an overview of how DHCS will move from the current "As Is" HIT environment to achieve the "To Be" vision for health information exchange.

Figure 14 - HIT Roadmap – Updated November 2011



6.1.1 DHCS Programs "To Be" Vision

This section will describe DHCS's strategic pathway to move from the current "As Is" HIT Landscape to the desired "To Be" HIT Vision.

EHR Incentive Payment Program

The EHR Incentive Program activities began in January 2010 with the PAPD and will continue through final provider payments in 2021. The implementation of the program will serve as a catalyst for additional Alaskan medical providers to join the state-wide HIE as it is implemented. Given the ever-rising cost of health care in Alaska, small improvements in cost efficiencies and outcomes will impact the situation. DHCS has implemented the SLR module supporting the EHR Incentive Payment program. .DHCS is working with ACS, the Fiscal Agent and MMIS software maintenance vendor to modify the SLR to support provider and hospital MU attestation. These modifications are planned to be available on January 2, 2012.

MMIS Replacement Implementation

The MMIS replacement represents an enormous technical move forward for DHCS. In addition to web-based graphical user interfaces (GUIs), Medicaid operations, members and providers alike will benefit from the enhanced interoperability features of the new MMIS. The system implementation is expected to be complete in 2012.

MMIS Related Activities

In addition to MMIS replacement a number of projects are planned to expand, leverage or replace existing systems and features, dependent upon the completion of the MMIS replacement. DHCS expects to include MMIS members in its Master Client Index (see Section 2.9.1.4), extend eprescribing functionality and replace the existing decision support system.

Federally mandated MMIS project include planning, assessment and compliance with International Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) and 5010, as well as D.0. and 3.0.

T-CHIC Project

The project started in 2009 and continues for five years, ending in 2014. The first phase of the project is planning for the remaining phases. The demonstration will test the combined impact of patient-centered care delivery models and health information technology in improving the quality of children's health care. The three States are working together to develop and validate quality measures, improve infrastructure for electronic or personal health records utilizing health information exchanges, and implement and evaluate medical home and care coordination models.

Alaska has three grantees that are providers serving children and adolescents (ages 0-20) enrolled in Medicaid and Denali Kid Care willing to participate in a medical home demonstration project. All three grantees are using EHRs, two are expected to be meaningful users, and the third does not expect to be due to small size. Each grantee all will be using their EHRs to generate some of the reports needed on specific quality measures.

The first "learning collaborative" was held in September 2011. The Tri-State partners (AK, OR and WV) with Alaska health care providers, policy makers, and other stakeholders shared experience, skills and knowledge.

Public Health HIT Systems Projects

VacTrAK and Vital statistics systems are expected to be included in the Master Patient Index and interfaced to the HIE. The tools manage data that is essential for the Public Health measures of Meaningful use. Alaska is poised to make vaccination information available to all providers statewide. (See also 2.9.2.2)

Alaska HIE

The AeHN has completed the process of developing an RFP and evaluated the responses. Following the execution of a contract, AeHN expects the Design, Development, Implementation

(DDI) process to begin in 2011, the HIE will be available for use by participants beginning in October 2011.

The AeHN selected Orion Health to provide the Alaska HIE infrastructure late in 2010. Orion Health will provide a Software as a Service (SaaS) solution to Alaska medical providers, citizens, payers and commercial pharmacies and labs. Three provider sites began pilot activities in February 2011. User acceptance testing started in August 2011. AeHN plans to begin use by participants by December 2011. The software functionality will expand incrementally over time. As services such as immunization and state-required disease reporting are made available, the business case for Alaska HIE participation will expand as well.

VacTRAK, the state immunization system and the LIMS will be connected to the HIE through HIE implementation of approximately 20 state interfaces that will be included in the agreement between AeHN and the HIE vendor.

Broadband expansion

Broadband expansion is a critical infrastructure improvement needed to allow the remote locations in Alaska to receive the benefits of many of the initiatives listed above.

The FCC Pilot project's first phase was completed in September 2009, the second phase is due to begin in October 2010.

The Southwest TERRA project is underway. Terrestrial Broadband will be available to rural communities in Northwest Alaska in the near future. Alaska Growth Capital, Waveland Ventures, Travois New Markets and U.S. Bank have worked together to obtain New Markets Tax Credit financing for Unicom's TERRA-NW project. Alaska Growth Capital is an Arctic Slope Regional Corporation company that has secured $90 million in New Markets Tax Credit through three competitive application rounds since 2002.

Provider Portal

DHSS is in the definition stage of a Provider Portal to support the authentication and access controls for providers who need state services.

Medicaid providers will require access to update immunization records, submit lab requests and review results and submit reportable disease results. Additionally Medicaid providers participating in the Seniors and Disabled Services (SDS) program can benefit from interactions with an automated service plan through the portal as well.

Each of these activities requires secure access to sensitive data that must be browser based to minimize individual technical support needs. The Provider portal enables a common solution to the authorization and authentication necessary for each application.

Statewide HIE Integration Architecture Implementation

DHSS plans to integrate applicable State systems with the Alaska Statewide HIE. DHCS commissioned an evaluation of the logical architecture solutions available to DHSS IT that would satisfy the Seven Conditions and Standards identified in Medicaid IT Supplement (MITS-11-01-v1.0) and allow the state to provide at least one alternative to Alaskan providers to meet MU objectives. The evaluation recommended the a logical architecture that leverages an

interface engine (as depicted in Section 4.11 of this SMHPU). DHSS will develop the Interface Engine infrastructure that will support the integration of the State systems with the HIE for the next five years and will be extendable to a more robust solution of an Enterprise Service Bus should that option be necessary based on future volume of use.

Personal Care Assistance Pilot Project

There are a variety of program designs and technology options available in developing this pilot option. This pilot project will explore point of care options for visit verification and commission a service that fits Alaska's unique needs.
Using the information gathered from caregivers at the point-of-care via Electronic Visit Verification technology, will enable a single, real-time composite view of all authorized services and care delivered within an EHR. This will enable to state to monitor and audit encounters, billing, care plan delivery and quality of care service benchmarks.
The ultimate goal of the project is to identify potential PCS fraud and abuse while also creating administrative efficiencies and improving coordination and optimization of patient care.
DHCS expects that this project will further promote the use of EHRs and encourage the electronic exchange of healthcare data.

DHCS Role in the Alaska EHR Incentive Program

This section will describe DHCS's role in administration of the Provider Incentive Program.

MITA Reference: Draw and Report FFP (PG18) and Manage FFP for Services (PG19)

For purposes of the Alaska EHR Incentive Program, DHCS by necessity must identify and track EPs and EHs attestations of meaningful use, Medicaid patient volume percentage, NLR registration information, payments to providers, and receipt of meaningful use measures. Additionally, DHCS must audit and verify payments are correct and accurately calculated, recoupment activities occur for any duplicate payments, and FFP drawdown is audited for appropriateness of monies received from the Federal government for provider payments and administrative services. This will require modifications to the PEP systems, in the form of an additional SLR "module" and development of program operation policies and administrative procedures to support these functions. During the implementation phase, DHCS must develop the policies and procedures necessary for accountability under ARRA. DHCS is charged with encouraging and assisting Alaska Medicaid providers in adoption and conversion to certified EHR/EMR. Outreach to the providers is ongoing and DHCS is collaborating and coordinating these efforts with the AeHN REC..

6.1.1.1 *DHCS Oversight of Program Payments*

The oversight of payments has four distinct components, payment eligibility, calculation, payment reporting and audit. These are all current functions of Alaska and the EHR incentive payments will be incorporated into them. In addition to Alaska controls and processes, the NLR will be relied upon to assist the State in assuring providers are not receiving payments from Medicare or other states.

6.1.1.2 *HIT Solution Considerations*

The ARRA has mandated incentive payments to certain eligible Medicaid providers to encourage the adoption and meaningful use of certified EHRs technology by 2014, resulting in changes to the Alaska Medicaid program administration and a need for changes to the PEP system. The first initiative to be completed is capturing, distributing, tracking, and monitoring the incentive payments. Changes to the PEP are required to accommodate provider enrollment and registration in the program and interface activities to the NLR as well as verification of eligibility.

A second phase of the overall HIE initiative is to provide the capability to exchange EHR data between private and public insurers, facilities, other State agencies, and clinicians, and to allow members access to their own EHR data. This includes having the ability to accept EHR data into the system and provide EHR data when necessary.

The second phase requirements will be further developed in 2011, and implemented by 2012. This HIE/EHR enhancement function must accept the following inputs: MMIS subsystem data including but not limited to DW/SURS, claims, provider, and member; clinical data; lab results data; electronic attachments; prescriptions; and ARRA incentive payment amounts.

The HIE/EHR enhancement function must accommodate the following capabilities:

- Provide the capability to track, issue, and report on provider incentive payments in the SLR including identification of designated providers in provider database, system calculation of payments, capability for voiding, auditing, tracking, and reporting requirements, and changes to CMS 64, etc.
- Provide capabilities within DSS/DW to collect, store, retrieve, and report on EHR data including clinical data, lab results data, x-rays, scans, etc.

The HIE/EHR enhancement function must provide the following outputs:

- Reports as defined by the state and federal government for the reporting of gaps, issues, monitoring, and tracking of incentive funds.
- Provider incentive payments for EHRs
- EHR data to authorized requestor

The HIE/EHR enhancement function must accept an interface with the following: State HIE, NHIN, Private Insurer EHR systems, other State agency EHR systems, Facility EHR systems, and Clinician EHR systems.

6.1.1.2.1 Information Technology (IT), Fiscal, and Communication Systems Supporting the Alaska EHR Incentive Program

This section identifies the IT, fiscal, and communication systems that will be used to implement the EHR Incentive program.

DHCS plans to use its existing PEP web-based system to validate provider registration information. In addition, DHCS plans to enhance this solution to include a SLR module that supports attestations, patient volume and payment calculations, required meaningful use data and reporting.

The AKSAS financial system will support the submission and distribution of incentive payments; along with the supporting financial reports. The standard Direct Connect software product will be used to exchange NLR information with CMS.

6.1.1.2.2 Anticipated MMIS Modifications

No modifications to the Legacy MMIS are anticipated at this time.

6.2 DHCS Participation in Health Information Exchange (HIE)

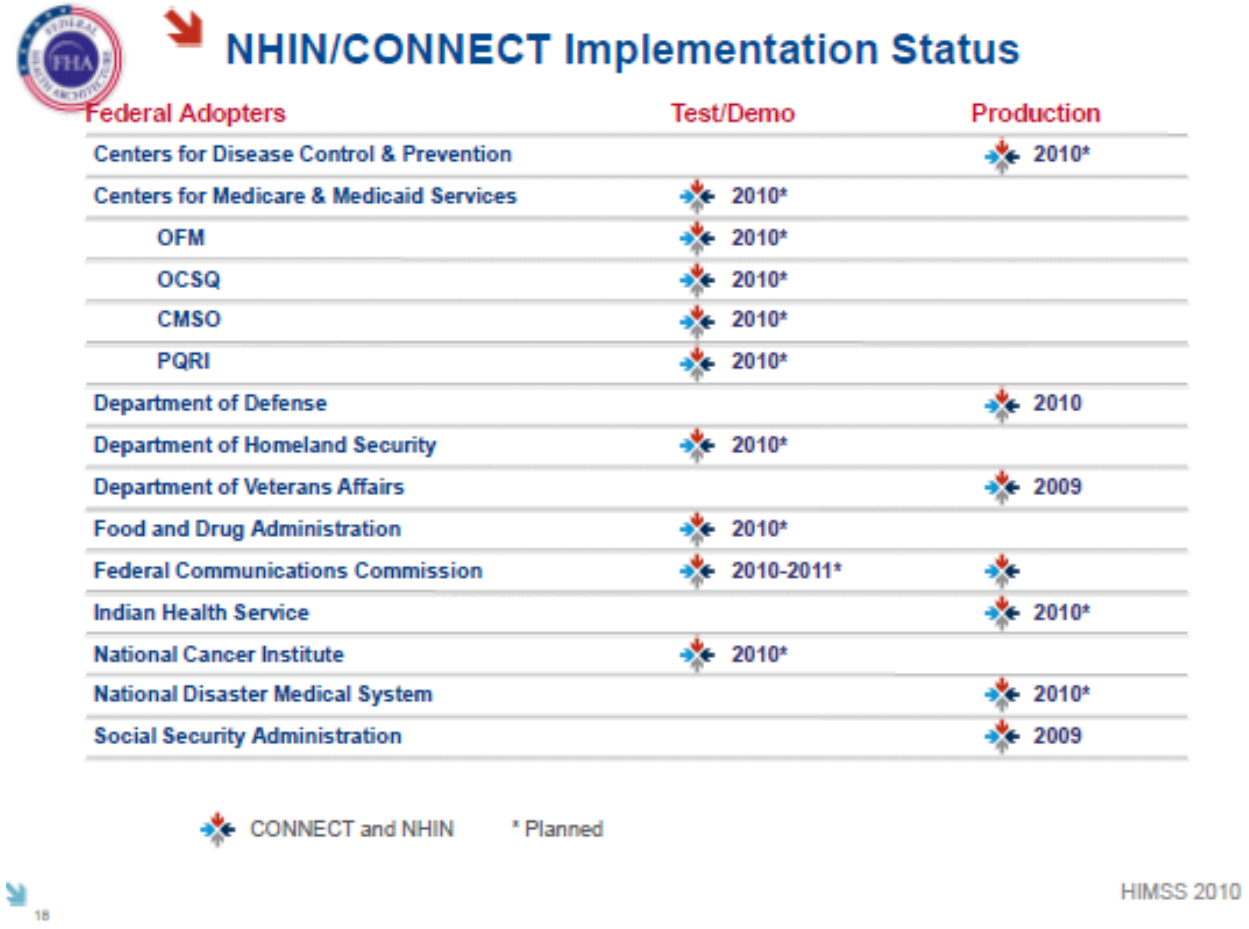
DHCS is an active partner in the development of the state's HIE solution. The State's HIT Coordinator participates in AeHN workgroups to develop the requirements, RFP and is participating in the selection of the state's HIE product.

