STATE OF ALASKA

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

STATE MEDICAID HEALTH INFORMATION TECHNOLOGY (HIT) PLAN UPDATE

Version 4.0

Spring 2018

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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 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), in the development of a plan that provides incentive payments for the adoption, implementation, and upgrade of certified EHRs and Meaningful Use (MU) 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 HealtheConnect Alaska (legally Alaska eHealth Network (AeHN) 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 (SaaS) 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 (NHIN) and enhanced through ARRA stimulus. Today, Alaska's HIE provides clinical communication pathways to over 470 provider organizations and more than 3,000 health care providers throughout the state with over 40 Electronic Health Records providing 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 over the past year by the AeHN Board of Directors and stakeholders has lead the HIE organization to set the wheels in motion for major changes, including an organizational 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 will be the new vendor for HealtheConnect Alaska and will provide 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 the Alaska's EHR Incentive 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 (ASMA), 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 is in the Request for Proposals (RFP) development stage of implementing 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 approach taken during planning for Alaska's EHR Incentive Program administration was to review MITA business processes and identify and integrate the EHR Incentive Program processes into Alaska's MITA business processes and existing day-to-day operations. In cases where processes did not exist, new processes were developed. Examples of these processes would include Alaska's EHR Incentive Program eligibility determination, verification of member volume, attestation receipt and validation, and certain audit functions.

Alaska's SMHP 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 EHR Incentive Program. Subsequent sections of the SMHP provide a detailed description of the plan for administering Alaska's EHR Incentive 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 a modernized MMIS, extending web based access to providers and members, 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 EHR Incentive Payment 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 and provide 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 current version of the SMHP as submitted on January 2, 2017, and approved on May 24, 2017
- An updated audit strategy outlining through Stage 3 MU was submitted on January 29, 2018, and approved on February 20, 2018

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 EHR Incentive Payment 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 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 of building on what has been completed, and developing and implementing existing and planned projects and initiatives that will significantly contribute to Alaska's health care transformation. By leveraging implementation of new technologies such as the modernized MMIS that extends web based access to providers and members, 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 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 EHR Incentive Payment 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 EHR Incentive Payment 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 EHR Incentive Payment Program and HIE, and meaningful use of health information technology.

Of the 26 hospitals in Alaska, 22 are eligible for the Medicaid EHR Incentive Payment 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), 2015), 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 program in 2011:

EHR Incentive Program Statistics by Calendar Year

Eligible Professionals	CY2011	CY2012	CY2013	CY2014	CY2015	CY 2016	CY2017	Total
Total Providers Paid (number) AIU	61	240	198	167	72	31	40	**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	**1274**
Total Amount Paid MU	$0	$331,500	$209,667	$3,271,084	$2,966,500	$3,092,584	$2,724,250	**$12,595,585**
Total Amount Paid	**$1,296,250**	**$5,389,002**	**$4,417,167**	**$6,777,334**	**$4,496,500**	**$3,751,334**	**$3,754,250**	**$29,881,837**

* Financial data includes recoupments resulting from audits

Eligible Hospitals	CY2011	CY2012	CY2013	CY2014	CY2015	CY 2016	CY2017	Total
Total Hospitals Paid (number) AIU	5	12	3	1	0	0	0	**21**
Total Amount Paid AIU	$2,817,708	$9,094,291	$972,250	$303,530	-$416,181	$0	$0	**$12,771,598**
Total Hospitals Paid (Number) MU	0	4	4	13	8	4	5	**38**
Total Amount Paid MU	$0	$2,259,886	$2,058,191	$5,141,864	$1,263,961	$312,047	$843,763	**$11,879,713**
Total Amount Paid	**$2,817,708**	**$11,354,177**	**$3,030,441**	**$5,445,394**	**$847,780**	**$312,047**	**$843,763**	**$24,651,331**

* Financial data includes adjustments resulting from audits

Attestations by Provider Type	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY2016	CY2017	Total by Provider Type
Physician	39	185	186	368	254	257	231	**1520**
Nurse Practitioner	17	51	19	83	70	81	44	**365**
Dentist	0	18	12	18	19	4	9	**80**
Optometrist	0	0	0	0	0	0	0	**0**
Pediatricians	0	6	1	2	0	2	0	**11**
Physician Assistants	1	6	4	5	8	0	10	**34**
Acute Hospitals	5	16	7	14	8	4	5	**59**
Children's Hospitals	0	0	0	0	0	0	0	**0**
Total by Calendar Year	**62**	**282**	**229**	**490**	**359**	**348**		

There has been a significant number of payments made to FQHC providers throughout the course of the EHR Incentive Payment Program. To date, there have been 39 total payments made to FQHC facilities with an overall amount paid of $15,117,250.

