STATE OF ALASKA

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

STATE MEDICAID HEALTH INFORMATION TECHNOLOGY (HIT) PLAN UPDATE

Version 5.0

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EXECUTIVE OVERVIEW

Originally, the approach taken by Alaska Department of Health and Social Services (DHSS) in preparing the State Medicaid HIT Plan (SMHP) was to develop a plan with the intent to implement the Alaska Promoting Interoperability (PI) Program {formerly, the Electronic Health Record (EHR) Incentive Program} in January 2011. This allowed Alaska's Eligible Providers (EP) 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), and subsequent rules, in the development of a plan that provides incentive payments for the adoption, implementation, and upgrade of certified EHRs, and Promoting Interoperability of Certified EHR Technology (CEHRT).

In May 2009, Alaska Senate Bill 133 was signed into law requiring 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 (ONC) for HIT 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) (now called healtheConnect Alaska) to be the non-profit governing board that would procure and manage Alaska's HIE. In November 2010, healtheConnect Alaska contracted with Orion Health Inc. to implement the Software as a Solution HIE solution for Alaska.

The establishment of the non-profit governing board built 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 resulted in the culmination of over 10 years of statewide and regional health information exchanges and concepts created in the National Health Information Network and enhanced through ARRA stimulus. Today, Alaska's HIE provides clinical communication pathways to over 470 provider organizations and more than 1,200health care providers throughout the state with over 40 Electronic Health Records provide patient data into the HIE. In addition, the HIE acts as the conduit for public health reporting including sending immunization, syndromic surveillance, and reportable laboratory data to DHSS from connected organizations. Strategic planning efforts by the AeHN Board of Directors and stakeholders led the HIE organization to set the wheels in motion for major changes, including an organization's name change to 'healtheConnect Alaska.' After research, analysis and extensive discussion a decision to select a new HIE vendor was also made, to address expanded functionality and the need to improve the value proposition of the exchange. Audacious Inquiry is the new vendor for healtheConnect Alaska and provides new technology, including Event Notification Services and a unified landing page.

Alaska's HIT Coordinator participates on the HIE governing board and other work groups to ensure efficiency and effectiveness of planning efforts. Basic outreach to educate providers on Alaska's PI Program was completed by healtheConnect Alaska who was the State's Regional Extension Center (REC). Education materials were developed and made available through

provider workshops and quarterly meetings to minimize duplication of efforts. Professional associations collaborating with healtheConnect Alaska include Alaska State Medical Association, Alaska Hospital Association (AHA), Alaska Primary Care Association (APCA), Federally Qualified Health Centers (FQHC), and Alaska Native and Tribal Heath Network.

DHSS completed its initial Medicaid Information Technology Architecture (MITA) State Self-Assessment (SS-A) in 2008 to support the Medicaid Management Information System (MMIS) Replacement Project. The initial MITA SS-A did not include all the elements to support development of this SMHP, and, as a result, a MITA 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. DHSS developed a Request for Proposals (RFP) to select a vendor to implement a robust solution, including personnel services, for completing a MITA SS-A which will be applied across the entire department including MMIS, Eligibility & Enrollment, Health Information Technology for Economic and Clinical Health Act (HITECH), and other systems supporting Alaska's Medicaid program. The MITA 3.0 SS-A contract is in procurement.

The approach taken during planning for Alaska's PI Program administration was to review MITA business processes and identify and integrate the PI 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 PI Program eligibility determination, verification of member volume, attestation receipt and validation, and certain audit functions.

Alaska's SMHP provides readers with an understanding of the continuing activities DHSS employs to implement section 4201 Medicaid provision of the ARRA, focusing on the implementation of the Program. Subsequent sections of the SMHP provide a detailed description of the plan for administering Alaska's PI Program.

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 EHRs, and HIE networks, DHSS is doing 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 shifts the focus from treatment to prevention.

SMHP UPDATE DOCUMENT PURPOSE

Since the initial submission and approval of the original SMHP in 2010, there have been significant changes and updates within the State of Alaska that have impacted the plan. As such, a multitude of addendums and updates have been submitted and approved throughout the course of time to ensure that the plan accurately reflects the current status of activities and plans relative to the PI Program and HIT initiatives within the State. The purpose of this document is to consolidate all past documents and provide any relevant updates to the SMHP. This consolidation will include updates to the following previously submitted and approved documents:

- SMHP submitted and approved in November 2010 and related Implementation Advance Planning Document (IAPD) submitted and approved in November 2010
- State Medicaid Health Information Technology Plan Update (SMHPU) submitted in February 2013 addressing the 2013 program year changes and Stage 2, as delineated in the 42 CFR 495.302-495.306 revised on September 4, 2012
- SMHPU submitted in October 2014 addressing revisions mandated by the 2014 Flexibility Rule
- State Medicaid Health Information Technology Plan Addendum to address 2015-2017 Stage 3 rule and required State Level Registry (SLR) screen changes submitted in February 10, 2017 and approved on April 3, 2017
- The most recent HIT IAPDU was submitted on July 30, 2018, amended on August 30, 2018, and approved on September 18, 2018.
- The most current version of the SMHP was approved on August 27, 2018
- Alaska's most recent audit strategy was approved on June 10, 2019.

BACKGROUND

The Centers for Medicare and Medicaid Services (CMS), through provisions of the ARRA, has implemented incentive payments to EPs, Eligible Hospitals (EH), and Critical Access Hospitals (CAH), and acute care hospitals participating in Medicare and Medicaid programs that are meaningful users of CEHRT. Goals for the national program include

- Enhance care coordination and patient safety
- Reduce paperwork and improve efficiencies
- Facilitate electronic information sharing across providers, payers, and state lines
- Enable data sharing using state HIE and other national networks (eHealth Exchange, Carequality, Commonwell, and the Trusted Exchange Framework as it develops)

DHSS has worked closely with federal and state partners to ensure the Alaska PI Program fits into the overall strategic plan for the statewide HIE, thereby advancing national goals for HIE. Achieving these goals will improve health outcomes, facilitate access, simplify care, and reduce costs of healthcare nationwide.

VISION OF HIT FUTURE

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 remaining core challenges. In developing its vision for HIT for the future, DHSS has defined the following overall goals:

- Ensure the best available evidence is used for making decisions
- Increase price and quality transparency
- Pay for value
- Engage employers to improve health plans and employee wellness
- Enhance quality and efficiency of care on the front-end
- Increase dignity and quality of care for seriously ill patients
- Focus on prevention

- Build the foundation of a sustainable health care system

DHSS believes that access to good health care services for both physical and mental health needs is essential to all Alaskans' abilities to actively participate in and contribute to their families, schools, places of employment, and communities.

While progress has been achieved, the DHSS vision for HIT in the future continues to be a multi-year vision. We will build on our progress. We will continue to develop and implement current and planned projects that will significantly contribute to Alaska's health care transformation. By leveraging implementation of new technologies such as , EHRs, and HIE networks, DHSS will continue to do its part in supporting a healthcare system for Alaska that places individual Alaskans, their families, and communities at the center of their healthcare experience and ultimately shifts the focus from treatment to prevention.

Alaska's vision for HIT also relies heavily on leveraging HIE technologies and utilizing clinical information obtained through adoption, implementation, and upgrade (AIU) of certified EHR systems by providers and facilities. The future of Alaska Health Information Technology includes the following components:

- Simplified access to healthcare information and services for beneficiaries
- Simplified interaction with the healthcare infrastructure for providers
- Improved healthcare outcomes measured by increased usage of performance criteria
- Evolved use of modern information technology to improve the delivery of healthcare and outcomes, identify administrative efficiencies, coordination, and optimization of care
- Integrated medical service delivery model that includes high quality Medicaid providers
- Move from "client" focus to "family" or "community" based healthcare

This SMHPU describes the near and long-term goals set by DHSS to meet the above objectives. DHSS will work towards these goals throughout the duration of the SMHPU to leverage the successes achieved thus far and enhance the overall capability for electronic health information exchange and utilization of patient data to realize improved healthcare outcomes.

A. CURRENT HIT LANDSCAPE ASSESSMENT – THE "AS IS" ENVIRONMENT

A.1 Current Extent of EHR Adoption

Alaska has seen steady growth in the use of CEHRT among the provider population since the issuance of the 2010 SMHP and the implementation of the PI Program. This growth has been further augmented by the implementation of the statewide HIE. DHSS considers and utilizes information obtained from the administration of the PI Program and progress made thus far in terms of provider adoption and electronic data exchange capabilities to plan initiatives geared toward increasing electronic interoperability, participation in the PI Program and HIE, and meaningful use of health information technology.

Of the 26 hospitals in Alaska, 22 are eligible for the Medicaid PI Program. Of the 22 EHs, one has not been able to meet the patient volume requirements. The State has 13 hospitals currently

identified by the Flex Monitoring Team as CAHs (2015). There are no Rural Health Clinics in Alaska (CMS QCOR search, January 2019), and 29 FQHCs provide services at 165 sites in the State (Health Resources and Services Administration (HRSA), 2015). Most Alaskans have some form of health insurance coverage, although 10.3 percent of its residents lack any health insurance (Gallup, 2015).

The following tables highlight the progress made since the inception of the PI Program in 2011.

Table 1 - Attestations by Provider Type (2011-2018)

Attestations by Provider Type	CY 11	CY 12	CY 13	CY 14	CY 15	CY16	CY 17	CY 18	Total by Provider Type
Physician	39	185	186	368	254	257	231	174	1694
Nurse Practitioner	17	51	19	83	70	81	44	56	421
Dentist	0	18	12	18	19	4	9	6	86
Optometrist	0	0	0	0	0	0	0	0	0
Pediatricians	0	6	1	2	0	2	0	0	11
Physician Assistants	1	6	4	5	8	0	10	7	41
Acute Hospitals	5	16	7	14	8	4	5	1	60
Children's Hospitals	0	0	0	0	0	0	0	0	0
Total by Calendar Year	62	282	229	490	359	348	299	244	2313

Table 2 - PI Program Statistics by Calendar Year

Eligible Professionals	CY2011	CY2012	CY2013	CY2014	CY2015	CY 2016	CY2017	CY 2018	Total
Total Providers Paid (number) AIU	61	240	198	167	72	31	40	0	809
Total Amount Paid AIU	$1,296,250	$5,057,502	$4,207,500	$3,506,250	$1,530,000	$658,750	$850,000		$17,106,252
Total Providers Paid (Number) MU	0	39	25	332	292	315	271	245	1519
Total Amount Paid MU	$0	$331,500	$209,667	$3,271,084	$2,966,500	$3,092,584	$2,724,250	$2,146,250	$14,741,835
Total Amount Paid	$1,296,250	$5,389,002	$4,417,167	$6,777,334	$4,496,500	$3,751,334	$3,754,250	$2,146,250	$29,881,837

* Financial data includes recoupments resulting from audits

Eligible Hospitals	CY2011	CY2012	CY2013	CY2014	CY2015	CY 2016	CY2017	CY2018	Total
Total Hospitals Paid (number) AIU	5	12	3	1	0	0	0	0	21
Total Amount Paid AIU	$2,817,708	$9,094,291	$972,250	$303,530	-$416,181	$0	$0	0	$12,771,598
Total Hospitals Paid (Number) MU	0	4	4	13	8	4	5	1	39
Total Amount Paid MU	$0	$2,259,886	$2,058,191	$5,141,864	$1,263,961	$312,047	$843,763	$148,000	$11,879,713
Total Amount Paid	$2,817,708	$11,354,177	$3,030,441	$5,445,394	$847,780	$312,047	$843,763	$148,000	$24,651,331

* Financial data includes adjustments resulting from audits

There has been a significant number of payments made to FQHC providers throughout the course of the PI Program. To date, there have been 42 total payments made to FQHC facilities with an overall amount paid of $15,533,750.

The PI Program has made additional data available, primarily Syndromic Surveillance and electronic lab reporting (ELR) data by hospitals. Prior to the program, participation was inconsistent. With hospitals adopting CEHRTs, the submitted data has improved in both quantity and quality.

Given Alaska's population density and rural geography, the enhanced capability for electronic exchange of information plays a vital role in increasing the overall quality of healthcare services available to Alaskans. Increased adoption and meaningful use of CEHRT combined with the implementation of the Alaska statewide HIE has enabled expanded data sharing which is a critical component to allow for the provision of higher quality and better coordinated care to residents of smaller and more rural communities in the State.

A.1.1 Environmental "As-Is" Scan

To fully understand the current "As-Is" landscape relative to HIT, EHR adoption, and HIE participation within the State, the Alaska DHSS Health Information Technology Office conducted an updated environmental scan. Responses received were analyzed and will be used in strategic planning efforts moving forward.

The environmental scan utilized a survey instrument that included 43 sections and 83 total questions and was deployed to a broad range of providers within the State. The survey was deployed electronically utilizing a tool that was supported by Google and was configured with skip logic to streamline the experience for respondents. Paper copies were made available to those respondents who were unable to, or preferred not to, respond electronically.

The survey response timeframe concluded on December 15, 2017. Responses were received from 84 respondents representing an approximate 13 percent response rate.

The responses and analysis of the Environmental Scan were utilized to determine the current "As-Is" landscape in Alaska as it relates to HIT, HIE, and EHR usage. The following represents a high-level overview of the findings:

- Most respondents have high speed internet access
- Many respondents have adopted an EHR
- Thirty percent of those who had adopted an EHR also utilize paper charts or some other mechanism for patient record storage
- Certain provider types, such as dental providers, have EHR adoption rates that fall significantly below that of the overall survey population
- EHR systems are more heavily utilized for internal practice operations and data storage than for the electronic exchanging of data
- Electronic exchange of referral data is limited
- Electronic notification of hospital admission and discharge is limited
- Telehealth is not widely used within the state with the exception of tribal affiliated providers

- HIE adoption rates are very low throughout the state with the exception of certain provider types such as hospitals
- Those who have connected to the HIE indicated infrequent use

The following chart provides EHR adoption and HIE participation rates by provider type based on responses received during the environmental scan.

Table 3 – EHR Adoption and HIE Connection Rates by Provider Type

Provider Type	CEHRT Adoption Rate	HIE Participation Rate
Behavioral Health/Mental Health	59%	31%
Hospitals (including critical access)	100%	89%
Dental	50%	0
Physician Office/Ambulatory Care	82%	19%
Tribal Affiliated Providers	89%	50%
Affiliated with IPA	60%	0
Affiliated with FQHC	100%	63%
Affiliated with Larger HealthCare Entity	50%	60%
All Respondents	**68%**	**28%**

*Note: Percentages were calculated based upon respondent data for those who provided a response to the relevant question
**Note: CEHRT adoption rates based upon responses that specifically indicated adoption of Certified EHR Technology. In some cases, CEHRT is being used in conjunction with paper charts.

The overall barriers cited for EHR adoption and HIE participation tend to overlap with lack of knowledge, staffing limitations, and financial limitations being key factors that are presenting barriers to those who have not adopted.

A.2 Telecommunications and Broadband Access

A.2.1 Universal Services Administrative Company/Universal Services Fund

The Universal Service Administrative Company 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 Healthcare Providers (HCP) 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.

healtheConnect Alaska and its partners are closely coordinating the activities of the Rural Health Care Pilot Project with the USF to ensure sustainability of the completed healthcare infrastructure, particularly as related to rural healthcare facilities throughout the State.

A.2.2 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.

New fiber optic cable has been installed in the Arctic expands internet/communication capabilities for rural Alaska in the communities of Nome, Kotzebue, Point Hope, Wainwright, Barrow, and the North Slope camps. Most of the work was completed by 2016. The new cable was installed on the floor of the Bering and Chukchi seas. The project is run by Quintillinon Subsea Operations in partnership with GCI and other Alaskan infrastructure partners. It is the first fiber optic cable through the Northwest Passage.

In 2011, Alaska-based operator GCI began its Terrestrial for Every Rural Region in Alaska (TERRA) network, a massive Alaska infrastructure project. This project connects 84 rural communities to modern technology with high speed terrestrial broadband. This service will make 3G/4G mobile service possible; critical bandwidth has been made available to numerous public, private, and nonprofit entities such as school districts, regional health corporations, and Alaska Native organizations; high speed data streaming for use in video conferencing and telemedicine is now available, as well as increased network capacity and improved reliability for these communities through one of the largest fiber-microwave networks in the country.

See TERRA Project Map below.

Figure 1 – TERRA Project Map
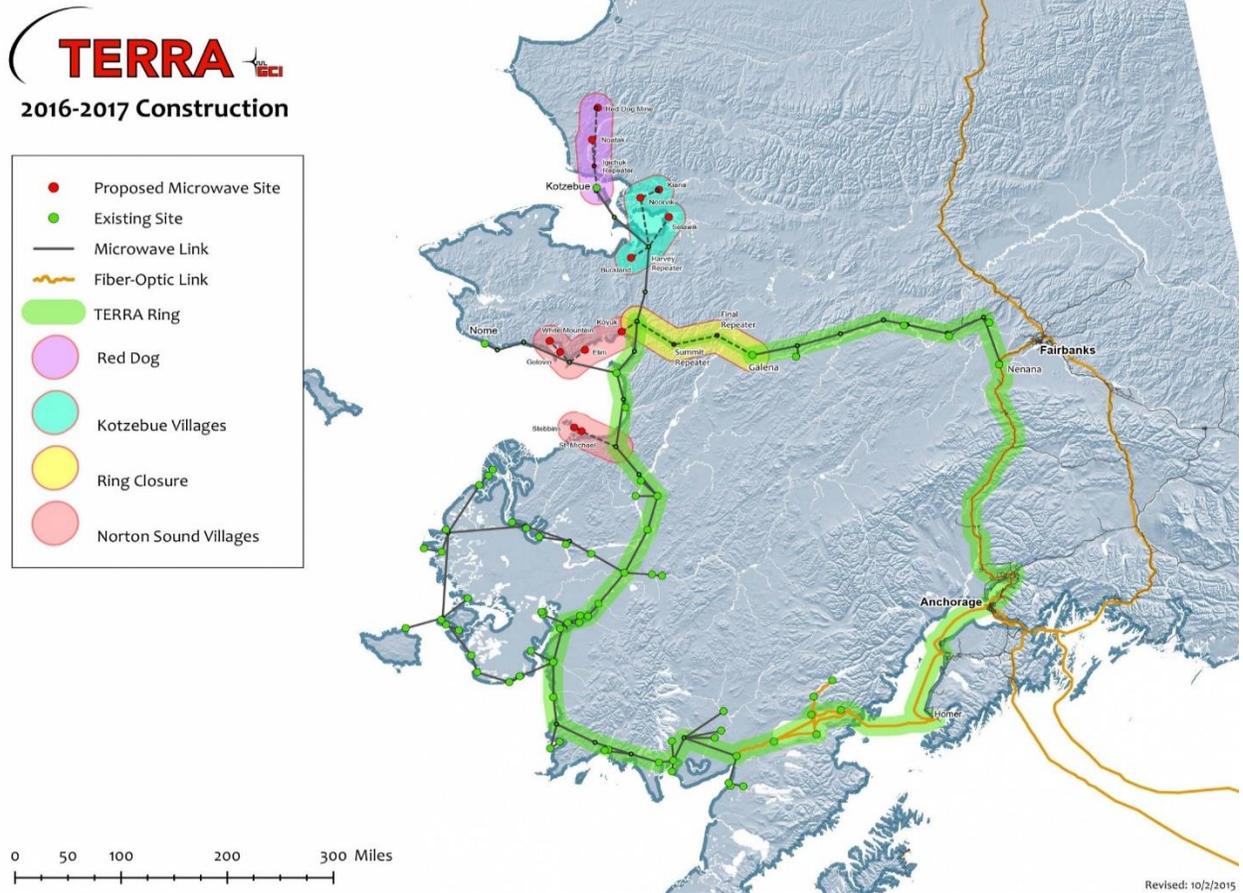
A.3 HRSA Grants

The Alaska Quality Improvement Network (AQuIN), Alaska's Health Center Controlled Network (HCCN), is comprised of 16 Participating Health Centers (PHC) from across the state of Alaska. As a program of the Alaska Primary Care Association (APCA), AQuIN is housed in the Alaska Center for Healthcare Quality (ACHQ), a division of the APCA. AQuIN is advised by a Steering Committee (a committee of the APCA Board of Directors), comprised of one voting representative from each PHC. Project staffing includes a project director, clinical quality programs manager, clinical quality coordinator, clinical applications coordinator, and integration coordinator– all staff from the ACHQ.

