STATE OF ALASKA

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

STATE MEDICAID HIT PLAN UPDATE (SMHPU)

Version .06
Date: February 18, 2013

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REVISION HISTORY

Version Number	Date	Reviewer	Comments
.05	1/8/2013		Initial Submission
.06	2/18/2013	CMS	Update per 2/13/2013 comments

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1.0 SMHP Update Document Purpose

Alaska Department of Health & Social Services (DHSS) has prepared this State Medicaid Health Information Technology Plan Update (SMHPU) to inform the Centers for Medicare and Medicaid Services (CMS) of the plans to support the Electronic Health Record (EHR) Incentive Payment Program due to changes in Stage 2 Meaningful Use necessary in 2013. DHSS anticipates a subsequent update will be necessary as the complete implementation of the remaining rule changes take place.

This document contains only the updates to the SMHPU Version 2.02 approved in July 2012, determined to be necessary to implement 2013 program changes. Readers should refer to the SMHPU Version 2.02 for complete program information.

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

2.1 Concept of Operations

2.1.1 Recent Changes in State Laws or Regulations

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.

DHSS has prepared a rule modification to support the 2013 Stage 2 Meaningful Use Rule changes. The modification refers to the 45 Code of Federal Regulations (CFR) 495.302 - 495.306 revised on September 4, 2012. The amended rule also refers to 42 CFR 495.4 the revised definition of “hospital based”, the 42 CFR 495.6 changes to the type of provider, and replaces references to “Medicaid covered service” to “services” to be consistent with the Stage 2 final rule. Additionally, the revisions allow the State to terminate or suspend participation in the Alaska Medicaid Program should the provider be found deficient in any program area, while preserving the provider’s right to appeal such a decision.

The full text of the proposed regulation change is included in Appendix A.

The regulation additions have been developed and published for public comment under the title “Electronic Health Records Incentive Program 7AAC165” as required by state statute. The regulation revisions will be effective on January 20, 2013. The revisions will be in place prior to issuing 2013 incentive payments to providers.

2.2 Provider Eligibility for Incentive Payments

Determining patient volume is a critical component of establishing eligibility for incentive payment. Medicaid encounters that comprise patient volume are defined consistent with the final rule and include encounters for which Medicaid paid in whole or in part, such as those within Medicaid fee-for-service, 1115 waiver programs (includes Title XIX and Title XXI funded Medicaid expansions), and certain zero-pay claims. Zero-pay claims include:

- Claims denied because the Medicaid beneficiary has achieved maximum service limits
- Claims denied because the service wasn’t covered under the State’s Medicaid Program

- Claims paid at $0 because another payer's payment exceeded the Medicaid payment (third party liability)
- Claims denied because the claim was not submitted timely.

DHSS will also allow encounters where the services rendered on any one day to a Medicaid-enrolled individual regardless of the payment liability (Medicaid recipient seen but Medicaid not billed as the service not a Medicaid covered service). The provider will be responsible for providing proof of these patient encounters. DHSS will use the "encounter" option (as described in the final rule) for all eligible professionals.

2.2.1 Eligible Provider Types

Provider type program eligibility is based on the provider type and specialty associated with the provider in the Medicaid Management Information System (MMIS) system. Pediatricians are an exception. DHSS 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.

The Alaska EHR Incentive Program Registration component of the State Level Registry (SLR) web site will be limited to the following MMIS provider types:

Table 1: Eligible Provider Types/Specialty Types

Eligible Entity per Final Rule	MMIS Provider Type	MMIS Specialty Type	Comment
Physician	20	All	
Physician Assistant (practicing in a Federally Qualified Health Center (FQHC) or Rural Health Centers (RHC) led by a Physician Assistant(PA)	20	730	Medical Physician Assistant
Pediatrician	20 20	038 041 042 043 049 129 123	Pediatrics Allergy-Pediatric
Nurse Practitioner	68	All	
Certified Nurse Midwife	38	099	
Dentist	30	All	
Acute Care Hospital	01 04 05 07 08	see Comment	All Alaska Hospitals and types listed in Appendix B

Eligible Entity per Final Rule	MMIS Provider Type	MMIS Specialty Type	Comment
Critical Access Hospital(CAH)	01 04 05 07 08	see Comment	All Alaska Hospitals and types listed in Appendix B
Children's Hospital	01 04 05 07 08	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 28 and 29
- Chiropractor – Provider type 25 and 24
- 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).

2.2.2 Methodology for Eligible Professional Patient Volume

DHSS has adopted the Final Rule CMS patient volume definition for the Alaska EHR Incentive Program.
Eligible Professionals (EPs) will need to meet patient volume thresholds to be eligible for incentive payments.

- The Alaska patient volume thresholds are calculated using as the numerator the individual EP's total number of Alaska Medicaid encounters in any consecutive 90-day period in the previous full calendar year or in the most recent 12 month period preceding attestation, or any consecutive 3 month period greater than or equal to 90 days and the denominator is all patient encounters for the same individual professional over the same selected time period.
- EPs who work predominantly in FQHCs or RHCs may meet "needy individual" volume requirements when the clinical location for over 50% of his/her total patient encounters over a period of 6 months in the prior calendar year occurs at an FQHC or RHC. 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.
- DHSS 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.

- DHSS will validate the provider patient volume numerator by evaluating the number of Medicaid claims submitted by the provider during the time 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. DHSS does not have an independent source of validation for the EP denominator; these will be audited in program post-payment audit.
- 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.
- Hospital based EP's could be eligible starting in 2013 if they meet the CMS guidelines. If the EP can demonstrate use of their own funds for acquisition, implementation and maintenance of certified EHR technology, although they may be "hospital based", they may be eligible for an EHR Incentive Payment.
- DHSS 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.

2.2.3 Methodology for Eligible Hospital Patient Volume

Eligible Hospitals (EHs) will also need to meet 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).

A number of items will be verified for EHs, including:

- A Medicare CMS Certification Number (CCN) in the appropriate range.
- Average length of stay and Medicaid volume based MMIS data.
- A state-issued provider number.

For Acute Care and Critical Access Hospitals to meet the required 10 percent Medicaid volume, AK allows hospitals to calculate volume based on patient discharges, including ER visits that result in inpatient stays

2.2.4 Medicaid Stage 1 Meaningful Use Changes

DHSS recognizes that Stage 2 Final Rule will require some changes to SLR related to system attestation criteria to process Stage 1 MU attestations beginning in 2013. DHSS has conducted an assessment of Stage 1 changes published in the Stage 2 Final Rule. AK DHSS and Xerox State Healthcare, LLC have submitted proposed SLR changes for CMS approval in an online walkthrough. SLR screen changes presented for CMS approval are included in Appendix C.

Stage 2 Final Rule, CMS finalized the ability to use a batch reporting process for meaningful use, which will allow groups to submit attestation information for all of their individual EPs in one

file. DHSS will investigate the feasibility of accepting batch attestations; no decision is available until this analysis is complete.

The Stage 1 Meaningful Use changes planned by DHSS and Xerox State Healthcare, LLC are outlined in the table below.

Table 2: Analysis of Meaningful Use Stage 1 Changes

Proposed Change	Comments/Status
Children's Hospital definition is revised to include any separately certified hospital, freestanding or hospital within a hospital that predominately treats individuals under age 21 without a CMS certification number because these facilities do not serve Medicare beneficiaries. These hospitals will be issued an alternative number by CMS to enroll in the incentive program. There is potential change to CMS interface to accept new number.	No change anticipated, no Children's Hospitals have been identified in Alaska. DHSS has worked closely with each Alaska hospital to determine program eligibility.
At least 50% of EP outpatient encounters used for EP patient volume is required at a location equipped with certified EHR technology during the payment year for which the EP is attesting.	No system change required. The existing functionality in SLR verifies 50% of encounters are at locations with certified EHR technology.
The rule expands the definition of what constitutes a Medicaid patient encounter, which is a required eligibility threshold to include zero pay claims.	No system change required. DHSS will recognize the expanded definition of encounters for EPs. The existing functionality in SLR accepts total number of encounters reported. User manual and help text will be revised to include the expanded definition of encounters for EPs.
90 day representative period – Add an option for providers to elect to use either a 90 day period in the previous calendar year or a 90 day period in the 12 months immediately preceding the attestation.	This is an either/or scenario. DHSS will allow this option. EPs electing to use the most recent 90 day period for MU reporting may have approval delayed due to claims lag until DHSS is able to validate claims volume. System change is required to capture the selected 90 day period.
Panel Member encounters change from previous 12 months to previous 24 months	This change does not apply as there is no Managed Care in Alaska
Hospital based EP revision: EPs who can demonstrate that they fund the acquisitions, implementation, and maintenance of CEHRT, including supporting hardware and interfaces needed for meaningful use without reimbursement from an eligible hospital or CAH —and use such CEHRT at a hospital, in lieu of using the hospital's CEHRT—can be determined non-hospital based and receive an incentive payment.	Minimal impact. SLR sample text is included in the Appendix C screen shots.