The EHR Incentive Program has made additional data available, primarily Syndromic Surveillance and Electronic Lab reporting data by hospitals. Prior to the program, participation was inconsistent; but 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 has conducted an updated environmental scan. Responses received have been 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 to include skip logic to streamline the experience for each respondent. 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, and responses were received from 84 respondents representing an approximate 13 percent response rate.

The responses and analysis of the Environmental Scan have been 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 adopted the HIE indicated infrequent use

The following chart provides an overview of EHR and HIE adoption rates compiled based upon the provider responses received during the environmental scan.

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 both EHR adoption and HIE adoption 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.

For further information regarding the latest environmental scan, please see Appendix A for the full list of questions included in the latest environmental scan.

A.2 Telecommunications and Broadband Access

A.2.1 Universal Services Administrative Company/Universal Services Fund

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

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

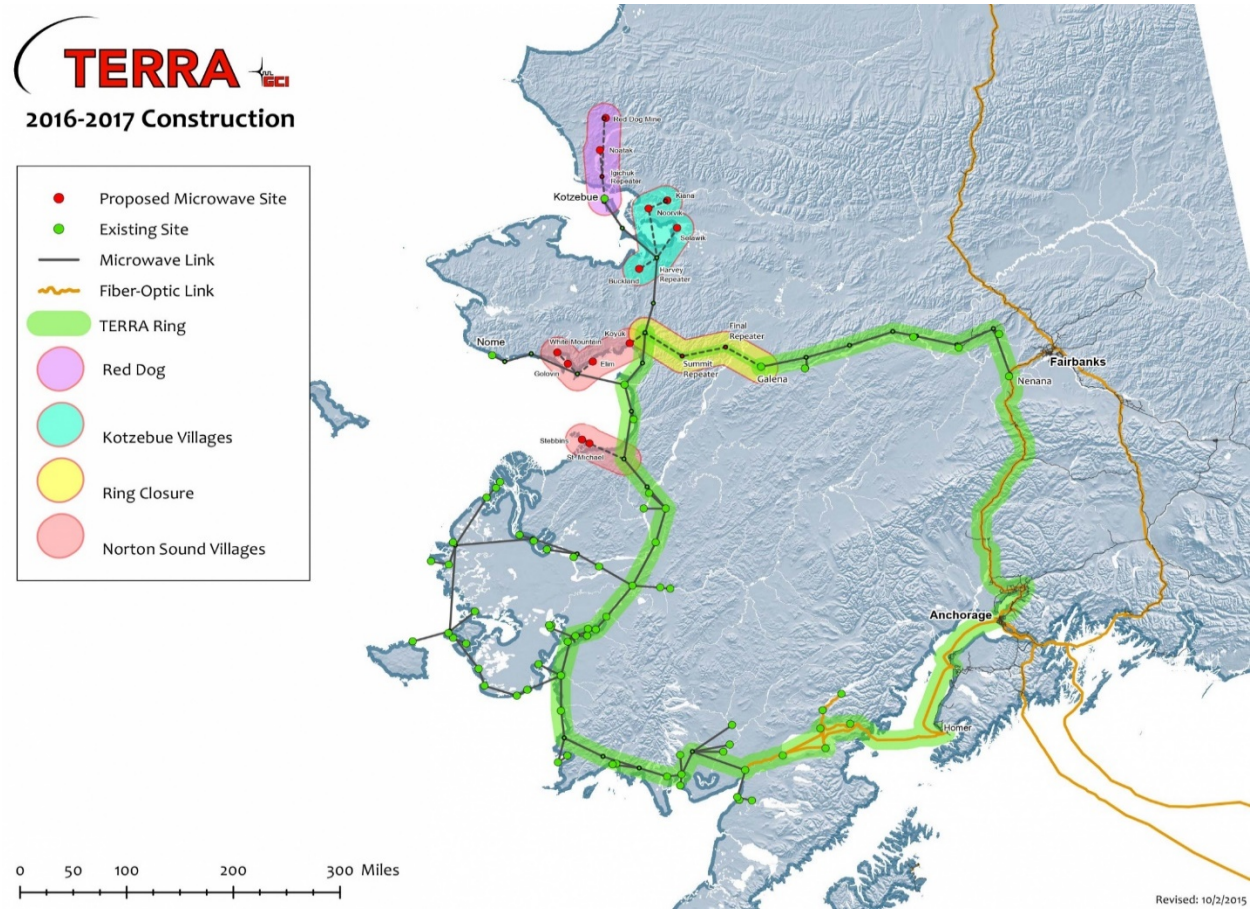
New fiber optic cable has been installed in the Arctic expands internet/communication capabilities for rural Alaska in the communities of Nome, Kotzebue, Point Hope, Wainwright, Barrow, and the North Slope camps. Most of the work was completed by 2016. The new cable was installed on the floor of the 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) is the name of the Alaska Health Center Controlled Network Project, a HRSA-funded grant program. AQuIN is a statewide Community Health Center (CHC) quality improvement collaborative effort that utilizes aggregated patient data from participating health centers' EHR systems to produce and report quality measures and engages in data-driven coordinated quality improvement activities to improve the health status of participants' patients.