AQuIN PHCs utilize two data warehouse and analytics platforms that receive routine, periodic data feeds from each PHC's Electronic Health Record (EHR). One platform, Azara Healthcare's DRVS, is used by 13 of the PHCs; three PHCs that employ the Alaska Tribal Health System's Cerner EHR will use the Health Catalyst platform. The data warehouses are queryable by APCA and PHCs – they return each PHC's data in the form of reports, registries, and clinical and operational outcome data for quality improvement and population health management purposes, and for comparisons to other PHCs. A set of reports from the data analytics platforms are pre-formatted for regular reporting requirements and desired data points and setting performance measures, but reports can also accommodate special data queries. Implementation of the data analytics platforms with the final few PHCs is occurring now, and all 16 PHCs will be connected to one of the platforms by July 31, 2020. AQuIN PHCs may decide to increase the platforms' functionality by implementing additional modules in this performance period, such as care management and claims integration.

The overall purpose of AQuIN is Quality Improvement for better health outcomes, increased patient and family engagement, increased provider experience, and lower costs. As the health care market demands better performance and a focus on population health, Alaska's Health Center Program grantees recognize the need to own their own data and to be able to respond to that data for improvement in value, efficiency, and effectiveness. The data analytics platform aims to strengthen quality, efficiency, and safety through the data-driven support of PCMH models, optimization of the clinics' EHRs, and promoting interoperability. And as Alaska explores alternative payment methodologies, AQuIN will position PHCs to be able to participate in value-based arrangements. The Alaska Department of Health & Social Services and the Alaska Legislature have called for the development and strengthening of infrastructure supporting health information exchange and telemedicine/health. Health Center Program grantees see this HCCN opportunity as the timely and critical step in building the systems PHCs need in order to position safety-net providers for success in partnering with the State to execute its Medicaid strategies and implement programs to reduce healthcare costs and improve results.

A.3.1 FQHCs and Rural Health Clinics (RHC)

DHSS anticipates that FQHCs will continue to be active participants in the development of the state's HIE and HIT solutions. Currently, there are no RHCs in Alaska. No HRSA HIT grants have been issued to Alaska's FQHCs.

The FQHCs are active in the APCA. The APCA provides outreach and education to FQHCs, provides 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. FQHCs in Alaska also receive technical assistance from the DHSS Health Planning and Systems Development unit.

24 FQHCs have signed a participation agreement with healtheConnect Alaska for HIE and Direct Secure Messaging services. Fifteen are submitting data to the HIE and have HIE query access; three of those are for public health reporting.

A.4   Veterans Administration and Indian Health Service Facilities

A.4.1 Veterans Administration and Department of Defense

The Veteran's Health Administration (VHA) developed the Veterans Information Systems and Technology Architecture (VistA), an open-source, highly integrated, and interoperable EHR system. These systems are deployed in six clinics in Alaska (Anchorage, Wasilla, Fairbanks, Kenai, Juneau, and Homer) and serving approximately 34,000 enrolled Veterans accounting for over 164,000 visits in 2017.

The Department of Defense (DoD) has its own EHR. The 673rd Medical Group is a DoD/VA Joint Venture medical facility located in Anchorage on Joint Base Elmendorf Richardson with 60 inpatient beds. DoD and VA share a Joint Legacy Viewer (JLV) which allows each system to access information in the other system as well as community provider health summaries for those community providers who participate in the HIE.

The VA and DoD participate in the healtheConnect Alaska HIE project serving on the governance board and providing staff resources for workgroups. Alaska has completed connectivity with the eHealth Exchange and the ability to query the VA. Onboarding is in progress with the DoD.

A.4.2 National Indian Health Board National Regional Extension Center

The National Indian Health Board (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) in 2011. The AI/AN National REC provided assistance to Tribal health providers to achieve meaningful use of 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 was an active participant in the development of the grant proposal.

A.4.3 Tribal Regional Extension Center

The NIHB and the Alaska Tribal Regional Health Center (REC) signed an agreement in July 2011 to support tribal health care providers in Alaska. By the end of July 2015, the Tribal REC reported engagement of approximately 274 tribal providers, meeting Milestone 3. The agreement with NIHB expired at that time as the scope of work was only for four years.

A.4.4 Tribal HIE Participation

Alaskan Tribal Health Organizations actively participant with the HIE. The Alaska Native Tribal Health Consortium is a member of the healtheConnect Alaska Board of Directors and the Consortium was one of the partners that contributed funding for the initial project. The Consortium participated in the evaluation of HIE proposals and vendor demonstrations.

The Tribal Health Organizations implemented a solution enabling them to send health level standard HL7 messages (Common Clinical Data Set (CCDS) or otherwise) into the statewide HIE, resulting in increased participation in the HIE by the Tribal facilities and clinics.

A.4.5 Behavioral Health Providers

DHSS received HITECH funding to onboard Behavioral Health providers to the HIE. Please see Section A.9.1.5 for further details.

A.5 Stakeholder Engagement with HIT/E Activities

A.5.1 Stakeholder Engagement

Senate Bill 133 – Creation of Health Information Exchange System, implemented in 2009, paved the way for the creation of the Alaskan HIE. The bill also defined the required members of the HIE Board of Directors, including representation for the following areas:

- Commissioner, DHSS
- Hospitals and nursing home facilities
- Private medical providers
- Community–based primary care providers
- Federal health care providers
- Alaska tribal health organizations
- Health insurers
- Health care consumers
- Employers or businesses
- Non-voting liaison to the Board of Regents of the University of Alaska

The Board also considers input from voluntary advisory workgroups, including the Consumer Advisory Group, comprised of interested community members, and the Clinical Advisory Group of clinicians, healthcare leaders, and payers who participate in the delivery of healthcare services. Additionally, there are a number of operational workgroups, including:

- Privacy & Security Workgroup
- Technology Workgroup
- Clinical Workgroup

The mandated membership of the board and the formation of the advisory groups in conjunction with the operational workgroups demonstrate Alaska's commitment to including all stakeholders involved with HIT and HIE activities.

A.5.2 Stakeholders Promoting Interoperability

The combination of Medicaid expansion and the enactment of Alaska Senate Bill 74 – Medicaid Redesign, implemented in 2016, as well as the publishing of the CMS 2015-2017/Stage 3 Rule, have highlighted the need for enhanced health information exchange. DHSS, partner agencies, and stakeholders have developed a comprehensive plan to meet these challenges and enhance provider ability to meet PI requirements while increasing participation with the statewide HIE. This plan includes

- Expansion of the existing Master Client Index (MCI) to include additional Behavioral Health, Long-Term Care, and Public Health systems and registries, offering expansion of the provider population in the HIE and increased opportunities for data exchange and meeting PI measures.
- Extension, upgrades, and additional support of an Enterprise Service Bus (ESB) and Client Services Dashboard.
- Extension of Public Health systems, MCI, and Master Provider Index (MPI) to integrate with the Alaska statewide HIE implementation to allow Alaska HIE participants to further meaningful use of EHR systems by allowing for the exchanging of new lab requests, immunization administration, and reportable disease events with the respective state systems and to make the following available to HIE participants:
  - State lab results
  - Immunization records
  - Vital statistics
  - Client and provider information
- Upgrades to the Division of Behavioral Health (DBH) Alaska Automated Information Management System (AKAIMS) database to connect directly to the HIE to allow for the transmission of data that supports EP and EH ability to meet PI requirements for the transition of care/health information exchange measures.
- Expansion of the Alaska Statewide HIE to leverage the exchange of data to improve health outcomes for Alaskans.
- Expansion of specialized registries will support provider attestations and EP and EH ability to meet PI requirements.

A.6 State Medicaid Agency HIT/E Relationships with Other Entities

DHSS recognizes that Alaska has a large number of healthcare organizations at varying degrees of adoption of health information technology. DHSS also understands that provider adoption of health information exchange through EHRs is dependent upon the availability of clinically relevant patient data for a large percentage of a provider's patients. DHSS recognizes that the majority of patient care occurs in local communities, and that the goal of local health information exchange (HIE) efforts will be connecting providers with local sources of patient data. DHSS, with the input of multiple stakeholders, has identified and continues to identify what value could be brought to the local HIE efforts to help them achieve critical mass and significant provider adoption.

Planned HIE efforts are discussed in detail in Sections A.9.1 and B.5.1.

A.7   Alaska HIE Governance

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 and communicating with the Alaska HIE executive management and solicits feedback from its advisory workgroups.

The State Medicaid Agency (SMA), located within DHSS, is an integral part of the Alaska HIE governance model. In addition, DHSS convenes a quarterly IT Governance meeting to review progress on all IT projects, including the HIE. This discussion includes representation from the DHSS Executive Leadership, DHSS Divisions, State HIT Coordinator, Project & Portfolio Review Team, DHSS IT Managers, and other DHSS stakeholders.

The Alaska HIE solution allows all medical providers to have access to relevant patient records. Alaska anticipates that this statewide HIE infrastructure will continue to support the state's medical providers and patient population for the foreseeable future.

A.7.1 HIE Board of Directors

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

Table 4 – HIE Board of Directors

Affiliation	Officers	SB 133 Required Areas
Community Mental Health Services Anchorage & Fairbanks	President	Behavioral Health Providers
LaTouch Pediatrics	Vice President	Private Medical Care Providers
Premera Blue Cross Blue Shield	Secretary	Health Insurers
Alaska Native Health Board	Treasurer	Alaska Tribal Health Organizations
Alaska Chamber of Commerce	Member	Employers or Businesses
Alaska Primary Care Association	Member	Community-Based Primary Care Providers
University of Alaska	Non-voting Liaison Member	Liaison to the Board of Regents of the University of Alaska
Alaska VA Healthcare System	Member	Federal Health Care Providers
Alaska Department of Health & Social Services	Member	Commissioner DHSS

A.7.2 healtheConnect Alaska (formerly Alaska eHealth Network (AeHN))

healtheConnect Alaska is a 501(c) (3) Alaska non-profit corporation, organized and managed by Alaskans. The organization was originally designed in 2005 as the Alaska Regional Health Information Organization (RHIO), a project under the Alaska Telehealth Advisory Council. It was designed as a network of public and private organizations and businesses involved in healthcare, to work on adoption of EHRs and on HIE activities. The project was initially funded by a federal grant along with 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 reorganized and renamed AeHN in 2008 and is now known as healtheConnect Alaska.

In 2009, Alaska DHSS contracted with healtheConnect Alaska to procure and manage Alaska's HIE grant program, and to assist the State in establishing HIE capability among healthcare providers and hospitals in Alaska. healtheConnect Alaska coordinated an effort to develop HIE product requirements, write an RFP, evaluate responses, and select an HIE vendor. This process included over 80 participants which represented various provider and payer entities. The RFP received eight responses which were evaluated resulting in the selection of four vendors to deliver technical and workflow demonstrations based on specific pre-defined criteria. Based on the results of these demonstrations, Orion Health was selected as the initial HIE vendor. Orion provided HIE and clinical portal services. The HIE platform has since been upgraded to Audacious Inquiry. healtheConnect Alaska uses NextGate as the statewide Master Client Index.

healtheConnect Alaska deployed the HIE and direct secure messaging (DSM) technologies using a hosted, software-as-a-service model. healtheConnect Alaska 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. healtheConnect Alaska began connecting additional Alaska providers in December 2011, and today, provides clinical communication pathways to 472 provider organizations and more than 1,200 healthcare providers throughout the State, with over 40 EHRs provide patient data into the HIE. In addition, healtheConnect Alaska acts as the conduit for public health reporting, sending immunization, syndromic surveillance, and reportable laboratory data to DHSS from connected organizations. Eleven participating provider organizations are submitting immunization data via the HIE to Alaska's Immunization Registry VacTrAK. Seventeen organizations are submitting syndromic surveillance data via the HIE to BioSense and nine hospitals are submitting lab data via the HIE to Alaska's Electronic Laboratory Reportable (ELR) database, AKSTARS.

Table _: Sources of HIE Data as of July 2019

HOSPITALS	PROVIDERS/CLINICS
Bartlett Regional Hospital	Alaska Family Care Associates
Central Peninsula General Hospital	Alaska Island Community (FQHC)
Fairbanks Memorial Hospital	Bethel Family Clinic (FQHC)

Ketchikan Medical Center (PeaceHealth)	Fairbanks Cancer Center
MatSu Regional Medical Center	Girdwood Health Clinic Inc. (FQHC)
Petersburg Medical Center	LaTouche Pediatrics
Providence Alaska Medical Center	Peninsula Internal Medicine
Providence Kodiak Island Medical Center	Seldovia Village Tribe (FQHC)
Providence Seward Medical Center	Tanana Valley Medical Surgical Group
South Peninsula Hospital	
Valdez Community Hospital	**PAYERS/CARE MANAGEMENT**
Wrangell Medical Center	Premera

The updated mission of healtheConnect Alaska is "To provide safe, secure transport for health information to improve quality and safety of patient care and to increase efficiencies for hospitals and medical practices." healtheConnect Alaska is a carefully planned solution to better communicate vital medical information electronically facilitating coordinated patient care, reducing duplicative treatments, and avoiding costly mistakes. healtheConnect Alaska operates a secure statewide, standards-based electronic health information exchange which allows health care providers to exchange electronic medical data for treatment and billing.

healtheConnect Alaska's predecessor organization, the Alaska Telehealth Advisory Council (1996-2005), and, subsequently, AeHN and its workgroups 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 healtheConnect Alaska.

Below is a depiction of healtheConnect Alaska "As-Is." Please see Section B.1 for healtheConnect Alaska "To-Be."

Figure 3 – "As-Is" healtheConnect Alaska
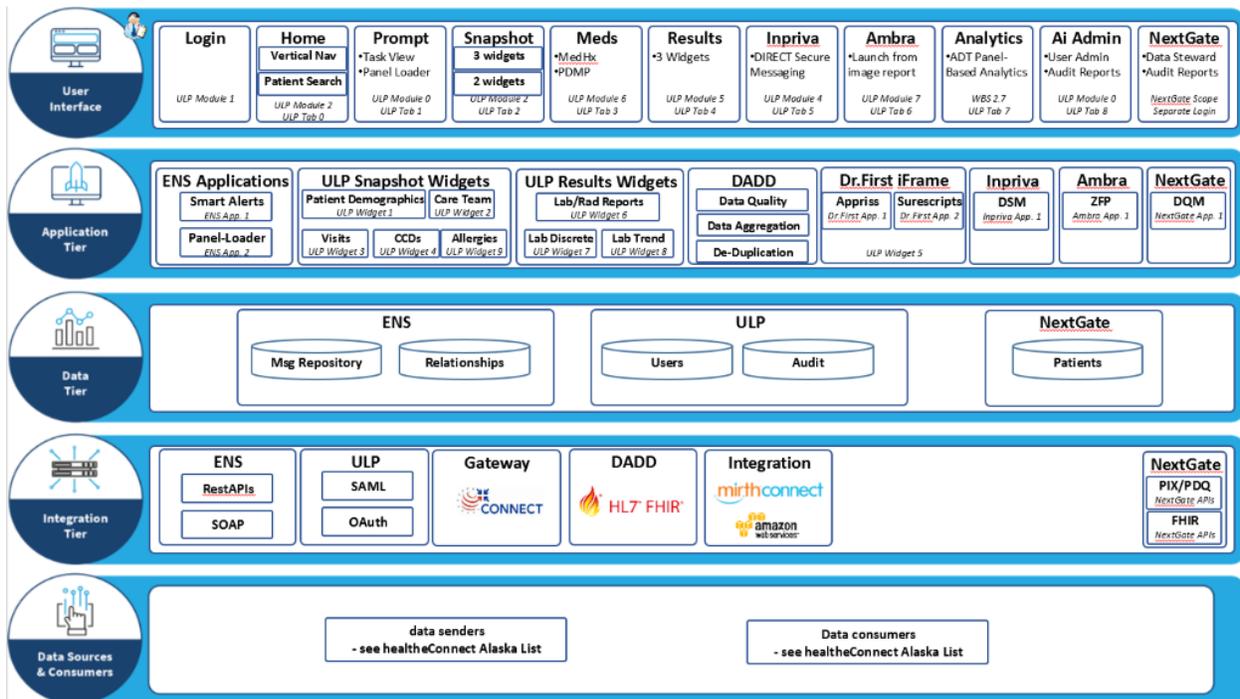
A.7.3 Alaska Regional Extension Center

In addition to the contract to provide the non-profit governing board to procure and manage the HIE, in 2010, healtheConnect Alaska received $3,632,357, from the ARRA to establish one of 60 nationwide HIT REC. The Alaska REC provides technical assistance to EPs and EHs that select and implement electronic record systems to assist them in achieving widespread meaningful use of HIT and promoting electronic health record utilization for every citizen of Alaska. healtheConnect Alaska 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
- Determination of CMS incentive fund eligibility qualifications
- EHR evaluation, selection, and implementation
- Providing workflow analysis
- CMS registration and attestation assistance for applicable incentive programs
- Performing Meaningful Use gap analysis and assessment of practice readiness and assistance in mitigation strategies
- Providing comprehensive privacy and security risk assessments
- Assisting with auditable data practice and compilation
- 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

DHSS collaborates with the REC to share information collected in the Environmental Scan and to ensure consistent messaging to providers. The REC engaged and enrolled over 800 eligible providers (for REC incentives). healtheConnect Alaska enrollment is open to all providers and participants (exclusive of eligibility). REC services are available to all; however, REC incentive funding is limited to eligible providers.