DHCS expects that the MMIS and Master Client Index will likely interface directly with the HIE.

6.2.1 Participation in Federal National Health Information Network (NHIN)

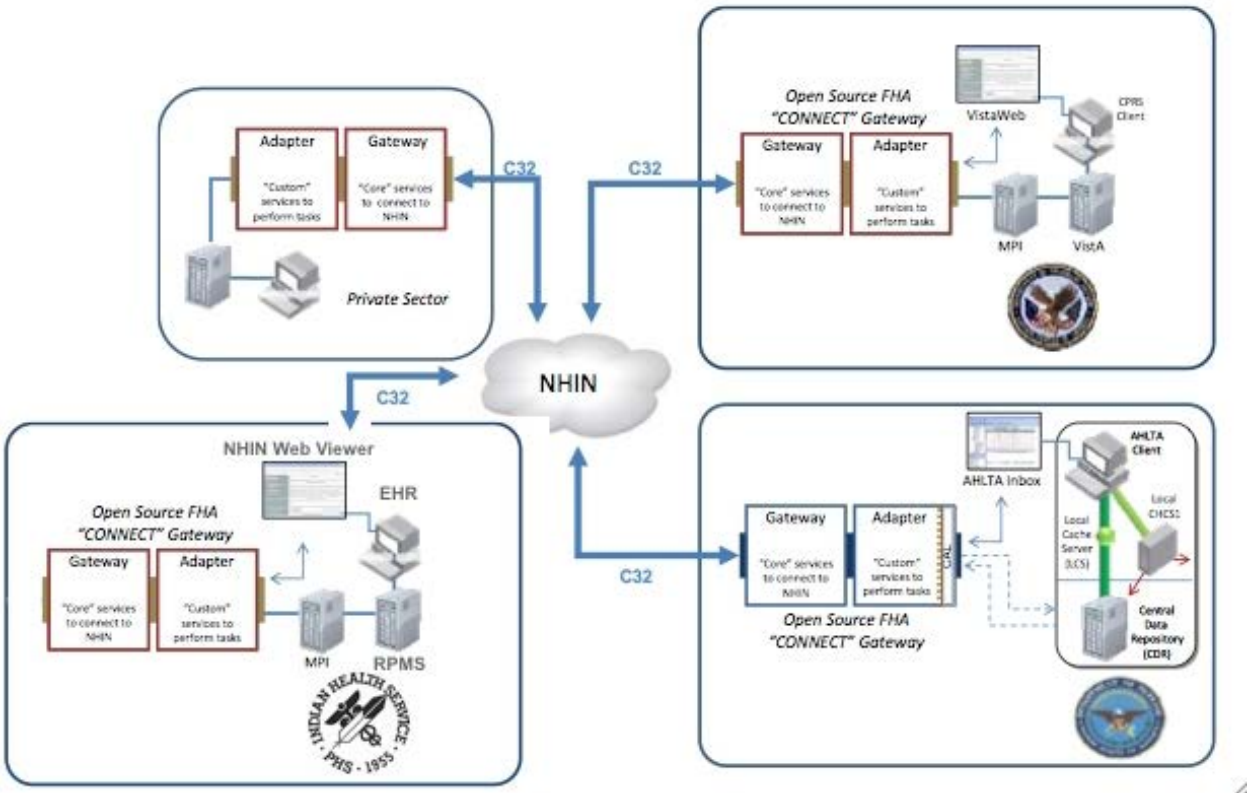
DHCS understands the importance of the National Health Information Network to successful implementation and use of HIT and HIE in Alaska. DHCS understands and is supportive of the policies and standards established by NHIN and believes it provides a solid infrastructure for linking not only many isolated communities across Alaska but also with the rest of the lower 48. DHCS has also been monitoring the progress of NHIN/CONNECT through regular dialogue with its partners at the DOD and VA. DHCS understands the value of NHIN/Connect as both a platform for participation and innovation and is monitoring the progress of both federal and non-federal implementations. Particularly of interest to DHCS are NHIN/CONNECT implementations of our federal partners, the VA and DOD and our non-federal partners, EPIC and Kaiser who are significant providers in Alaska's health care community.

Figure 15 – NHIN/Connect Implementation Status



Again, DHCS understands the importance establishing strong linkages with our partners who are NHIN/CONNECT adopters and are working collaboratively with AeHN, DOD, VA and others to ensure that of making that the Alaska HIE is inclusive of our entire health care community so that health care is not only improved for the individual but of our collective population. The figure below describes NHIN/CONNECT. Alaska's HIE will need to establish a link with the NHIN/CONNECT infrastructure.

Figure 16 – NHIN/CONNECT Infrastructure



6.2.1.1.1 Interoperability with HIT Solutions

AeHN is currently in the selection process for the HIE. The response to this question will be deferred until planning activities are complete and projects and timeline are available.

Provide a description of the data-sharing components of the HIT solution.

The response to this question will be deferred until planning activities are complete and projects and timeline are available.

A description of the role of the MMIS in current HIT/HIE environment.

See Section .2.9.1.1 Medicaid Management Information System (MMIS).

6.2.2 Participation in Statewide, Regional, and/or Local HIE Initiatives

This section will include a description of DHCS participation in Statewide, Regional and Local HIE initiatives, including vision objectives and the projected date(s) to begin data exchanges. DHCS is working collaboratively with many entities throughout Alaska to identify the interdependencies within the current Alaska HIT projects, as well as new ones that develop during strategic and operational planning of the AeHN.

All providers in the state are expected to connect to the statewide HIE, including Medicare, Medicaid and commercial providers as well as the Alaska Tribal Health system, and eventually federal partners in Alaska such as VA, DOD and the Coast Guard.

6.2.2.1 HIT Objectives for Meaningful Use of Clinical Data

A solution for capturing clinical quality data from EPs and EHs has been determined. The HIT Program Office will evaluate use of the HIE to capture meaningful use data once the HIE vendor is chosen.

Use of Meaningful Use Clinical Data

Initially, DHCS will only be collecting required meaningful use measures from a small subset of eligible providers, which will be of limited utility. However, over time the coverage and amount of data submitted will increase, and with that will come increasing opportunities for utilizing the data in a variety of ways.

Early on, DHCS will have access to the meaningful use measures only. While somewhat limited, this data will have value in monitoring progress in EHR adoption and meaningful use achievement over the various stages both at the individual provider level as well as in aggregate for the contractor population.

As the program evolves and providers progress in their adoption of EHR and achieving meaningful use DHCS may eventually request submission of the source data behind the meaningful use measures, which would provide a greater capacity for analysis and therefore greater value in the data. These data would potentially provide greater capability for a wider range of analyses not just for measuring EHR adoption and areas of clinical quality but for other uses as well. This data may provide somewhat more detailed monitoring, trend, and quality information and allow for some limited analysis of the data beyond the measures it was submitted to support. With the ability to view the actual medical record on an EHR, narratives included, the issue of physician legibility could become a non-issue.

Over time, the widespread adoption of EHR and utilization of electronic information exchange will provide the capacity to access population-based patient specific clinical data. Data at this level can serve a wide variety of uses. While all uses will need to be further investigated for utility, priority, and feasibility

Meaningful Use Data Timeline

In 2011 DHCS will not be able to collect Meaningful Use data, aside from the required Quality Measures, as the agency will be in the process of a MMIS replacement. The current plan is to

collect quality measures using the SLR that will be implemented to support the EHR Incentive Payment program.

In 2011, DHCS plans to identify an appropriate technical solution that is in alignment with the new MMIS, the state's HIE and supports the collection of Meaningful use clinical and quality data. By January of 2012, DHCS expects to have this solution in place to support providers that will be in a position to demonstrate Meaningful Use of the EHR systems.

This project has not been scheduled, but it will include the implementation of national standards (HL7) for transmission and receipt of such data. This SMHP will be revised when more information is known about this part of the plan.

6.2.2.2 *Leveraging Information Technology (IT) Assets to Advance Statewide and Regional HIE*

The AeHN HIE Statewide plan has been developed. The Statewide HIT plan is being developed in parallel with this SMHP. DHCS will include detail in this area in an updated SMHP.

6.2.2.3 *Changes to Transform MMIS to Desired MITA Maturity Level*

During the Planning Phase DHCS updated its MITA SS-A and business processes (standard MITA and planned Provider Incentive Program business processes) to determine those that could be integrated and to identify new State-Specific business processes (e.g., provider submission of attestation; update the NLR, etc.). DHCS will provide the MITA update documentation to CMS with the IAPD.

6.2.2.4 *EHR Program Technology Outcomes*

DHCS' new MMIS system with its modern technology and updated security will be in a position to move forward with connections to the HIE and other mandated/desired services to providers attempting to achieve meaningful use. Additional functionality to receive and interpret HL7 messaging structures will be added.

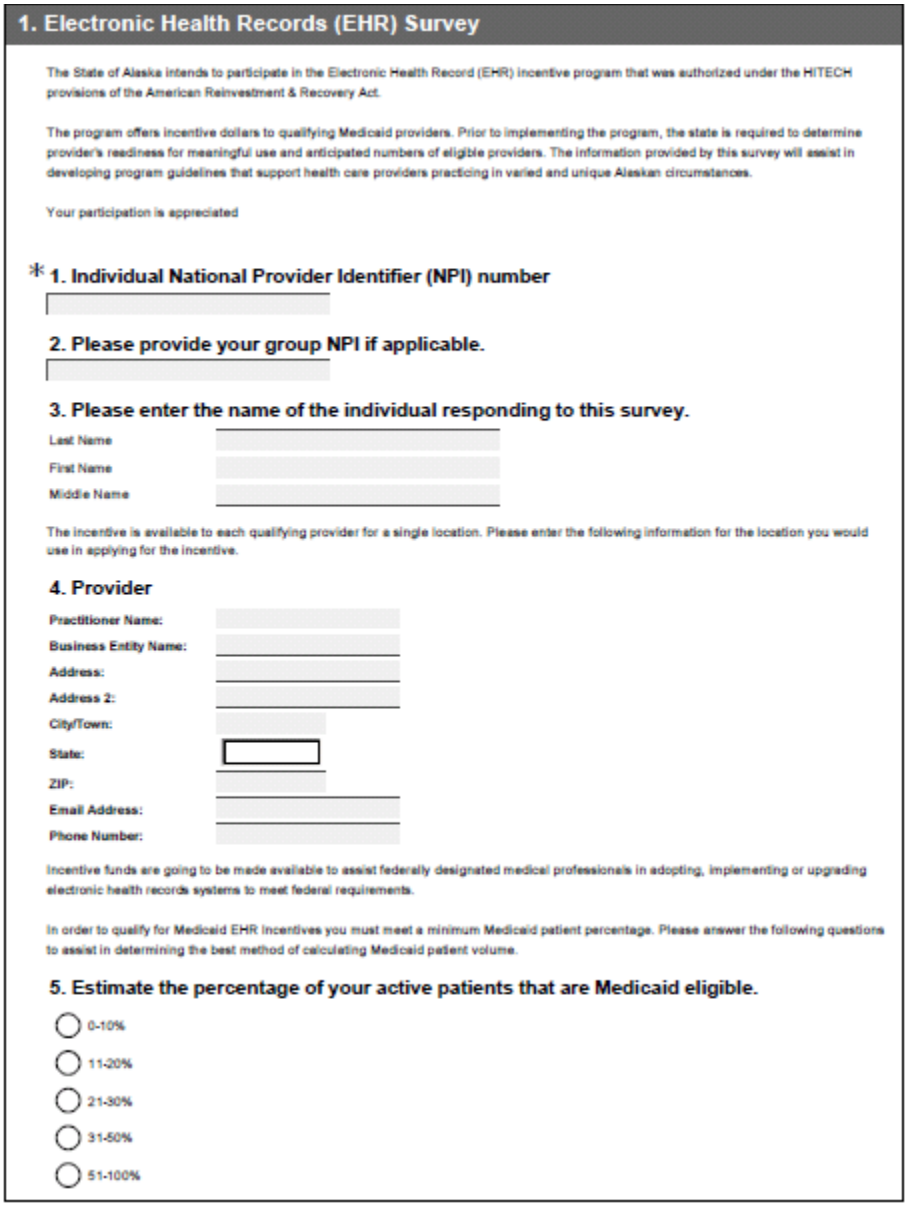
The MMIS currently supports secure data exchange, compliant with HIPAA regulations, with providers, as well as with business partners and contractors.

Alaska has already adopted national data standards X12 transactions and HL7 messaging for health data exchange. The new MMIS will be compliant with MITA open system standards. As new data exchange standards become available, DHCS will implement them according to the national implementation schedule.

7 ALASKA EHR INCENTIVE PAYMENT PROGRAM AUDIT STRATEGY

This section has been removed for confidential purposes.

APPENDIX A EP ENVIRONMENTAL SCAN QUESTIONS



1. Electronic Health Records (EHR) Survey

The State of Alaska intends to participate in the Electronic Health Record (EHR) incentive program that was authorized under the HITECH provisions of the American Reinvestment & Recovery Act.

The program offers incentive dollars to qualifying Medicaid providers. Prior to implementing the program, the state is required to determine provider's readiness for meaningful use and anticipated numbers of eligible providers. The information provided by this survey will assist in developing program guidelines that support health care providers practicing in varied and unique Alaskan circumstances.