AQuIN is comprised of 10 participating health centers from across the state of Alaska. As an APCA program, the AQuIN is housed in the Alaska Center for Healthcare Quality (ACHQ), a division of the APCA. Staff of the ACHQ are experienced, competent health professionals, highly qualified in Quality Improvement and the Model for Improvement. With over 54 combined years of experience with Alaska Health Centers, this staff is uniquely qualified to serve in this role. The ACHQ experience will be augmented by a partnership with a successful HCCN in another state. Through that formal, negotiated partnership, AQuIN staff will implement and adapt successful best practices from HCCN, data analytics, and clinical care coordination experts.

AQuIN is advised by a steering committee, comprised of representatives from each participating health center. Project staffing includes a project director, clinical quality coordinator, clinical services coordinator, primary care integration coordinator, practice management coordinator, and an Information Technology (IT) contractor. All project staff will be from the ACHQ.

Through competitive procurement, AQuIN selected the Azara Healthcare Data Reporting and Analytics Solutions (DRVS) platform to meet the reporting needs of member CHCs. The process of connecting member health centers to the DRVS platform is currently underway. DRVS is EHR-agnostic which will allow for interoperability with the wide variety of EHRs in use by the member CHCs. However, each of the estimated 10 EHR vendors will be implemented separately with the process of accurately mapping the data fields to the common dictionary in DRVS taking approximately 8 weeks. It is estimated that all CHCs will be connected to DRVS by the end of 2018. Once implementation is complete, DRVS will allow CHCs to run their Uniform Data System (UDS) reports, with the exception of financial reports, directly from DRVS. DRVS provides access to approximately 300 pre-formatted reports including allowing clinic staff to drill-down to a single patient, look at a registry of patients of a certain PCP, or track their open referrals. DRVS also has the capability of incorporating payers and Medicaid claims.

This initiative will allow member CHCs to fully harness the information available on their patients to effect overall health outcomes. AQuIN Quality Improvement (QI) consultants will work with member health centers on diving deep into their data to determine the best path for making a difference in their health outcomes and measures. Azara QI experts and other QI experts will be participating in a summit twice per year to provide expertise on the system and latest trends on QI, population health, data analytics, and health system reforms and how to prepare. In addition, monthly meetings will be held, half of them academic in nature (helping clinic staff to understand

a measure, a disease condition, best practices for treating a condition, etc.) and the other half participatory (consultants assisting clinic staff in looking at their own data, and interpreting it, and translating the gaps or shortfalls into workflow or care delivery changes).