ONC funding for the REC activities ended in April 2016,. By the end of the program, the REC had provided services to 1,128 primary care providers and 11 critical access hospitals.

healtheConnect Alaska, as the REC, continues to provide HIT technical assistance services to providers and hospitals on a fee-for-service basis and offers: 1) an all-inclusive PI consulting package (or customized upon request), 2) EHR selection, 3) EHR implementation, 4) workflow improvement, and 5) Privacy & Security Risk Assessments in addition to other services.

A.7.4 Health Information Security and Privacy Collaboration (HISPC)

HISPC 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, propose solutions to address identified challenges, and increase expertise about health information privacy and security protection in communities. States and territories selected to participate were charged with developing 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.

healtheConnect Alaska, Alaska's representative for the HISPC, 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 healtheConnect Alaska HIE.

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

- Increase patient privacy and security in exchanging medical records – patient's personal medical information is shared through the network for billing and treatment only. Patients are provided an opportunity to opt-out of electronic health data exchange. Prior to releasing any personal information, the identity of anyone using the EHR system is carefully confirmed to prevent unauthorized access or cases of mistaken identity. Digicert is the certificate authorizing body for Direct certificates of use. Patients and providers are identified through their personal provider office and organizations, respectively.
- 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 healtheConnect Alaska agreements and procedures.

A.8 Role of the Medicaid Management Information System (MMIS)

The Division of Health Care Services (DHCS) rebuilt the State's Medicaid claims processing and payment system. The new MMIS went into production in 2013 and was certified by CMS in 2018.

The State's previous MMIS was over 20 years old and was replaced with more modern technology. In September 2007, the department awarded a contract to Xerox (formerly Affiliated Computer Services and now known as Conduent) for a new MMIS. The contract included: 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 MMIS, known as Alaska Medicaid Health Enterprise, has been operational since October 2013. The system is available to providers 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 has self-service features so users can access the system through a user-friendly web portal. This MMIS system has incorporated 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. DHSS envisions making this data available to the HIE to support provider billing, member eligibility, and provider participation inquiries. 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. The provider web portal could be made available to support administration of the EHR Incentive Payment Program.

Additional features of the nMMIS include an interface to the National Provider Identifier (NPI) database and enhanced secure web-based provider enrollment, maintenance, communication, and tracking that is available through the provider self-service web portal.

Alaska's contract with its MMIS vendor is ending soon. Alaska is beginning to explore modernization through modularity starting with an updated MITA State Self-Assessment.

A.8.1 MITA State Self-Assessment (SS-A)

A.8.1.1 *MITA SS-A Overview*

In July 2008, Xerox 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, many 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:

- Update of MITA Maturity determination based on the MITA 2.01 Framework
- Completion of a MITA technical assessment that includes a view of the current systems

- 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, DHSS 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 business areas. The MITA SS-A update sessions revisited the "As-Is" and "To-Be" business processes and included a re-assessment of MITA maturity levels. Additionally, FOX completed a Technical Assessment of the systems that are currently supporting the Alaska Medicaid Enterprise.

A.8.1.2 *MITA SS-A Vision and To Be Roadmap*

CMS released the MITA Framework, version 3.0 on March 28, 2012. Additionally, CMS has published the MITA HITECH systems including a MITA Maturity model and workbooks for HITECH. Alaska has received CMS approval and requested Federal Financial Participation (FFP) to implement a HITECH MITA SS-A commercial off-the-shelf solution which will allow DHSS to complete a HITECH MITA 3.0 SS-A and continue to update and maintain MITA business processes as Alaska's HIT landscape changes. The contract for an updated MITA SS-A is currently going through procurement. All progress related to this effort will be reported in subsequent SMHP updates.

A.9 Current State Activities

Alaska is focused on enhancing the functions and capabilities to expand the statewide HIE. Alaska has requested and been granted funding assistance in an updated IAPD for a number of initiatives to increase the functionality and use of the statewide HIE. It is anticipated that the enhanced capabilities of the HIE will encourage providers toward meaningful use of CEHRTs and to begin exchanging data electronically, furthering objectives of the PI Program and increasing HIE participation.

A.9.1 HIE Initiatives

The HIE initiatives include efforts described below.

A.9.1.1 *HIE Sustainability Plan*

The HIE is in the early stages of developing a sustainability plan.

A.9.1.2 *Upgrading HIE Platform and Core Services*

The Alaska HIE upgraded its platform from Orion Health to Audacious Inquiry in 2018. Core services are also being upgraded with a Best-in-Breed approach which utilizes multiple technology vendors to provide HIE services. The review is well under way with "like to like" transition of functionality to be complete by the end of June 2019.

A.9.1.3 *Onboarding Support*

DHSS was granted HITECH funds to support continued marketing and improvements for onboarding and outreach efforts to EPs and EHs in the Medicaid PI Program. The physical landscape of the state of Alaska provides a barrier for outreach and onboarding activities due to the vast rural areas, tribal communities, and communication barriers that are created due to the

lack of Internet connectivity in some areas. To combat these barriers, the DHSS developed targeted onboarding campaigns particularly focused on the following activities to assist with increasing the ability for EPs and EHs to achieve meaningful use. The activities included:

- Onboarding providers to the HIE to support PI requirements
- Assisting EPs in moving forward with PI requirements

Moving into the final years of the PI Program, efforts will focus on increasing meaningful use of EHR systems and onboarding providers to the HIE as the window to begin participation in the program and attest to AIU has passed. The Alaska Trauma Registry and the AURORA system for EMT/Emergency Responders will also be onboarded to the HIE to enable the electronic exchange of trauma and emergency information. Both are expected to go live by the end of January 2020.

A.9.1.4 *Medicaid Claims Feed to the HIE*

Alaska plans to integrate the MMIS claims data into the HIE, allowing Medicaid providers to view their patients' Medicaid claims. This initiative will require contractor assistance from Xerox, LLC, (now Conduent) to complete required MMIS changes as well as Alaska's HIE service provider, Audacious Inquiry, to implement the necessary HIE updates. The DHSS IT Planning Office will coordinate the efforts of the vendors.

A.9.1.5 *Behavioral Health HIE Onboarding*

Developing a comprehensive and cohesive information technology system is a crucial element in accessing the rapidly developing behavioral health continuum of care within Alaska. DHSS will expand the use of HIE by behavioral health providers to improve coordination of care and overall quality of care provided to all patients across the state with the design, development, and implementation of a fully integrated behavioral health information management system that has the capability of exchanging secure information and is onboarded to the Alaska statewide HIE. The initiative is designed to accomplish four main goals:

- Increase coordination of care through onboarding to the statewide HIE
- Improve provider ability to meet meaningful use
- Increase behavioral health patient care across the state, specifically in times of critical need
- Improve data analytics capability at state level, leading to overall improvement in quality of care

A.9.1.6 *AKAIMS*

AKAIMS is the Alaska Division of Behavioral Health (DBH) web-based application that serves as a management information system (MIS), electronic medical record (EMR), and database for behavioral health providers. Originally developed for mental health and substance abuse grantee providers, AKAIMS users have expanded to include:

a. DBH grantee providers of substance abuse and mental health services
b. Alcohol Safety Action Program Providers
c. Fetal Alcohol Spectrum Disorder Diagnostic Teams

d. BRS children's residential service providers
e. Therapeutic Court
f. Department of Corrections substance abuse services

The vendor for AKAIMS will work with the DBH to develop a robust reporting database which will import and store the AKAIMS minimal data set, along with the minimal data set sent from provider agencies through the statewide HIE to increase coordination of care. Transition and coordination of care will be improved through this initiative as both primary care and behavioral health providers will have the ability to access critical behavioral health information when necessary. Patients in crisis will have improved care during critical times at the initial point of care through a fully operational two-way exchange health information system.

Although AKAIMS has been operational since 2003, this initiative also focuses on upgrading and developing the system to allow for HL7 transactions, ensuring Health Insurance Portability and Accountability Act (HIPAA) compliance. The development of AKAIMS as a comprehensive data repository with primary care and behavioral health data will allow the state stakeholders to utilize the data for federal reporting requirements and standards. Following the state analysis of the data, the state will be able to develop targeted outreach, marketing, and public health programs for specific patient populations to determine diagnosis trends throughout the state.

This initiative will assist with onboarding a total of 50 Behavioral Health providers to the HIE. healtheConnect Alaska reports that 17 behavioral health providers are in the onboarding queue.

Below is a listing of high-level tasks that will be completed during the implementation of the behavioral health IT initiative:

- Requirements/Gap Analysis - completed
- Implementation and Configuration (including development and testing) - completed
- Deployment for Customer Acceptance Testing - completed
- Deployment to Production - completed
- Onboarding of Providers – in process

Additionally, for this project Alaska DHSS has received monies from the Alaska Mental Health Trust Board that will support the initial onboarding cost to the HIE for 50 behavioral health providers. It is expected that onboarding behavioral health providers to the HIE will improve care coordination and management in the comprehensive and integrated behavioral health system. It will also directly allow behavioral health providers to support the eligible professionals and eligible hospitals with achieving meaningful use by supporting transition of care for mutual patients. The total amount for this specific onboarding effort is $1,348,000 with a 90/10 FFP. These funds will be paid to behavioral health providers through a grant process.

A.9.1.7 *Prescription Drug Monitoring Program*

The statewide Prescription Drug Monitoring Program (PDMP) database is now connected to the HIE. The implementation of this initiative and the ability to onboard additional providers to the PDMP gives them real-time, point-of-care electronic access to patient data. This technical structure utilizes and emphasizes the relationship with the connectivity to the HIE and empowers

providers across the state with access to critical patient information; it also enhances the opportunity to decrease misuse, abuse, and diverting usage of controlled substances.

The implementation also encourages cooperation and coordination among local, state, and federal agencies. Coordination of care activities will be improved as scheduled drug information is now available to pharmacists and other treating health care providers, ensuring a seamless transition through the continuum of care. The onboarding of providers will also increase their capability to attest to the 2015-2017/Stage 3 Final Rule Meaningful Use requirements for HIE as another mechanism for data to be transmitted to the HIE and consumed within the HIE.

Below is a listing of high-level tasks completed during the implementation of the PDMP initiative:

- Coordination with the Alaska Board of Pharmacy
- Requirements/Gap Analysis with HIE and vendor
- Configuration and testing of connection between HIE and PDMP solution
- Implementation/Deployment to production environment
- Onboarding activities - ongoing
  - Phase 1: Medicaid Providers (Approximately 30,000 providers)
  - Phase 2: Remaining Providers Statewide (Approximately 3,400 more providers)

A.9.1.8 *Public Health PRISM System Development*

DHSS has received HITECH HIE funding for the design, development, and implementation of an automated lab result system and establishment of a specialized registry for automated HIV/Sexually Transmitted Disease (STD) lab reports, allowing an additional option for EPs and EHs to achieve meaningful use. Within the Division of Public Health (DPH), the HIV/STD Program addresses critical public health issues and activities with the goal of preventing STDs and HIV infection in Alaska as well as their impact on health.

The implementation of the PRISM project will develop an automated electronic lab record from the HIE to the PRISM system. The PRISM system is the HIV/STD lab reporting system. Currently, the PRISM system does not have any mechanism of receiving HL7 messages. The requested funding would allow the PRISM system to receive HL7 messages, allowing automated system development and information exchange. In a six-month timeframe, it is expected that there are over 2,700 lab results received for chlamydia and gonorrhea (STDs) alone. The development of an electronic lab record system would give providers the ability to achieve meaningful use through a specialized registry and would reduce the administrative burden of the current manual submission process.

The PRISM STD/HIV system receives Electronic Lab Results (ELRs) that are reported to the AK STARS system. DPH staff print ELRs and manually input data into PRISM. The PRISM ELR automation project is designed to automate four ELR feeds into PRISM to eliminate manual data entry. The four data feeds are:

- The HIE
- LabCorp
- Quest
- Alaska State Public Health Labs (ASPHL)

UAT and final adjustments to the three lab feeds are in progress and expected to be in production in the summer of 2019. However, additional work will be needed after the ASPHL goes live with LIMS.

Connecting to the HIE will be more complex because it isn't one entity (like LabCorp) but provides data from many sources. Data feeds must be individually configured for each source that sends ELR through the HIE.

The project will support the following objectives to complete the implementation of the PRISM project:

- Gather requirements of HL7 messages to begin preparing to receive ELR messages
- Configure internal BizTalk HL7 processes to translate the HL7 messages to PRISM
- Onboard lab providers – in progress
- Develop and implement the process of splitting STD/HIV messages from other EPI messages
- Onboard with the statewide HIE
- Perform testing activities

A.9.1.9 *Public Health System Modernization*

The Public Health System Modernization initiative is to give EPs and EHs the tools to report electronically to support and increase meaningful use and improve the coordination of care, the transition of care, and the availability of specialty registries.

DHSS, in partnership with DPH, has identified multiple public health systems and registries in which the current "As-Is" is a manual process for reporting and data submission of public health data. Through this modernization initiative, over 15 public health systems have been defined as meeting the specifications as specialized registries. However, the submissions vary in format, transport, and destination. Additionally, the registry data is housed in multiple databases that are used across the agency.

The following registries could be improved to allow electronic reporting:

- AK Facility Data Reporting – hospital inpatient and outpatient discharges (hospitals only)
- AK Trauma Registry – trauma related injuries and subsequent treatment information
- Lead Electronic Lab Reporting – currently reported by hospitals; this will be expanded for EP electronic submission
- OZ System – newborn screening and hearing detection, including post-discharge follow-up
- AK Birth Defects Registry – infants and young children with birth defects
- Death and Injury Reporting – including multiple registries:
  - AK Firearm Injury Reporting Surveillance System – firearm related injuries
  - AK Fatality Assessment and Control Evaluation Registry – occupational injury data collection
  - AK Violent Death Reporting – injuries resulting in death
  - AK Drowning Surveillance System – drowning related fatalities

Electronic reporting is currently available for the following registries:

- VacTrAK – immunization registry
- Lead ELR – currently available to hospitals only
- Cancer Registry
- AKSTARS – reportable disease registry
- BioSense – syndromic surveillance reporting
- Electronic Lab Results reporting – hospitals only

The project will provide a mechanism for the design, development, and implementation of a registry database that will store registry data in a centralized location; improving security of the data, reliability, performance, and integration of datasets, and the range of analytical methods available. This modular approach will yield rapid integration of the MCI with registries and can support the DHSS ESB which already supports integration with the statewide HIE.

The projected data flow, named the DHSS Gateway, is as follows:

Figure 4 – DHSS Gateway
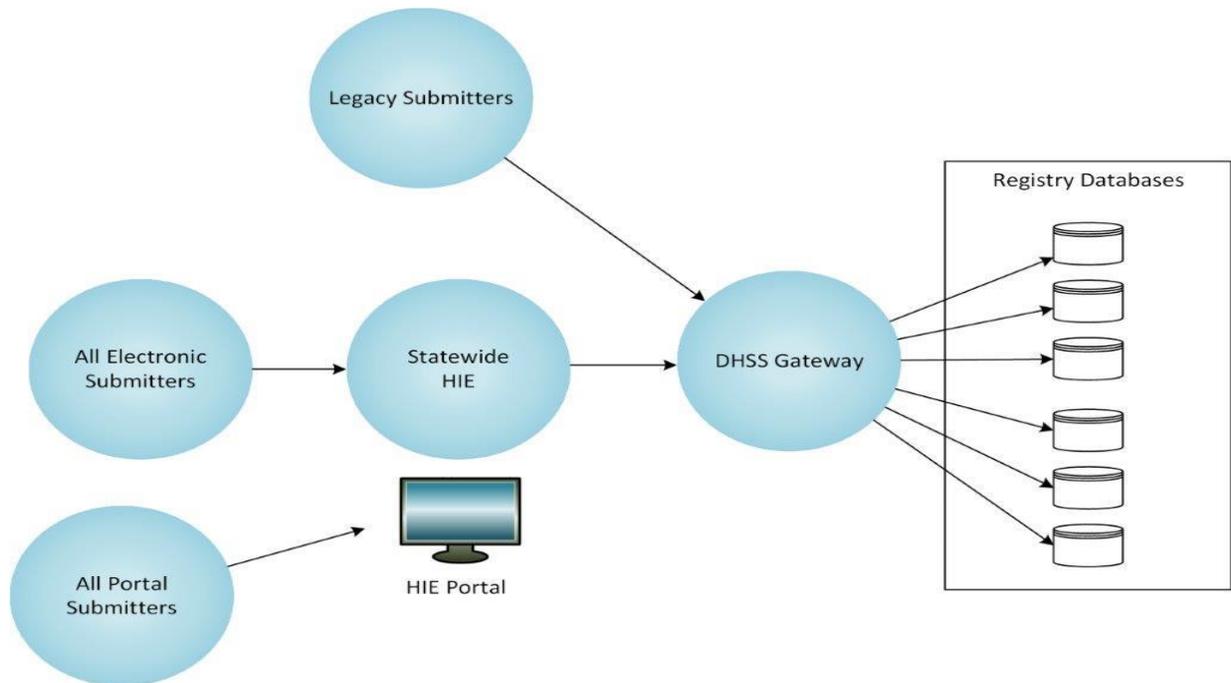
Through the implementation of the modernization initiative, providers will have the ability to submit public health data to a single point of entry, the HIE. The HIE will then pass the received submissions through the DHSS Gateway to store and parse the data for the individual registries, offering a streamlined and efficient method of submission.

A.9.1.10 *MCI Enhancements*

DHSS is expanding its support for the continued Design, Development, and Implementation (DDI) of modifications to the statewide MCI to improve activities for EPs and EHs trying to achieve meaningful use across the state of Alaska. This DDI effort will enhance the functionality of the MCI, ESB, and Decision Support System which will support other projects. Additionally, this DDI effort will allow for the development of automated data feeds to the DHSS Decision Support

System, helping providers improve their capability for transition of care and care coordination activities for all Alaskans.

Further development of the MCI will support and improve the interoperability of certified EHR technology by enabling providers to submit health care data to DPH and other state agencies via the Direct Gateway. Additionally, MCI development will facilitate the integration of services across DHSS, and it will also enable identity management functions across all connected services.