Your participation is appreciated

* **1. Individual National Provider Identifier (NPI) number**

2. Please provide your group NPI if applicable.

3. Please enter the name of the individual responding to this survey.

Last Name
First Name
Middle Name

The incentive is available to each qualifying provider for a single location. Please enter the following information for the location you would use in applying for the incentive.

4. Provider

Practitioner Name:
Business Entity Name:
Address:
Address 2:
City/Town:
State:
ZIP:
Email Address:
Phone Number:

Incentive funds are going to be made available to assist federally designated medical professionals in adopting, implementing or upgrading electronic health records systems to meet federal requirements.

In order to qualify for Medicaid EHR incentives you must meet a minimum Medicaid patient percentage. Please answer the following questions to assist in determining the best method of calculating Medicaid patient volume.

5. Estimate the percentage of your active patients that are Medicaid eligible.

- 0-10%
- 11-20%
- 21-30%
- 31-50%
- 51-100%

6. On average, approximately what percentage of your weekly office visits are for Medicaid eligible patients?

- ◯ 0-10%
- ◯ 11-20%
- ◯ 21-30%
- ◯ 31-50%
- ◯ 51-100%

7. Which of the following did you use in determining the percentage?

- ◯ Scheduled appointments
- ◯ Actual visits
- ◯ Number of claims
- ◯ Dollar value of claims

Other (please specify)

8. If you meet the EHR incentive program eligibility criteria do you intend to participate?

- ◯ Yes
- ◯ No

9. What type of internet connection do you have at your practice?

- ◯ Dial-up connection
- ◯ Wired broadband (i.e., DSL or cable modem) or faster connection (e.g. T1 or T3 line)
- ◯ Cellular connection
- ◯ Satellite connection
- ◯ No internet connection

10. Does your practice setting use an EHR?

- ◯ Yes, EHR with a Practice Management system
- ◯ Yes, EHR without a Practice Management system
- ◯ No EHR

3. EHR Readiness

In order satisfy the program requirements providers will have to meet the Center for Medicare and Medicaid Services (CMS) "meaningful use" guidelines at a point in time to be determined by CMS. These questions will assess your EHR's readiness for the proposed meaningful use guidelines.

11. Please indicate with which entities (if any) you are sharing health information electronically using your EHR?

- [ ] None
- [ ] Hospital(s)
- [ ] Laboratory(s)
- [ ] Other provider(s)
- [ ] Pharmacy(s)

Other (please specify)

12. Please rate how fully you are using your EHR.

- ◯ 1 - Software has been purchased
- ◯ 2 - Software has been installed
- ◯ 3 - Staff has been trained
- ◯ 4 - Some information is entered by Nurses or Admin staff
- ◯ 5 - Most information is entered by Nurses and Doctors
- ◯ 6 - Information in the EHR is used proactively

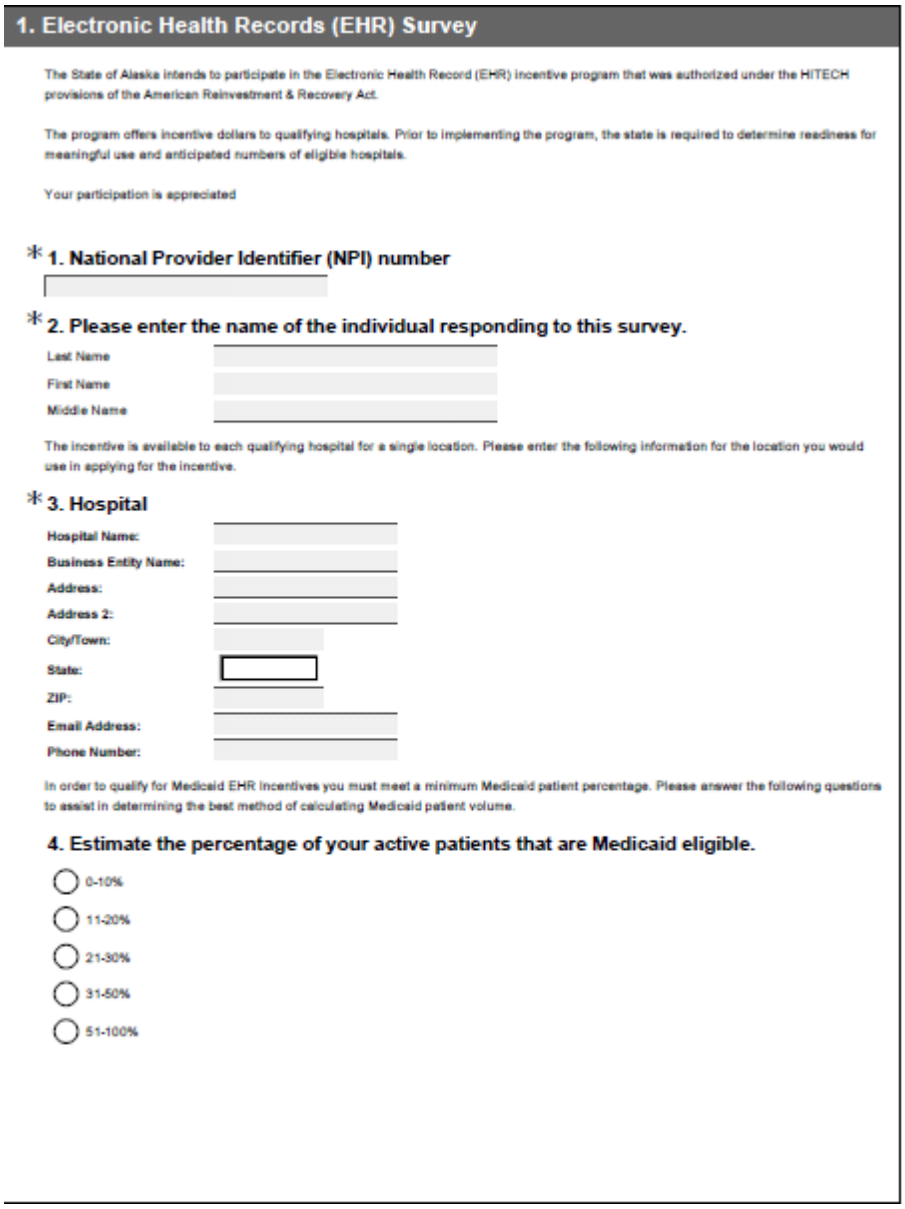
13. Was your choice of EHR product determined by the presence of functions that are specific to your type of practice or specialty?

- ◯ Yes
- ◯ No

14. For each of the following proposed meaningful use criteria please identify if your EHR supports and whether you are using the specified criteria.

	Yes	No	Functional Not Available	Not Sure
Are you using Computerized Provider Order Entry (CPOE)?	○	○	○	○
Are you using drug-drug interaction checks?	○	○	○	○
Are you using drug-allergy checks?	○	○	○	○
Are you using drug-formulary checks?	○	○	○	○
Are you using patient problem lists?	○	○	○	○
Are you using patient medication lists?	○	○	○	○
Are you using patient medication allergy lists?	○	○	○	○
Are you using patient demographics?	○	○	○	○
Are you recording patient vital signs?	○	○	○	○
Are you recording smoking status for patients 13 years or older?	○	○	○	○
Are you recording clinical lab test results?	○	○	○	○
Are you recording patients by specific condition?	○	○	○	○
Are you using a feature that supports at least five clinical decision support rules?	○	○	○	○
Are you using insurance eligibility checking?	○	○	○	○
Are you using medication reconciliation?	○	○	○	○
Are you using a feature that allows transmission and receipt of summary care records for transitions of care and referrals?	○	○	○	○
Are you using patient electronic access?	○	○	○	○
Are you using electronic prescribing?	○	○	○	○

APPENDIX B HOSPITAL ENVIRONMENTAL SCAN QUESTIONS



1. Electronic Health Records (EHR) Survey

The State of Alaska intends to participate in the Electronic Health Record (EHR) incentive program that was authorized under the HITECH provisions of the American Reinvestment & Recovery Act.

The program offers incentive dollars to qualifying hospitals. Prior to implementing the program, the state is required to determine readiness for meaningful use and anticipated numbers of eligible hospitals.

Your participation is appreciated

* **1. National Provider Identifier (NPI) number**

* **2. Please enter the name of the individual responding to this survey.**

Last Name
First Name
Middle Name

The incentive is available to each qualifying hospital for a single location. Please enter the following information for the location you would use in applying for the incentive.

* **3. Hospital**

Hospital Name:
Business Entity Name:
Address:
Address 2:
City/Town:
State:
ZIP:
Email Address:
Phone Number:

In order to qualify for Medicaid EHR incentives you must meet a minimum Medicaid patient percentage. Please answer the following questions to assist in determining the best method of calculating Medicaid patient volume.

4. Estimate the percentage of your active patients that are Medicaid eligible.

- 0-10%
- 11-20%
- 21-30%
- 31-50%
- 51-100%

2. EHR Readiness

In order satisfy the program requirements providers will have to meet the Center for Medicare and Medicaid Services (CMS) "meaningful use" guidelines at a point in time to be determined by CMS. These questions will assess your EHR's readiness for the proposed meaningful use guidelines.

* **9. Please indicate with which entities (if any) you are sharing health information electronically using your EHR?**

- [ ] None
- [ ] Other hospital(s)
- [ ] Laboratory(s)
- [ ] Provider(s)
- [ ] Pharmacy(s)

Other (please specify)

* **10. Please rate how fully you are using your EHR.**

- ◯ 1 - Software has been purchased
- ◯ 2 - Software has been installed
- ◯ 3 - Staff has been trained
- ◯ 4 - Some information is entered by Nurses or Admin staff
- ◯ 5 - Most information is entered by Nurses and Doctors
- ◯ 6 - Information in the EHR is used proactively

11. For each of the following proposed meaningful use criteria please identify if your EHR supports and whether you are using the specified criteria.

	Yes	No	Functional Not Available	Not Sure
Are you using Computerized Provider Order Entry (CPOE)?	◯	◯	◯	◯
Are you using drug-drug interaction checks?	◯	◯	◯	◯
Are you using drug-allergy checks?	◯	◯	◯	◯
Are you using drug-formulary checks?	◯	◯	◯	◯
Are you using patient problem lists?	◯	◯	◯	◯
Are you using patient medication lists?	◯	◯	◯	◯
Are you using patient medication allergy lists?	◯	◯	◯	◯
Are you using patient demographics?	◯	◯	◯	◯
Are you recording patient vital signs?	◯	◯	◯	◯
Are you recording smoking status for patients 13 years or older?	◯	◯	◯	◯
Are you recording clinical lab test results as structured data?	◯	◯	◯	◯
Are you recording patients by specific condition?	◯	◯	◯	◯
Are you using a feature that supports at least one clinical decision support rule?	◯	◯	◯	◯
Are you using medication reconciliation?	◯	◯	◯	◯
Are you using a feature that allows transmission and receipt of summary care records for transitions of care and referrals?	◯	◯	◯	◯
Are you using patient electronic access?	◯	◯	◯	◯
Are you using electronic prescribing?	◯	◯	◯	◯
Are you providing patients with an electronic copy of their discharge instructions upon request?	◯	◯	◯	◯
Are you providing patients with an electronic copy of their health information upon request?	◯	◯	◯	◯
Are you recording advanced directives for patients 65 or older?	◯	◯	◯	◯
Do you use EHR technology to identify patient specific education resources and provide them to the patient?	◯	◯	◯	◯
Do you have the capability to report ambulatory clinical quality measures to CMS and the state?	◯	◯	◯	◯
Do you have the capability to provide electronic syndromic surveillance data to public health agencies?	◯	◯	◯	◯
Do you have the capability to submit electronic data to immunization registries?	◯	◯	◯	◯
Do you have the capability to provide electronic submission of reportable lab results to public health agencies?	◯	◯	◯	◯
Do you have the capability to	◯	◯	◯	◯

APPENDIX C EHR INCENTIVE PROGRAM REGULATION NOTICE

Electronic Health Records Incentive Program

NOTICE OF PROPOSED CHANGES IN THE REGULATIONS OF THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAM

The Department of Health and Social Services, Division of Health Care Services, proposes to adopt regulations in a new Chapter 165 of Title 7 and propose to amend regulations in Chapter 105 of Title 7 of the Alaska Administrative Code, to establish state-specific procedures and requirements for participation in the electronic health record incentive program created by the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5) that will encourage health care providers to invest in the technology needed to meaningfully use electronic health records and ultimately to use the statewide electronic health information exchange system created under AS 18.23.300. The proposed changes include the following:

1. 7 AAC 165.001 is proposed to be adopted to identify the purpose and scope of the electronic health record incentive program.

2. 7 AAC 165.010 is proposed to be adopted to establish the qualifications for participating in the Alaska Medicaid electronic health record incentive program, addressing the types of providers eligible and minimum patient volume requirements.

3. 7 AAC 165.020 is proposed to be adopted to establish the provider registration and attestation process, which includes submitting information on-line through the Alaska Medicaid state level registry internet portal.

4. 7 AAC 165.030 is proposed to be adopted to identify how participation and payment determinations are made and a provider's right to appeal an adverse determination by the department.

5. 7 AAC 165.040 is proposed to be adopted to identify the federal regulations that establish the standard used to determine the incentive payment amount and to address the distribution of an incentive payment over multiple payment years.

6. 7 AAC 165.050 is proposed to be adopted to establish the standards for provider participation in the Alaska Medicaid electronic health record incentive payment program, to address methods the department will use to monitor and verify compliance, and to address recoupment of incentive payments.

7. 7 AAC 165.080 is proposed to be adopted to establish a multi-tier process for a provider who wishes to appeal a determination of the department under this chapter.

8. 7 AAC 165.090 is proposed to be adopted to establish definitions related to the Alaska Medicaid electronic health records incentive program.

9. 7 AAC 105.400 is proposed to be amended to expand the grounds for sanctioning a Medicaid provider to include failure to cooperate with recoupment of an electronic health record incentive payment.