The overall purpose of the AQuIN is Quality Improvement for better health outcomes, increased patient and family engagement, and lower costs. As the healthcare market demands better performance and a focus on population health, Alaska's Health Centers recognize the need to own their data and to respond to that data for improvement in value, efficiency, and effectiveness. AQuIN aims to strengthen quality, efficiency, and safety through the data-driven support of Patient-Centered Medical Home (PCMH) models, optimization of the clinics' EHRs, and attainment of Meaningful Use. As Alaska explores alternative payment methodologies, the AQuIN will position Health Centers to be able to participate in value-based pay. The Alaska DHSS report on improving the Medicaid program calls for the development and strengthening of infrastructure supporting health information exchange. In the current budget deficit climate of this state, Health Centers see this HCCN opportunity as the timely and critical step in building the systems they need so the safety-net network can partner with the State to execute its Medicaid strategies and implement programs to reduce Medicaid 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 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.

At the end of the first calendar quarter of 2018, a total of 24 FQHCs had signed a participation agreement with HealtheConnect Alaska for HIE and Direct Secure Messaging services. Six submit 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) has used EHR technology since the early 1980s. The Veterans Affairs (VA) is the largest integrated healthcare system in the United States, providing care at 1,240 healthcare facilities including 170 VA Medical Centers and 1,060 outpatient sites of care of varying complexity. The VHA employs 25,769 physicians and 97,102 nurses (CRNA, RN, LPN and NA) to provide care for Veterans. In Fiscal Year (FY)16, the VHA completed 59 million appointments. In January 2018 alone, the VA completed more than 4.8 million appointments. In January 2018, average wait times for completed appointments were 4.63 days for primary care,

7.75 days for specialty care, and 3.53 days for mental health care. There are over 21 million Veterans who are eligible for services and over 11 million Veterans enrolled for VA healthcare. In response to this significant demand, the VA has developed the Veterans Information Systems and Technology Architecture (VistA), the largely internal EHR to be an open-source, highly integrated, and interoperable EHR system.

The system includes remote viewing of patient medical records and system alerts for routine screening and critical care information. In addition, the VHA has implemented a patient centered tool “My HealtheVet” that includes features to allow veterans to have secured messaging access to medical professionals, request prescription refills online, schedule appointments, and view medical records. The VHA has also developed VistA Imaging. This system integrates clinical images, scanned document, and other non-textual data into patient’s electronic medical record. VistA imaging can capture and manage images such as endoscopy, pathology, dermatology, cardiology, radiology, scanned clinical and administrative documents, and EKG waveforms. The Alaska VA Healthcare System (AVAHS) purchases care from other providers in the community. These records are imaged and made available through the VistA Imaging system. Captured images are combined with text data to facilitate a clinician’s task of correlating information and making timely and accurate patient care decisions.

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 673d 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.

A Veteran enrolled and receiving care at a VA Medical Center can “Connect Your Docs” through the Veterans Health Information Exchange (VHIE), also known as the Virtual Lifetime Electronic Record (VLER) Program. This program gives VA and participating community care providers secure access to certain parts of the Veteran’s electronic health record. This access reduces the need for Veterans and their families to request and carry paper medical records from one healthcare provider to another. It also provides other potential benefits to Veterans and their providers.

Important improvements in patient and provider access were released in 2017. The VHA’s Community Viewer is a secure, web-based application that allows community providers to view Veteran's EHR using a browser. It does not require any software installation and is accessed with a username and password provided by VA Community Care staff. The Veteran Appointment Request (VAR) App is now available at 100 VA facilities nationwide. VAR is a web application accessible through smartphones, tablets, desktops, or any device with an internet connection. Currently, VAR gives Veterans the opportunity to self-schedule primary care appointments and request assistance in booking both primary care and mental health appointments at facilities where they already receive care. The new VA Video Connect application connects Veterans with

their healthcare team from anywhere using encryption to ensure a secure and private session. The app makes VA healthcare more convenient and reduces travel times for Veterans, especially those in very rural areas with limited access to VA healthcare facilities, and it allows quick and easy healthcare access from any mobile or web-based device. There are other patient centered health applications accessed through the VA App Store. The VA and DoD participate in the HealtheConnect Alaska HIE project serving on the governance board and providing staff resources for workgroups. Alaska has been closely monitoring the activities of the eHealth Exchange, now governed by The Sequoia Project. HealtheConnect 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 (NIHB) National Regional Extension Center

The NIHB received an award from the ONC to establish the operations of the American Indian/Alaska Native National Regional Extension Center (AI/AN National REC) 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 (ANTHC) was an active participant in the development of the grant proposal.