This project will support the State of Alaska's HIE approach and improve transition of care and care coordination efforts by supporting the following activities:

- Technical assistance upgrading the MultiVue environment including knowledge transfer and documentation
- Requirements gathering to build MCI infrastructure based on DHSS business use cases including design of the security framework for defined user roles and views
- Updated MCI infrastructure including data dictionary, suite of universal web services, security framework, connection with BizTalk, and web services for service-oriented architecture
- Creation of a beta solution with static dataset to show preliminary results for identified DHSS use cases and test the usability and workflow of the overall system
-
- Inclusion of data from MMIS and Vital Stats along with the opportunity to bring in new feeds from other DHSS systems

A.9.2 HIT Activities Impact on Alaska Medicaid Members

Alaska has implemented Results Based Accountability across the entire department where all activities/programs/finances roll up to meet the Department's core services and mission. Every program is evaluated on its support for the state health goals.

DHSS IT Governance is the committee responsible for reviewing, approving and prioritizing all information technology spend (people and dollars), using Results Based Accountability in the scoring and prioritization of all new and existing business needs.

HIT is integrated within the department and is evaluated for its continued impact on the State health goals. Specifically, HIT has the following performance measures:

Priority: Promote the health of Alaskans - to maintain and improve the physical and mental health of Alaskans requires sound policy, sufficient services, health coverage and access to care

Core Service: Manage health care coverage for Alaskans in need:

- Percentage of providers connected to the HIE for Direct Exchange
- Percentage of providers connected to the HIE for Query based Exchange
- Cost per provider to operate the HIE

Priority: Promote the health of Alaskans - to maintain and improve the physical and mental health of Alaskans requires sound policy, sufficient services, health coverage, and access to care.

Core Service: Facilitate access to care**:**

- Percentage of providers who attest to meeting PI requirements to provide online access to patients

These integrated relationships throughout the department demonstrate how HIT is helping Alaska meet state health goals.

A.10 State Medicaid Agency Relationship with State HIT Coordinator

Alaska has a State HIT Coordinator working directly for the DHSS Commissioner who is ultimately responsible for the State Medicaid Agency. The HIT Coordinator's role is to manage all HIT activities for Alaska DHSS, including working with the Division Directors who support the Medicaid environment to align with their specific IT activities.

Alaska's HIT Coordinator participates on the healtheConnect Alaska Board of Directors and other work groups to ensure efficiency and effectiveness of planning efforts.

A.11 Other Activities

All activities relevant to this SMHP have been reported elsewhere in this document.

A.12 State Laws and Regulations

A.12.1 Alaska Medicaid Expansion

Alaska expanded Medicaid in 2016, and as of December 31, 2018, nearly 47,000 Alaskans have qualified for health coverage under Medicaid expansion. Medicaid expansion is particularly important in Alaska. Previously if an Alaskan was single or a married couple without dependent children it was not possible for these individuals to qualify for Medicaid under any circumstance.

While Medicaid expansion has provided significant benefit to Alaskans it did not significantly change the number of Medicaid health care providers in Alaska. Alaska is addressing this challenge by enhancing electronic data exchange capability, modernizing Public Health electronic capability, and other measures to assist providers in meeting the needs of the increased Medicaid population. Specific steps to achieve these goals are detailed in subsequent sections of this SMHP.

More details about Medicaid in Alaska can be found at the following link:
http://dhss.alaska.gov/HealthyAlaska/Pages/dashboard.aspx

A.12.2 Senate Bill 74 – Medicaid Redesign

In June 2016 Governor Bill Walker signed Senate Bill 74 into law, making way for significant financial savings to the state and expansion of health care services offered to Medicaid recipients in Alaska. Some of the reform measures included in this bill are as follows:

- Expanding the use of telemedicine
- Expanding the use of primary care case management and health homes for people who have chronic health conditions and behavioral health needs
- Reforming the behavioral health system

- Enhancing a public/private partnership to reduce non-urgent use of emergency room services
- Setting up better protections to prevent opioid dependence
- Enhancing fraud detection measures

Other provisions include piloting health care delivery models and innovative payment models that move Alaska's Medicaid program from paying for volume to paying for value, while considering the unique needs of Alaska.

Senate Bill 74 directs DHSS to develop a health information infrastructure that will provide the data required by providers for care coordination and quality improvement, and to provide the information support to enable the development and implementation of the provisions of Senate Bill 74.

A.12.3 Promoting Interoperability Program Specific Proposed Regulation

New final regulations that went into effect in program year 2017 made the following changes

- Removed the mandate for the EP/EH to submit a signed original attestation to the EHR office. They are able to upload it to the SLR
- Mandated that EPs connect and maintain participation in the Alaska Health Information Exchange to support meaningful use, including transmitting public health date via the statewide HIE
- Updated the appeals section to reflect the appropriate Alaska Statute to suspend or terminate participation in the Medicaid Program. The new appeals section reflects Program Integrity procedures

A.13 HIT/E Activities Across State Borders

healtheConnect Alaska has completed connectivity with the eHealth Exchange and is currently planning to engage with Carequality and the CommonWell Health Alliance during the third quarter of calendar year 2019. Engagement with these national networks will facilitate interoperability and health information exchange beyond Alaska's state borders.

A.14 Interoperability of the State Public Health Systems

The following sections describe the Alaska Public Health systems that are available to support Alaska's HIT efforts.

Alaska is also funded to conduct a modernization of the Public Health systems to establish increased electronic submission capability in support of Meaningful Use. Please see Section A.9.1.9.

A.14.1 VacTrAK (Immunization Registry)

VacTrAK is a consolidated immunization information system that has been developed in states over several years. It now counts over 4 million immunizations, including immunizations from Public Health Nurses, using the Resource and Patient Management System (RPMS). Due to the "infancy" and 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 in a central database where 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. The State of Alaska has issued 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.

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 record updates from individual provider EHRs, historical records, and state-supplied vaccine inventory control. VacTrAK is interfaced with the HIE using a pass-through solution for immunization information. Several health care entities are sending production data through HIE to meet PI requirements.

A.14.2 Syndromic Surveillance

Currently DHSS is accepting de-identified syndromic surveillance data from hospital emergency departments in Alaska. The data is sent from hospital EHRs thru the HIE to the Centers for Disease Control and Prevention (CDC) web-based program called BioSense. The data can be searched by syndrome names such as respiratory infections. This gives DHSS the capacity to monitor data to observe health trends within Alaska. In July 2016, BioSense was changed to a more robust syndromic surveillance and statistical program called Essence. As of this report 17 hospitals are transmitting syndromic surveillance data via the HIE.

A.14.3 Cancer Registry

Currently, submission to the Cancer Registry is done via Direct Secure Messaging. A component of the Public Health Systems Modifications (Section A.9.1.11) is planned to allow electronic submission via the HIE. Discussions are underway between the State and the HIE.

A.14.4 Specialized Registries

DHSS in partnership with the DPH has identified multiple public health systems and registries in which the current "As-Is" process is a manual process for reporting and data submission of public health data. Through this modernization initiative (Section A.9.1.11), over 15 public health systems have been defined as meeting the specifications as specialized registries. However, the submissions vary in format, transport, and destination. Additionally, the registry data is housed in multiple databases that are used across the agency. This initiative will allow these identified registries to be made available for electronic submission by providers. For additional information regarding the specialized registries, see Section A.9.1.10 of this SMHPU.

A.14.5 Lab Information Management System (LIMS)

A.14.5.1 ASPHL. With respect to the Alaska State Public Health Labs, he Alaska LIMS system supports two state labs via two separate LIMS databases; one in Fairbanks and one in Anchorage. Starting in June of 2019, LIMS uses Horizon™ LIMS version 12.6 in a single unified database. Prior versions required the use of two separate lab databasesand systems due to bandwidth limitations between the two labs. With the new LIMS, a new paradigm has been incorporated to increase efficiency and reduce needless data transmission between the two labs. A mirror, near real time backup data base is maintained in Fairbanks for disaster recovery.

In 2012, a review was conducted to determine the status of Alaskan labs' capability of enabling electronic lab data submission. The study found that the existing infrastructure and software limited electronic data submission. With Horizon™ LIMS version 12.6, many of these barriers have been eliminated or reduced. Lab result reporting via cloud-based faxing will become a reality in calendar year 2019. A web portal to request tests as well as reporting results will be initiated in 2020. ASPHL currently sends reportable lab results directly to Epidemiology through a secure link using HL7 messaging. There are no plans to connect ASPHLs to the HIE.

A.14.5.2 Provider ELR. On the provider side, the Alaska Department of Public Health worked with the HIE to facilitate ELR via provider interface with the HIE using ORU.

A.14.6 Vital Statistics

Alaska has implemented a new Vital Statistics system called EVRS. The system can be interfaced with the HIE after some administrative processes are defined to allow for tracking and billing.

A.14.7 Resource and Patient Management System (RPMS)

RPMS is an information management system administered by the U.S. Indian Health Service (IHS) that includes clinical, business practice, and administrative information management applications, and it 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.

A.14.8 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 Logical Observation Identifiers Names and Codes (LOINC) and SNOMED terminology codes.

The information is subsequently transmitted to CDC as required. Currently, AK Stars uses the Public Health Information Network Messaging System. The system securely sends and receives encrypted data over the Internet to public health information systems using Electronic Business Extensible Markup Language (ebXML) technology. The Lab Information Management System (LIMS, detailed in A.14.5 above) 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.

Alaska is currently accepting electronic reportable laboratory results from hospital EHRs through the HIE.

A.15 HIT Related Grants

Alaska has not received additional grants since the last SMHP update.

B. 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 achieves 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 healthcare in Alaska.

B.1   HIT/HIE Goals and Objectives

DHSS has achieved many of the goals initially established at the beginning of the program. As we move to the final years of the PI Program, we will continue to work toward our overarching goals of improvements in the availability of services delivery, cost containment, and improved outcomes. These achievements will be made possible through improved data quality, enhanced functionality, and assisting providers in achieving meaningful use.

The state's ultimate goal is to improve access to healthcare and assure quality of healthcare for Alaskans. Specifically, the mission of the DHSS is to promote and protect the health and well-being of all Alaskans. DHSS's overall goals continue to drive increases in provider participation with EHRs and improvement in the quality of care, patient safety, and healthcare outcomes.

We will encourage providers to meaningfully use EHRs by facilitating provider-to-provider communication and electronic data exchange; broadening Public Health Reporting options; and, focusing on initiatives to increase EHR adoption and HIE participation by Behavioral Health, Long Term Care, and Public Health providers to improve overall coordination of care.

HIE goals focus on expanded participation and use of the statewide HIE including:

- Increased use of the HIE for Public Health reporting
- Improving the overall performance of the HIE

B.1.1 Vision for HIT Environment

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

DHSS recognizes that it plays a significant role in transforming healthcare in Alaska and has developed its vision for HIT to address many of the core challenges described above. To establish the foundation for effective HIT of the future, DHSS has defined the following goals:

- Ensure the best available evidence is used for making decisions
- Increase price and quality transparency
- Pay for value
- Engage employers to improve health plans and employee wellness
- Enhance quality and efficiency of care on the front-end
- Increase dignity and quality of care for seriously ill patients
- Focus on prevention

- ▪ Build foundation of a sustainable health care system

DHSS believes that access to good healthcare services, both physical and mental, is essential to all Alaskans' ability to actively participate in and contribute to their families, schools, places of employment, and communities.

The DHSS vision for Alaska's future HIT continues to be a multi-year plan which consists of existing and planned projects and initiatives that will significantly contribute to Alaska's health care transformation. By leveraging implementation of new technologies DHSS will continue to do its part in supporting a healthcare system that places individual Alaskans, their families, and communities at the center of their healthcare experience. Ultimately, the focus will shift from treatment to prevention.

Alaska's vision for HIT also relies heavily on leveraging HIE technologies and utilizing clinical information obtained through adoption, implementation, and upgrade of certified EHR systems by providers and facilities.

The future of Alaska HIT includes the following six components and related strategies:

- ▪ Simplified access to HealthCare Information and Services for Beneficiaries
  - o Enhance secure web-based Beneficiary information, communication, outreach and tracking
  - o Provide enhanced provider online search capabilities
  - o Improve service delivery through Interactive Voice Response (IVR) and Voice Over Internet Protocol (VOIP) technologies, where possible
  - o Design and implement online capabilities to enhance quality consumer-directed access to care
  - o Develop a strong Medical Home model delivery system
  - o Increase collaboration between all state payers and providers
  - o Streamline Point-of-Service functions (e.g. Smart Cards)
  - o Fully develop e-Prescribing functionality
- ▪ Simplified interaction with the Health Care infrastructure for Providers
  - o 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
  - o 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 option
    - ▪ Enhance web-based prior authorization function
    - ▪ Enhance web-enabled claims processing functionality

- ▪ Improve eligibility coordination and knowledge sharing between agencies and business partners
  - o 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
    - ▪ Fully develop e-Prescribing functionality
- ▪ Improved Health Care outcomes measured by increased usage of performance criteria
  - o Create clear outcomes and expectations for providers to address pay for performance and quality of care
  - o Incentivize providers to use quality preventative care
  - o Utilize HIE/HIT to improve health care quality and safety
  - o Develop and expand innovative approaches to prevention
  - o Develop a comprehensive statistical profile for delivery and utilization patterns
- ▪ Evolving use of modern information technology to improve the delivery of healthcare
  - o 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 including regulatory vs. contract monitoring
    - ▪ Develop webcasts and other online training accessible to MMIS users
    - ▪ Enhance web-based prior authorization function
    - ▪ Facilitate move to total electronic claims
    - ▪ Enhance web-enabled claims processing functionality
    - ▪ Automate Third Party Liability functionality
    - ▪ Fully develop e-Prescribing functionality
    - ▪ Enhance pre-payment and post-payment pattern analysis
    - ▪ Provide contractor system supports to improve efficiency of contracting process
  - o Coordination of Care
    - ▪ Develop enhanced interfaces to existing registries
    - ▪ Develop strong Medical Home model delivery system
  - o Optimization of Care
    - ▪ Provide secure, web-based assessment tool for waiver, senior, and disability functions
- ▪ Improve service delivery through IVR and VOIP technologies where possible

- o Provide clear and accurate Early and Periodic Screening, Diagnostic and Treatment services and tracking
- o Explore health care literacy program to reduce Emergency Department (ED) use by Medicaid population
- o Implement Statewide HIE to improve episode of care management
- o Develop and expand innovative approaches to prevention.
- o Streamline Point-of-Service functions (e.g. Smart Cards)
- Integrated medical service delivery model that includes high quality Medicaid providers
  - o Encourage and promote retention of quality Medicaid providers
  - o Explore healthcare literacy program to reduce ED use by Medicaid population
  - o Implement Statewide HIE to improve episode of care management
  - o Improve eligibility coordination and knowledge sharing between agencies and business partners
- Move from "client"-focus to "family-" or "community-" based healthcare.
  - Develop strong Medical Home model delivery system

B.2   IT System Architecture

DHSS IT implemented the architectural design and project plans to execute this state of integration by leveraging an interface engine-supported logical architecture.

Figure 5 – Anticipated Logical Architecture 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, the figure highlights the state MCI and MPI that will be made available to the HIE infrastructure via the interface engine.

Figure 5 – DHSS Enterprise Service Bus Logical Architecture
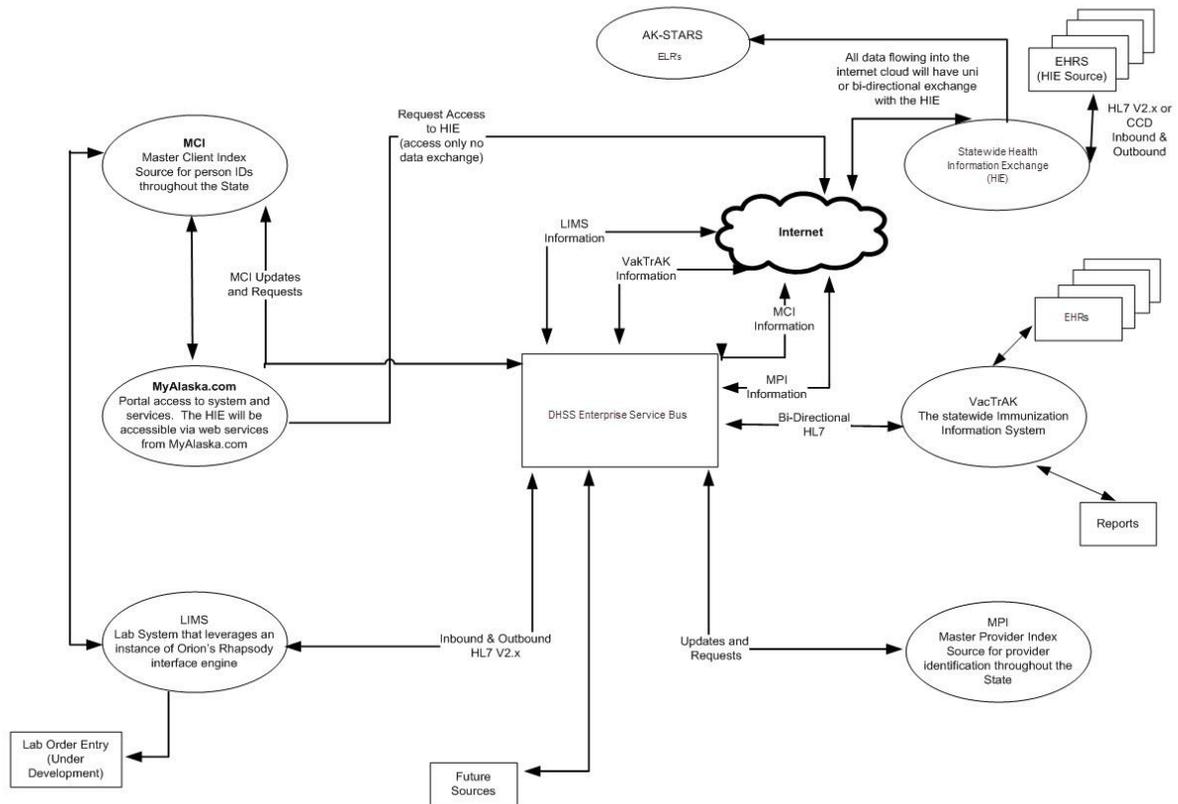
B.2.1 Data Sharing Components of Alaska HIT solutions

The Alaska HIE is the centerpiece of data sharing in Alaska. The Alaska HIE implementation has evolved over time with increased participation. As Alaska HIT systems are integrated with the HIE the overall value proposition of the HIE will be further increased. It is anticipated that this increase in value proposition will drive increased HIE participation rates moving forward. The sections below describe some of the essential components of the HIE infrastructure.

B.2.2 Direct Project Implementation

healtheConnect Alaska, through multiple vendors, is committed to modernizing and maintaining the HIE's relevance as the secure messaging provider for Alaska. They have selected two new vendor partners to support their secure communications stack. TigerConnect (for Direct-certified text messaging) and Inpriva (Direct Secure Messaging) are leaders in their respective areas and significantly expand the HIE's offerings as one of the largest DSM providers in the country.