Proposed Change	Comments/Status
EH Calculation to allow use of information from the most recent continuous 12 month period	DHSS will continue to use cost reports from prior year to calculate EH payments; information on discharges within the most recent continuous 12 month period will not be allowed.
Allow Hospitals to switch States – Include capability to capture historical information from another state and use captured data to calculate the hospital incentive payment from the previous state and year to ensure the calculated amount is correct.	DHSS has no knowledge of other hospitals wanting to change states and apply through the AK program. If AK is contacted by a hospital in another state DHSS will work with the provider to accommodate this requirement.
CMS proposed MU auditing/ appeals for Medicaid only hospitals.	No change. AK DHSS plans to allow CMS to do the EH MU auditing/appeals. Alaska has submitted a signed agreement in Appendix D requesting CMS to conduct post-payment hospital audits.
Stage 1 Computerized Physician Order Entry (CPOE) alternate objective: more than 30% of medication orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE).	Optional for 2013 forward for providers attesting to Stage 1 of MU. Screen shot in Appendix C includes the SLR revision.
Stage 1 ePrescribing – Add an exclusion for any EP who does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period.	Required for 2013 forward for EPs attesting to Stage 1 of MU. Screen shot in Appendix C includes the exclusion text for the SLR system change.
Stage 1 Vital Signs change – add second denominator definition with ability for EP to indicate which denominator is being used for reporting. More than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department during the EHR reporting period have blood pressure for patients age 3 and over only and height and weight for all ages recorded as structured data. (Optional)	Optional for 2013 only. Screen shot in Appendix C includes the SLR revision.
Stage 1 Vital Signs exclusions change – Modify exclusions to allow BP to be separated from height/weight. Any EP who 1) sees no patients 3 years or older is excluded from recording blood pressure; 2) Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them; and 3) Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure, or 4) Believes that blood	Optional for 2013 only. Screen shot in Appendix C includes the SLR revision

Proposed Change	Comments/Status
pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording weight and weight. (Optional)	
Stage 1 Test of electronic transmission of key clinical information. (Mandatory removal for 2013 and beyond)	Mandatory removal for 2013 and beyond. Screen shot in Appendix C includes the SLR revision
Stage 1 Report ambulatory (hospital) clinical quality measures to CMS or the states (Mandatory removal for 2013 and beyond)	Mandatory removal for 2013 and beyond. Screen shot in Appendix C includes the SLR revision.
Stage 1 Public Health Objectives (Mandatory removal for 2013 and beyond)	Mandatory for 2013 and beyond. Screen shot in Appendix C includes the SLR revision.

2.2.5 Medicaid Stage 2 Meaningful Use

DHSS will continue to work with Xerox State Healthcare, LLC to determine how additional Stage 2 requirements will be implemented in the SLR. DHSS will update its SMHPU at a later date to include plans and implementation dates for meeting the remainder of Stage 2 requirements.

2.2.6 Allowed Attestation Grace Period

DHSS will allow EPs to submit their EHR Incentive Payment program attestation up to 60 days beyond the calendar year. For example, EPs can select any representative, consecutive three month period that is greater than or equal to 90 days in the previous calendar year or in the most recent 12 month period preceding attestation or one full year to demonstrate patient volume for program attestation until March 1, 2013.

DHSS 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 any representative, consecutive three month period that is greater than or equal to 90 days in the previous full calendar year or in the most recent 12 month period preceding attestation or one full year in FFY 2011 to demonstrate Medicaid patient volume for program attestation until December 31, 2011. DHSS will allow EH's to select a 60 day or greater period in FFY 2012 to demonstrate Medicaid patient volume until November 29, 2012.

2.3 Provider Payment Calculations

2.3.1 Eligible Professionals (EPs) Payment Calculations

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 Pediatricians qualifying at the lower patient volume 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 EPs may have difficulty producing data for a 90 day period due to capabilities of their software and other entity reporting requirements. DHSS will also allow EPs to use any representative, consecutive three month period that is greater than or equal to 90 days in the previous full calendar year or in the most recent 12 month period preceding attestation or one full year for calculating patient volume and meeting meaningful use requirements if this is practical and advantageous for the professional or group.

2.3.2 Eligible Hospitals (EHs) Payment Calculations

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

DHSS 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. DHSS will also allow hospitals to select any representative, consecutive three month period that is greater than or equal to 90 days in the previous full calendar year or in the most recent 12 month period preceding attestation or one full year for calculating patient volume and meeting meaningful use requirements if this is practical and advantageous for the hospital.

2.4 Hospital Attestation Tip Sheet

The DHSS 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, as well as Children's Hospitals that do not have a CCN but have an alternate number assigned by CMS.

The hospital Medicaid patient volume is established by selecting any representative, consecutive three month period that is greater than or equal to 90 days in the previous full calendar year or in the most recent 12 month period preceding attestation or one full year 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 Title XIX 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 Alaska Tribal Hospitals will use modified cost reports. A Tribal Hospital Tip Sheet made available to assist Tribal hospitals completing attestation is included in Appendix E.

2.5 E-Prescribing

Alaska will implement the e-prescribing MU exclusion for any EP who does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period. DHSS will leverage monthly Surescripts e-prescribing pharmacy data to validate the exclusion.

APPENDIX A: ALASKA RULE CHANGE NOTIFICATION

Alaska Medicaid Electronic Health Record Incentive Program

NOTICE OF PROPOSED CHANGES IN THE REGULATIONS OF THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES

BRIEF DESCRIPTION
The Department of Health and Social Services proposes regulations on electronic health record incentives and requirements for Medicaid providers.

The Department of Health and Social Services proposes to adopt regulation changes in Title 7, Chapters 165, of the Alaska Administrative Code, dealing with the Alaska Medicaid Electronic Health Record Incentive Program, including:

7 AAC 165.010, Participation in the Alaska Medicaid electronic health record incentive program, is proposed to be amended to update the participation requirements for providers with the new final rule issued by the Centers for Medicare and Medicaid Services on September 6, 2012.

7 AAC 165.020, Provider registration and attestation, is proposed to be amended to change the attestation requirements for first time participants with the new final rule issued by the Centers for Medicare and Medicaid Services on September 6, 2012.

7 AAC 165.040, Incentive payments, is proposed to be amended to revise the incentive payment requirements in accordance with the new final rule issued by the Centers for Medicare and Medicaid Services on September 6, 2012.

7 AAC 165.050, Program standards for continuing participation, is proposed to be amended to revise the actions the department may take if a provider is deficient in any of the program participation requirements.

7 AAC 165.080, Appeals, is proposed to be amended to revise the reasons for which a provider may appeal a department decision.

7 AAC 165.900, Definitions, is proposed to be amended to revise definitions relating to the Alaska Medicaid electronic health record incentive program in accordance with the new final rule issued by the Centers for Medicare and Medicaid Services on September 6, 2012.

You may comment on the proposed regulation changes, including the potential costs to private persons of complying with the proposed changes, by submitting written comments to JoLynn Cagle, Division of Health Care Services, 3601 C Street, Suite 902, Anchorage, AK 99503; Email: jolynn.cagle@alaska.gov

The comments must be received no later than 4:00 p.m. on November 19, 2012.

If you are a person with a disability who needs a special accommodation in order to participate in this process, please contact JoLynn Cagle at the address above or by phone at (907) 334-4489 no later than November 14, 2012 to ensure that any necessary accommodations can be provided.

For a copy of the proposed regulation changes, contact JoLynn Cagle at the address, phone number, or E-mail address above, or go to the Department of Health and Social Services public notice website at: http://hss.state.ak.us/apps/publicnotice/regulations.aspx

After the public comment period ends, the Department of Health and Social Services will either adopt

these or other provisions dealing with the same subject, without further notice, or decide to take no action on them. The language of the final regulations may be different from that of the proposed regulations. YOU SHOULD COMMENT DURING THE TIME ALLOWED IF YOUR INTERESTS COULD BE AFFECTED.

Statutory Authority: AS 47.05.010, AS 47.07.030, AS 47.07.040.
Statutes Being Implemented, Interpreted, or Made Specific: AS 47.05.010, AS 47.07.030, AS 47.07.040.
Fiscal Information: The proposed regulation changes are not expected to require an increased appropriation.

Date: 10/15/2012

/s/William J. Streur, Commissioner
Department of Health and Social Services

APPENDIX B ALASKA HOSPITALS AND HOSPITAL TYPES

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

Note that no hospitals in Alaska are categorized as “Children’s Hospitals” at this time.

APPENDIX C: REVISED SLR SCREEN SHOTS

The revised SLR screen shots are included in this appendix.

A list of the changes are provided in the sequences of the screen shots.