ADDITIONAL INFORMATION: Additional information about the Alaska Medicaid electronic health records incentive program and the State Level Registry can be found at the department's provider outreach page at the following Internet address: http://ak.arraincentive.com/default.aspx.

APPENDIX D ALASKA HOSPITALS AND HOSPITAL TYPE

Provider #	Contractor	Provider Name	Tie In	Hospital Type *	**Matched w/ PECOS All Statuses**
20001	322	Providence Alaska Medical	7/1/1966	ACUTE	20001
20006	52280	Mat Su Regional Med Center	12/1/2003	ACUTE	20006
20012	52280	Fairbanks Memorial Hosp	1/1/2004	ACUTE	20012
20017	52280	Alaska Regional Hospital	1/1/2002	ACUTE	20017
20024	322	Central Peninsula Pain Ma	8/5/1971	ACUTE	20024
20026	4001	Alaska Native Med Center	10/1/1983	ACUTE	20026
20027	4001	Mt Edg PHS Asas NH	10/1/1983	ACUTE	20027
20008	322	Bartlett Regional		ACUTE	#N/A
20018	4001	Yukon Kuskawin DSU	10/1/1983	ACUTE	#N/A
21301	322	Providence Valdez Med Cnt	1/1/2005	CAH	21301
21302	322	Providence Seward Med Cnt	5/1/2003	CAH	21302
21303	322	Sitka Community Hospital	7/1/2001	CAH	21303
21304	322	Petersburg Medical Center	7/1/2001	CAH	21304
21305	322	Wrangell Medical Center	7/1/2002	CAH	21305
21306	322	Providence Kodiak Island	6/1/2003	CAH	21306
21307	322	Cordova Community Medical	7/1/2003	CAH	21307
21308	322	Norton Sound Hospital	11/1/2003	CAH	21308
21309	4001	BBAHC-Kanakanak Hospital	10/1/2004	CAH	21309
21310	4001	Maniilaq Health Center	2/1/2005	CAH	21310
21311	323	Ketchikan Gen Hospital	8/21/2006	CAH	21311
21312	4001	Samuel Simmonds Memorial	10/1/2007	CAH	21312
21313	322	South Peninsula Hospital	8/7/2008	CAH	21313

*Hospital Types:

ACUTE – Acute Care Hospitals

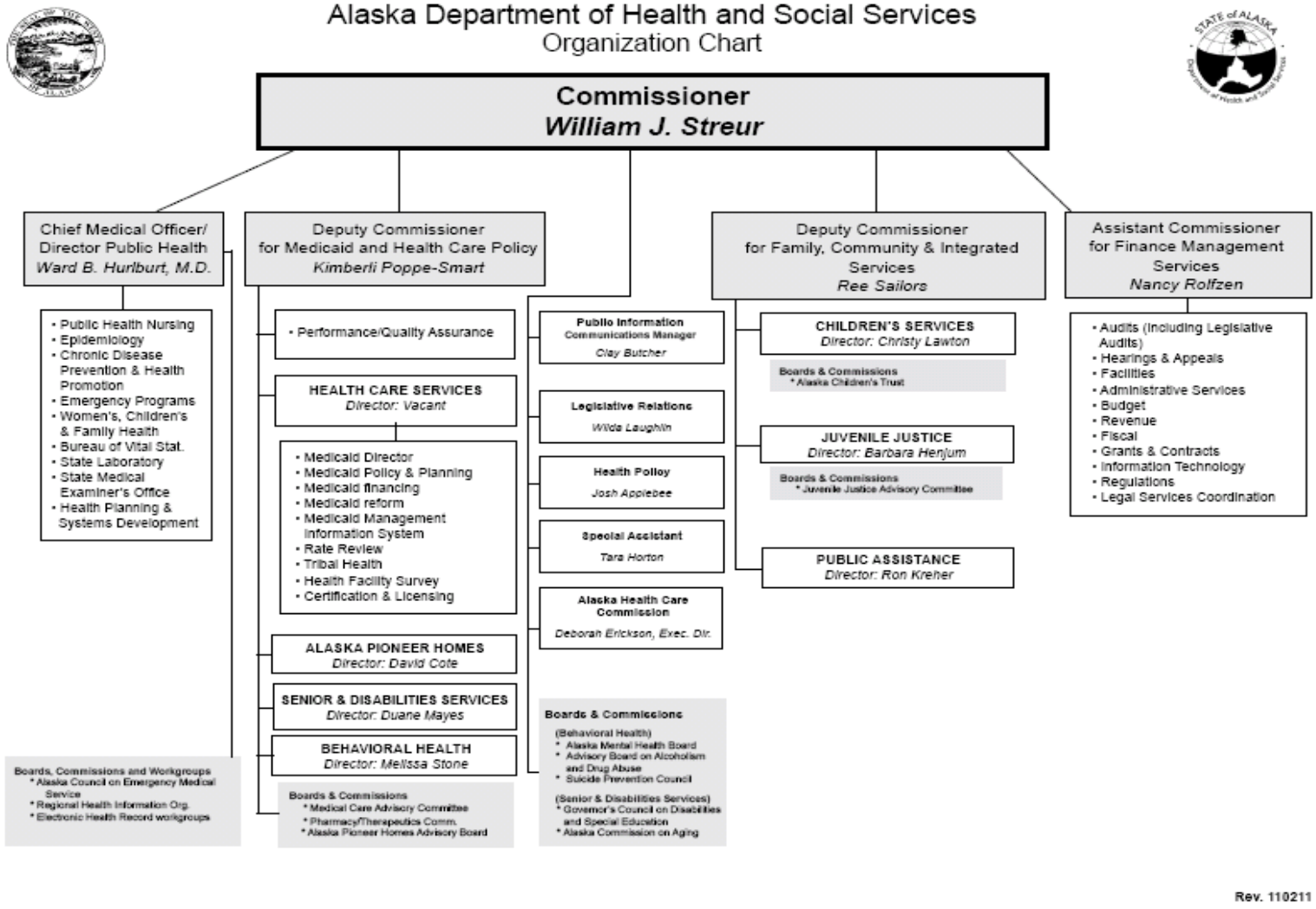
CAH – Critical Access Hospitals

APPENDIX E: QUALIFYING PATIENT VOLUME TABLE

Qualifying Patient Volume Threshold for the Alaska EHR Incentives

Program Entity	Minimum 90-day EHR Incentive Patient Volume Threshold	
Physicians	30%	Or the EP practices predominantly in an FQHC or RHC - 30% “needy individual” patient volume threshold
Pediatricians	20%	
Dentists	30%	
Certified nurse midwives	30%	
Physician Assistants when practicing at an FQHC/RHC led by a physician assistant	30%	
Nurse Practitioner	30%	
Acute care hospital	10%	
Children's hospital		

APPENDIX F DHSS ORGANIZATION CHART


Alaska Department of Health and Social Services
Organization Chart
Commissioner
William J. Streur
Chief Medical Officer/
Director Public Health
Ward B. Hurlburt, M.D.
• Public Health Nursing
• Epidemiology
• Chronic Disease Prevention & Health Promotion
• Emergency Programs
• Women's, Children's & Family Health
• Bureau of Vital Stat.
• State Laboratory
• State Medical Examiner's Office
• Health Planning & Systems Development
Boards, Commissions and Workgroups
* Alaska Council on Emergency Medical Service
* Regional Health Information Org.
* Electronic Health Record workgroups
Deputy Commissioner
for Medicaid and Health Care Policy
Kimberli Poppe-Smart
• Performance/Quality Assurance
HEALTH CARE SERVICES
Director: Vacant
• Medicaid Director
• Medicaid Policy & Planning
• Medicaid financing
• Medicaid reform
• Medicaid Management Information System
• Rate Review
• Tribal Health
• Health Facility Survey
• Certification & Licensing
ALASKA PIONEER HOMES
Director: David Cote
SENIOR & DISABILITIES SERVICES
Director: Duane Mayes
BEHAVIORAL HEALTH
Director: Melissa Stone
Boards & Commissions
* Medical Care Advisory Committee
* Pharmacy/Therapeutics Comm.
* Alaska Pioneer Homes Advisory Board
Public Information
Communications Manager
Clay Butcher
Legislative Relations
Wilda Laughlin
Health Policy
Josh Applebee
Special Assistant
Tara Horton
Alaska Health Care Commission
Deborah Erickson, Exec. Dir.
Boards & Commissions
(Behavioral Health)
* Alaska Mental Health Board
* Advisory Board on Alcoholism and Drug Abuse
* Suicide Prevention Council
(Senior & Disabilities Services)
* Governor's Council on Disabilities and Special Education
* Alaska Commission on Aging
Deputy Commissioner
for Family, Community & Integrated Services
Ree Sailors
CHILDREN'S SERVICES
Director: Christy Lawton
Boards & Commissions
* Alaska Children's Trust
JUVENILE JUSTICE
Director: Barbara Henjum
Boards & Commissions
* Juvenile Justice Advisory Committee
PUBLIC ASSISTANCE
Director: Ron Kreher
Assistant Commissioner
for Finance Management Services
Nancy Rolfzen
• Audits (including Legislative Audits)
• Hearings & Appeals
• Facilities
• Administrative Services
• Budget
• Revenue
• Fiscal
• Grants & Contracts
• Information Technology
• Regulations
• Legal Services Coordination
Rev. 110211

APPENDIX G ALASKA SAMPLE HOSPITAL CALCULATION

Enter Hospital Name | Revised 9/2011

Calculation of Medicaid Electronic Health Records (EHR) Incentive Payment

Yellow highlighted areas are for data input from your hospital cost reports

The overall "EHR" amount is the sum over 4 years of (a) the base amount of $2,000,000 plus (b) the discharge related amount defined as $200 for the 1,150 through the 23,000 discharge for the first payment year then a pro-rated amount of 75% in yr 2, 50% in yr 3, and 25% in yr 4
For years 2-4 the rate of growth is assumed to be the previous 3 years' average.

Step 1: Compute the average annual growth rate over 3 years using previous hospital cost reports.

Total Discharges per the Hospital Cost Report (Worksheet S-3, Part I, Column 15 listed as "Total All Patients", line 12-sum of acute care inpatient, excluding nursery and swing bed discharges)

	Previous Year	Fiscal Year	Increase	Growth Rate
Fiscal Year 2007		2,107		
Fiscal Year 2008	2,107	2,121	14	0.66%
Fiscal Year 2009	2,121	2,258	137	6.46%
Fiscal Year 2010	2,258	2,153	(105)	-4.65%
	Total % Inc			2.5%
	Divide by 3 years			3
The Average Annual Growth Rate				0.82%

Step 2: Compute total discharge related amount using proper transition factors

> discharges are capped at 23,000 each year

Total Discharges				2,153
	Allowed Discharges	Disallowed Discharges 1,149	Per Discharge Amount $200	Amount
Year 1	2,153	(allowed dischg - 1,149) x $200		$200,800
Year 2	2,171	(allowed dischg - 1,149) x $200)		$204,400
Year 3	2,189	(allowed dischg - 1,149) x $200)		$208,000
Year 4	2,207	(allowed dischg - 1,149) x $200)		$211,600
Total 4 year discharge related amount				$824,800

Step 3: Compute the initial amount for 4 years

	Year 1	Year 2	Year 3	Year 4
Base Amount per year	$2,000,000	$2,000,000	$2,000,000	$2,000,000
Discharge related amount	$200,800	$204,400	$208,000	$211,600
Aggregate EHR Amount	$2,200,800	$2,204,400	$2,208,000	$2,211,600

***Step 4:* Apply Transition Factor**

Transition Factor			
Year 1	Year 2	Year 3	Year 4
1.00	0.75	0.50	0.25
$2,200,800	$1,653,300	$1,104,000	$552,900

Step 5: Compute the overall EHR amount for 4 years	$5,511,000

Step 6:	Computation of Medicaid Share from the Medicare cost report	Most recent years data	
			Revised 9/2011
	(Medicaid Inpatient Bed Days + Medicaid Managed Care Inpatient Bed Days) / (est. Total IP-bed-days x ((est. total charges - est. charity care charges) / est. total charges))		
	Total Medicaid Inpatient Bed Days (Worksheet S-3, Part I, Column 5 listed as "Total Title XIX", line 12-sum of acute care inpatient, excluding nursery and swing bed days)	1,244	
	Total Medicaid Managed Care Inpatient Bed Days (No Medicaid managed care days in Alaska)	0	
	Total Medicaid and Managed Care Inpatient Bed Days		1,244
	Total Hospital Charges (Worksheet C, Part I, Column 8 listed as "Total charges", line 101)	$139,177,864	
	Charity Care Charges or Uncompensated Care Charges (Worksheet S-10, line 30)	$4,875,739	
	Total Hospital Charges - Charity Chgs	$134,302,125	
	Divided by Total Hospital Charges	$139,177,864	
	Non-charity percentage	96.50%	
	Total Inpatient Bed Days (Worksheet S-3, Part I, Column 6 listed as "Total All Patients", line 12-sum of acute care inpatient, excluding nursery and swing bed days)	7,373	
	Non-Charity Total Hospital Days		7,115
	(Total Medicaid and Managed Care Inpatient Days) divide Non-Charity Hospital Days		17.48%

Step 7:	Computation of Medicaid aggregate EHR incentive amount	
	Aggregate EHR amount for 4 years	$5,511,000
	Medicaid Share	17.48%
	Medicaid Aggregate EHR Incentive Amount	**$963,322.80**

Step 8:	Computation of Medicaid EHR incentive amount by year	
	Year One payment = 50%	$481,661.40
	Year Two payment = 40%	$385,329.12
	Year Three payment = 10%	$96,332.28