TigerConnect will seamlessly integrate into the Audacious Inquiry unified landing page and will be integral in the HIE 2.0 initiative. TigerConnect will provide ADT triggered text messaging to participating providers of record for their patients and will support new DSM alert notifications. TigerConnect is already being used in Alaska with the Alaska Native Tribal Health Consortium,

Imaging Associates, and many other provider organizations. By healtheConnect Alaska's new partnership, they will be able to expand the secure texting directory for all participants.

Inpriva brings a sorely needed modernization to the HIE's DSM platform by supporting mobile devices, digital verification, and overhauling healtheConnect Alaska's process for onboarding new DSM participants. healtheConnect Alaska is able to issue new accounts within 72 hours of receiving the notarized identification form which is a significant decrease from the 2-4 week wait with Orion Health, the Alaska HIE's previous vendor. Additionally, Inpriva regularly uploads accounts to the national direct registry to facilitate secure directory access for all participants. All DSM users have been migrated to Inpriva.

B.2.3 HIT Data and Technical Standards

The Alaska HIE has incorporated, where appropriate, data, and technical standards which enhance data consistency and data sharing through common data-access mechanisms which are currently available to Alaska HIE participants.

B.2.3.1 *National Standards*

The HIE incorporates the following national data standards for health information exchange:

- Continuity of Care Documents (CCD)
- HL7
- Secure Socket Layer (SSL) encrypted Simple Object Access Protocol (SOAP)
- XML
- LOINC
- SNOMED
- NCPDP

B.2.3.2 *Secure Data Exchange*

An HIE relies on systems using trusted data exchange standards. The new healtheConnect Alaska solution will use a combination of technologies to ensure secure data exchanges with sending and subscribing organizations. First, connections will be created between organizations and the HIE using the Mirth Integration Engine to manage electronic messaging. This is an open source tool that has been successfully deployed in many other state HIEs and is easily configurable by a combined state and vendor team in order to accelerate development for the transition from the Orion Solution. Secure communication between the sending organizations and the Mirth Integration Engines will be sent over site-to-site VPN connections. Sending organizations data feeds will be fed through the NextGate Enterprise Master Person Index (eMPI) solution to ensure the most accurate patient matching can occur so that subscribing organizations only see relevant data about their patients. Communication between the various system components are secured with transport layer security and all persistent data stores are encrypted at rest. Finally, Audacious Inquiry's Encounter Notification Service and Unified Landing Page ensure that the appropriate consent, authentication, authorization, and audit occur to ensure secure data exchange. These tools implement a robust mechanism to perform role-based access control to the information that is made available to the users of the subscribing organizations.

B.2.4 Leveraging the SLR Beyond the Incentive Program

The Alaska SLR allows providers to apply for and receive PI Program payments and submit electronic CQMs.

B.2.4.1 *Integration of Clinical and Administrative Data*

DHSS convened a clinical work group with representatives from DHSS and DPH 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 workgroup identified goals for meaningful use attestation, clinical quality measures, and eventually clinical data to be made available for program evaluation through the Alaska HIE infrastructure.

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 identified included
    - Immunization Registry
    - Cancer Registry
    - Alaska Trauma Registry
    - Alaska Behavioral Risk Factor Surveillance System
    - Lead Electronic Reporting
    - AK Stars Disease Reporting System
- Collect as much registry information as possible in the Alaska HIE to reduce provider reporting burden and enhance the Alaska HIE business case

DHSS began the initial stages of a DPH Modernization process by evaluating each of the existing registries to identify upgrades needed for participation with data exchange. There are plans for specific projects such as connecting the Alaska Trauma Registry but other Public Health registries are not ready yet for modernization due to a lack of human resources to support the project.

Goal #2 – Ensure that Medicaid providers can become meaningful users.

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

Goal #3 – Improve provider participation.

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

Goal #4 – Improvement in Population Health Outcomes.

- Define specific Target Population Health measures, many of which are aligned with the PI clinical quality measures such as:
  - Diabetes prevention and monitoring
  - Heart Disease and cancer monitoring, education, and prevention

Incorporate the Medicaid claims data from the MMIS to share claims data with Medicaid providersThe HIE Clinical Workgroup, comprised of stakeholders internal and external to DHSS, is enthusiastic about richer clinical data that contributes to improvements in care. The Alaska HIE will also provide an opportunity to develop measurements in a broader (non-Medicaid) population that has not been previously available.

DHSS expects that the availability of clinical data in the Alaska HIE 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.

B.2.5 Medicaid Providers Interfacing with the State Medicaid Agency IT Systems

Access to the Alaska MMIS is restricted and, when granted, limited according to business need. Providers can access the secure Medicaid portal to update their information, such as address, and perform permitted actions, such as checking eligibility. Opportunities to enhance provider information via the use of Public Health reporting via the HIE are planned and detailed in sections below.

B.2.6 Local and State Programs Interfacing with the State Medicaid Agency IT Systems

Many state agencies interface with the Alaska MMIS, including Medicaid eligibility, state licensing, the Attorney General's Department for fraud and abuse, and the state Public Health systems. Opportunities to enhance and streamline these interfaces were included in the MMIS development project.

B.3   State Medicaid Agency IT System Interfaces

Providers utilize the SMA's state level repository (SLR) to demonstrate compliance with PI Program requirements. The SLR allows providers to attest for AIU and Meaningful Use, including submission of CQMs. Initial registration, or changes to registration, is done via the CMS Registration and Attestation (R&A) system; the R&A system transmits a B6 transaction notifying the states that the provider is applying for the state's PI Program.

The state system, in addition to processing multiple transactions to and from the National Level Repository (NLR), also has an automated real-time interface with the Certified Health IT Product List (CHPL) to verify an attested provider's EHR has been certified and is eligible for incentive payments. The state system also receives provider-related data from the MMIS, including the number of provider Medicaid encounters.

Additional discussion of the state's SLR process is described in Section C.

B.4   HIE Governance

HIE governance is discussed in detail in Section A.10.

The DHSS Commissioner (or their delegate) has a seat on the HIE Board of Directors. Medicaid and DHSS convene quarterly IT Governance meetings which include the HIE. Also, Medicaid and

DHSS are involved in statewide issues relative to the HIE and participate in meetings held by HIE Stakeholder Groups.

B.5 Encourage Provider Adoption Strategies

Alaska is focusing on enhancing HIE functions and capabilities to expand the statewide HIE to encourage the meaningful use of CEHRT, increase electronic exchange of health data, promote interoperability, and increase HIE participation.

B.5.1 HIE Initiatives

healtheConnect Alaska, through its evolution over the past decade, has built a governance model, a legal framework, policies, awareness, and ultimately trust to allow the exchange of health information. As DHSS and other healthcare stakeholders look to reform healthcare in Alaska, patient information becomes increasingly valuable. Given this market need, an alternative path forward matches technologies and services with proven HIE offerings for value-based care arrangements:

- An ADT network to enable notifications to providers to coordinate care between settings
- An MCI to resolve patient identity, tuned by leveraging unique data sources to optimize matching.
- A user management solution to provide identity and access management.
- A gateway to the national networks (eHealth Exchange, Carequality, CommonWell, etc.)

The approach is also differentiated by several strategic factors:

- Build incrementally by prioritizing low risk, high value services.
- Focus on core HIE services (MPI, User Management, Interfaces, etc.).
- Transition from a clinical data repository to a federated "gateway" to national networks (limiting centralized data stores).
- Onboard key data sources (for example, all hospital ADTs).
- Leverage Open Source and Cloud Technologies (to minimize vendor-lock). Provide access to data via APIs (to enable EMR workflows and Patient Engagement Apps)

Section A.9.1 discusses current and planned HIE initiatives, which also include:

1. Developing an HIE sustainability plan.

2. The HIE has migrated to a Best-in-Breed approach utilizing multiple technology vendors to provide HIE services. Platform upgrade has been completed and old platform has been decommissioned. All interfaces (CDC, IZ, ELR, CH) and data feeds (ADTs, ORUs, and CCDs) have been migrated. Information is accessed by providers through healtheHUB, a unified landing page and web-based query portal that integrates applications, services, and other health information exchange data sources on one platform. Core services are also being upgraded as indicated below:

   o Implement ADT alerting: use Audacious Inquiry's Encounter Notification Service to create data feeds for subscribing organizations based on their patient panels and work to integrate those alerts into the organization's EHR.

- o PROMPT Task View/Census View: this allows for review of notifications received and tracking of status of action required as a result of notifications to prioritize care coordination activities by subscribing organizations. This service is live.
- o All Direct Secure Messaging users have been migrated to a more robust solution offered by Inpriva. This user base includes the state users. The number of users is 5000+ which is less than the 6500+ users previously reported. During our migration, we discovered a high number of user accounts that had been deactivated but were still being counted as users.
- o Ambra Image Exchange: connect the HIE with Ambra Image Gateway to allow for subscribing organizations to see images completed at other facilities. This service is live.
- o HIE Integration of Social Determinants of Health (SDoH) and Community Engagement: The Health Information Exchange will leverage data received from participants that contains social determinants of health data and be able to display and share this information with HIE participants through the unified landing page. healtheConnect Alaska will engage the provider community around SDoH and will connect with a variety of stakeholders who collect SDoH data today to include: behavioral health providers, data sets from other Alaska projects already collecting data such as the Mat-Su Foundation, HIE participants' EHRs that are collecting SDoH data, and other community survey tools and systems collecting SDoH data. This project will also provide a connection to social service agencies to ensure that patients who indicate a social need will get services.

2. HIE Onboarding Support will continue for:
   - o Behavioral health providers, tribal providers, and partner tribal providersCorrections facilities
   - o Medicaid providers that are not eligible for the PI Program
   - o Alaska Trauma Registry AURORA System which will allow EMT/Emergency Responders to submit and receive data to the HIE. This project also provides for disaster response services to make patient data available in the event of a disaster.

3. The environmental scan was completed and results were incorporated into the HIIP. The HIIP was submitted to the Department in August 2018 and a response to the report from the Department was included in the legislative update in Fall 2018. The Department continues to explore potential opportunities for IT support and implementation based on the recommendations in the HIIP.

4. Medicaid Claims Data Feed project will occur after DHSS's MMIS has been evaluated to determine best method to share claims data.

5. Integrate Alaska Psychiatric Institute's (AkPI) data into the HIE (on-boarding activity): using a pull methodology, the HIE will access the state's only inpatient psychiatric hospital's data on a nightly basis and store the raw CCD in a repository. When subscribing organizations make queries for their patients, those queries will be matched against the CCD repository and in compliance with the implemented consent policy, information will be shared using Audacious Inquiry's Unified Landing Page or through AkPI connections to EHRs.

- o Work directly with Wellpath who is taking on the operational role for AkPI to integrate Alaska Psychiatric Institute's data into the HIE. This would be a robust bi-directional flow of data so that AkPI would receive important community data for patients who are admitted as well as sending relevant AkPI data to providers who are seeing AkPI patients. We will leverage our notification service to make sure that providers are receiving timely notifications regarding this sensitive population of patients.

- o Behavioral Health Unified Landing Page Integration: Design, development and implementation to integrate behavioral health data into the Unified Landing Page application for the statewide HIE. This deliverable will also include the development and implementation of a robust consent management model that will allow for proper sharing of behavioral health data in Alaska including 42 CFR Part 2 data.

6. AKAIMS to further support Meaningful Use
7. Add Prescription Drug Monitoring Program (PDMP) access via Single sign-on: connect with Alaska's PDMP using Appriss gateway and also integrating medication fill history data via Dr.First data feeds (which will be connected using HL7 compliant connectivity).
8. DPH PRISM System Development as a specialized registry: this project also includes integrating the State Lab results data into the HIE by connecting the Laboratory Management Information System (LIMS) to the HIE for query by subscribing organizations.
9. Public Health System Modernization to increase opportunities for meeting PI requirements through Public Health reporting.
10. In the summer of 2018, the Alaska HIE migrated from its NextGate identity management solution to an enhanced Nextgate EMPI in order to improve patient matching. In addition, the HIE will implement consent policy and Master Patient Index integration: enhance the HIE master patient index by integrating additional data sources, including the DHSS Master Client Index, and automating consent policies in compliance with state and federal requirements.
11. Other healtheConnect Alaska initiatives include:
    - Provider Directory project
    - HIE sustainability planning with Briljent
    - Smart Alerts (expansion of event notification system which sets the stage for e-case reporting)
    - Electronic case reporting
    - VacTrAK bidirectional interfaces
    - Immunization widget
    - Vital Statistics integration
    - Encounters timeline of ADT patient data
    - Technology hub model
    - Onboarding correctional facilities
    - Single Sign-On to the HIE healtheHub portal to integrate into provider workflows

- Audit reporting for state agencies to include PDMP and registries

The following picture relates healtheConnect Alaska's "To Be" vision of an interoperable HIE platform combining multiple "best in breed" technologies. See *Figure 6 – healtheConnect Alaska approach*, below.

Figure 6 – healtheConnect Alaska Approach

B.5.2 Outreach Initiatives

In 2015 and extending into 2016, much of the outreach activities focused on identifying eligible Medicaid providers, encouraging them to participate in the PI Program, and informing them that 2016 is the last year to begin participation. Outreach efforts are now focused on Stage 3 and program year 2019 PI Program requirements. Outreach will focus on the reduced PI requirements which started in 2015 and may enable providers to successfully attest for Meaningful Use. Also, we continue to inform providers of the expanding capabilities of the HIE and how these capabilities will assist them in achieving Meaningful Use.

DHSS will continue to develop outreach materials and other methods of communications to encourage providers to continue attesting for Meaningful Use.

B.5.3 Medicaid Expansion

Alaska implemented Medicaid expansion in June 2016. While the number of Medicaid participants increased, there was not an increase in the number of providers. Alaska and DHSS are taking steps to increase the efficiency of healthcare delivery for Medicaid providers in an effort to assist them with larger Medicaid populations.

B.6   FQHCs with HRSA HIT/HIE Funding

Alaska's FQHCs did not receive additional HRSA funding for HIT. However, the FQHCs are active in the APCA. The APCA provides outreach and education to FQHCs and is able to provide technical IT 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.

FQHCs in Alaska also receive technical assistance from the DHSS Health Planning and Systems Development Unit.

B.7 Technical Assistance for Medicaid Providers

DHSS appreciates that providers have faced significant change in recent years: the PI Program rule changes for 2015–2017, the beginning of Stage 3 in 2018, and the need to upgrade CEHRT to the 2015 Edition.

The DHSS EHR Medicaid Incentive Program staff will continue to support providers directly with support from a vendor-staffed help desk and a dedicated email address, to resolve provider questions and issues. The DHSS EHR Medicaid Incentive Program staff maintain a comprehensive website with information and resources to understand the program, including tip sheets, FAQs, and links to external resources.

B.7.1 Provider Expansion

DHSS has detailed, in the sections above, the efforts to include Behavioral Health, Public Health, labs, and other provider types in the HIE to enhance the capability of eligible providers to participate in Meaningful Use and encourage additional participation in the statewide HIE.

B.8 Populations with Unique Needs

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.

Following are examples of DHSS initiatives to serve populations with unique needs:

- Through a systems integration grant for children with special health care needs, the section of Women's, Children's, & Family Health (WCFH) has successfully partnered with a local pediatric practice and the Anchorage School District to pilot the use of a shared plan of care for children with complex medical conditions.
- Public education is provided to prevent and reduce opioid misuse and abuse by launching the state's first opioid public education website in partnership with the DHSS Public Information Team, enabling remote parts of Alaska access to such information.
- Three new grants focus on drug overdose and opioid addiction, with two focused on better data and one to distribute Naloxone to first responders and the general public. The Naloxone effort, in particular, has generated vast interest and partnerships in communities statewide.

B.9   Grant Awards

Alaska has not received grant awards.

B.10 State Legislation

Currently, Alaska does not need new regulations or laws to support the PI Program. In addition to the previously-established SB 133 creating the HIE, new laws impacting HIT, HIE, and healthcare delivery in Alaska are more fully described below.

B.10.1 Alaska Senate Bill 133 - Creation of Health Information Exchange System

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

- Ensures confidentiality
- Improves health care quality
- Reduces medical error
- Increases care efficiency
- 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 health care outcomes,
- Improves coordination of information and services through an effective infrastructure for the secure and authorized exchange and use of health care information

Further details can be found by visiting:
http://gov.alaska.gov/administration-focus/medicaid-reform-and-expansion/

B.10.2 Medicaid Legislation

See discussion of Alaska Medicaid Expansion in Section A.12.1 and Medicaid Redesign in Section A.12.2.

B.11 Other Issues to be Addressed

SB 74 provided state funding, which has been combined with federal funding, to reform healthcare delivery. The Medicaid expansion has demonstrated a need to provide assistance to healthcare providers with increased patient loads. Alaska issued an RFP and selected HealthTech Solutions to review the DHSS infrastructure for ways to accommodate the changes and enhance integration and interoperability among the various systems. The result of the infrastructure review will drive what additional activities will be needed to effectively support the new initiatives. HealthTech Solutions led internal and external stakeholder meetings and strategic planning sessions to establish the "As-Is" and "To-Be" environment. Results of this work were compiled in the HIIP which was submitted to the Department in August 2018 and a response to the report from the Department was included in the legislative update in Fall 2018. The Department continues to

explore potential opportunities for IT support and implementation based on the recommendations in the HIIP.

C. ACTIVITIES NECESSARY TO ADMINISTER AND OVERSEE THE ALASKA PROMOTING INTEROPERABILITY PROGRAM

This section includes a high-level description of the DHSS PI 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.

DHSS manages the PI Program using resources located in the IT Planning Office within DHSS. This Office supports the review and approval of PI Program requests received from the NLR, monthly payment processing, and required PI payment reporting. The office also provides coordination and oversight of the DHSS Program Integrity unit performing the field audits of provider data.

The Office leverages existing DHSS Medicaid business processes to manage the program including 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.

C.1   Verification of Properly Licensed/Qualified Providers

DHSS's existing processes for checking provider licensure and sanctioning are part of the pre-verification process completed each program year for the PI 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 providers new to the State are sanctioned. DHSS's Program Integrity Office informs the PI Program payment office of providers who are sanctioned and provides alerts if their status as an eligible provider may be in question.

The current enrollment process also leverages the professional 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.

Verifying Alaska professional license issue and expiration date and identifying any action against the license is part of the prepayment validation process which can be queried at: https://www.commerce.alaska.gov/cbp/Main/Search/Professional

Tribal providers who are working in an IHS facility are required to have a current professional license. Those providers must provide proof that they are licensed by a state or territory in the United States.