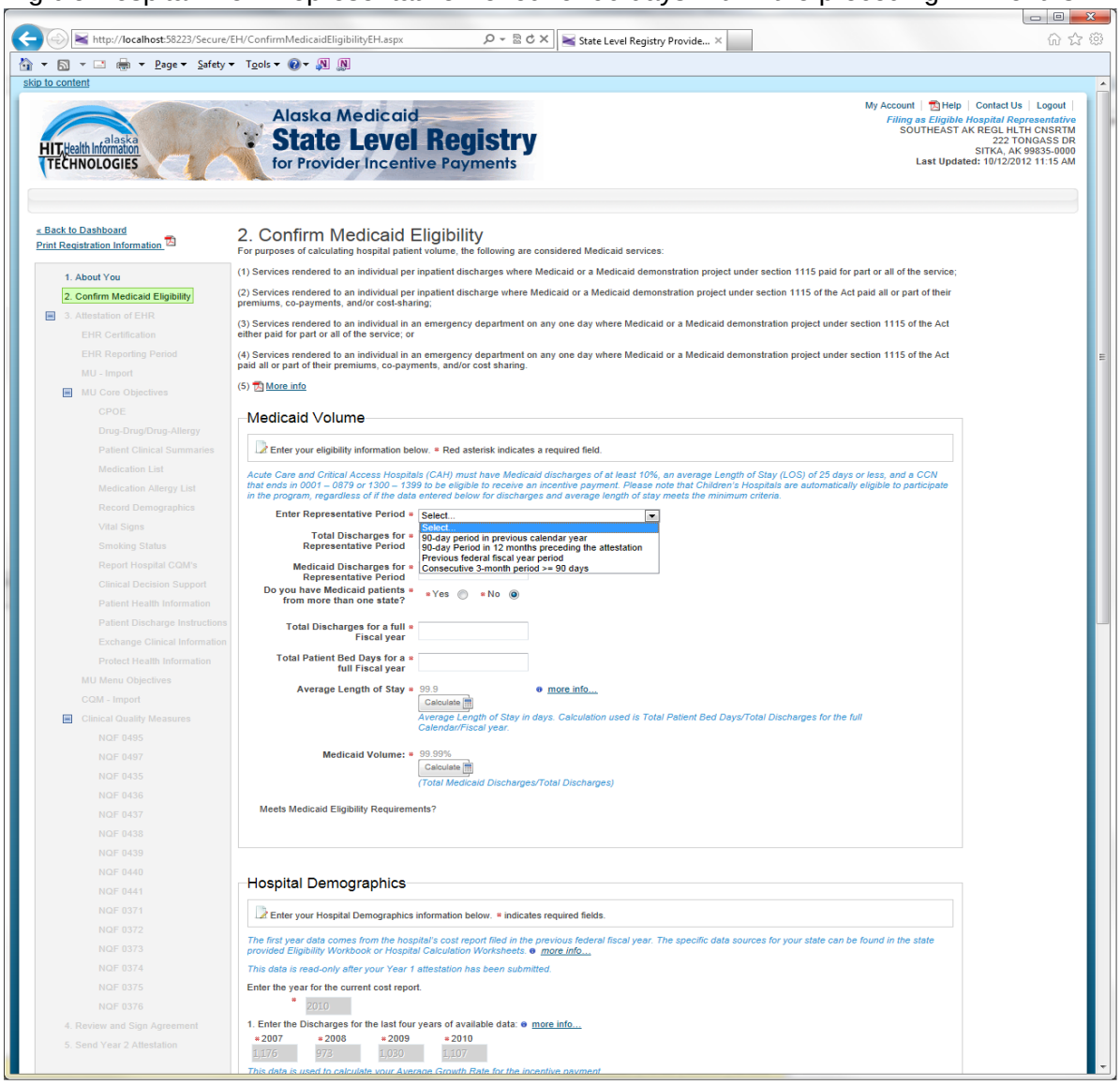
Eligible Hospitals:

- New Representative Period for 90 days within the preceding 12 months
- CPOE Alternate Measure
- CPOE with Alternate measure selected
- Immunization Registry
- Reportable Labs
- Syndromic Surveillance
- Eliminated Objectives

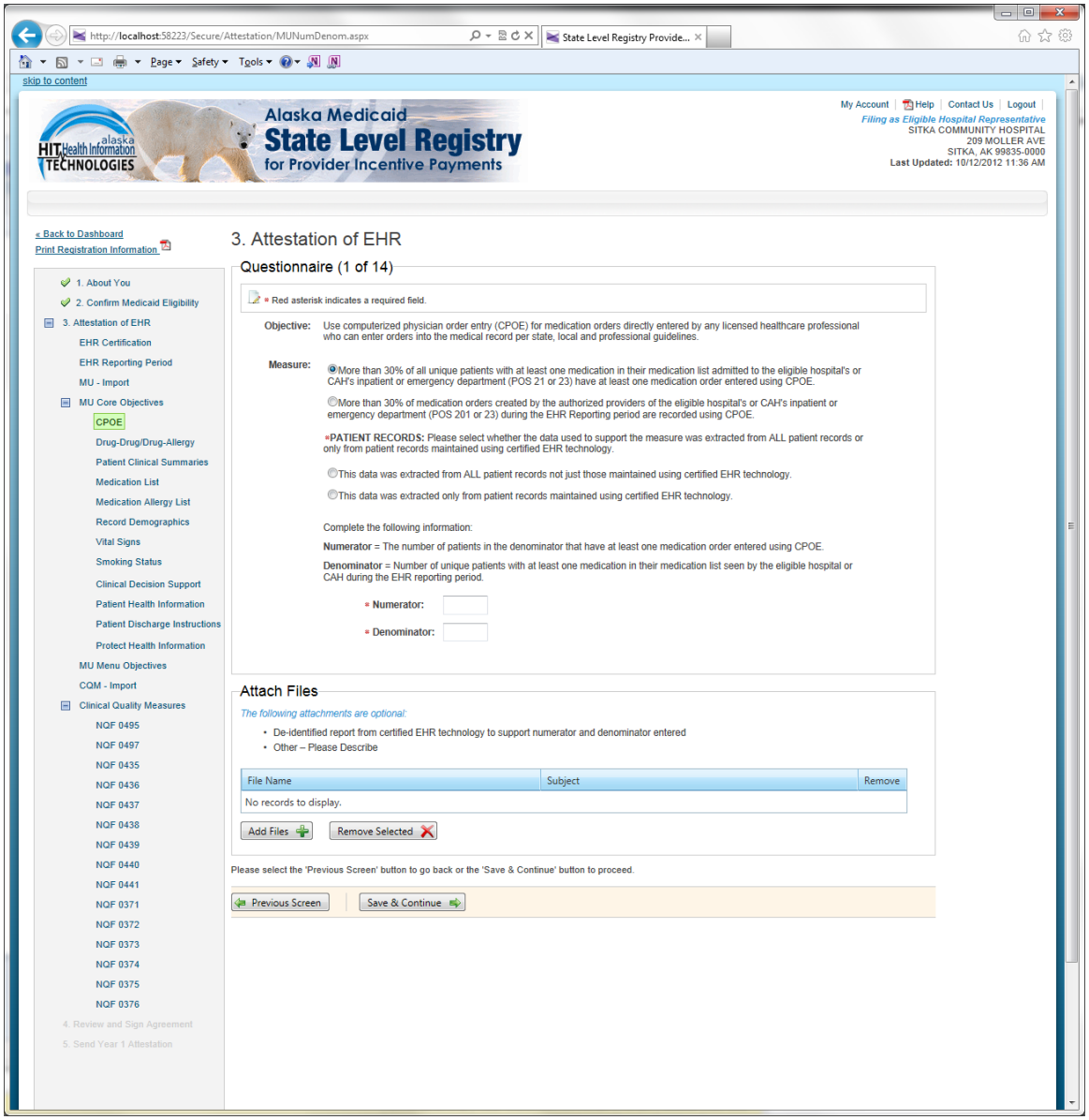
Eligible Professionals:

- Revised Medicaid Encounter definition
- Hospital Based Exclusion revised text
- New Representative Period for 90 days within the preceding 12 months
- Revised text for predominate practice at FQHC or RHC
- CPOE Alternate Measure
- CPOE with Alternate measure selected
- e-Prescribing exclusion
- Immunization Registry
- Syndromic Surveillance

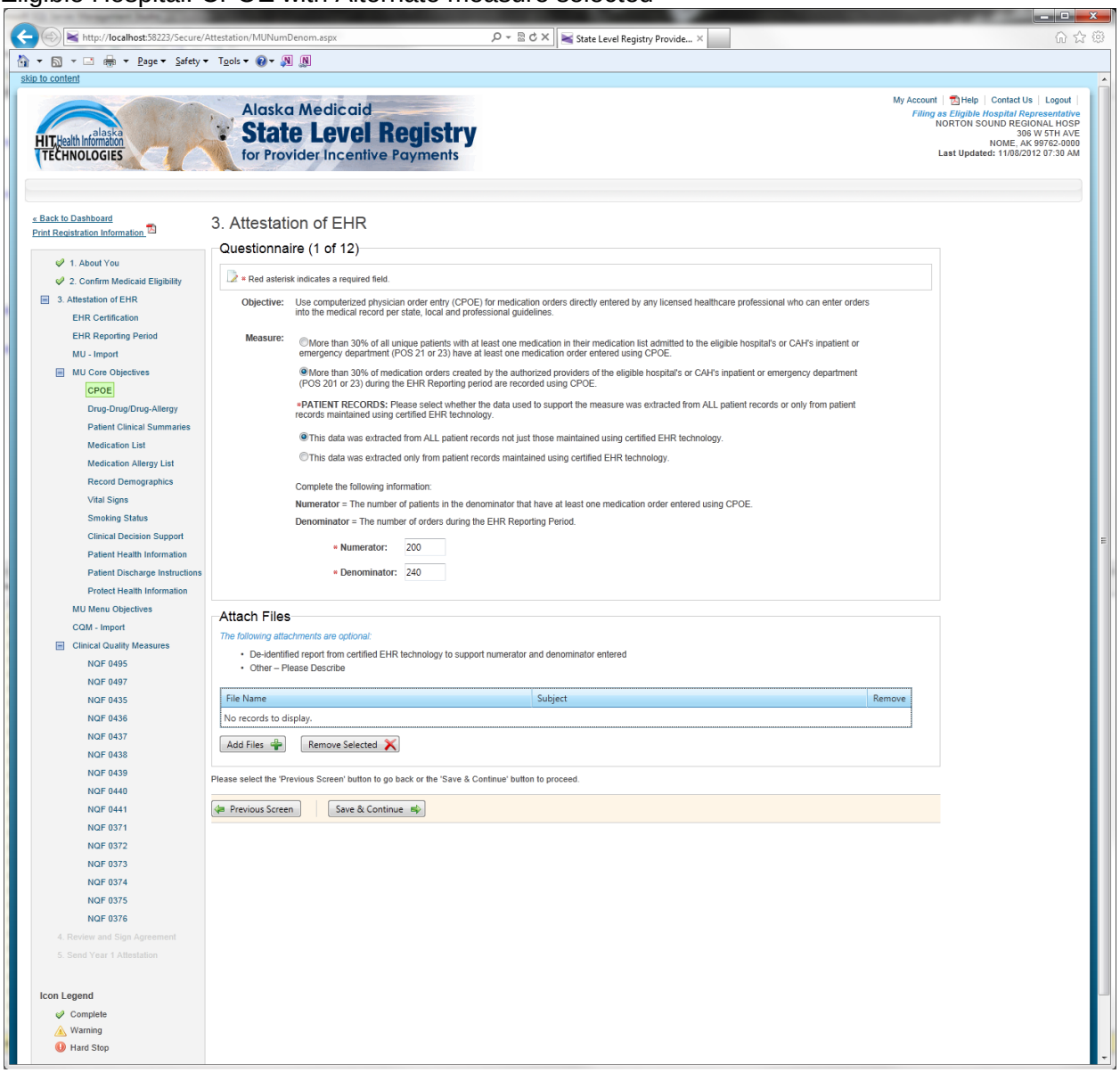
Eligible Hospital: New Representative Period for 90 days within the preceding 12 months