APPENDIX H PRE-PAYMENT VALIDATION CRITERIA

Criteria		Data Source	Provider Type	Conducted By
Valid Attestation	Attestation is complete in the SLR and we receive the signed attestation	Validate on the original attestation the signature is the authorized representative	Professional Hospital	HIT Program Office Manual Validation
Valid Attestation	Validate on the original attestation the signature is the authorized representative	Validate on the original attestation the signature is the authorized representative	Professional Hospital	HIT Program Office Manual Validation
Valid NPI/TIN	Validate that the NPI and TIN combination is in the Alaska Master Provider File(MPF)	NLR transaction Data compared to MMIS Data	Professional	SLR Automated Validation
Enrolled Medicaid Provider	The Alaska Medicaid ID number is active with Medicaid (this validates they have enrolled with AK Medicaid)	MMIS	Professional Hospital	SLR Automated Validation
Valid Alaska License	Validates an AK license is on file in the MPF	MMIS	Professional	SLR Automated Validation
Valid Provider Type	Validate that the provider is an eligible provider type	MMIS	Professional	HIT Program Office Manual Validation
Validate Pediatrician	Validate if the provider has a pediatric specialty in MMIS	MMIS	Pediatrician	HIT Program Office Manual Validation
Validate Pediatrician	Pediatricians will be required to submit certification from ABP or American Osteopathic Board of Pediatrics (AOBP) with application	Documentation submitted by Provider	Pediatrician	HIT Program Office Manual Validation
Valid Medical License	Validate that the provider has a current license in division of occupational license		Professional	HIT Program Office Manual Validation
Not on Death Registry	Validate that the provider is not in the vital statistic death registry	Death Registry	Professional	HIT Program Office Manual Validation
Validate Practices Predominately in FQHC	Validate that they have approximately 50% of services over a 6 month time period in the FQHC	MMIS	Professional at FQHC	HIT Program Office Manual Validation
Not Sanctioned	Verify provider not on OIG or EPLS list	OIG or EPLS websites	Professional	HIT Program Office Manual

Criteria		Data Source	Provider Type	Conducted By
				Validation
Patient Volume	Compare the number of Medicaid encounters with STARS data	MMIS and STARS	Professional	HIT Program Office Manual Validation
Validate Patient Volume	Validate total needy individual patient volume is within 10% of data submitted by provider		Professional at FQHC	HIT Program Office Manual Validation
Valid Hospital Type	Validate that the CCN from NLR has the last 4 digits of CCN=0001 – 0879 or 1300 – 1399	CCN from NLR Transaction	Hospital	SLR Automated Validation
Valid Length of Stay	Validates that the average Length of Stay is 25 or less		Hospital	SLR Automated Validation
Patient Volume %	Validates that the Medicaid Encounter % meets the patient volume criteria	Numerator and Denominator entered by provider in SLR	Professional Hospital	SLR Automated Validation
Valid 90 day Period	Validates the 90 day period is within the previous federal fiscal year	Date Range Entered by the Provider	Hospital	SLR Automated Validation
Data for Payment Calculation	Validates that all fields have been completed including: • Discharge data for 4 FFY • Discharge data for prior FFY • Total Inpatient Bed Days • Total hospital charges •Total charges for charity care	Data entered by the Provider	Hospital	SLR Automated Validation
Validates that the provider has either adopted, implemented or upgraded	Validates that the EP has confirmed and checked off that the EHR technology is on the ONC list		Professional Hospital	SLR Automated Validation
Valid Certified EHR Technology	Validates that what the provider entered as their certification is on the ONC certified technology list	Interface with ONC Certified Health IT Products Listing (CHPL)	Professional Hospital	SLR Automated Validation
Validates that the provider has either adopted, implemented or upgraded	Validate that the documentation uploaded by the provider supports A/I/U. Examples are signed contract, letter of agreement, implementation or upgrade action plan, training plan.	Documentation uploaded by the provider	Professional Hospital	HIT Program Office Manual Validation

Criteria		Data Source	Provider Type	Conducted By
Not Hospital Based	Validates that the provider identified that 90% of their services are not in ER or inpatient setting		Professional	SLR Automated Validation
	The SLR re-validates prior to submitting the attestation: If the NLR record is on file The provider is still in the PMF Eligibility formulas meet criteria		Professional Hospital	SLR Automated Validation
Valid Attestation	Validates that the provider has printed and uploaded the attestation into the SLR	SLR		SLR Automated Validation
Not Sanctioned	Validate that the authorized representative is not sanctioned on OIG or EPLS list		Professional Hospital	Manual
Valid License	Validate from the licensing board that the provider is licensed as an acute care or CAH hospital	Licensing Board	Hospital	Manual
Patient Volume Reasonableness	Validate that the patient volume submitted is within 10% of the STARS patient volume	STARS claims data	Professional Hospital	Manual
Validate Payment Calculation	Validate the 4 years of discharge data to determine the average growth rate	Hospital Cost Reports	Hospital	Office of Rate Review Manual Validation
Validate Payment Calculation	Validate the discharge entered by the provider matches the inpatient discharges on most recent cost report	Hospital Cost Reports	Hospital	Office of Rate Review Manual Validation
Validate Payment Calculation	Validate from STARS the Medicaid IP bed days or Validate from Cost report (when available)	STARS or Hospital Cost Report	Hospital	Office of Rate Review OR HIT Program Office Manual Validation
Validate Payment Calculation	Validate the Total inpatient bed days from most recent cost report	Hospital Cost Report	Hospital	Office of Rate Review Manual Validation
Validate Payment Calculation	Validate the Total hospital charges from the most recent cost report	Hospital Cost Report	Hospital	Office of Rate Review Manual Validation
Validate Payment Calculation	Validate the charity care or uncompensated care charges from cost report	Hospital Cost Report	Hospital	Office of Rate Review Manual Validation

Criteria		Data Source	Provider Type	Conducted By
Validate Out of State Encounters	Contact Out of State Medicaid Agency to verify Out of State encounters if necessary		Professional	HIT Program Office Manual Validation

APPENDIX I HOSPITAL TIP SHEET

Confirm Medicaid Eligibility for Eligible Hospitals

Acute Care and Critical Access Hospitals (CAH) must have:

- Medicaid discharges of at least 10% for the Medicaid patient volume,
- An average Length of Stay (LOS) of 25 days or less,
- A CCN that ends in 0001 – 0879 or 1300 – 1399 to be eligible to receive an incentive payment
- Children's Hospitals with a CCN that ends in 3300 – 3399 are automatically eligible

The hospital Medicaid patient volume is established by selecting a representative 90 day period or greater from the previous federal fiscal year. For purposes of calculating eligible hospital patient volume, a Medicaid encounter is defined as services rendered to an individual (1) per inpatient discharge, or (2) on any one day in the emergency room * where TXIX Medicaid or another State's Medicaid program paid for:

1. Part or all of the service;
2. Part or all of their premiums, co-payments, and/or cost-sharing;

*In order for emergency room encounters to count towards the patient volume the emergency department must be part of the hospital.

Note that you will be requested to enter a variety of data from your cost reports into the State Level Registry.

Representative Period	You must select a representative 90 day period or greater. This field is where you will enter the start date of the period that you have chosen to determine your Medicaid patient volume.
Total Discharges for the Representative Period	These are your total discharges for all payers, including Medicaid, for the representative period that you have chosen to determine eligibility.
Medicaid Discharges for the Representative Period	These are your total Medicaid "encounters" for the representative period that you have chosen to determine eligibility.
Location On Cost Report - *CMS 2552-96 cost report data fields*	**When totals are requested for inpatient bed days and discharges, theses totals must NOT include nursery or swing bed counts.**
Average Length of Stay	Your Average Length of Stay can be calculated using data reported in your most recently filed cost report. The most recently filed costs report is defined as the hospital cost report ending prior to the start of the current federal fiscal year *Total Inpatient Bed Days* (S-3, Part I, Column 6 listed as "Total All Patients", line 12-sum of acute care inpatient) *Total Discharges* (S-3, Part I, Column 15 listed as "Total All Patients", line 12-sum of acute care inpatient)

7/15/11

Prior Year Discharges Data	Discharge data from 4 prior years is used to calculate the growth rate for your hospital. Alaska has designated your most recently filed cost report for the period ending prior to the start of the current federal fiscal year plus the filed cost reports for the three years preceding it. A number is required in all fields. You may not enter a zero. (S-3, Part I, Column 15 listed as "Total All Patients", line 12-sum of acute care inpatient)	
	As listed in the SLR, if the date of your most recently filed Cost Report is 2010: *Year 4* is 2007 *Year 3* is 2008 *Year 2* is 2009 *Year 1* is 2010	
	Location On Cost Report - *CMS 2552-96 cost report data fields*	**Location on SLR's *Confirm Alaska Medicaid Eligibility* Page**
Discharges	S-3, Part I, Column 15 listed as "Total All Patients", line 12-sum of acute care inpatient	Lines 1 and 2 Total Discharges
Medicaid Inpatient Bed Days	S-3, Part I, Column 5 listed as "Total Title XIX", line 12-sum of acute care inpatient	Line 3 Total Medicaid Inpatient Bed Days
Total Medicaid Managed Care Inpatient Bed Days	Alaska does not have Medicaid Managed Care Inpatient Bed Days; it is included in the hospital calculation sheet only because it is a data field in the SLR. Hospitals may enter a "0" in this field in the SLR.	Line 4 Total Medicaid Managed Care Inpatient Bed days
Total Inpatient Bed Days	S-3, Part I, Column 6 listed as "Total All Patients", line 12-sum of acute care inpatient	Line 5 Total Inpatient Bed Days
Total Hospital Charges	Worksheet C, Part I, Column 8 listed as "Total charges", line 101	Line 6 Total Hospital Charges
Total Charity Care *(as defined for Medicare cost reporting purposes)*	S-10, Line 30, if your cost report does not contain this information determine if the hospital accounting records or hospital financial statements supports the input of charity care charges as defined for Medicare cost reporting purposes, hospitals will be required to provide this financial documentation to the Medicaid EHR Program Office.	Line 7 Hospital Charity Care Charges

APPENDIX J TRIBAL HOSPITAL TIP SHEET

Confirm Medicaid Eligibility for Eligible Tribal Hospitals

Acute Care and Critical Access Hospitals (CAH) must have:

- Medicaid discharges of at least 10% for the Medicaid patient volume,
- An average Length of Stay (LOS) of 25 days or less,
- A CCN that ends in 0001 – 0879 or 1300 – 1399 to be eligible to receive an incentive payment
- Children's Hospitals with a CCN that ends in 3300 – 3399 are automatically eligible

The hospital Medicaid patient volume is established by selecting a representative 90 day period from the previous federal fiscal year. For purposes of calculating eligible hospital patient volume, a Medicaid encounter is defined as services rendered to an individual (1) per inpatient discharge, or (2) on any one day in the emergency room * where TXIX Medicaid or another State's Medicaid program paid for:

1. Part or all of the service;
2. Part or all of their premiums, co-payments, and/or cost-sharing;

*In order for emergency room encounters to count towards the patient volume the emergency department must be part of the hospital.

Note that you will be requested to enter a variety of data from your cost reports into the State Level Registry.

Field Name	Description
Representative Period	You must select a representative 90 day period or greater. This field is where you will enter the start date of the period that you have chosen to determine your Medicaid patient volume.
Total Discharges for the Representative Period	These are your total discharges for all payers, including Medicaid, for the representative period that you have chosen to determine eligibility.
Medicaid Discharges for the Representative Period	These are your total Medicaid "encounters" for the representative period that you have chosen to determine eligibility.
Location On Cost Report - *CMS 2552-96 cost report data fields or other data sources*	**When totals are requested for inpatient bed days and discharges, theses totals must NOT include nursery or swing bed counts.**

<table>
<tr><td>Field Name</td><td colspan="2">Description</td></tr>
<tr><td>Average Length of Stay</td><td colspan="2">Your Average Length of Stay can be calculated using data reported in your most recently filed cost report. The most recently filed costs report is defined as the hospital cost report ending prior to the start of the current federal fiscal year

Total Inpatient Bed Days(IHS National IP Statistics)
–
Total Discharges (S-3, Part I, Column 15 listed as "Total All Patients",
line 12-sum of acute care inpatient, or IHS HQ Reports)</td></tr>
<tr><td rowspan="4">Prior Year Discharges Data</td><td colspan="2">Discharge data from 4 prior years is used to calculate the growth rate for your hospital. Alaska has designated your most recently filed cost report for the period ending prior to the start of the current federal fiscal year plus the filed cost reports for the three years preceding it. A number is required in all fields. You may not enter a zero.

(S-3, Part I, Column 15 listed as "Total All Patients", line 12-sum of acute care inpatient, or IHS HQ Reports)</td></tr>
<tr><td colspan="2">As listed in the SLR, if the date of your most recently filed Cost Report is 2010:

Year 4 is 2007
Year 3 is 2008
Year 2 is 2009
Year 1 is 2010</td></tr>
<tr><td>Location on Cost Report – CMS 2552-96 or other data sources</td><td>Location on SLR’s Confirm Alaska Medicaid Eligibility Page</td></tr>
<tr><td>Discharges</td><td>S-3, Part I, Column 15 listed as "Total All Patients", line 12-sum of acute care inpatient, or IHS HQ Reports</td><td>Lines 1 and 2
Total Discharges</td></tr>
<tr><td>Medicaid Inpatient Bed Days</td><td>State Reports</td><td>Line 3 Total Medicaid Inpatient Bed Days</td></tr>
<tr><td>Total Medicaid Managed Care Inpatient Bed Days</td><td>Alaska does not have Medicaid Managed Care Inpatient Bed Days; it is included in the hospital calculation sheet only because it is a data field in the SLR. Hospitals may enter a “0” in this field in the SLR.</td><td>Line 4 Total Medicaid Managed Care Inpatient Bed days</td></tr>
<tr><td>Total Inpatient Bed Days</td><td>IHS National IP Statistics</td><td>Line 5 Total Inpatient Bed Days</td></tr>
</table>

Field Name	Description	
Total Hospital Charges	IHS Cost Report Summaries	Line 6 Total Hospital Inpatient Charges
Total Charity Care	IHS National IP Statistics	Line 7 Hospital Inpatient Charity Care Charges

APPENDIX K A/I/U AUDIT THRESHOLDS

This section was removed for confidential purposes

APPENDIX L MEANINGFUL USE DATA VALIDATION AND AUDIT

The real time notification of MU does not occur until the provider saves the data. All saves are stored. The SLR will flag multiple entries for the same measure as an exception. The state will review and clear all exceptions prior to the SLR the D16 transaction submission. The state will flag providers that make more than one change for audit.