C.2   Verification of Hospital Based Providers

When providers register for the PI Program, they are asked to attest that they are not hospital based. DHSS 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 place of service is 21 (inpatient) or 23 (Emergency Department) for 90 percent or greater of the Medicaid encounters, the provider

will be considered hospital-based. DHSS will initially deny eligibility and advise the provider to ask for eligibility reconsideration if he/she can provide proof to the contrary. Beginning with payment year 2013, an EP who meets the definition of hospital-based (90 percent or more of their attested Medicaid encounters are performed in POS 21 and/or 23), may be determined by CMS to be a non-hospital-based EP if they

- Demonstrate to CMS that the EP funds the acquisition, implementation, and maintenance of CEHRT, including supporting hardware and interfaces needed for meaningful use, without reimbursement from an EH or a CAH, and
- Uses such CEHRT in the inpatient or emergency department of a hospital (instead of the hospital's CEHRT)

This determination is via an administrative process. If an EP is determined non-hospital based through this process, in subsequent payment years the EP must attest to continuing to meet the exception.

C.2.1 Verification of Overall Content of Attestations

The SLR conducts validation steps to assure that incentive payments are made only to eligible providers, including:

- Validation that the provider is an enrolled Medicaid provider, based on NPI number and provider Taxpayer Identification Number (TIN)
- Validation that the provider is a provider type that is eligible to participate in the PI Program

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. Additionally, the SLR queries the CHPL site to verify that the provider's CEHRT is certified.

The IT Planning Office applies additional controls to ensure that payments are made to an eligible provider. This process includes examination of the following resources to determine if providers should be excluded from participation in the PI Program:

- US Department of Health and Human Services Office of the Inspector General Exclusion list
- System for Award Management (SAM), 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

As part of prepayment validation, DHSS also accesses the Alaska Vital Statistics death registry to ensure the provider is not deceased.

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

Finally, a quick overall review is done, especially of the Meaningful Use measures, to ensure the attested numeric values are reasonably consistent.

C.3 Provider Communication

DHSS has continued to keep the EP and EH communities informed of changes to the PI Program through emails, job aids, and updated provider manuals with each CMS Final Rule announced. Our outreach plan includes

- Sharing information for program year 2019 with an email list of EPs, EHs, and organization representatives. Our ongoing plan is to send out quarterly email updates to providers and organization representatives regarding the Medicaid PI Program.
- Updating and posting Alaska's provider manual on the State HIT website (http://dhss.alaska.gov/hit/Pages/Default.aspx) and the Provider Outreach Portal (http://ak.arraincentive.com/).
- Creating and updating job aids for the EPs/EHs to use in preparation for their attestations including:
  - Documentation to save in case of an audit
  - FAQs
  - Meaningful Use Measures
  - Program Changes
  - Tip Sheets for AK SLR
- Representing the PI Program by attending health-related and EHR-related CMS conferences and seminars
- Updating presentation materials and program brochures for exhibit tables at local health-related conferences and for presentations at health-related organizational meetings
- Creating stand-alone slide shows and live webinars for EPs/EHs with detail about
  - Meaningful Use Measures
  - Program Changes
  - General Program Overview
  - Information for Specialists
  - Medicaid Encounter Volume
  - Completing the attestation process
- Contacting relevant provider associations to develop partnerships and to link our information on their webpages, including
  - Sending introductory emails from PI Program staff
  - Asking to submit PI Program-related articles to their newsletters
  - Requesting to have a link to our PI Program information on their website
  - Adding the association to the EP/EH outreach email list once partnership is created
  - Supporting their partnership by attending and presenting at their annual meetings and events
- Sponsor workshops and presentations for EPs/EHs:
  - Attestation documentation to save for Audit
  - How to successfully conduct or review a Security Risk Analysis

C.4 Patient Volume Calculation

DHSS has adopted the Final Rule CMS patient volume definition for the Alaska PI Program.

C.4.1 Verifying EP Patient Volume

EPs 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. 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 clinic location for over 50 percent 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:

- Received medical assistance from Alaska or the Children's Health Insurance Program
- Were furnished uncompensated care by the provider
- 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 EPs in their practice if the three conditions are met:

- The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP
- There is an auditable data source to support the clinic's patient volume determination
- 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.

For group encounters, the clinic or practice has two choices; they must use the entire practice's patient volume and not limit it in any way, or they can limit the entire practice's patient volume by only those who are of the eligible provider type for the incentive program. 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), the clinic/practice level determination includes only those encounters associated with the clinic/practice.

Hospital-based EPs 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, they may be eligible for an PI 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.

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 (including 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 services are rendered on any one day to a Medicaid-enrolled individual, regardless of the payment liability (e.g. Medicaid recipient seen but Medicaid not billed as the service was 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.

C.4.2 Verifying Hospital Patient Volume

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, Alaska allows hospitals to calculate volume based on patient discharges, including ER visits that result in inpatient stays.

C.5 Data Sources Used in Verifying Patient Volumes

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 denominator; these will be audited in program post-payment audit.

C.6 FQHC/RHC Practice Predominately Verification

This criterion is applicable only to EPs who attest to Needy Individual patient volume. These EPs must attest that during a six-month reporting period during the prior calendar year, the clinic location for over 50 percent of their patient encounters occurred at the FQHC/RHC facility.

The Practice Predominantly criterion is based on each individual EP's encounters data. EPs may not use group data to attest to this criterion:

- Practice Predominantly reporting period: six months during the calendar year prior to the payment year.
- Denominator: total encounters at all locations that the EP provided during the Practice Predominantly reporting period.
- Numerator: the sum of the EP's FQHC/RHC encounters during the six-month prior year reporting period.

The Practice Predominantly criterion is not applicable to non-FQHC/RHC EPs who attest using Medicaid patient volume encounter data.

Verification of the Practice Predominately numerator is done via review of the Medicaid encounters during the same 6-month period. Due to the "needy" component, the Medicaid encounter will not match; however, it gives an indication of the accuracy of the numbers. If necessary, the Practice Predominantly will be verified during a post-payment audit when the provider will be expected to present documentation supporting the attestation.

C.6.1 Alaska Tribal Hospitals and Clinics

CMS has previously issued guidance stating that healthcare 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 FQHCs in order to be considered as an FQHC for the purposes of the Medicaid PI Program. In June 2011, CMS revised this policy and will allow any such tribal clinics to be considered as FQHCs for the Medicaid PI Program, regardless of their reimbursement arrangements, per CMS FAQ 3017.

Therefore, EPs practicing predominantly in an FQHC or a Tribal Clinic will be evaluated according to their "needy individual" patient volume. To be identified as a "needy individual," patients must meet one of criteria described in C.4.1, above.

C.7 Verification of Meaningful Use

C.7.1 Rule and Policy Changes Impacting Program Administration

There have been many changes and updates impacting the administration of the PI Program since program inception. These include:

- CMS Final Rule in October 2015 addressing criteria for Stage 3 and Modifications to Meaningful Use in program years 2015-2017
- CMS Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Final Rule which established the groundwork for the Medicare Quality Payment Program (QPP)

- QPP regulations finalized in October 2016 which included modifications to the PI Program
- Finalization and update of payment rates and policy changes in the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System for calendar year (CY) 2017 by CMS in November 2016, CY 18 in August 2017, and CY 19 in August 2018
- Medicare Physician Fee Schedule for CY 19

This SMHPU provides a description of the responses to these final rules, as well as Medicaid program changes and changes to the administration of the PI Program. Beginning in 2019, all EHs, EPs, and CAHs are required to use 2015 edition CEHRT and meet the new requirements outlined in the 2019 IPPS final rule ..

EPs will complete the SLR PI Stage 3 attestation process indicating:

- The 8 Objectives and Objective Measures
- 6 Core Measures related to their scope of practice, including numerator and denominator or exclusion for each, if applicable to their practice, report on at least one outcome measure or one high-priority measure

EHs will complete the SLR PI attestation process indicating:

- 8 Objectives and Objective Measures
- The required number of Clinical Quality Measures, including numerator and denominator

The real-time notification of PI 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.

Coordination with Medicare, as well as other states, is accomplished via the D16 NLR transaction. After DHSS approves a provider for an incentive payment, a D16 is issued which checks to NLR to see if any other payments for that program year have been made to that provider. The D16 transaction performs a duplicate payment check to verify payment has not already been made. Once the D16 verifies Alaska can make the payment, the payment is issued.

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

EHs will use the SLR to validate the EHR Certification Number and provide patient volume, average length of stays, and complete an attestation.

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

C.7.2 Stage 3 Attestation

The 2019 Medicare Physicians Fee Schedule (PFS) Final Rule made changes to the previously established Stage 3 Objectives and Measures. The threshold for Stage 3 Objective 6 Measure 1 (view, download, transmit) and Measure 2 (Secure Messaging) was set at five percent for the remainder of the Medicaid PI Program. In addition, the restriction that only EPs in urgent care

settings can use the Syndromic Surveillance measure to meet Objective 8 (Public Health Reporting) was removed.

Stage 3 includes flexibility within certain objectives to allow providers to choose the measures most relevant to their patient population or practice. The Stage 3 objectives with flexible measure options include:

- **Coordination of Care through Patient Engagement** – Providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective
- **Health Information Exchange** – Providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective
- **Public Health Reporting** – EPs must report on two measures and EHs must report on four measures. If an EP cannot satisfy at least two measures, they may take exclusions from all measures they cannot meet.

To meet Stage 3 requirements, all providers must use technology certified to the 2015 Edition. A provider who has technology certified to a combination of the 2015 Edition and 2014 Edition may potentially attest to the Stage 3 requirements, if the mix of certified technologies would not prohibit them from meeting the Stage 3 measures. However, a provider who has technology certified to the 2014 Edition only may not attest to Stage 3.

C.7.2.1 *State Level Registry System Change – EP Option to Attest to Stage 3 in 2019*

Upon advancing from the selection page to the detailed PI pages, each Stage 3 Objective displays with the 2019 Objective, measure text, and relevant exclusion criteria. Five Public Health measure options display for EP in 2019 under Stage 3. EPs must report on two measures. The SLR also allows Coordination of Care and Health Information Exchange objectives to pass validation when the thresholds are met for at least two of the three measures.

The Stage 3 PI option is disabled for providers that do not have a 2015 edition CEHRT validation on the EHR Certification Page in the SLR.

C.7.2.2 *State Level Registry System Changes - EH Option to Attest to Stage 3 in 2019*

On the initial MU PI page in the SLR, EHs attesting for 2019 MU PI will be presented with a selection option to report on Stage 3 Objectives.

Upon advancing from the selection page to the detailed PI pages, each Stage 3 Objective displays with the 2019 objective, measure text, and relevant exclusion criteria. Six Public Health measures options display for EH in 2019 under Stage 3. EHs must report on four measures. The SLR also allows Coordination of Care and Health Information Exchange objectives to pass validation when the thresholds are met for at least two of the three measures.

The SLR will populate MU PI objective data from the C5 received in 2019. The C5 in 2017 will not contain data for Clinical Decision Support and CPOE objectives, however the SLR will pass validation for these objectives and allow the EH to advance in the attestation process. Per the OPPS rule, the SLR will pass validation for objectives in C5 that contain reduced thresholds in

2017. These objectives include Patient Electronic Access, Coordination of Care, Health Information Exchange, and Public Health Reporting.

The Stage 3 MU PI option is disabled for EPs that do not have a 2015 edition CEHRT validation on the EHR Certification Page in the SLR.

C.7.2.3 Related Program Changes

Alaska will require EPs/EHs to upload the following documents to the SLR:

- Protect Patient Health Information Measure
    - Documentation of a security risk analysis that was completed within the program year.
- Health Information Exchange
    - Copy of the EP/EH HIE participation agreement form, or
    - Other written proof the EP/EH met this measure, or
    - Written proof the exclusion applies to the EP/EH
- Secure Electronic Messaging:
    - A copy of their secure messaging contract/agreement, or
    - A screenshot from their secure electronic messaging within their EHR, or
    - Written proof an exclusion applies to the EP
- Public Health Measures
    - The EP/EH must upload an ACK message from the EHR, or
    - Acknowledgement email from the HIE, or
    - Email confirmation the EP/EH is in the queue to be onboarded, or
    - Written proof the exclusion applies to the EP.

Alaska will be updating the Provider Manual (with 2019 screen guidance), the Provider Outreach Page, and the Meaningful Use webpages with information for program year 2019. The prepayment verification checklist will also be updated to reflect the changes. There will be, at a minimum, quarterly listserv emails sent out to the EP/EH contacts with updates to the Alaska Medicaid PI Program.

C.7.2.4 Audit Strategy

Alaska's most recent Audit Strategy was approved on June 10, 2019.

C.7.3 OPPS Rule

C.7.3.1 90-Day EHR Reporting Period

In the CY 2017 OPPS/ASC proposed rule (81 FR 45753), CMS proposed to change the definition of "EHR Reporting Period" in 2016 for returning participants from the full CY 2016 to any continuous 90-day period within CY 2016. This would mean that all EPs, eligible hospitals and CAHs may attest to meaningful use for an EHR reporting period of any continuous 90-day period from January 1, 2016 through December 31, 2016.

As of this date, CMS requires a full year reporting period for CQMs.

C.7.3.2 System Changes

The workflow for EPs and EHs allows the provider to report using an EHR reporting period of any continuous 90-day period in calendar year 2017, regardless of prior attestations, while retaining the standard reporting period requirements for subsequent years. As of the published date of this document, the system requires a full year CQM reporting period for providers returning to the PI Program.

C.7.4 Modifications to Measure Calculation Timeframe

Changes to the measure calculations policy specify that actions included the numerator must occur within the EHR reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the EHR reporting period occurs. If the reporting period is any continuous 90-day period, the action must occur between January 1 and December 31, 2019, but does not have to occur within the 90-day period.

C.7.4.1 *System Changes*

There is no system change to validate that actions included in the numerator data occur within the calendar year in which the EHR reporting period occurs. However, the SLR validates that EHR reporting period dates are in the appropriate calendar year. Additionally, the SLR displays an attestation statement at the EHR Reporting Period page that numerator and denominator data are in the reporting period. On each PI objective page, providers are required to enter data in numerator and denominator fields specific for applicable PI measures. The SLR calculates the percentage based on the data entered by the provider. The threshold is met when the calculated percentage meets or exceeds the requirement mandated by CMS. The system displays a confirmation that the provider has met the PI objective when all measure(s) meet the threshold(s).

C.7.5 Medicare Quality Payment Program (QPP)

C.7.5.1 *Updates to Definition of Meaningful EHR User*

This section includes updates that support information exchange and prevent information blocking.

C.7.5.2 *System Changes*

For program year 2019, the SLR displays three attestation statements on the EHR Certification page. These statements are related to Supporting Health Care Providers with the Performance of CEHRT (SPPC). First, providers are required to select a check box confirming that they engaged in SPPC activities as stated by the rule. A second check box is optional. Selection of the optional checkbox indicates confirmation of engagement in surveillance of health information, as stated by the rule.

On the same EHR Certification page, the SLR displays a third attestation statement related to the support for health information exchange and the prevention of information blocking. Providers are required to select a check box confirming that they did not engage in health information blocking, as stated by the rule.

When the two required attestation statements are selected, the SLR allows the provider to continue to the next step. The optional attestation statement checkbox is not required in order for the provider to advance to the next step.

If the provider fails to select required checkboxes, the SLR displays an error message that the fields are required and the provider cannot advance until the selections are made.

C.7.6 Updates to Definition of Meaningful EHR User – SPPC and HIE and Prevention of Information Blocking

The final rule further updated the definition of Meaningful User to include Supporting Health Care Providers with the Performance of CEHRT (SPPC).

C.7.6.1 *System Changes*

Please see Section 3.1 for information on system changes.

C.7.7 Policy Changes

As the program matures, the IT Planning Office continues to refine day-to-day program operations. New Final Rules have been issued and clarified, and any policy changes to DHSS's program are noted in subsequent sections.

C.7.8 Recent Changes in State Laws or Regulations

The DHSS Administrative Regulations Unit identified the need to describe the state's participation in the PI Program within Alaska Administrative Code. These regulations refer to 45 CFR 170.102 - 45 CFR 170.306, "the Final Rule", and define provider participation requirements in Alaska.

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

A regulation change was proposed for program year 2017 to:

- Remove the requirement for an EP and EH to submit a hardcopy of the attestation that is already uploaded to the SLR and,
- Require EPs and EHs participating in the Medicaid PI Program to onboard to the Alaska Health Information Exchange in order to support meaningful use, including transmitting their Public Health data to the state via the HIE.

The following changes were made, effective with the beginning of program year 2015:

- Updated the verification process to validate
  - o Active Medicaid participation
  - o License and sanctions
  - o Encounters
  - o CEHRT
  - o Meaningful Use
  - o Attestation Agreement
  - o CMS/SLR interfaces
- Upload a copy of the Security Risk Assessment
- Upload a copy of the provider's W9

C.8 Proposed Changes to Meaningful Use Definition

Alaska does not intend to propose changes to the Meaningful Use or PI definition.

C.8.1 Allowed Attestation Grace Period

DHSS will allow EPs to submit their PI Program attestation up to 90 days (or the designated length of the grace period for a program year) beyond the calendar year. For example, if the grace period for program year 2019 is 90 days, EPs can select either a 90 day or greater period from calendar year 2019 or a 90 day or greater period within the 12 months preceding the attestation date to demonstrate patient volume for program attestation until March 29, 2020.

DHSS will allow EHs to submit their PI Program attestation up to 90 days (or the designated length of the grace period for a program year) beyond the Federal Fiscal Year (FFY). For example, EHs can select a 90 day or greater period in FFY 2019 to demonstrate Medicaid patient volume for program attestation until December 31, 2019.

DHSS appreciates that extensions of grace periods beyond 900 days in the new calendar year requires CMS approval.

C.9   Verify Providers Use of CEHRT

Providers attesting to PI must upload reports from their certified system. The reports must include their name and the dates of their reporting period. PI providers must include the CMS Certification ID of their CEHRT, which will be verified against the ONC CHPL site.

C.10 Collection of PI Data Including CQMs

Dually-eligible hospitals enter their CQM data into their Medicare attestation; the Meaningful Use data, including their CQM data, is sent to the Alaska SLR via the C5 electronic transaction.

Providers participating in the PI Program are required to report CQMs. Beginning in 2014, Medicare EPs, Medicare EHs, and Dually Eligible EHs who have completed at least one year of PI must submit CQMs electronically.

In early 2013, providers began reporting CQMs electronically to the Alaska SLR.

C.11 Aligning Data Analysis with Collection of CQMs

CQMs are shared with the Division of Public Health on a quarterly basis. The Alaska Heart Disease and Stroke Prevention and Diabetes Prevention Programs use the Medicaid Meaningful Use data to track the percentage of Medicaid provider's patients whose high blood pressure and diabetes are in control. Additionally, these programs track the number of providers who implement one clinical decision support rule, an up-to-date problem list, and who send reminders to patients for follow up care. These metrics are reported to the CDC as part of the performance measures tracked under the federal grant: CDC-RFA-DP13-1305 State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors, and Promote School Health.