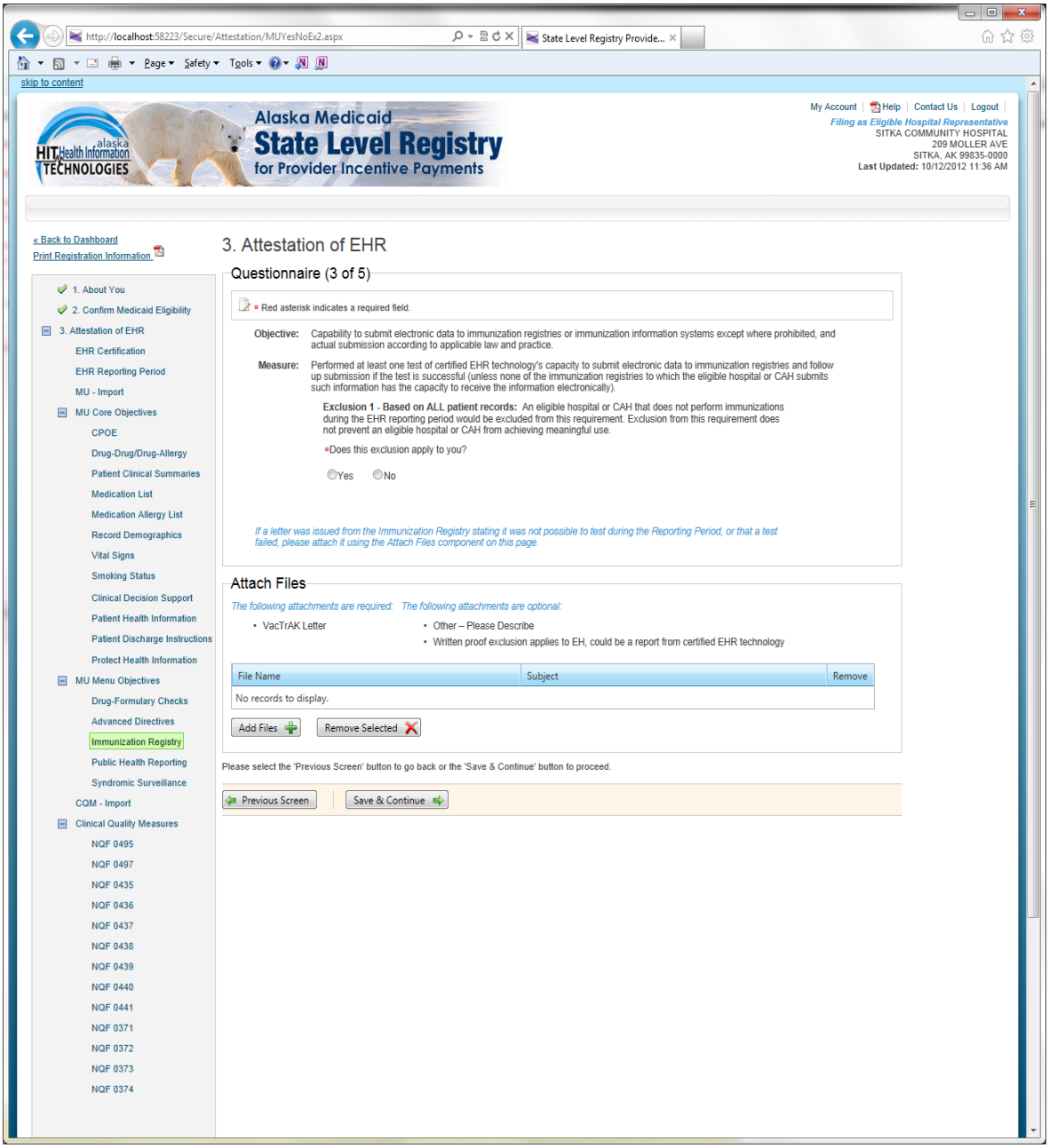
Eligible Hospital: CPOE Alternate Measure



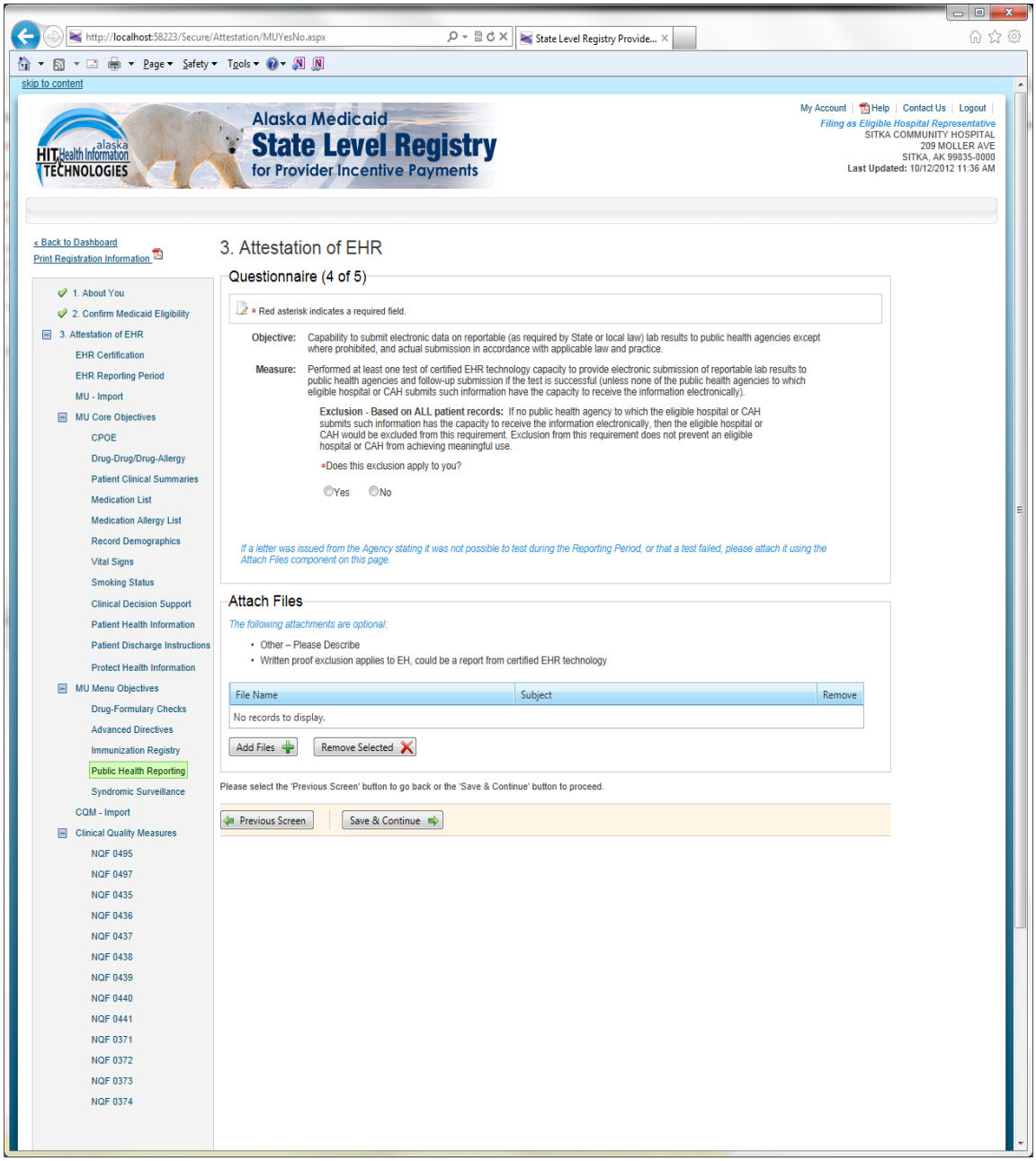
Eligible Hospital: CPOE with Alternate measure selected