Numerators and denominators will be evaluated based upon a report of encounters by day from the relevant reporting period.

Each objective will be visually inspected to ensure that the measure has been met by the provider, in addition to the system validation. Objectives will be validated to ensure that the criterion for the number of measures has been met by the provider according to the table below:

EP/EH	Measure Type	Validation
EP	Menu Objectives	Validate that the provider has met at least 5 Menu Objectives
EH	Menu Objectives	Validate that the provider has met at least 5 Menu Objectives
EP	Clinical Quality Measures	Validate that the provider has met at least 3 of 6 for Core/Alternative measures
EP	Clinical Quality Measures	Validate that the provider has met at least 3 of 38 for Additional measures
EH	Clinical Quality Measures	Validate that the provider has met at 15 of 15 CQMs

Measure	Measure Title	Measure Description	Exclusion	Pre-Payment Audit Mechanism	Post-Payment Audit Mechanism	SLR support
CORE OBJ 1 (EP) EPCMU01	Use computerized provider order entry **(CPOE)** for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines	More than **30 %** of all unique patients with at least one medication in their medication list seen by the EP have **at least one medication order entered using CPOE**	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.	Validate the exclusion, when selected: Audit of MMIS FFS encounter claims data for reporting period to verify that < 100 Pharmacy claims were submitted Validate denominator for Core Objective #1 <= EPCMU 03	Post payment audit based on risk or random sample will request and review EHR data for compliance	
CORE OBJ 1 (EH) EHCMU01	Use computerized provider order entry **(CPOE)** for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines	More than **30 %** of all unique patients with at least one medication in their medication list admitted to the eligible hospital's or CAH's inpatient or emergency dept **(POS 21 or 23)** have **at least one medication order entered using CPOE**	No Exclusions	Validate denominator for Core Objective #1 is <= EHCMU 03	Post payment audit based on risk or random sample will request and review EHR data for compliance	
CORE OBJ 2 (EP) EPCMU02	Implement **drug-drug and drug-allergy interaction checks**	The EP has enabled this functionality for the entire EHR reporting period	No Exclusions		Post payment audit based on risk or random sample will request and review EHR data for compliance	
CORE OBJ 2 (EH) EHCMU02	Implement **drug-drug and drug-allergy interaction checks**	The eligible hospital or CAH has enabled this functionality for the entire EHR reporting period	No Exclusions		Post payment audit based on risk or random sample will request and review EHR data for compliance	

Measure	Measure Title	Measure Description	Exclusion	Pre-Payment Audit Mechanism	Post-Payment Audit Mechanism	SLR support
CORE OBJ 3 (EH) EHCMU03	Maintain an up-to-date problem list of **current and active diagnoses**.	More than **80 %** of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department **(POS 21 or 23)** have at least one entry (or an indication that no problems are known for the patient) recorded as structured data.	No Exclusions	Validate the denominator for Core Objective #3 = EHCMU 04, EHCMU 05, EHCMU 06, EHMMU 05	Post payment audit based on risk or random sample will request and review EHR data for compliance	SLR will capture both Problem and No Problem to avoid the occurrence of No problem as a default.
CORE OBJ 3 (EP) EPCMU03	Maintain an up-to-date problem list of current and active diagnoses.	More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.	No exclusion	Validate denominator for Core Objective #3 is = EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 06, EPMMU 05 Validate denominator for Core Objective #3 is >= EPCMU 08, EPCMU 09, EPMMU 04	Post payment audit based on risk or random sample will request and review EHR data for compliance	SLR will capture both Problem and No Problem to avoid the occurrence of No problem as a default.
CORE OBJ 4 (EP) EPCMU04	**Generate** and **transmit** permissible **prescriptions** electronically (era)	More than **40%** of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.	Validate the exclusion, when selected: Audit of MMIS FFS encounter claims data for reporting period to verify that < 100 Pharmacy claims were submitted	Post payment audit based on risk or random sample, will contact the e-prescribing service and/or pharmacy for validation.	SLR will capture the e-prescribing service and a pharmacy
CORE OBJ 4 (EH) EHCMU 04	Maintain **active medication list**	More than **80 %** of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department **(POS 21 or 23)** have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	No Exclusions	Validate the denominator for Core Objective #4 is = EHCMU 03, EHCMU 05, EHCMU 06, EHMMU 05	Post payment audit based on risk or random sample will request and review EHR data for compliance	

Measure	Measure Title	Measure Description	Exclusion	Pre-Payment Audit Mechanism	Post-Payment Audit Mechanism	SLR support
CORE OBJ 5 (EP) EPCMU05	Maintain **active medication list**	More than **80 %** of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	No Exclusions	Validate denominator for Core Objective #5 is= EPCMU 03, EPCMU 06, EPCMU 07, EPMMU 05, EPMMU 06 Validate denominator for Core Objective #5 is >= EPCMU 08, EPCMU 09, EPMMU 04	Post payment audit based on risk or random sample will request and review EHR data for compliance	
CORE OBJ 5 (EH) EHCMU 05,	Maintain **active medication allergy list**	More than **80 %** of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department **(POS 21 or 23)** have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	No Exclusions	Validate the denominator for Core Objective #5 is = EHCMU 03, EHCMU 04, EHCMU 06, EHMMU 05	Post payment audit based on risk or random sample will request and review EHR data for compliance	
CORE OBJ 6 (EP) EPCMU06	Maintain **active medication allergy list**	More than **80 %** of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	No Exclusions	Validate denominator for Core Objective #6 is = EPCMU 03, EPCMU 05, EPCMU 07, EPMMU 06, EPMMU 05 Validate denominator for Core Objective #6 >= EPCMU 08, EPCMU 09, EPMMU 04	Post payment audit based on risk or random sample will request and review EHR data for compliance	

Measure	Measure Title	Measure Description	Exclusion	Pre-Payment Audit Mechanism	Post-Payment Audit Mechanism	SLR support
CORE OBJ 6 (EH) EHCMU 06	Record all of the following **demographics**: (A) Preferred Language (B) Gender (C) Race (D) Ethnicity (E) Date of Birth (F) Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH	For more than 50% of all unique patients age 2 and over admitted to the eligible hospital or CAH, height, weight, and blood pressure are recorded as structured data.	No Exclusions	Validate the denominator for Core Objective # 6 is = EHCMU 03, EHCMU 04, EHCMU 05, EHMMU 05	Post payment audit based on risk or random sample will request and review EHR data for compliance	
CORE OBJ 7 (EP) EPCMU07	Record all of the following **demographics**: (A) Preferred Language (B) Gender (C) Race (D) Ethnicity (E) Date of Birth (F) Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH	More than **50 %** of all unique patients seen by the EP have demographics recorded as structured data.	No Exclusions	Validate denominator for Core Objective #7 is = EPCMU 03, EPCMU 05, EPCMU 06, EPMMU 05, EPMMU 06 Validate denominator for Core Objective #7 >= EPCMU 08, EPCMU 09, EPMMU 04	Post payment audit based on risk or random sample will request and review EHR data for compliance	Add field to capture count from the numerator (if any) of unique patients with most but not all demographic information entered as structured data

Measure	Measure Title	Measure Description	Exclusion	Pre-Payment Audit Mechanism	Post-Payment Audit Mechanism	SLR support
CORE OBJ 7 (EH) EHCMU 07	Record and chart changes in the following **vital signs**: (A) Height (B) Weight (C) Blood Pressure (D) Calculate and display body mass index (BMI) (E) Plot and display growth charts for children 2-20 yrs, including BMI	For more than **50 %** of all unique patients age 2 and over admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), **height, weight, and blood pressure** are recorded as structured data.	No Exclusions	Validate the denominator for Core Objective #7 is <= EHCMU 03, EHCMU 04, EHCMU 05, EHCMU 06, EHMMU 05	Post payment audit based on risk or random sample will request and review EHR data for compliance	Add field to capture count from the numerator (if any) of unique patients with most but not all demographic information entered as structured data
CORE OBJ 8 (EP) EPCMU08	Record and chart changes in the following **vital signs**: (A) Height (B) Weight (C) Blood Pressure (D) Calculate and display body mass index (BMI) (E) Plot and display growth charts for children 2-20 yrs, including BMI	For more than **50 %** of all unique patients age 2 and over seen by the EP, **height, weight, and blood pressure** are recorded as structured data.	Any EP who either sees no patients 2 years or older, or who believes that all three vital signs of height, weight and blood pressure of their patients have no relevance to their scope of practice.	Validate the exclusion, when selected: Audit of MMIS FFS encounter claims data for reporting period to verify that - if selected 1)provider doesn't see patients in the reporting period over 2 years or older 2) validate provider type for relevance to scope of practice Validate that the denominator for Core Objective # 8 is <= EPCMU 03, EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 05, EPMMU 06	Post payment audit based on risk or random sample will request and review EHR data for compliance	Add drop down for pre-defined list of exclusions and require provider to select from list if they indicate an exclusion
CORE OBJ 8 (EH) EHCMU 08	Record **smoking status** for patients 13 years old or older.	More than **50 %** of all unique patients 13 years old or older or admitted to the eligible hospital's inpatient or emergency dept (POS 21 or 23) have **smoking status** recorded as structured data.	Any eligible hospital or CAH that admits no patients 13 years or older to their inpatient or emergency dept (POS 21 or 23)	Validate the exclusion, when selected: Audit of MMIS FFS encounter claims data for reporting period to verify that provider doesn't see patients in the reporting period over 13 years or older Validate the denominator for Core Objective # 8 is <= EHCMU 07, EHCMU 06	Post payment audit based on risk or random sample will request and review EHR data for compliance	Add drop down for pre-defined list of exclusions and require provider to select from list if they indicate an exclusion

Measure	Measure Title	Measure Description	Exclusion	Pre-Payment Audit Mechanism	Post-Payment Audit Mechanism	SLR support
CORE OBJ 9 (EP) EPCMU09	Record **smoking status** for patients 13 years old or older.	More than **50 %** of all unique patients 13 years old or older seen by the EP have **smoking status** recorded as structured data.	Any EP who sees no patients 13 years or older.	Validate the exclusion, when selected: Audit of MMIS FFS encounter claims data for reporting period to verify that provider doesn't see patients in the reporting period over 13 years or older Validate that the denominator for Core Objective # 9 is <= EPCMU 03, EPCMU 05, EPCMU 06, EPCMU 7, EPMMU 05, EPMMU 06	Post payment audit based on risk or random sample will request and review EHR data for compliance	
CORE OBJ 9 (EH) EHCMU09	**Report hospital clinical quality measures** to the CMS or the State of Alaska.	Successfully **report to CMS hospital clinical quality measures (CQM)** selected by CMS or the State of Alaska in the manner specified by CMS or the State of Alaska.	No Exclusions	Ensure that at least one CQM is submitted (not all excluded)	Post payment audit based on risk or random sample will request and review EHR data for compliance - specifically targeting the CQM identified	Add free text field to capture which Clinical Quality Measure (CQM)
CORE OBJ 10 (EP) EPCMU10	**Report ambulatory clinical quality measures** to the State of Alaska	Successfully **report to CMS hospital clinical quality measures** selected by the State of Alaska in the manner specified by the State of Alaska.	No Exclusions	Ensure that at least one CQM is submitted (not all excluded)	Post payment audit based on risk or random sample will request and review EHR data for compliance - specifically targeting the CQM identified	Add free text field to capture which Clinical Quality Measure (CQM)
CORE OBJ 10 (EH) EHCMU10	Implement **one clinical decision support rule** related to a high priority hospital condition along with the ability to track compliance with that rule	Implement one clinical decision support rule.	No Exclusions		Post payment audit based on risk or random sample will request and review EHR data for compliance- targeting the CDS rule indicated	Add free text field for provider to indicate which CDS rule was implemented

Measure	Measure Title	Measure Description	Exclusion	Pre-Payment Audit Mechanism	Post-Payment Audit Mechanism	SLR support
CORE OBJ 11 (EP) EPCMU11	Implement **one clinical decision support rule** related to specialty or high clinical priority along with the ability to track compliance with that rule	Implement one clinical decision support (CDS) rule.	No Exclusions		Post payment audit based on risk or random sample will request and review EHR data for compliance - targeting the CDS rule indicated	Add free text field for provider to indicate which CDS rule was implemented
CORE OBJ 11 (EH) EHCMU11	Provide patients w an **electronic copy** of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures) upon request	More than **50 %** of all patients of the inpatient or emergency dept of the eligible hospital or CAH **(POS 21 or 23)** who request an **electronic copy** of their health information are provided it within 3 business days.	Any eligible hospital or CAH that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.		Post payment audit based on risk or random sample will request and review EHR data for compliance	
CORE OBJ 12 (EP) EPCMU12	Provide patients w an **electronic copy** of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request	More than **50 %** of all patients who request an **electronic copy** of their health information are provided it within 3 business days.	Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.	Validate denominator in Core Objective #12 is < EPCMU 04	Post payment audit based on risk or random sample will request and review EHR data for compliance	
CORE OBJ 12 (EH) EHCMU12	Provide patients w an **electronic copy of their discharge instructions** at time of discharge, upon request.	More than **50 %** of all patients who are discharged from an EH/CAH's inpatient or emergency dept **(POS 21 or 23)** and who request an **electronic copy of their discharge instructions** are provided it.	Any eligible hospital or CAH that has no requests from patients or their agents for an electronic copy of the discharge instructions during the EHR reporting period.		Post payment audit based on risk or random sample will request and review EHR data for compliance	