The Alaska SLR is the primary system used by providers to attest to the Alaska PI Program. Attestations are submitted to the SLR, reviewed by state staff, and approved or denied for payment. There is a transaction to the CHPL website to verify the attested CEHRT. Additionally, there are interfaces with the MMIS used to verify Medicaid eligibility and other provider information, and to verify the provider's attested Medicaid encounters.

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 attestation
- Submission of completed forms to State Medicaid entities
- Messaging to providers from State Medicaid entities
- Payment history log
- Initiation portal for providers' appeals
- Online 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

Transactions are received and sent to the NLR to establish initial eligibility, verify that payments for the program year have not been made, and to send notification of the payment being made. The SLR exchanges data with the CMS NLR through a secure FTPS protocol using Extract Transform Load (ETL) interfaces. Components of the NLR exchanges include

- 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.

C.12 IT System Changes for the Promoting Interoperability Program

Alaska submitted changes for program year 2017 and Stage 3 in February 2017 with implementation occurring later in 2017. Funding was requested and approved in November 2017 for FFY 2018.. Alaska's IAPD update for FFYs 19 and 20 is under development and will be submitted shortly.

C.13 IT Timeframe for Systems Modification

The program year 2018 attestation period closed on March 7, 2019. We are planning to implement program year 2019 changes in time to open the attestation period on January 6, 2020. In preparation for closing the PI Program, we are considering opening the program year 2020 attestation period before the end of the calendar year and holding program year 2021 attestations from July 1 to August 30, 2021.

C.14 Readiness to Test Interface with the CMS NLR

The Alaska SLR has been communicating with the NLR since the program began in January 2011. All subsequent updates to the transactions have been implemented.

C.15 Accepting Registration Data from the CMS NLR

The Alaska SLR accepts the B6 NLR transaction form the NLR. Providers register the CMS R&A the first time they attest (or when their CMS information changes) which triggers a B6 transaction to the state. The SLR accepts and processes the B6, returning a B7 transaction to the NLR verifying the provider's state eligibility.

The SLR exchanges data with the CMS NLR through a secure FTPS protocol using ETL interfaces. Components of the NLR exchanges include:

- 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.

C.16 Provider Enrollment and Program Information Website

The EHR staff also maintain a comprehensive website with information and resources to understand the program, including tip sheets, FAQs, and links to external resources.

The website can be accessed by providers prior to registrations, with no additional access requirements. It contains relevant dates to remember, such as including reminders that 2016 was the last year EPs could begin participation. The website also contains EHR provider manuals, FAQs, the ability to ask a question, audit guidance, links to CMS sites, and Meaningful Use Education Modules. Returning providers are served through the website as it contains information about what Meaningful Use requires, changes to Meaningful Use, and how to prepare to attest for Meaningful Use.

The public Alaska EHR website can be accessed via the following link:
http://ak.arraincentive.com/

C.17 Anticipated Modifications to the MMIS

Alaska's MMIS, known as Alaska Medicaid Health Enterprise, has been operational since October 2013 and was certified in 2018. The system is available to providers who participate in the medical assistance programs as well as the FA and state staff. Alaska Medicaid Health Enterprise is a web-enabled solution for administering all Medicaid programs. It has self-service features so users can access the system through a user-friendly web portal. This MMIS system has incorporated innovative features and advancements that provide the foundation for future growth and evolution of HIT and Alaska's Medicaid program.

As mentioned earlier, Alaska's contract with its MMIS vendor is ending soon. Alaska is beginning to explore further modernization through modularity staring with an updated MITA SS-A. The RFP for assistance with a new MITA SS-A is currently in procurement.

C.18 Addressing Provider Questions Regarding the PI Program

The SLR vendor, Xerox, maintains a provider call center support process to respond to Alaska EP and EH inquiries regarding issues with the SLR. The IT Planning Office will provide FAQs and technical support to the Xerox provider services unit to ensure uniform responses to provider inquiries.

DHSS maintains a generic email address for providers to submit questions for the PI Program Staff. The staff also responds to phone call from providers.

In addition, the PI Program staff also maintain a comprehensive website with information and resources to understand the program, including tip sheets, FAQs, and links to external resources.

C.19 Appeal Process for the PI Program

The appeals policy details the steps a provider may take if an PI Program payment is denied, and the steps the State will take to process, track, and make a determination on the appeal. A provider may submit a written request to the department as provided under 7 AAC §165.080 and in accordance with 42 C.F.R. §495.370 and 42 C.F.R. §447.253 (e) no later than 30 days after the date of the department's letter denying participation, suspending payment, requiring full repayment, or terminating participation in the incentive program.

DHSS has a two-level appeals process. The department's IT Planning staff conducts the first-level appeal review and will notify the provider in writing of the appeal decision. 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 if 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.

A provider who is dissatisfied with the first-level appeal decision may request a second-level appeal by submitting a written request to the Commissioner no later than 30 days after the date

of the first-level appeal decision. A decision by the Commissioner is the final administrative decision of the department.

A provider's request for a first-level appeal must be submitted in writing, must specify the basis upon which the department's decision is challenged, and must include any supporting documentation. A request for a second-level appeal must include all the following:

- A copy of the department's first-level appeal decision
- A description of the basis upon which the decision is being appealed
- A copy of the first-level appeal submitted by the provider
- Any additional documentation that supports the basis upon which the provider is making an appeal

C.19.1 Incentive Payment Recoupment

In the event DHSS determines monies have been overpaid inappropriately, the current recoupment process is leveraged to recover the funds. Payments amounts may need to be collected and would be refunded to CMS via the appropriate CMS 64 adjustment. The existing practice allows DHSS to work out an acceptable repayment period dependent upon the provider circumstances and amount of the Account Receivable.

All recoupments, overpayment, and underpayments that are identified post-payment, either before or after an audit, are identified in the SLR and are finalized outside the SLR. All EPs and EHs identified as needing any sort of adjustment to their incentive payment are given proper notice of the adjustment (whether negative or positive) with the reason for the adjustment/recoupment. This process is detailed in the Audit Strategy. If an underpayment is identified, the supplemental payment is created in the PI Program office and sent through the normal payment process with the state financial office. If an overpayment or recoupment is identified, once the monies are received the check is deposited back into the same Payment appropriation it originated from. The documents accompanying these monies are created in the PI payment office and sent to the state financial office for complete tracking purposes. Documents included with overpayment or recoupment monies include the original attestation, the original invoice the payment was made from, and all the correspondence between the EP/EH and the PI Payment Office and DHSS Program Integrity Office.

Incentive payment adjustments are transmitted to the NLR via a D18 transaction with an adjustment code of "7".

Additionally, recoupments and overpayments are reported on the next RO Quarterly report submitted to CMS within 30 days after the end of a quarter.

C.20 Assurance and Accountability of Federal Funding

In order to ensure that no amounts higher than 100 percent of FFP will be claimed for reimbursement, payments to PI 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.

As providers are approved for payment, an invoice is created in the SLR. The invoice, appropriate attestations, and substitute W9 form are electronically sent to the state finance office for payment. A specific funding code will be applied to provider incentive payments such that they can be tracked independently.

Payments are routed, as specified by the "payee" information from the CMS NLR most recent registration transaction and the substitute W9 form supplied by the provider, to the EFT account or payee address on file for the payee TIN as identified on the substitute W9 form. Providers are batched by payee NPI and TIN as often as possible to reduce the number of payments.

System controls are in place to ensure the provider is still eligible to receive payment in the state. Once the prepayment validation is complete, a request for payment (D16 interface) is sent to CMS. The next day, on average, an approval for payment is returned. Occasionally, a provider has moved to another state or chosen to attest with Medicare and changed their affiliation. In this situation, CMS returns notification that payment is not approved. This process will also ensure that EPs have not previously received Medicare payment for the same Program Year.

C.20.1 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. Once an EP/EH registers on the NLR for Alaska, a B6 transaction is sent to the state ensuring the EP/EH is an eligible provider/hospital in Alaska. The B6 also identifies a provider transferring from another state or from the Medicare program. 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.

C.20.2 Process to ensure that PI Program Payments are made for no more than Six Years and that no EP or EH begins receiving Payments after 2016

Provider participation in the PI Program will be tracked in the SLR. The Provider's status relative to PI 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. DHSS will maintain, in each participating Provider record, the year in which payments are requested and the PI Program requirements relative to the year of the request. Each eligible provider will be limited to a maximum of six payments. New provider PI Program participation requests will not be allowed after Program Year 2016 closes.

In addition, DHSS will submit program participation data via the Annual report 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.

C.21 Frequency for Making PI Payments

The state has up to 45 days to issue the payment after the date the D18 transaction is transmitted to the NLR. While DHSS seeks to issue payments in advance of the 45-day limit, the actual date of payment is variable based on the number of attestations undergoing review and approval. For example, DHSS usually receives a very high number of attestations within the last month of allowed attestations (the grace period) and the review and approval process takes additional time.

Once a provider has enrolled in the NLR, DHSS 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 and calculating patient volume. DHSS 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 timing for the manual validation check is variable depending on the submitted number of attestations.

The state calculates the payment amount and transmits a D16 request to pay to the NLR. A D16 response approving the payment is transmitted from the NLR to the state.

The state makes the invoice payments to the identified payee. When the payment is issued, the payment date and amount is updated in the SLR and a D18 transaction is sent to the NLR.

The payment process is illustrated in Figure 7 – PI Payment Process.

Figure 7 – PI Payment Process

C.22 Assuring Medicaid Payments are Paid Directly without Deduction

Payments issued by the PI Program will not be used to offset existing liens or overpayments that a provider may currently owe.

An incentive payment may be held if Medicaid Program Integrity has flagged the payee's Medicaid file that no payments may be issued.

Payments are made directly to a Medicaid EP or Hospital, or to an employer or facility to which a provider has assigned 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. DHSS 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 Provider Master File system, which includes all Medicaid providers receiving payment from DHSS.

DHSS 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. Current business and system processes support the use of TIN to identify provider payments.

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

C.23 Payments to Entities Promoting the Adoption of CEHRT

This topic is no longer required to be addressed.

C.24 Incentive Payments Disbursed Through Managed Care Plans

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

C.25 Payment Calculations Consistent with Regulations

The pre-payment verification process assures that payment is issued to only those Alaskan providers eligible for the incentive payment who meet the requirements for payment. Also, the post-payment audit process conducts a risk assessment to identify providers that may not have met all standards to choose for post-payment audits. The post-payment audits are conducted with detailed information not readily available for pre-verification.

The findings of post-payment audits, both negative and not negative, inform the pre-verification process. The "lessons learned" from post-payment audits are applied to pre-verification. As an example, if it is found that not requiring a minimal variance for the threshold of a Meaningful Use measure has shown that the measure has presented compliance issues found on the post-

payment, the state may elect to review the threshold variance in more detail during the pre-verification process.

C.25.1 Provider Payment Calculations

C.25.1.1 *Eligible Professionals (EP) Payment Calculation*

Each EP will receive the full PI payment of $21,250 in their first year, with the exception of Pediatricians 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 an EP participate for longer than six years or receive payments 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. DHSS will allow EPs to use any representative 90 days or greater period of time from either the previous calendar year or within 12 months preceding the date of attestation, 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.

C.25.1.2 *Eligible Hospital Payment Calculation – Update November 2011*

DHSS clarified the PI Hospital calculation in November 2011 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.

EHs 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 allow EPs to use any representative 90 days or greater period of time from either the previous calendar year or within 12 months preceding the date of attestation, as the time period for calculating patient volume and meeting meaningful use requirements. DHSS will allow hospitals to use a 90-day period if that is advantageous and practical for the provider or provider group.

C.25.2 Validation of Hospital Cost Report Data

DHSS will leverage Form CMS-2552-96 Hospital Cost Reports and form CMS-2552-2010 Hospital Cost Reports as submitted to verify the information entered into the SLR by the hospital. The information received on the SLR from the hospital is shared with Alaska's Office of Rate Review for validation of the last "as filed" cost report.

C.25.3 Validation of Tribal Hospital Cost Report Data

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

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

The Alaska PI Payment Calculation has not changed from the prior approved SMHP.

C.26 Contractors Role in the PI Program

Alaska's MMIS and Fiscal Agent vendor is Xerox (now Conduent); they are also the vendor for the Alaskan SLR. Xerox provides an EHR Help Desk in support of the Alaska SLR. Xerox also providers issue resolution should problems arise in the operation of the SLR. Xerox also, in conjunction with DHSS and the other states utilizing the Xerox SLR, develops the requirements for CMS mandated changes (such as the recent 2015–2017 changes) for the SLR and implements the changes for each state.

Alaska also contracts for post-payment audit services, and Technical Assistance with the development of IAPDs, SMHP, outreach strategies, conducting an environmental scan, and conducting the MITA 3.0 SS-A.

Alaska does not have a separate Pharmacy Benefit Manager.

C.27 Alaska's Assumptions

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. DHSS 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. DHSS 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.

Also, Alaska assumes the following:

- Federal funding will be available for the remaining years of the program
- CMS will provide clear and concise guidance
- CMS will provide answers to questions in a timely manner
- Changes to the NLR will be communicated in a timely manner

- Access to the NLR will continue to be provided
- Access to CHPL, or an alternate means of verifying CEHRT, will be provided

D. ALASKA PI PROGRAM AUDIT STRATEGY

D.1 DHSS Audit Approach

D.1.1 Fraud and Abuse Prevention

Managing risk is an important component to the success of this implementation. 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 is validated against other databases to help ensure the legitimacy of the provider's account.

The Audit Strategy describes the pre-payment and post-payment audit functions that may lead to the detection of fraud or abuse of the PI Program. DHSS maintains its Audit Strategy in a separate document. All aspects of the Alaska PI Program audit strategy, including pre-payment verification and post-payment auditing are detailed. An updated audit strategy was approved on June 10, 2019.

Please refer to the separate Alaska Audit Strategy document for details about the Alaska PI Program auditing process.

E. HIT ROADMAP

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

E.1 Alaska Vision for Moving from "As Is" to "To Be" HIT Landscape

The Medicaid Health Information Technology Roadmap is a high-level plan to address the current state of the Alaska PI Program and future Medicaid HIT/HIE goals. The roadmap contains high-level steps DHSS will take to continue administering the PI Program and fulfill Medicaid's HIT/HIE goals and objectives. The Roadmap is not a static plan. It is a living document that will continue to evolve as the HIT/HIE strategic business direction and technology environment as well as MITA planned activities are further defined.

E.1.1 As-Is/To-Be Pathway

The DHSS "As Is" and "To Be" pathways are shown below in Figures 8 and 9. These representations reflect recent changes in the Alaska HIE's platform.

Figure 8 – Alaska HIT/E "As-Is" - updated
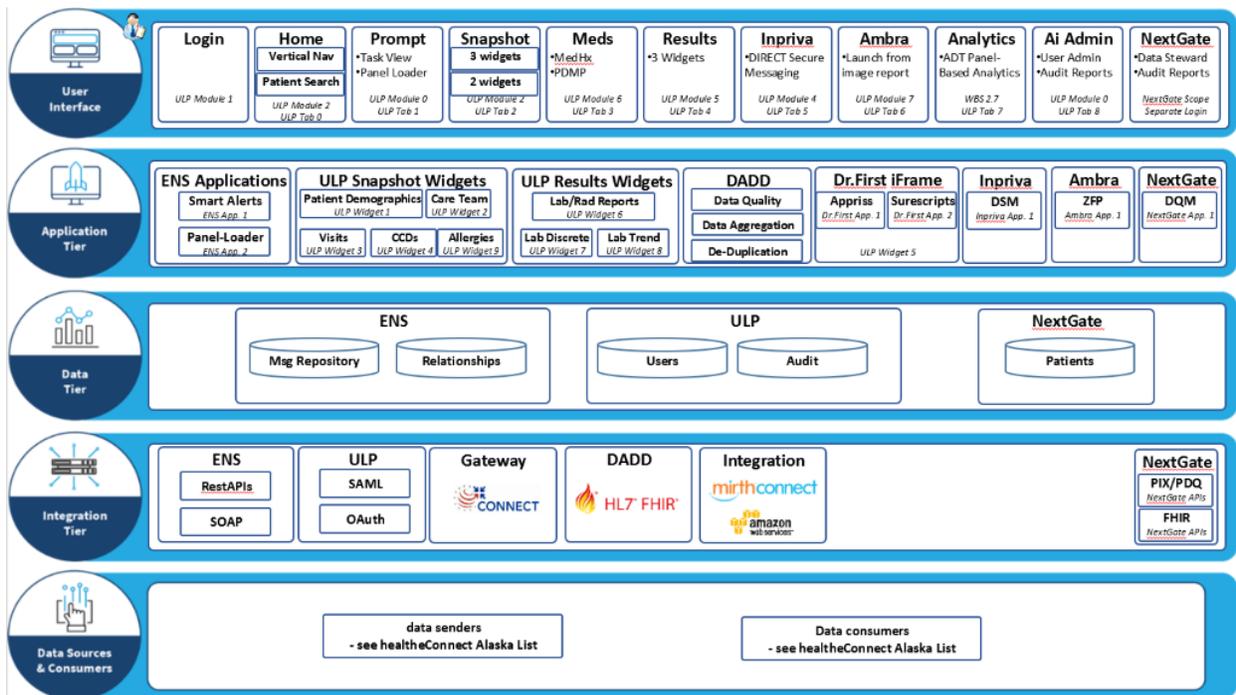
Figure 9 – Alaska HIT/E "To-Be"

E.1.2 Alaska's Pathway Narrative

Table 5. Alaska's HIT/E Pathway

Initiative	Current State	Future Activity
PI Program	PI Program activities began in January 2010 with the PAPD and will continue through final provider payments in 2021. The agency has responded to the changes mandated by additional CMS rules and developed outreach initiatives to encourage and support provider attestations. As the program has matured, the focus has been on electronic data sharing and interoperability between providers. Alaska has encouraged data sharing and interoperability via its HIE and has offered enhanced opportunities for data sharing.	DHSS will continue to administer the PI Program until its anticipated end date in 2021. DHSS has received funding to further expand data sharing and interoperability as described in other sections. While the recent Medicaid Expansion has not increased the number of providers, Medicaid membership has increased. DHSS is offering enhanced interoperability to assist providers with increased patient populations. DHSS is also expanding the number of participating providers on the statewide HIE to include both Eligible Providers as well as those that are not able to participate in the PI Program, such as Behavioral Health providers, enabling increased opportunities to meet PI requirements as well as enabling data sharing across all providers involved in patient care.