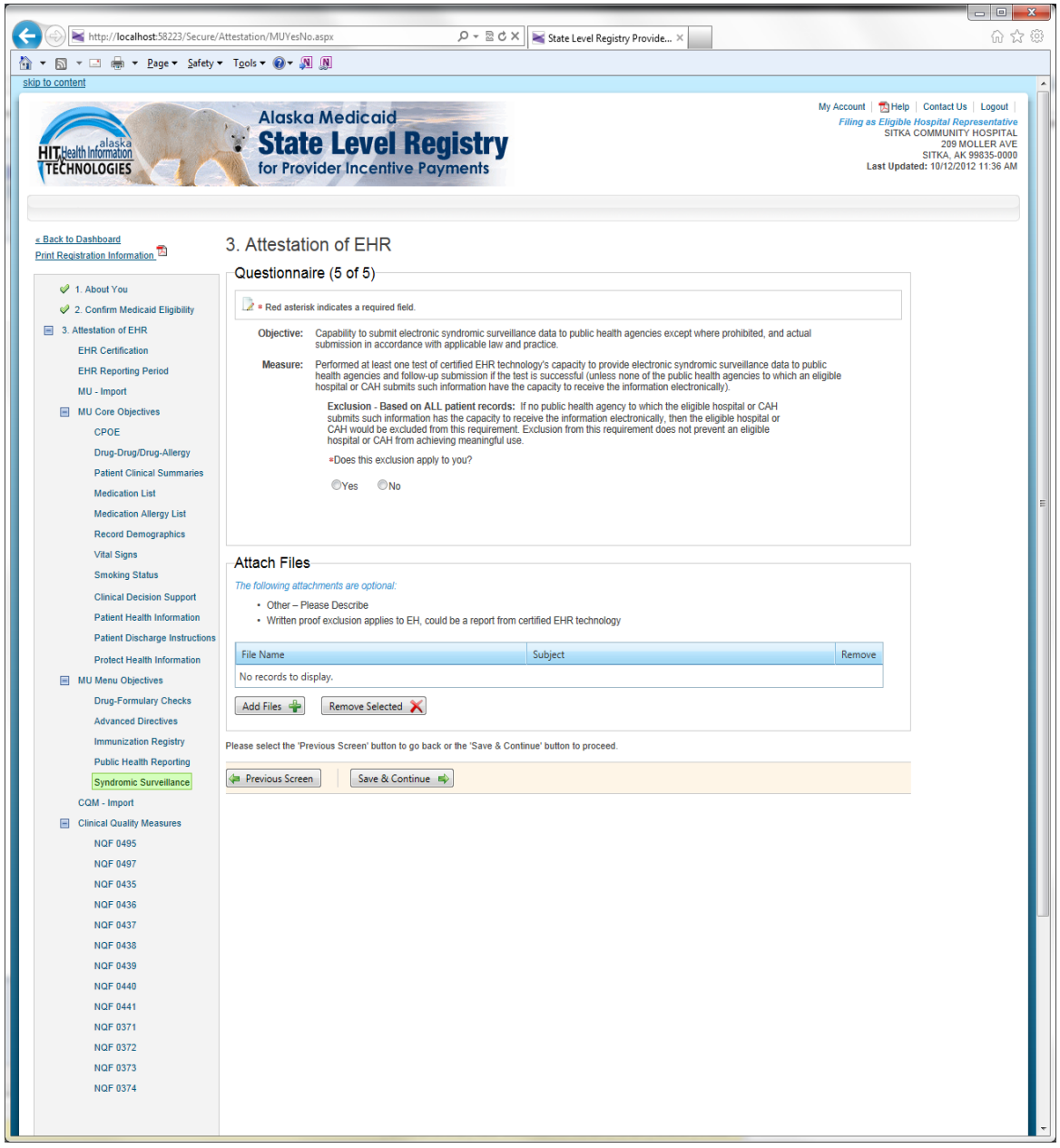
Eligible Hospital: Immunization Registry