A.4.3 Tribal Regional Extension Center (REC)

The NIHB and the Alaska Tribal Regional Health Center signed an agreement in July 2011 to support tribal health care providers in Alaska. By the end of July 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 have been active participants 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 the HIE proposals and the 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 has received HITECH funding to onboard Behavioral Health providers to the HIE to enable EPs to share data. Please see Section A.9.1.6 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
- Non-voting liaison to the State commission established to review health care policy Alaska Health Care Commission (AHCC)

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 Meeting Meaningful Use

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 Meaningful Use 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 MU measures.

- Extension, upgrades, and additional support of an Enterprise Service Bus (ESB) and Client Services Dashboard to support projects such as the Medicaid Claims Data Feed to the HIE or Clinical Quality Measure (CQM) reporting via the HIE.
- 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 achieve meaningful use for the transition of care/health information exchange measures.
- Promote the expansion of the Alaska Statewide HIE and leverage the exchange of data to improve healthcare outcomes for Alaskans.
- Expansion of specialized registries and support for Microsoft's Dynamic CRM tool upgrades. This expansion will support provider attestations and EP and EH ability to achieve meaningful use.

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

DHSS has the responsibility for creating and administering a statewide health information network that will provide a state-level infrastructure and shared service capabilities directed by CMS, the Alaska Legislature, and as prioritized by Alaska healthcare stakeholders.

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 and the sustainability of the use of health information exchange through EHRs is solely 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.

The planned HIE efforts to be implemented are discussed in detail in Section A.9.1.

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

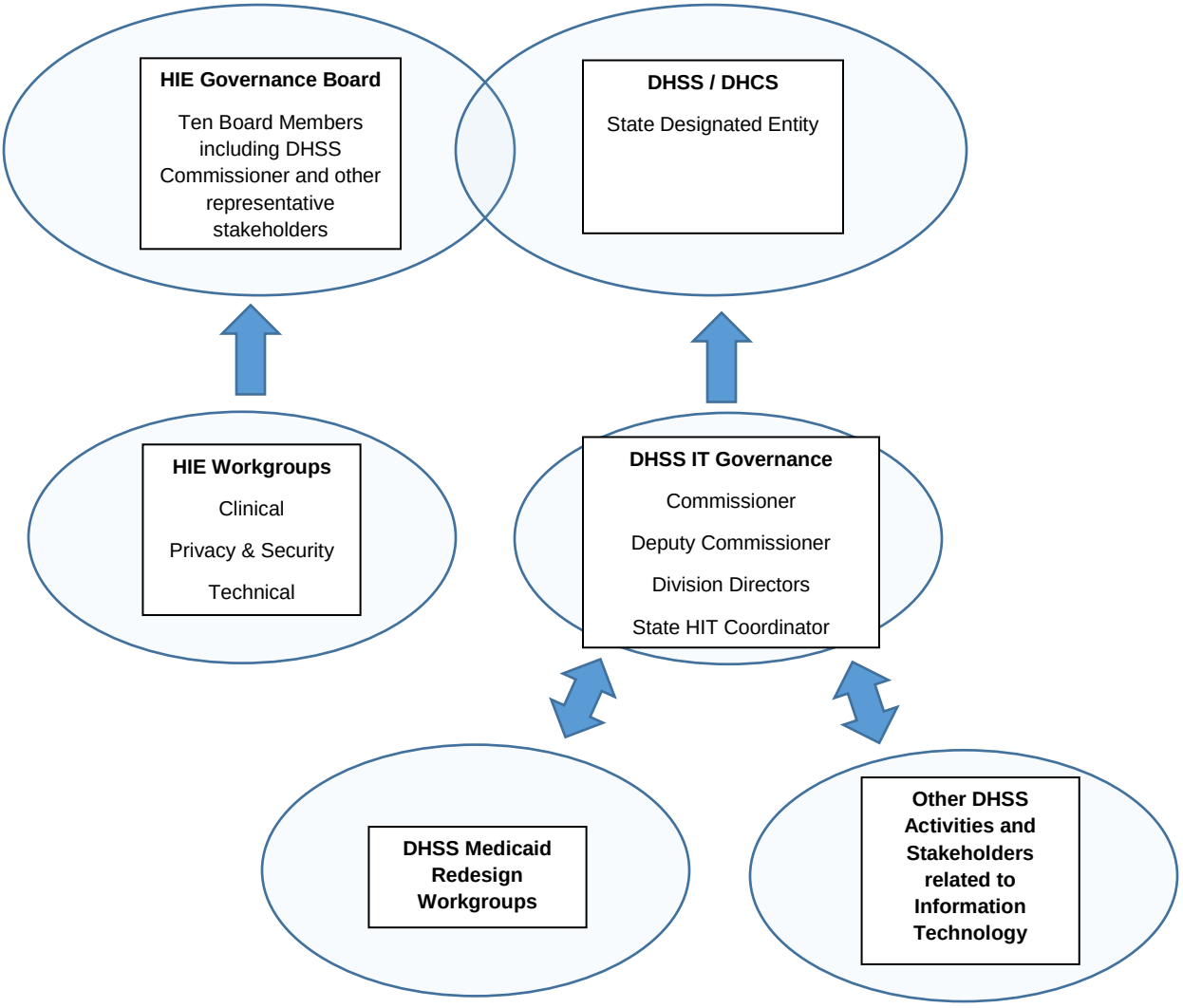
community and healthcare leaders. Organization by-laws define the governance and set organizational policy. The Board establishes protocols for decision-making and communicating with the Alaska HIE executive management and solicits feedback from its advisory workgroups.