Initiative	Current State	Future Activity
SLR Modifications	The current SLR has been in place since the beginning of the DHSS PI Program. It has been continuously modified in response to CMS changes to the program, including the Stage 2 and 2013 changes prescribed by the 2012 Rule, the changes for 2014 Flexibility, and the 2015 and 2016 program year changes for the 2015 – 2017/Stage 3 Rule.	Changes for PY19 have been released and are in production. Changes will be implemented for PY 20. Other changes will be implemented as needed. Current plans for attestation periods include: PY 19 from January to May of 2020; PY 20 in late 2020; PY 21 from July 1 through August 30 of 2021. DHSS intends to continue to use the current vendor through the end of the program.
Master Client Index (MCI) Implementation/Enhancements	The existing MCI has been in place since 2011. The MCI currently contains data on almost all Alaska citizens.	Alaska Medicaid supports continued DDI of the statewide MCI to assist EPs and EHs in meeting PI requirements. Additionally, this DDI effort will allow for the development of automated data feeds to the DHSS Client Services Dashboard, enabling providers to improve their capability for transition of care and care coordination activities for all Alaskans. Further development of the MCI will support and improve use of certified EHR technology by enabling providers to submit health care data to DPH and other state agencies via the Direct Gateway.

Initiative	Current State	Future Activity
MMIS Replacement Implementation	The MMIS known as Alaska Medicaid Health Enterprise has been operational since October 2013 and was certified in 2018. The system is available to providers who participate in the medical assistance programs as well as the FA and state staff. Alaska Medicaid Health Enterprise is a web-enabled solution for administering all Medicaid programs. It has self-service features so users can access the system through a user-friendly web portal.	The MMIS will continue to be modified as required. Alaska's contract with its MMIS vendor will end soon. Alaska is beginning to explore further modernization through modularity starting with an updated MITA SS-A.

Initiative	Current State	Future Activity
Alaska HIE Implementation	In 2018, healtheConnect migrated to a new HIE platform using multiple technology vendors to provide HIE services. All interfaces and data feeds have been migrated. Today, Alaska's HIE provides clinical communication pathways to 472 provider organizations and more than 1,200 health care providers throughout the state, with over 40 Electronic Health Records providing patient data into the HIE.	Alaska is focused on enhancing the functions and capabilities to expand the statewide HIE. Alaska has requested and been granted funding assistance in an updated IAPD for a number of initiatives to increase the functionality and use of the statewide HIE. It is anticipated that with the enhanced capabilities, the HIE will encourage providers toward meaningful use CEHRTs and begin exchanging data electronically, furthering PI objectives and increasing HIE participation. Please see Section A.9.1 for further details, as well as summaries contained in subsequent entries in this table.

Initiative	Current State	Future Activity
MITA 3.0 SS-A	DHSS completed its initial MITA SS-A in 2008 to support the 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 MITA 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.	Alaska has received CMS approval and requested FFP to implement a HITECH MITA SS-A commercial off the shelf solution which will allow DHSS to complete a HITECH MITA 3.0 SS-A and continue to update and maintain MITA business processes as Alaska's HIT landscape changes. The contract for the MITA 3.0 SS-A is in procurement. Results will be included in the next Alaska SMHP update.
HIE Onboarding Support	DHSS has been granted HITECH funds to support continued marketing and improvements for onboarding and outreach efforts to EPs and EHs in the Medicaid PI Program. DHSS has developed targeted onboarding campaigns, particularly focused on increasing the ability for EPs and EHs to achieve meaningful use.	Continue activities to increase participation in the statewide HIE to enhance data sharing between both EPs and non-EPs.

Initiative	Current State	Future Activity
Behavioral Health Provider HIE Onboarding	DHSS will expand the use of HIE by behavioral health providers to improve coordination of care and overall quality of care provided to all patients across the state with the design, development, and implementation of a fully integrated behavioral health information management system that has the capability of exchanging secure information and is onboarded to the Alaska statewide HIE.	Continue activities to increase participation in the statewide HIE to enhance data sharing between both EPs and non-EPs.
Environmental Scan	DHSS completed an updated Environmental Scan in late 2017. The scan survey included questions to assess the current "As-Is" landscape relative to EHR adoption and usage, health information exchange, and other health information technology related topics. Responses from the survey were compiled and analyzed in a final report which will be used to help shape the vision for the "To-Be" landscape of HIT within Alaska.	The responses to the 2017 Environmental Scan along with the analysis of those responses was used in the creation of the Health Information Infrastructure Plan that was developed in 2018 to help shape and guide the path to the desired "To-Be" HIT landscape within the state. The environmental scan results will be utilized in strategic planning efforts moving forward.
MMIS Claims Feed to the HIE		Alaska plans to integrate the MMIS Decision Support System into the HIE.

Public Health Modernization	DPH has identified multiple public health systems and registries which currently use a manual process for reporting and submission of public health data. Additionally, the registry data is housed in multiple databases that are used across the agency.	Through this modernization initiative, over 15 public health systems have been defined as meeting the specifications as specialized registries. However, the submissions vary in format, transport, and destination. DHSS will develop a solution that will store all registry data in a single database and provide the ability to submit public health data to a single point of entry, the HIE.

| AKAIMS | AKAIMS is the current statewide electronic health record for behavioral health providers affiliated with AK-DBH. It also stores and aggregates data from AKAIMS users across the state. | The vendor for AKAIMS will work with the DBH to develop a robust reporting database which will import and store the AKAIMS minimal data set, along with the minimal data set sent from provider agencies through the statewide HIE to increase coordination of care. Although AKAIMS has been operational since 2003, this initiative also focuses on upgrading and developing the system to allow for HL7 transactions, ensuring HIPAA compliance. The onboarding activities of the initiative will be completed in a phased approach, beginning with approximately 3 behavioral health provider organizations being targeted for onboarding in the initial fiscal year of implementation. Following the initial implementation, onboarding activities will increase with each subsequent year. |

Prescription Drug Monitoring Program (PDMP)	The PDMP is connected to the HIE.	The Alaska HIE connected to the statewide PDMP database. The implementation of this initiative and the ability to onboard additional providers to the PDMP provide them with real-time, point-of-care electronic access to patient data. This initiative gives Alaska's EPs and EHs the ability to connect to the PDMP solution.
DHSS Infrastructure Review	Senate Bill 74 provided state funding to reform healthcare delivery. Also, Medicaid expansion has demonstrated a need to give healthcare providers assistance with increased patient loads. Alaska issued an RFP to review the DHSS infrastructure for ways to accommodate changes and enhance integration and interoperability among the various systems. The contract was awarded to HealthTech Solutions. Work was completed in 2018.	The infrastructure review and analysis was completed and included in the Health Information Infrastructure Plan (HIIP) that was submitted to the Department in August 2018 and a response to the report from the Department was included in the legislative update in Fall 2018. The Department continues to explore potential opportunities for IT support and implementation based on the recommendations in the HIIP.

DPH PRISM Development	The current Department of Public Health PRISM system is the HIV/STD reporting system. The PRISM system	DHSS has received HITECH HIE funding for the design, development, and implementation of an

	did not have any mechanism for receiving HL7 messages. However, automated feeds from LabCorp, Quest, and ASPHL are in the final testing phase and will be connected to PRISM in the summer of 2019.	automated lab result system and establishment of a specialized registry for automated HIV/STD lab reports, allowing an additional option for EPs and EHs to achieve meaningful use. The requested funding would allow the PRISM system to receive HL7 messages, facilitating automated system development and information exchange. Also, the development of an electronic lab record system would give providers the ability to meet PI requirements through a specialized registry and would reduce the administrative burden of the current manual submission process.

E.2 Alaska's Expectations for EHR Adoption Over Time

2016 marked the final year in which providers could begin participation in the PI Program. Moving forward, a great deal of focus is being placed on increasing meaningful use with a specific focus on interoperability and increased participation with statewide HIE. Significant efforts will continue to be made to identify, reach, and track eligible providers to ensure they are able to meet the requirements of meaningful use.

The PI Program will continue to build on successfully established outreach tools such as webinars, provider meetings, collaboration with provider associations, and dissemination of information through the PI Program website.

E.3 Annual Benchmarks for SMA Goals

E.3.1 Annual Benchmarks for Promoting Interoperability Program Goals

The following are expected benchmarks by provider:

- Hospitals – ninety-five percent (95%) of all eligible hospitals have attested for an Alaska Medicaid EHR Incentive payment since 2011. Analysis of the Agency's hospital financial data indicates that an estimated 21 hospitals meet the Medicaid eligibility requirements. Hospital incentive payments have totaled close to $25 million.
- Eligible Professionals – As of calendar year 2018, Alaska issued EHR incentive payments to 2,322 unique EPs for a total of nearly $32 million.
- Outreach activities will continue to assure that at least
    - o 50% of EPs attesting in the program will meet PI requirements for two program years prior to program's end
    - o A 15% increase in new EPs will be in the program by the end of Program Year 2016

E.3.2 Annual Benchmarks for HIE Goals

The table below lists the Health Information Exchange goals and performance for 2018 through 2021:

Table 6: HIE Benchmark Goals and Performance, 2018- 2021

Number of providers successfully connected to the HIE each year

Definition: Providers employed by participating organizations. Metric is gathered from billing information and public records (in the case of DoD/VA providers that are connected by not billed by the HIE.)

- 2018: 1002
- 2019: 1200
- 2020 (target): 1500
- 2021 (target): 1800

Percentage of total providers possible successfully connected to the HIE each year

Definition: Total providers possible based on licensing information from the State of Alaska reports in the Health Care in Alaska, Alaska DHSS, April 14, 2014. Included provider types are: MD, DO, PA, and NP.

- 2018: 34%
- 2019: 48%
- 2020 (target): 60%
- 2021 (target): 75%

Number of total Medicaid providers successfully connected to the HIE each year, Percentage of total Medicaid providers successfully connected to the HIE each year

Alaska's HIE does not currently track providers by payer type, these metrics are not reportable at this time. If this information becomes available in the future, metrics will be updated.

Number of Hospitals successfully connected to the HIE each year

Definition: Hospital participating in the HIE via utilization of HIE resources to submit Public Health reporting to the State of Alaska or participation in the HIE via eHealth Exchange Gateway or full participation in the ADT network.

- 2017: 14
- 2018: 17
- 2019: 18*
- 2020 (target): 23
- 2021 (target) 24

Percentage of total Hospitals possible successfully connected to the HIE each year

Definition: Based on 27 hospitals in Alaska*

- 2017: 52%
- 2018: 61%
- 2019: 78%
- 2020 (target) 80%
- 2021 (Target): 89%

*Note: List of 27 Hospitals includes API. Previous list included Sitka Community Hospital which has been absorbed by SEARHC.

Number of Federally Qualified Health Centers (FQHC) successfully connected to the HIE each year

Definition 1: Grantee organizations minimally participating in the HIE via DSM and/or query access.

- 2018: 20
- 2019: 23
- 2020 (target): 26
- 2021 (target): 28

Definition 2: Grantee organizations participation in the HIE via either utilization of HIE resources to submit Public Health reporting to the State of Alaska or full participation in the ADT network.

- 2018: 10
- 2019: 15
- 2020 (target): 20
- 2021 (target): 22

Percentage of total FQHCs possible successfully connected to the HIE each year

Definition: Per the FQHC list published by DHSS, as of May 2018, there are 27 grantees in Alaska.

- Definition 1 (above): 74%
- Definition 2 (above) 37%

Total number of Medicaid covered lives with data in the HIE each year, Percentage of total Medicaid covered lives possible

The HIE does not track patients by Medicaid status at this time, unable to report on this metric. If this information becomes available in the future an update will be provided.

The five-year goal is to achieve an interoperable, sustainable HIE infrastructure.

## E.4 Annual Benchmarks for Audit and Oversight Activities

The EHRIP audit team recently completed audits for program year 2016. The team has completed risk assessments will begin actual audit work on the sample selected for program year 2017

shortly. The team reports on audit progress in the quarterly CMS report and on the HITECH user support interface.

APPENDIX A – DHSS ORGANIZATION CHART
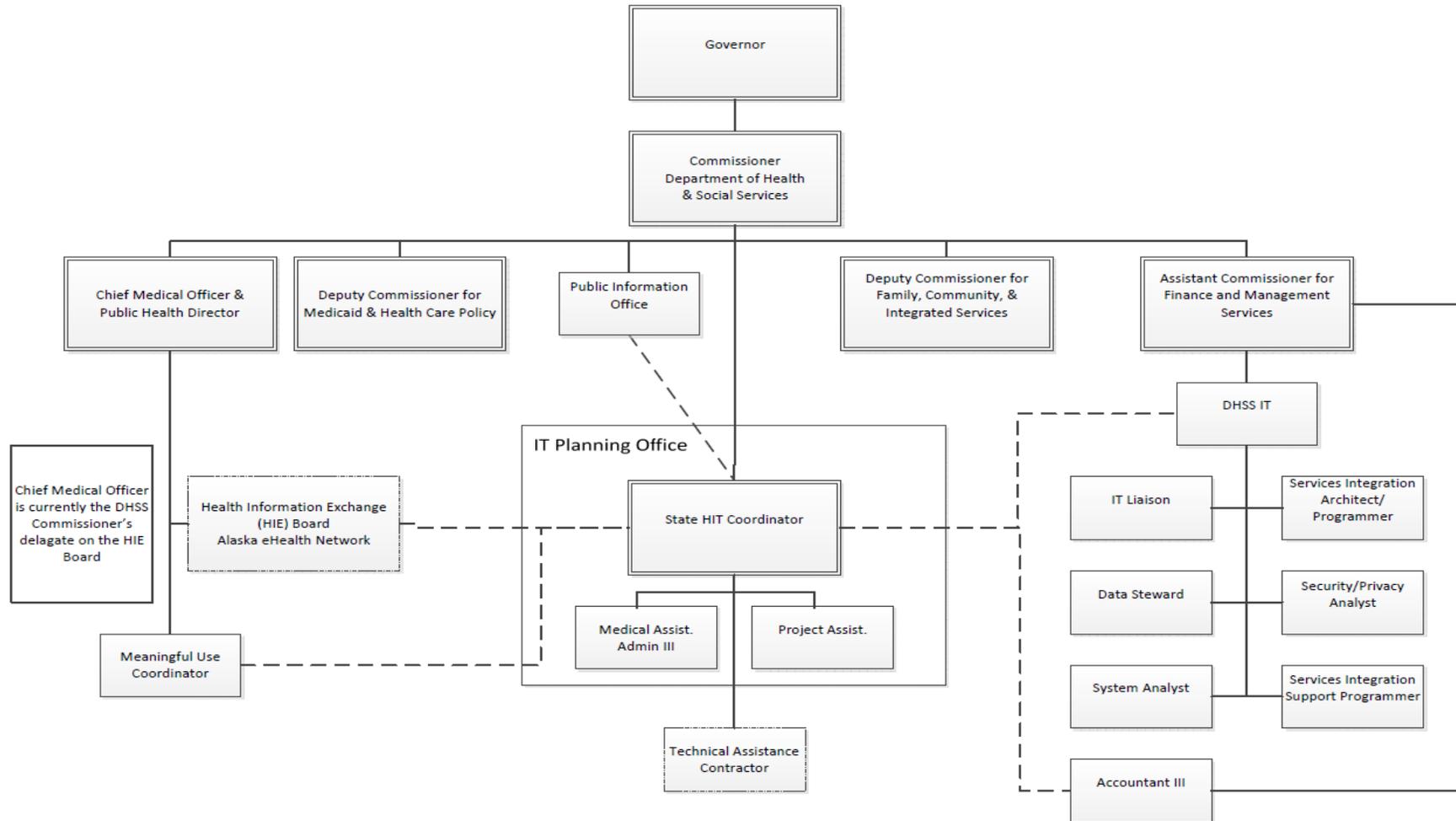
APPENDIX B - ACRONYMS

Acronym	Description
A/I/U	Adopt, Implement, and Upgrade
AAC	Alaska Administrative Code
AI/AN	American Indian/Alaska Native National Regional Extension Center
AKAIMS	Alaska Automated Information Management System
AkPI	Alaska Psychiatric Institute
AKSTARS	Alaska Services Tracking and Reporting Systems
APCA	Alaska Primary Care Association
API	Application Programming Interface
AQuIN	Alaska Quality Improvement Network
ARRA	American Recovery and Reinvestment Act of 2009
CAH	Critical Access Hospital
CCD	Continuity of Care Documents
CCN	CMS Certification Number
CDC	Centers for Disease Control
CEHRT	Certified Electronic Health Record Technology
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHPL	Certified Health IT Products Listing
CMS	Centers for Medicare & Medicaid Services
CoP	Community of Practice
CQM	Clinical Quality Measure
DDI	Design, Development, Implementation
DHCS	Division of Health Care Services
DHSS	Department of Health and Social Services
DoD	Department of Defense

Acronym	Description
DPH	Division of Public Health
DSM	Direct Secure Messaging
ebXML	Electronic Business Extensible Markup Language
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
EH	Eligible Hospital
EHR	Electronic Health Record
ELR	Electronic Laboratory Reports or Reporting
EMR	Electronic Medical Records
EP	Eligible Professional
ER	Emergency Room
ESB	Enterprise Service Bus
ETL	Extract, Transform, Load
FA	Fiscal Agent
FAQ	Frequently Asked Questions
FFP	Federal Financial Participation
FFY	Federal Fiscal Year
FQHC	Federally Qualified Health Center
HIE	Health Information Exchange
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

Acronym	Description
IHS	Indian Health Services
IRS	Internal Revenue Service
IT	Information Technology
IVR	Interactive Voice Response
LIMS	Laboratory Information Management System
LOINC	Logical Observation Identifiers Names and Codes
MAR	Management and Administrative Reporting System
MCI	Master Client Index
MITA	Medicaid Information Technology Architecture
MMIS	Medicaid Management Information System
MPI	Master Provider Index
MU	Meaningful Use
NETSS	National Electronic Telecommunications System for Surveillance
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
ONC	Office of the National Coordinator for Health Information Technology
PACS	Picture Archiving and Communication System
PDMP	Prescription Drug Monitoring Program
PI	Promoting Interoperability
POS	Place of Service
REC	Regional Extension Center
RFP	Request for Proposal
RHC	Rural Health Clinic
RHIO	Regional Health Information Organization

Acronym	Description
RPMS	Resource and Patient Management System
SB	Senate Bill
SDE	State Designated Entity
SLR	State Level Registry
SMHP	State Medicaid Health Information Technology Plan
SMHPU	State Medicaid Health Information Technology Plan Update
SMA	State Medicaid Agency
SNOMED	Systematized Nomenclature of Medicine
SPPC	Supporting Health Care Providers with the Performance of CEHRT
SQL	Structured Query Language
SS-A	MITA State Self-Assessment
SSL	Secure Socket Layer
TIN	Taxpayer Identification Number
VA	Veterans Administration
VistA	Veterans' Health Information Systems and Technology Architecture
VOIP	Voice over Internet Protocol
XML	Extensible Markup Language