Eligible Hospital: Reportable Labs

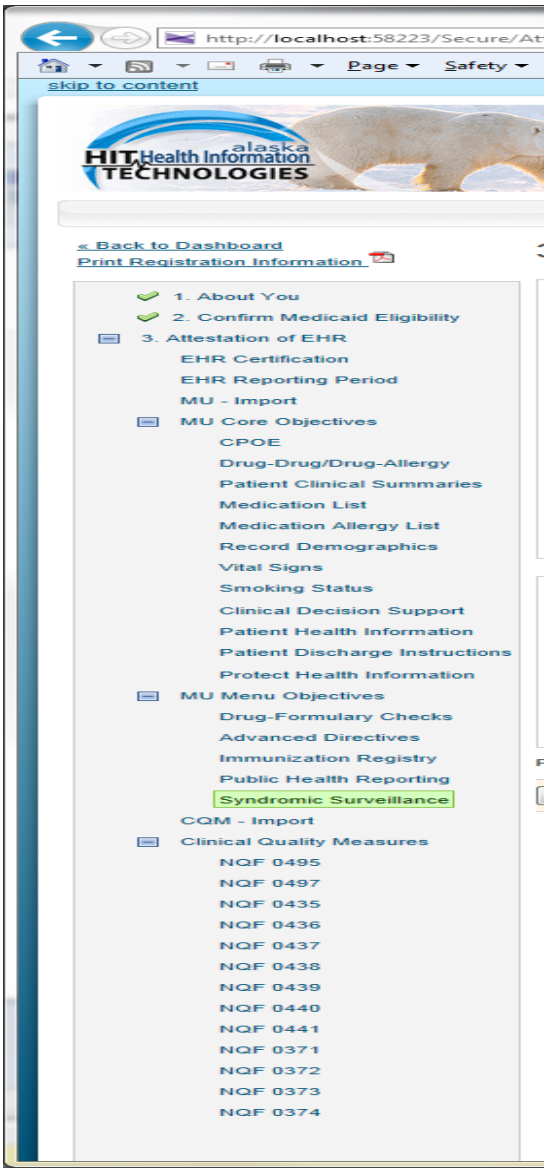


Eligible Hospital: Syndromic Surveillance

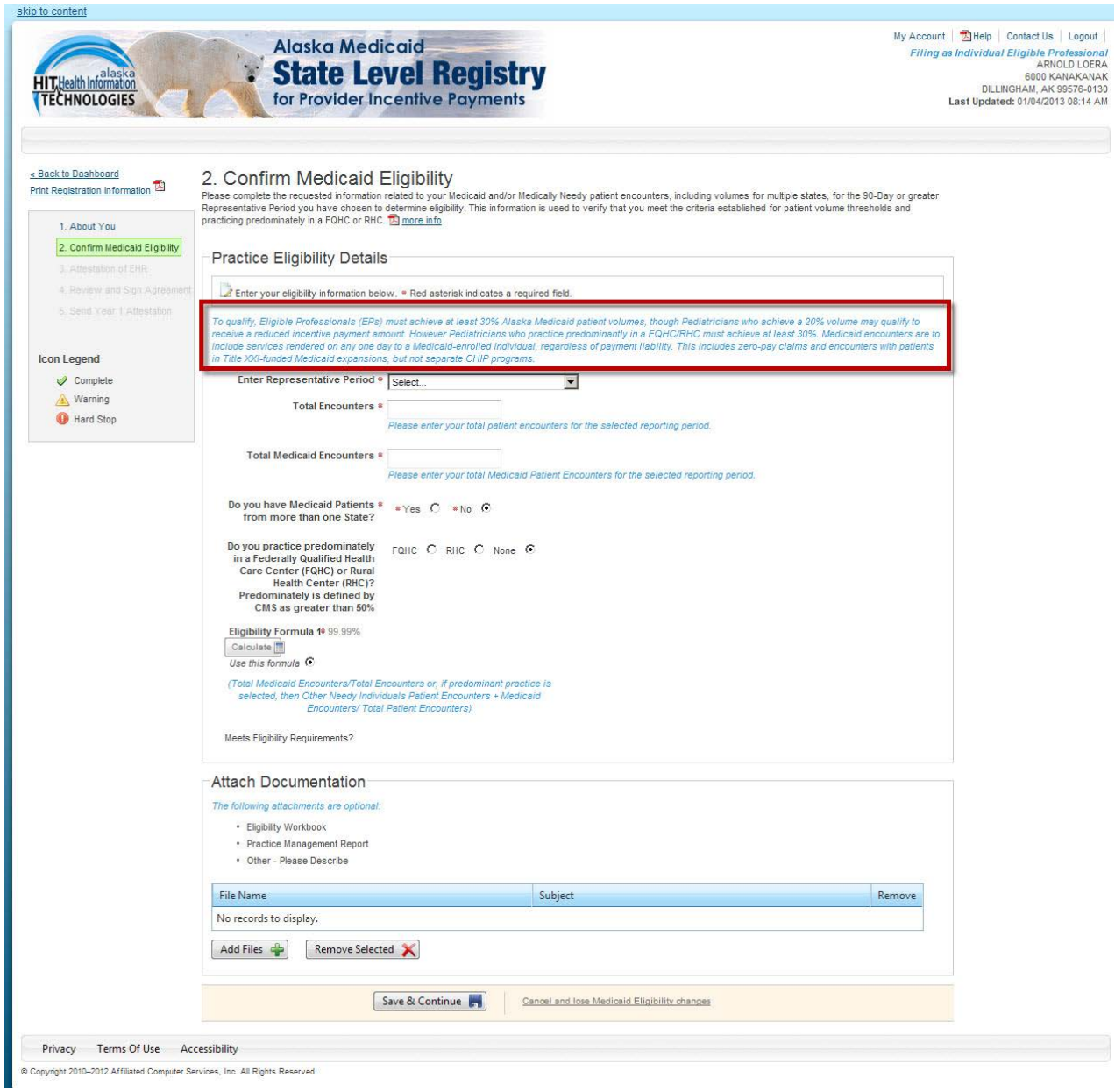


Eligible Hospital: Eliminated Objectives

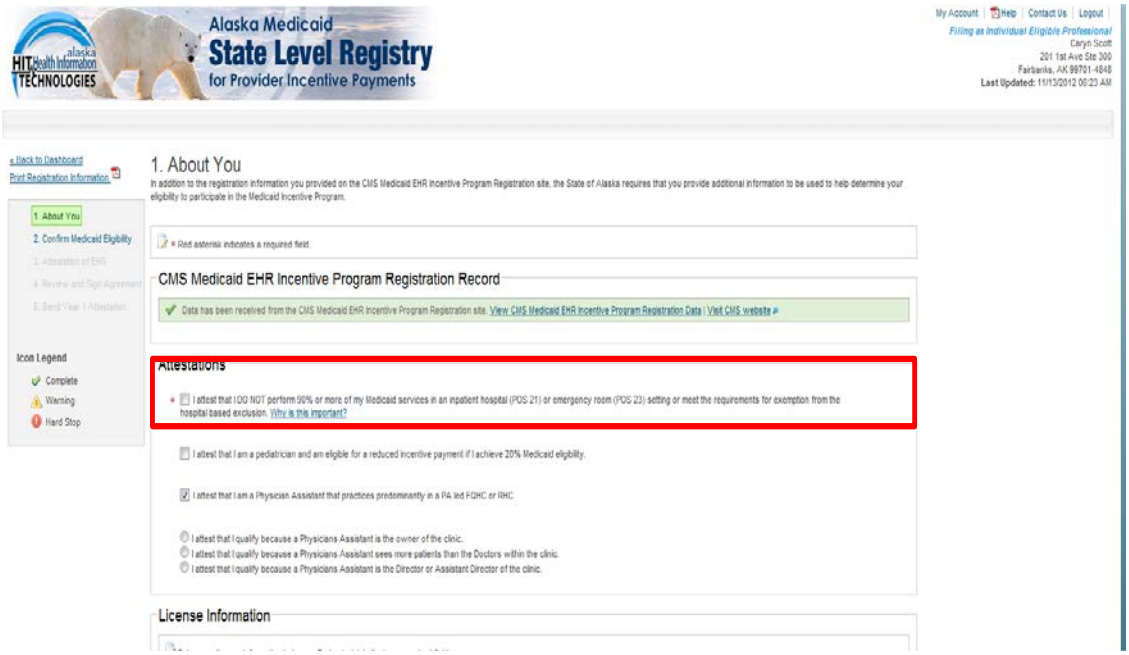
Clinical Transmission, Report CQMs and Exchange Key Clinical info electronically no longer display as objectives



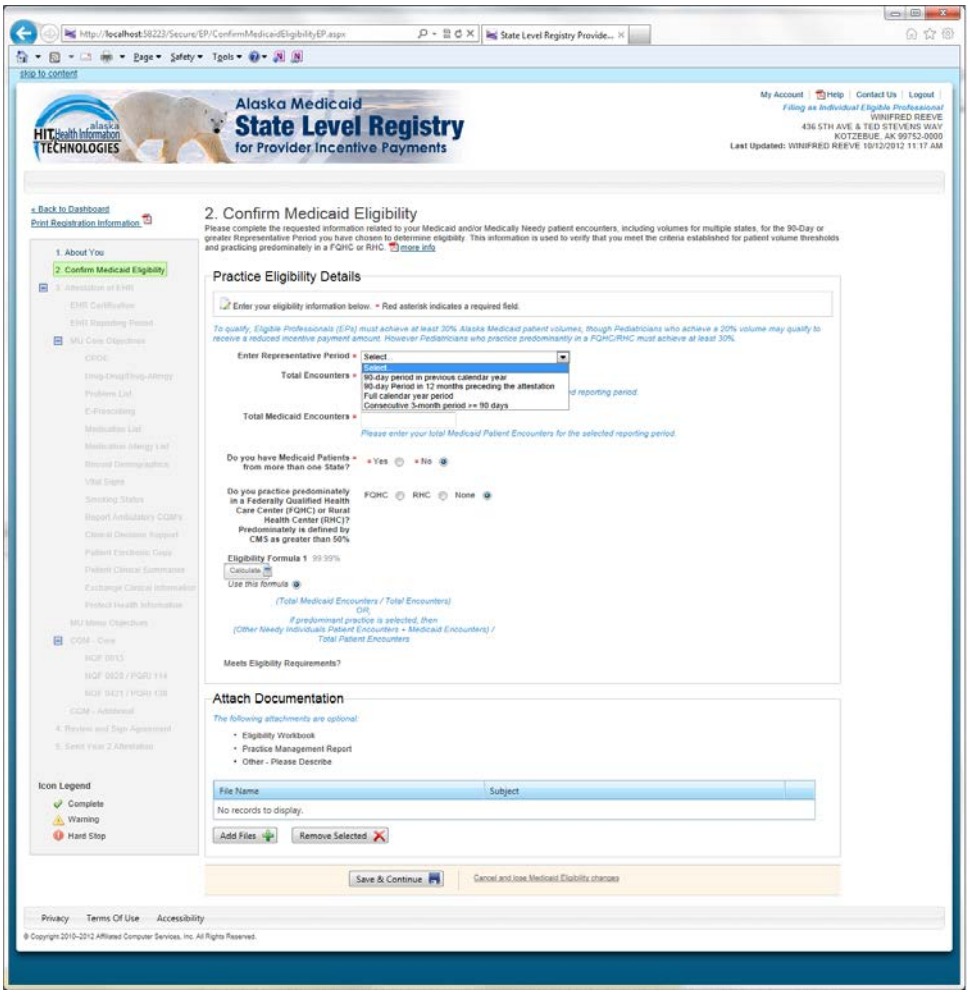
Eligible Professionals: Revised Medicaid Encounter definition



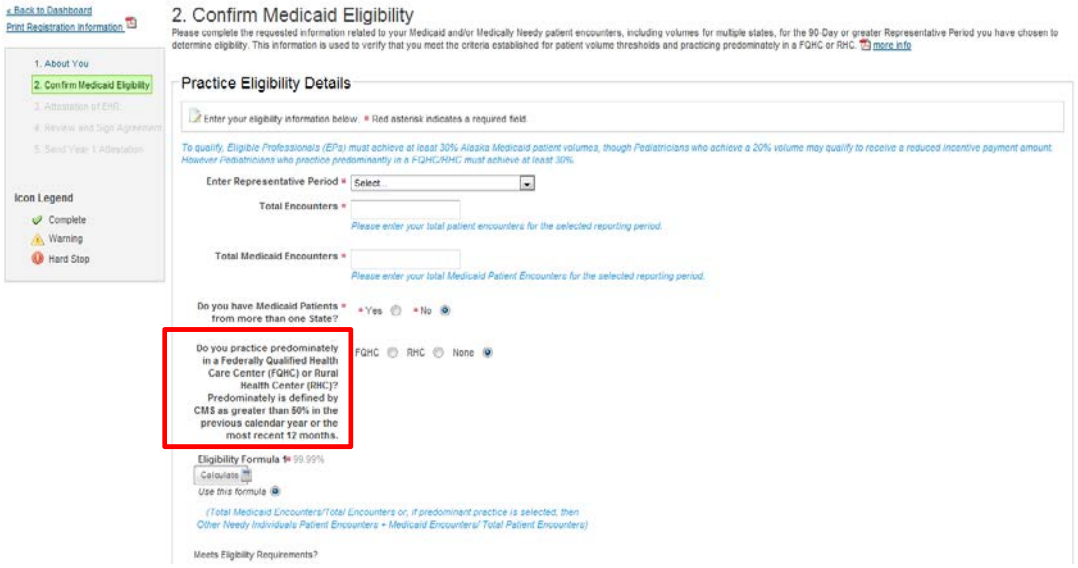
Eligible Professionals: Hospital Based Exclusion revised text



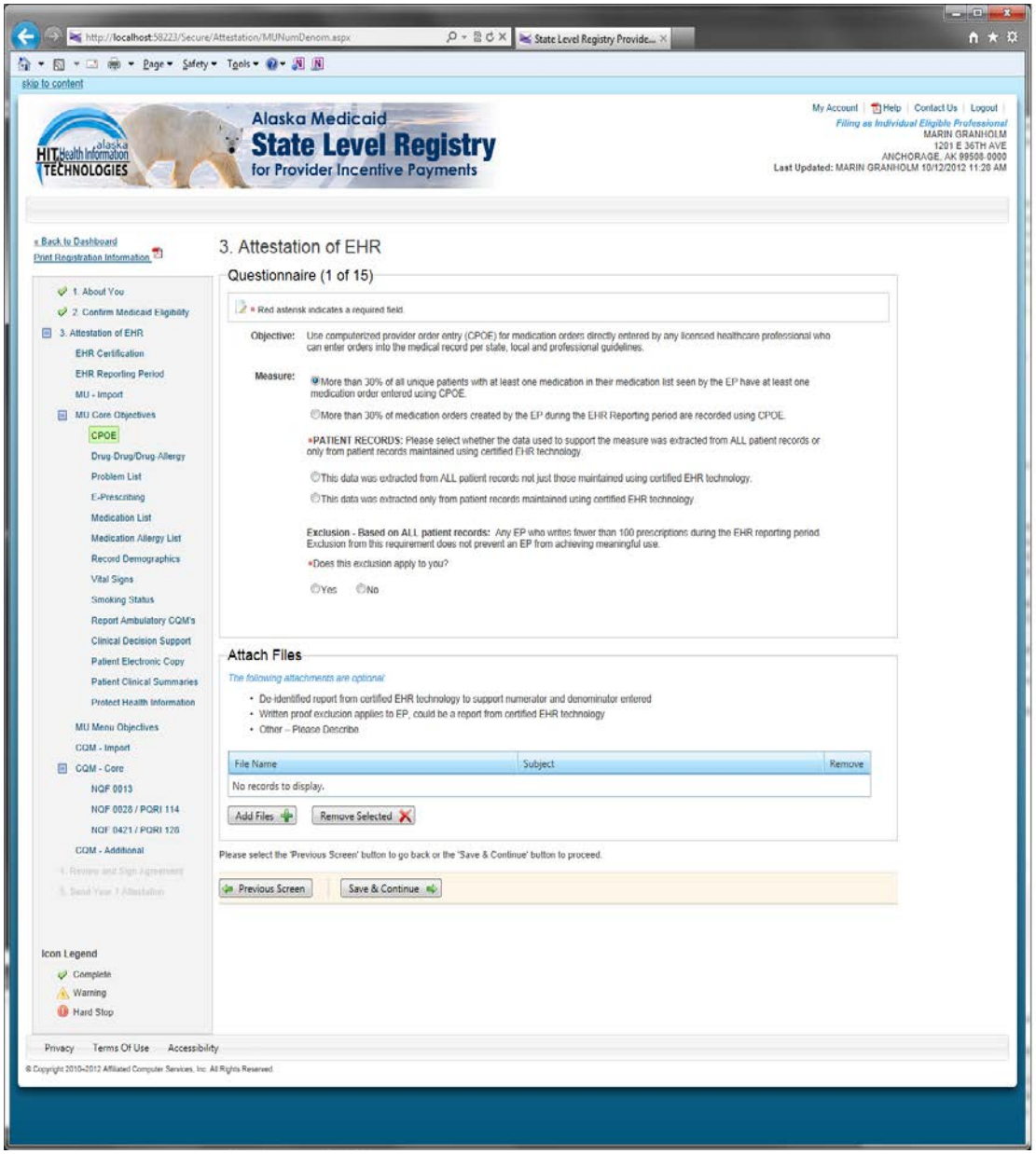
Eligible Professionals: New Representative Period for 90 days within the preceding 12 months