Measure	Measure Title	Measure Description	Exclusion	Pre-Payment Audit Mechanism	Post-Payment Audit Mechanism	SLR support
CORE OBJ 13 (EP) EPCMU13	Provide **clinical summaries** for patients for each office visit.	**Clinical summaries** provided to patients for more than **50 %** of all office visits within 3 business days.	Any EP who has no office visits during the EHR reporting period.	Validate the exclusion, when selected: Audit of MMIS FFS encounter claims data for reporting period to verify that no services were performed in an office Validate denominator for Core Objective #13 is >= EPCMU 0, EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 05, EPMMU 06 Validate the denominator for Core Objective #13 is >= EPCMU 08, EPCMU 09, EPMMU 04	Post payment audit based on risk or random sample will request and review EHR data for compliance	
CORE OBJ 13 (EH) EHCMU13	Capability to **exchange key clinical info** (for example, problem list, med list, med allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.	Performed at least **one test of certified EHR technology's capacity to electronically exchange** key clinical information.	No Exclusions		Post payment audit based on risk or random sample will request and review EHR data for compliance - specifically targeting information regarding with whom the test was conducted. Greater attention will be focused on failed test results	· Add free text field for provider to indicate with whom the test was done Add test result pass/fail selection
CORE OBJ 14 (EP) EPCMU14	Capability to **exchange key clinical info** (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.	Performed at least **one test of certified EHR technology's capacity to electronically exchange** key clinical information.	No Exclusions		Post payment audit based on risk or random sample will review EHR data for compliance specifically targeting information regarding with whom the test was conducted. Greater attention will be focused on failed test results	· Add free text field for provider to indicate with whom the test was done Add test result pass/fail selection

Measure	Measure Title	Measure Description	Exclusion	Pre-Payment Audit Mechanism	Post-Payment Audit Mechanism	SLR support
CORE OBJ 14 (EH) EHCMU14	Protect electronic health info created or maintained by the certified EHR technology through the **implementation of appropriate technical capabilities**.	Conduct or review a **security risk analysis** in accordance w the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk mgmt process.	No Exclusions		Post payment audit based on risk or random sample will request and review a security risk analysis document for compliance	
CORE OBJ 15 (EP) EPCMU15	Protect electronic health info created or maintained by the certified EHR technology through the **implementation of appropriate technical capabilities**.	Conduct or review a security risk analysis in accordance w the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk mgmt process.	No Exclusions		Post payment audit based on risk or random sample will request and review a security risk analysis document for compliance	
MENU SET 1 (EH) EHMMU01	Implement **drug formulary checks**	The eligible hospital or CAH has enabled this functionality and has access to at least **one internal or external formulary** for the entire EHR reporting period.	No Exclusions		Post payment audit based on risk or random sample will request and review EHR data for compliance	Add a drop down box so the provider can identify of either internal or external formulary was enabled
MENU SET 1 (EP) EPMMU01	Implement **drug formulary checks**	The EP has enabled this functionality and has access to at least **one internal or external formulary** for the entire EHR reporting period.	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.	Validate the exclusion, when selected: Audit of MMIS FFS encounter claims data for reporting period to verify that < 100 Pharmacy claims were submitted	Post payment audit based on risk or random sample will request and review EHR data for compliance	Add a drop down box so the provider can identify of either internal or external formulary was enabled

Measure	Measure Title	Measure Description	Exclusion	Pre-Payment Audit Mechanism	Post-Payment Audit Mechanism	SLR support
MENU SET 2 (EH) EHMMU02	Record **advance directives** for patient **65 years old** or older.	More than **50%** of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient (POS21) have an indication of an **advance directive status recorded** as structured data.	An eligible hospital or CAH that admits no patients age 65 years old or older during the EHR reporting period.	Validate the exclusion, when selected: Audit of MMIS FFS encounter claims data for reporting period to verify that provider doesn't see patients in the reporting period 65 years or older Validate denominator for Menu Objective #5 is <= EHCMU 04, EHCMU 05, EHCMU 06	Post payment audit based on risk or random sample will request and review EHR data for compliance	
MENU SET 2 (EP) EPMMU02	Incorporate **clinical lab test results** into EHR as structured data.	More than **40%** of all **clinical lab test results** ordered by the EP 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.	An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.		Post payment audit based on risk or random sample will request and review EHR data for compliance - greater attention will be placed on selection of an exclusion	Create drop down list to include options for HIE, Other Electronic method, and Manual Entry
MENU SET 3 (EH) EHMMU03	Incorporate **clinical lab test results** into EHR as structured data.	More than **40%** of all **clinical lab test results** ordered by the an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS21 and 23) 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.	No Exclusions		Post payment audit based on risk or random sample will request and review EHR data for compliance	Create drop down list to include options for HIE, Other Electronic method, and Manual Entry

Measure	Measure Title	Measure Description	Exclusion	Pre-Payment Audit Mechanism	Post-Payment Audit Mechanism	SLR support
MENU SET 3 (EP) EPMMU03	Generate **lists of patients by specific condition** to use for quality improvement, reduction of disparities, research, or outreach	Generate at least **one report listing patients** of the EP with a **specific condition**.	No Exclusions		Post payment audit based on risk or random sample will request and review EHR data for compliance - validating the condition reported	Add free text field for provider to indicate specific condition(s)
MENU SET 4 (EH) EHMMU04	Generate **lists of patients by specific condition** to use for quality improvement, reduction of disparities, research, or outreach	Generate at least **one report listing patients** of the eligible hospital or CAH with a **specific condition**.	No Exclusions		Post payment audit based on risk or random sample will request and review EHR data for compliance - validate the condition reported	Add free text field for provider to indicate specific condition(s)
MENU SET 4 (EP) EPMMU04	Send **reminders** to patients per patient preference for preventive/follow-up care.	More than **20%** of all patients 65 years or older or 5 years old or younger were sent an appropriate **reminder** during the EHR reporting period.	An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.	Validate the exclusion, when selected: Audit of MMIS FFS encounter claims data for reporting period to verify that provider doesn't have patients encounters in the reporting period over 65years or older or 5 years old or younger Validate the denominator for Menu Objective #6 is = EPCMU 03, EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 05, EPMMU 06	Post payment audit based on risk or random sample will request and review a security risk analysis document for compliance	
MENU SET 5 (EH) EHMMU05	Use certified EHR technology to identify **patient-specific education resources** and provide those resources to the patient if appropriate.	More than 10 % of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency dept (POS 21 or 23) are **provided patient-specific education resources.**	No Exclusions	Validate denominator for Menu Objective is = EHCMU 03, EHCMU 04, EHCMU 05, EHCMU 06, EHMMU 05	Post payment audit based on risk or random sample will request and review EHR data for compliance	

Measure	Measure Title	Measure Description	Exclusion	Pre-Payment Audit Mechanism	Post-Payment Audit Mechanism	SLR support
MENU SET 5 (EP) EPMMU05	Provide patients with **timely electronic access** to their health information (including lab results, problem list, medication lists, medication allergies) within **4 business days** of the information being available to the EP	More than 10% of all unique patients seen by the EP are **provided timely** (available to the patient **within 4 business days** of being updated in the certified EHR technology) **electronic access** to their health information subject to the EP's discretion to withhold certain information	Any EP that neither orders nor creates lab tests or information that would be contained in the problem list, medication list, medication allergy list (or other info as listed at 45 CFR 170.304(g)) during the EHR reporting period	Validate denominator of Menu Objective #7 is = EPCMU 03, EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 05, EPMMU 06 Validate denominator of Menu Objective #7 is >= EPCMU 08, EPCMU 09, EPMMU04 If EPMMU 02 > 0, then no exclusion can apply to Menu Objective #7	Post payment audit based on risk or random sample will request and review EHR data for compliance - focus will be on providers that select exclusion. DHCS will request a "guided tour of the portal features if needed.	Add Yes/No question to ask if EP has an online patient portal
MENU SET 6 (EH) EHMMU06	The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should **perform medication reconciliation**	The eligible hospital or CAH **performs medication reconciliation** for more than **50%** of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).	No Exclusions	Validate denominator for Menu Objective is <= EHCMU 04, EHCMU 05, EHCMU 06, EHMMU 05	Post payment audit based on risk or random sample will request and review EHR data for compliance	
MENU SET 6 (EP) EPMMU06	Use certified EHR technology to identify **patient-specific education resources** and provide those resources to the patient if appropriate.	More than 10 % of all unique patients seen by the EP are **provided patient-specific education resources.**	No Exclusions	Validate the denominator of Menu Objective #8 is = EPCMU 03, EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 05, EPMMU 06 Validate denominator of Menu Objective is >= EPCMU 08, EPCMU 09, EPMMU04	Post payment audit based on risk or random sample will request and review EHR data for compliance	

Measure	Measure Title	Measure Description	Exclusion	Pre-Payment Audit Mechanism	Post-Payment Audit Mechanism	SLR support
MENU SET 7 (EH) EHMMU07	The eligible hospital or CAH that **transitions** their patient to another setting of care or provider of care or **refers** their patient to another provider of care should **provide summary care record for each transition of care or referral.**	The eligible hospital or CAH that **transitions or refers** their patient to another setting of care or provider of care **provides a summary of care record** for more than **50 %** of transitions of care and referrals.	No Exclusions		Post payment audit based on risk or random sample will request and review EHR data for compliance	
MENU SET 7 (EP) EPMMU07	The EP who **receives** a patient from another setting of care or provider of care or believes an encounter is relevant **should perform medication reconciliation**.	The EP **performs medication reconciliation** for more than **50 %** of transitions of care in which the patient is transitioned into the care of the EP.	An EP who was not the recipient of any transitions of care during the EHR reporting period.	Validate the denominator is < EPCMU 03, EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 05, EPMMU 06	Post payment audit based on risk or random sample will request and review EHR data for compliance - emphasis placed on providers that indicate an exclusion	
MENU SET 8 (EH) EHMMU08	Capability to **submit electronic data to immunization registries or Immunization Information Systems** and actual submission in accordance with applicable law and practice	Performed at least one test of the certified EHR technology's capacity to submit electronic data to **immunization registries** and follow-up submission if the test is successful (unless none of the immunization registries to which the eligible hospital or CAH submits such information have the capacity to receive such information electronically)	An eligible hospital or CAH that administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.	Validate the exclusion, when selected: Audit of MMIS FFS encounter claims data for reporting period to verify that provider doesn't have immunization encounters in the reporting period DHCS will work with DPH to validate At least one public health measure must be selected by provider		

Measure	Measure Title	Measure Description	Exclusion	Pre-Payment Audit Mechanism	Post-Payment Audit Mechanism	SLR support
MENU SET 8 (EP) EPMMU08	The EP that **transitions** their patient to another setting of care or provider of care or **refers** their patient to another provider of care should **provide summary care record for each transition of care or referral.**	The EP that **transitions or refers** their patient to another setting of care or provider of care **provides a summary of care record** for more than **50 %** of transitions of care and referrals.	An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.	Validate the denominator is < EPCMU 03, EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 05, EPMMU 06	Post payment audit based on risk or random sample will request and review EHR data for compliance - focus will be on providers that select exclusion.	Add drop down for pre-defined list of exclusions and require provider to select from list if they indicate an exclusion
MENU SET 9 (EH) EHMMU09	Capability to submit electronic data on reportable (as required by state or local law) **lab results** to public health agencies and actual submission in accordance with applicable law and practice	Performed at least one test of certified EHR technology's capacity to **provide submission of reportable lab results** to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which the eligible hospital or CAH submits such information have the capacity to receive such information electronically)	No public health agency to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically.	Validate the exclusion - determine why DPH wasn't able to test At least one public health measure must be selected by provider		Add drop down list for public health agencies specific to the state Add Yes/No question to determine if test was successful Add Yes/No question to ask about follow up submission if test was successful Add drop down for pre-defined list of exclusions and require provider to select from list if they indicate an exclusion

Measure	Measure Title	Measure Description	Exclusion	Pre-Payment Audit Mechanism	Post-Payment Audit Mechanism	SLR support
MENU SET 9 (EP) EPMMU09	Capability to **submit electronic data to immunization registries or Immunization Information Systems** and actual submission in accordance with applicable law and practice	Performed at least one test of the certified EHR technology's capacity to submit electronic data to **immunization registries** and follow-up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive such information electronically)	An EP that administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.	Validate the exclusion, when selected: Audit of MMIS FFS encounter claims data for reporting period to verify that provider doesn't have immunization encounters in the reporting period DHCS will work with DPH to validate At least one public health measure must be selected by provider		Add drop down list for immunization registries specific to the state Add Yes/No question to ask about follow up submission if test was successful Add drop down for pre-defined list of exclusions and require provider to select from list if they indicate an exclusion
MENU SET 10 (EH) EHMMU10	Capability to **submit electronic syndromic surveillance data** to public health agencies and actual submission in accordance with applicable law and practice	Performed **at least one test** of certified EHR technology's capacity to **provide electronic syndromic surveillance data to public health agencies** and follow-up submission if the test is successful (unless none of the public health agencies to which an eligible hospital or CAH submits such information have the capacity to receive such information electronically)	No public health agency to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically.	Validate all exclusions – DHSS currently does not have electronic syndromic surveillance reporting in place At least one public health measure must be selected by provider		

Measure	Measure Title	Measure Description	Exclusion	Pre-Payment Audit Mechanism	Post-Payment Audit Mechanism	SLR support
MENU SET 10 (EP) EPMMU10	Capability to **submit electronic syndromic surveillance data** to public health agencies and actual submission in accordance with applicable law and practice	Performed **at least one test** of certified EHR technology's capacity to **provide electronic syndromic surveillance data to public health agencies** and follow-up submission if the test is successful (unless none of the public health agencies to which the EP submits such information have the capacity to receive such information electronically)	An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such info to any public health agency that has the capacity to receive the info electronically.	Validate all exclusions– DHSS currently does not have electronic syndromic surveillance reporting in place At least one public health measure must be selected by provider		

APPENDIX M MEANINGFUL USE SCREEN SHOTS

Due to the number of screenshots and the size of the file, the MU screenshots are available in a separate file: “Appendix_M_MUScreens 092011.docx”

APPENDIX N MU GAPS

The gaps included in the table below respond to CMS feedback regarding the MU Attestation Screens, CMS Design Recommendations and modifications identified by the states participating in the design of the SLR.