The State Medicaid Agency (SMA) is located within DHSS, and, as such, the SMA 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 and their patients to have access to relevant patient records. Alaska anticipates that this single central HIE infrastructure will continue to support the state's medical provider and patient population for the foreseeable future.

The relationships among the State Designated Entity (SDE), AHCC, HealtheConnect Alaska, and DHSS are depicted in the graphic in Figure 2 – Alaska State Designated Entity Organization Structure below.

Figure 2 – Alaska State Designated Entity Organization Structure



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 1 – 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 State Hospital and Nursing Home Association	Member	Hospital and Nursing Home Facilities
Alaska VA Healthcare System	Member	Federal Health Care Providers
Alaska Department of Health & Social Services	Member	Commissioner DHSS

A.7.2 HealtheConnect Alaska (legally 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 renamed and reorganized as HealtheConnect Alaska in 2008.

In 2009, Alaska DHSS contracted with the 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 a 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 HIE vendor. Orion provides HIE, clinical portal, and patient portal services. HealtheConnect Alaska uses NextGate as the statewide Master Patient Index.

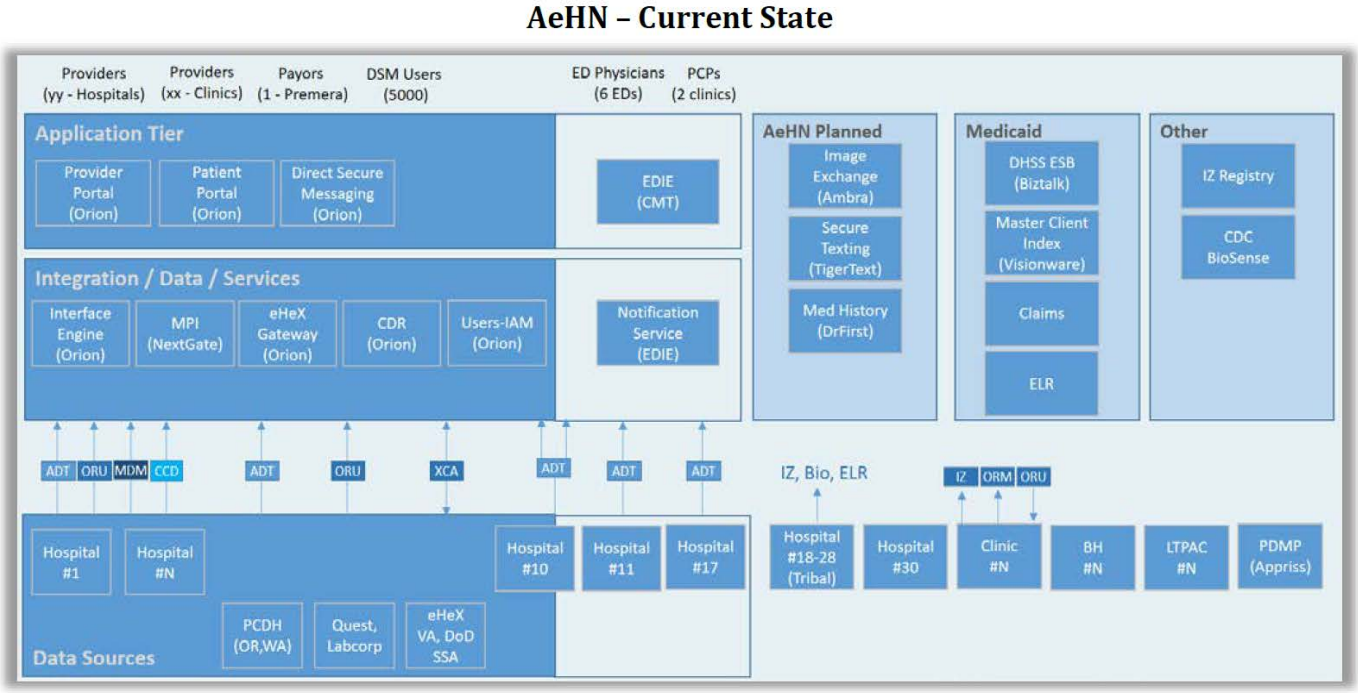
HealtheConnect Alaska deployed the health information exchange and direct secure messaging technologies using a hosted, software-as-a-service model. HealtheConnect Alaska launched a pilot program in February 2011 with one hospital and two clinics participating in the exchange of authorized medical information. 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 over 470 provider organizations and more than 3,000 healthcare providers throughout the State, with over 40 EHRs providing 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. Ten participating provider organizations are submitting immunization data via the HIE to Alaska's Immunization Registry VacTrAK. Sixteen 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.