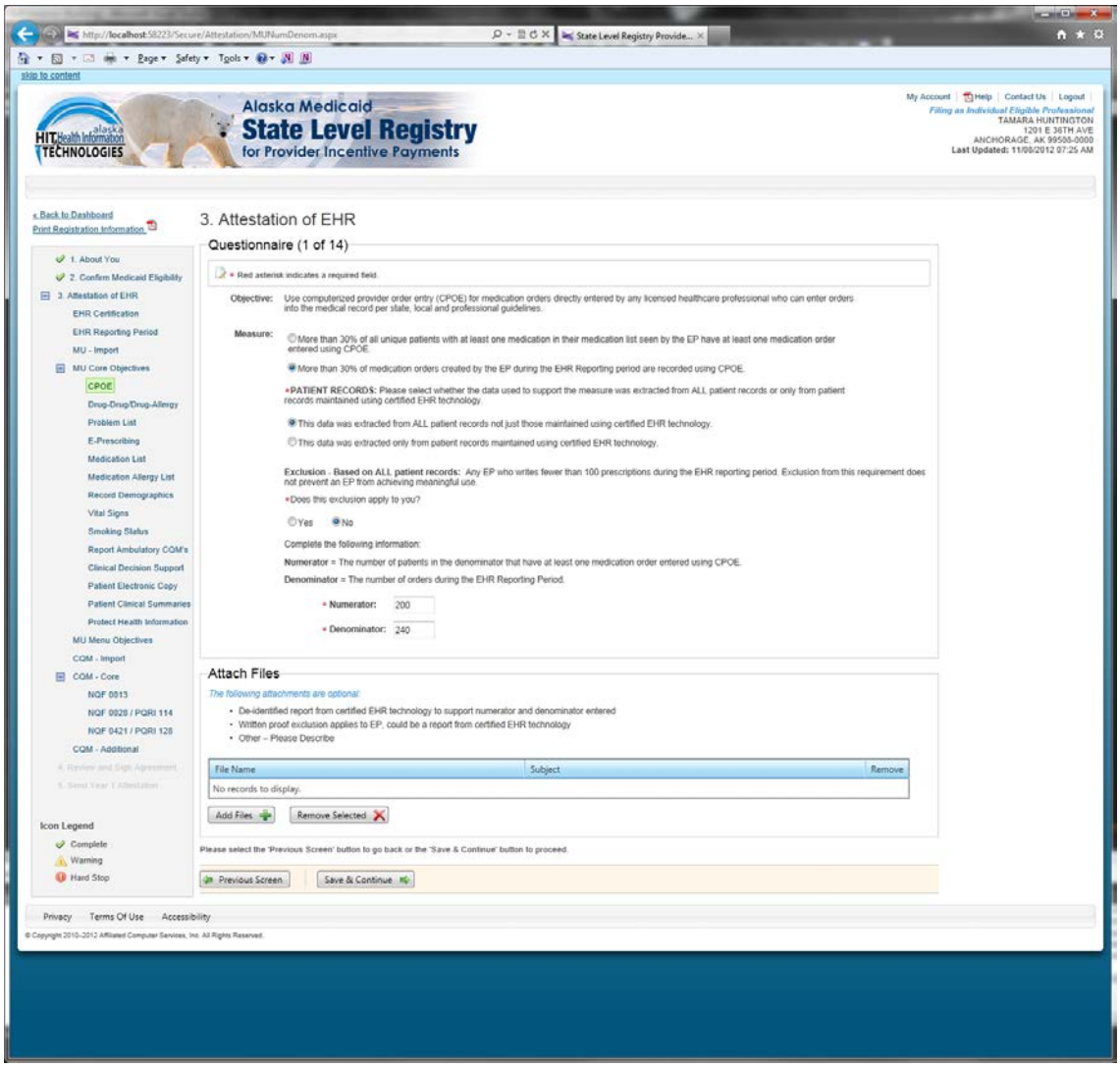
Eligible Professionals: Revised text for predominate practice at FQHC or RHC



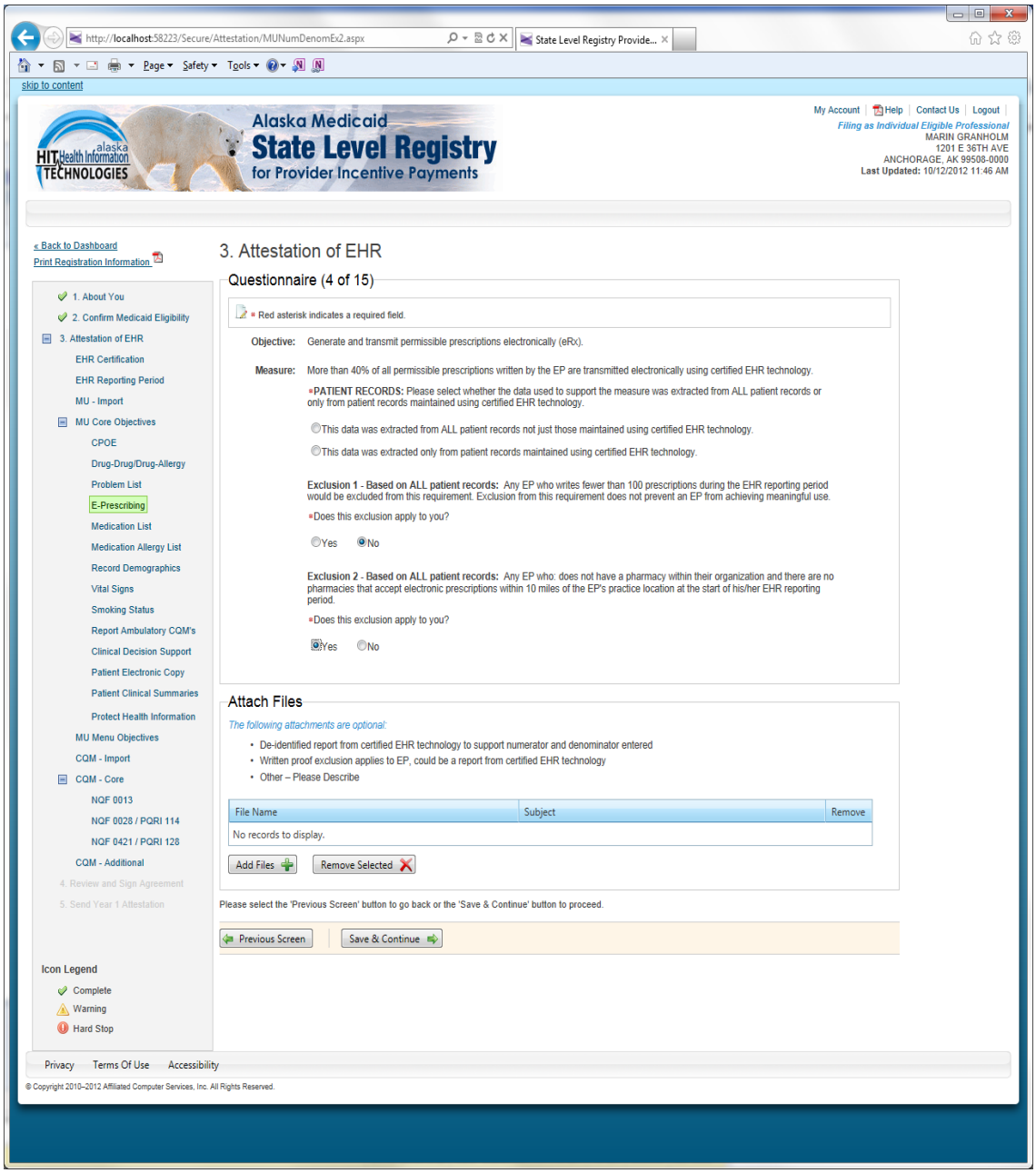
Eligible Professionals: CPOE Alternate Measure