These modifications are expected to be available in the SLR when it is implemented on January 2, 2012 to begin accepting MU attestations.

Page/Screen	Source of change	Proposed modification
Confirm Medicaid Eligibility	CMS feedback/ recommendations and client request	Add functionality for providers to enter encounters by location for the 90-day period and to indicate which locations have certified EHR technology
Certified EHR Technology	Jessica Kahn's feedback	Update the wording related to the number to reflect the correct process
EHR Reporting Period	Jessica Kahn's feedback	Ensure 90-day period is enforced and provider can't put in less than 90 days
EHR Reporting Period	CMS Design Recommendations	• Pull in location info entered in Confirm Medicaid Eligibility screen and have provider submit numerator and denominator for each site for total patients for the reporting period • Add numerator and denominator for number of unique patients with records in EHR
MU Attestation	CMS Design Recommendations	The real time notification of MU doesn't occur until the provider saves the data. All saves are stored. The SLR will flag multiple entries for the same measure as an exception. The state will review and clear all exceptions prior to the SLR the D16 transaction submission. The state will flag providers that make frequent changes for audit.
EP/EH Core Objective #3	CMS Design Recommendations	• Add fields for capturing numerator for both problem and no problem
EP Core Objective #4	CMS Design Recommendations	• Add two free text fields to capture which eRx service is used and a pharmacy the EP transmits to
EP Core	CMS Design	• Add fields for capturing numerator for

Page/Screen	Source of change	Proposed modification
Objective #5/ EH Core Objective #4	Recommendations	both medication and no medication
EP Core Objective #6/ EH Core Objective #5	CMS Design Recommendations	• Add fields for capturing numerator for both medication allergy and no medication allergy
EP Core Objective #7/ EH Core Objective #6	CMS Design Recommendations	• Add field to capture count from the numerator (if any) of unique patients with most but not all demographic information entered as structured data • Add drop down for pre-defined list of reasons not all data was captured (Patient Declined or Contrary to State Law)
EP Core Objective #8/ EH Core Objective #7	CMS Design Recommendations	• Add drop down for pre-defined list of exclusions and require provider to select from list if they indicate an exclusion
EP Core Objective #10/ EH Core Objective #9	Jessica Kahn's feedback	Update language to reflect reporting to States.
EP Core Objective #10	CMS Design Recommendations	• Add free text field to capture which Clinical Quality Measure (CQM)
EP Core Objective #11/ EH Core Objective #10	CMS Design Recommendations	• Add free text field for provider to indicate which CDS rule was implemented
EP Core Objective #14/ EH Core Objective #13	CMS Design Recommendations	• Add free text field for provider to indicate with whom the test was done • Add test result pass/fail selection
EP Menu Objective #2/ EH Menu Objective #3	CMS Design Recommendations	• Create drop down list to include options for HIE, Other Electronic method, and Manual Entry
EP Menu Objective #3/	CMS Design	• Add free text field for provider to indicate

Page/Screen	Source of change	Proposed modification
EH Menu Objective #4	Recommendations	specific condition(s)
EP Menu Objective #5	CMS Design Recommendations	• Add Y/N question to ask if EP has an online patient portal • Add verification process as part of pre-payment to address what type of information patient has access to and ask for guest access
EP Menu Objective #8/ EH Menu Objective #7	CMS Design Recommendations	• Add drop down for pre-defined list of exclusions and require provider to select from list if they indicate an exclusion
EP Menu Objective #9/ EH Menu Objective #8	CMS Design Recommendations	• Add drop down list for immunization registries specific to the state • Add Y/N question to determine if test was successful • Add Y/N question to ask about follow up submission if test was successful • Add drop down for pre-defined list of exclusions and require provider to select from list if they indicate an exclusion
EH Menu Objective #9	CMS Design Recommendations	• Add drop down list for public health agencies specific to the state • Add Y/N question to determine if test was successful • Add Y/N question to ask about follow up submission if test was successful • Add drop down for pre-defined list of exclusions and require provider to select from list if they indicate an exclusion
EP Menu Objective #10/ EH Menu Objective #10	CMS Design Recommendations	• Add drop down list for syndromic surveillance agencies specific to the state • Add Y/N question to determine if test was successful • Add Y/N question to ask about follow up submission if test was successful • Add drop down for pre-defined list of exclusions and require provider to select from list if they indicate an exclusion

APPENDIX O: ACRONYMS

Acronym	Description
A/I/U	Adopt, Implement, and Upgrade
AAC	Alaska Administrative Code
AAFP	American Academy of Family Physicians
AAP	American Academy of Pediatrics
AARP	American Association of Retired Persons
ACHIN	Alaska Community Health Integrated Network
ACS	Affiliated Computer Systems
AeHN	Alaska electronic Health Network
AeHRA	Alaska electronic Health Records Association
AHCC	Alaska Health Care Commission
AI/AN	American Indian/Alaska Native National Regional Extension Center
AKAIMS	Alaska Automated Information Management System
AKSAS	Alaska State Accounting System
AKSTARS	
AOBP	American Osteopathic Board of Pediatrics
ANMC	Alaska Native Medical Center
ANTHC	Alaskan Native Tribal Health Consortium
APCA	Alaska Primary Care Association
AR:	Accounts receivable
ARRA:	American Recovery and Reinvestment Act of 2009
ASMA	Alaska State Medical Association
ATAC	Alaska Telehealth Advisory Council
AVAHS	Alaska Veterans Administration Healthcare System
BIP	US Department of Agriculture Broadband Initiative Program

Acronym	Description
BMI	Body Mass Index
CAH	Critical Access Hospital
CCHIT:	Certification Commission for Health Information Technology
CCD	Continuity of Care Documents
CCN	CMS Certification Number
CDC:	Centers for Disease Control
CDS	Clinical Decision Support
CFR	Code of Federal Regulations
CHC	Community Health Center
CHIP:	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CHPL	Certified Health IT Products Listing
CMS	Centers for Medicare & Medicaid Services
CoP	Community of Practice
CPOE	Computerized Physician Order Entry
CPT	Current Procedural Terminology
CQM	Clinical Quality Measure
CRG	Craciun Research Group
CWG	Clinical Work Group
DDI	Design, Develop, Implementation
D.O.	Doctor of Osteopathic Medicine
DHCS	Division of Health Care Services
DHSS	Department of Health and Social Services
DOD	Department of Defense
DOD VA	Department of Defense Veterans Administration

Acronym	Description
DPH	Division of Public Health
DPA	Division of Public Assistance
DSS:	Decision Support System
DW	Data Warehouse
ebXML	Electronic Business Extensible Markup Language
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
EH	Eligible Hospital
EHR	Electronic Health Record
EKG	Electro Cardiogram
ELR	Electronic Laboratory Reports or Reporting
EMR	Electronic Medical Records
EP	Eligible Professional
EPE	Electronic Provider Enrollment
ePHI	Electronic Protected Health Information
EPLS	Excluded Parties List System
EPSDT	Early Periodic Screening, Diagnosis, and Treatment Program
ER	Emergency Room
ETL	Extract, Transform, Load
FA	Fiscal Agent
FAQ	Frequently Asked Questions
FCC	Federal Communication Commission
FFP:	Federal Financial Participation
FFS	Fee for Service
FFY	Federal Fiscal Year

Acronym	Description
FQHC:	Federally Qualified Health Center
GAGAS	Generally Accepted Government Accounting Standards
HCP	Health Care Providers
HIE	Health Information Exchange
HIMSS	Health Information Management and Systems Society
HIPAA	Health Insurance Portability and Accountability Act
HISPC:	Health Information Security and Privacy Collaborative
HIT:	Health Information Technology
HITECH:	Health Information Technology for Economic and Clinical Health Act
HL7	Health Level Seven
HRSA:	Health Resources and Services Administration
HSS IT	Health and Social Services Information Technology
IAPD:	Implementation Advance Planning Document
ICD-10:	International Classification of Diseases and Related Health Problems, 10th Revision
IHS:	Indian Health Services
IRS:	Internal Revenue Service
IT:	Information Technology
IVR	Interactive Voice Response
JCAHO	Joint Commission on Accreditation of Health Care Organizations
JSURS	Java Surveillance Utilization Review System
LIMS	Laboratory Information Management System
LLC	Limited Liability Corporation
LOS	Length of Stay
LOINC	Logical Observation Identifiers Names and Codes
MAR:	Management and Administrative Reporting System

Acronym	Description
MCC	Multiple Chronic Conditions
MCI	Master Client Index
MD	Medical Doctor
MFCU	Medicaid Fraud Control Unit
MITA	Medicaid Information Technology Architecture
MMIS	Medicaid Management Information System
MPF	Master Provider File
MPI	Master Provider Index
MU	Meaningful Use
NETSS	National Electronic Telecommunications System for Surveillance
NHIN:	National Health Information Network
NwHIN	Nationwide Health Information Network
NIHB	National Indian Health Board
NLR:	National Level Repository
NNDSS	National Notifiable Diseases Surveillance System
NPI:	National Provider Identifier
NPPES:	National Plan and Provider Enumeration System
NPRM	Notice of Proposed Rule Making
NTIA	National Telecommunications and Information Administration
OIG	Office of the Inspector General
ONC	Office of the National Coordinator for Health Information Technology
PA	Physician's Assistant
PACS	Picture Archiving and Communication System
PC Agency	Primary Care Agency
PEP	Provider Enrollment Portal

Acronym	Description
PERM	Payment Error Rate Measurement
PHR	Personal Health Record
PHIN MS	Public Health Information Network Messaging System
PI:	Program Integrity
PMF	Provider Master File
POS	Place of Service
PPACA	Patient Protection and Affordable Care Act
REC:	Regional Extension Center
RFP:	Request for Proposal
RHC:	Rural Health Clinic
RHIO:	Regional Health Information Organization
RPMS:	Resource and Patient Management System
RTI	Research Triangle Institute
R&S	Research and Support
SaaS	Software as a Service
SB	Senate Bill
SDE	State Designated Entity
SDS	Senior and Disabled Services
SLR	State Level Registry
SMHP	State Medicaid Health Information Technology Plan
SMHPU	State Medicaid Health Information Technology Plan Update
SMA	State Medicaid Agency
SMM	State Medicaid Manual
SNF/ICF	Skilled Nursing Facility/Intermediate Care Facility
SNOMED	Systematized Nomenclature of Medicine

Acronym	Description
SOA	Service Oriented Architecture
SQL	Structured Query Language
SS-A:	MITA State Self-Assessment
SSL	Secure Socket Layer
STARS	Services Tracking and Reporting Systems
SURS:	Surveillance Utilization Review System
TCC	Tanana Chiefs Conference
T-CHIC	Tri-State Children's Health Improvement Consortium
TIN:	Taxpayer Identification Number
TPL	Third Party Liability
UAT	User Acceptance Testing
USAC	Universal Service Administrative Company
USDHHS	United States Department of Health and Human Services
VA	Veterans Administration
VistA:	Veterans Health Information Systems and Technology Architecture
VLER	Virtual Lifetime Electronic Record
VOIP	Voice over Internet Protocol
WWAMI	Washington, Wyoming, Alaska, Montana, and Idaho
X12	ANSI standard that supplies that structure to EDI transactions
XML	Extensible Markup Language

APPENDIX P: GLOSSARY

Electronic Health Record (EHR): A subset of each care delivery organization's EMR, presently assumed to be summaries, like the Continuity of Care Record or the Continuity of Care Document, is owned by the patient and has patient input and access that spans episodes of care across multiple care delivery organizations within a community, region, or state (or in some countries, the entire country). The EHR in the United States will ride on the proposed National Health Information Network (NHIN).

Electronic Medical Record (EMR): An application environment composed of the clinical data repository, clinical decision support, controlled medical vocabulary, order entry, computerized provider order entry, pharmacy, and clinical documentation applications. This environment supports the patient's EMR across inpatient and outpatient environments, and is used by healthcare practitioners to document, monitor, and manage healthcare delivery within a care delivery organization. The data in the EMR is the legal record of what happened to the patient during their encounter at the care delivery organization and is owned by the care delivery organization.

Health Information Exchange (HIE): the mobilization of healthcare information electronically across organizations within a region, community or hospital system. HIE provides the capability to electronically move clinical information among disparate healthcare information systems while maintaining the meaning of the information being exchanged. The goal of HIE is to facilitate access to and retrieval of clinical data to provide safer, more timely, efficient, effective, equitable, patient-centered care. HIE is also useful to multiple public health authorities to assist in analyses of the health of the population and the effectiveness of treatments.

Health Information technology (HIT): encompasses a broad array of technologies involved in managing and sharing patient information electronically, rather than through paper records and non-standard transmittals.

Survey Monkey Online survey tool