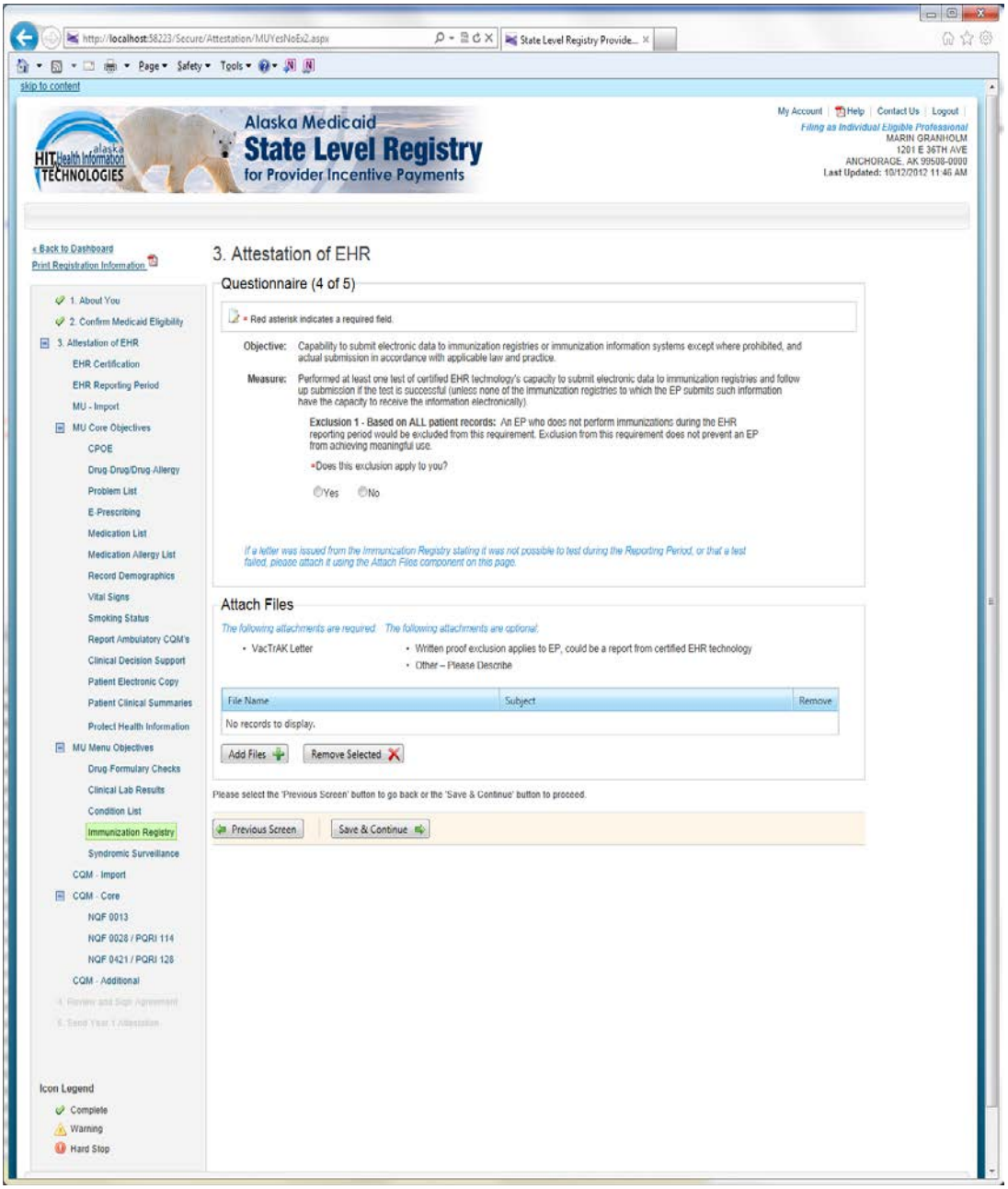
Eligible Professionals: CPOE with Alternate measure selected



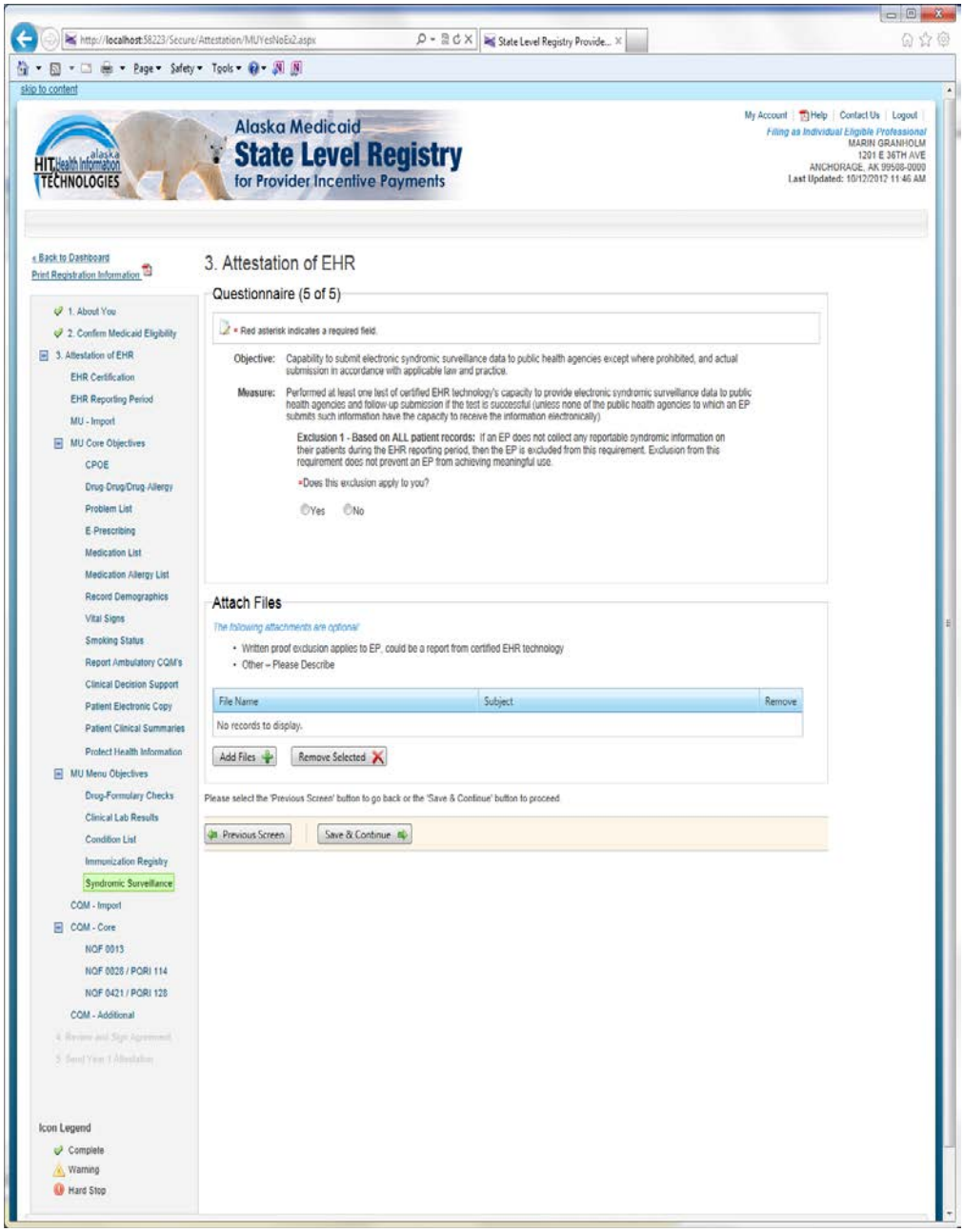
Eligible Professionals: e-Prescribing exclusion



Eligible Professionals: Immunization Registry



Eligible Professionals: Syndromic Surveillance



APPENDIX D: ELIGIBLE HOSPITAL MU AUDIT REQUEST LETTER

THE STATE of ALASKA
GOVERNOR SEAN PARNELL

Department of Health and Social Services

3601 C. Street, Suite 902
Anchorage, Alaska 99503
Main: 907.334.2483
Fax: 907.269.0060

December 18, 2012

Department of Health & Human Services
Centers for Medicare & Medicaid Services
Consortium for Medicaid and Children's Health Operations
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

To whom it may concern:

The State of Alaska Medicaid EHR Incentive Program is authorizing Centers for Medicare & Medicaid Services (CSM) to conduct the Eligible Hospital Meaningful Use audits except for auditing the Medicaid demographics including patient encounter volumes and average length of stay which will be audited by the State of Alaska auditing contractor in post-payment audits.

Sincerely,

Paul Cartland
State HIT Coordinator

APPENDIX E: TRIBAL HOSPITAL TIP SHEET

Confirm Medicaid Eligibility for Eligible Hospitals – Tip Sheet for 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, as well as Children's Hospitals that do not have a CCN but have an alternative number assigned by CMS.

The hospital Medicaid patient volume is established by selecting a representative 90 day period, any consecutive 3 month period greater or equal to 90 days or a full year 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;

And a Medicaid encounter can be defined as services rendered to an individual 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;

This means that an individual seen both as an inpatient and in the emergency room in a single day may count as two Medicaid encounters.

*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 an appropriate representative period. 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 2552-10, 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.

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*(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)	
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, or IHS HQ Reports)	
	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 2552-10, CMS 2552-96 or other data sources	**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, or IHS HQ Reports	Lines 1 and 2 Total Discharges
Medicaid Inpatient Bed Days	State Reports	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	IHS National IP Statistics	Line 5 Total Inpatient Bed Days
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 F: ACRONYMS

Acronym	Definition
A/I/U	Adopt/Implement/Upgrade
AAC	Alaska Administrative Code
CAH	Critical Access Hospitals
CCN	CMS Certification Number
CEHRT	Certified Electronic Health Record Technology
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CPOE	Computerized Physician Order Entry
CQM	Clinical Quality Measure
DHSS	Department of Health and Social Services
EH	Eligible Hospital
EHR	Electronic Health Records
EP	Eligible Professional
FFY	Federal Fiscal Year
FQHC	Federally Qualified Health Center
HIT	Health Information Technology
LLC	Limited Liability Corporation
LOS	Length of Stay
MMIS	Medicaid Management Information System
MU	Meaningful Use
PA	Physician's Assistant
POS	Place of Service
RHC	Rural Health Center
SLR	State Level Registry
SMHPU	State Medicaid Health Information Technology Plan Update