The mission of HealtheConnect Alaska is, "To improve the safety, cost effectiveness, and quality of healthcare in Alaska through widespread secure, confidential electronic clinical information systems including promotion of electronic health records and facilitation of health information exchange." 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 individual Alaskans to access their own health records and authorizes their health care providers to exchange electronic medical data for treatment and billing.

Over the course of the last ten years, HealtheConnect Alaska's predecessor organization, the Alaska Telehealth Advisory Council (ATAC, 1996-2005), and subsequently, HealtheConnect Alaska and its workgroups (2005-2010) have been actively engaged in the development of standardized HIE policies, procedures, participant agreements, provider agreements, data use agreements, and continued refinement of the business, technical, and communications plan for HIE in Alaska. In addition, providers from across Alaska have been regularly engaged in ongoing forums, discussions, and planning sessions for HIE through 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, the 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 has engaged and enrolled over 800 eligible providers (for REC incentives) to date. 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.

While ONC funding for the REC activities ended in April 2016, the REC will continue to provide services to providers using the HIE. By the end of the program, the HealtheConnect Alaska REC had provided services to 1,128 primary care providers and 11 critical access hospitals.

HealtheConnect Alaska, 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 MU 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)

The privacy and security project is a component of the United States Department of Health and Human Services strategy to identify variations in privacy and security practices and laws affecting electronic clinical health information exchange, develop best practices, propose solutions to address identified challenges, and increase expertise about health information privacy and security protection in communities. States and territories selected to participate are charged with bringing together a broad range of stakeholders to develop consensus-based solutions to problematic variations in privacy and security business policies, practices, and state laws. The participating states include: Alaska, Arkansas, Colorado, Iowa, Illinois, Indiana, Kentucky, Massachusetts, Maine, Michigan, Minnesota, Mississippi, North Carolina, New York, Ohio, Oklahoma, Rhode Island, Utah, Washington, Wisconsin, West Virginia, and Wyoming.

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

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

- Increase patient privacy and security in exchanging medical records – 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.

- Patients with internet access can review their own health and medical history via a secure account.
- Patients are now able to review who has accessed their personal medical information through the Personal Health Record.
- Employers will not have access to the secure network used to exchange information between healthcare providers.
- Special selected categories of the medical record will be protected from exchange.

The messages and policies developed during the HISPC project have been incorporated into the HealtheConnect Alaska agreements and procedures.

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

The Division of Health Care Services (DHCS) has rebuilt the State's Medicaid claims processing and payment system. 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 {ACS}) 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 progressive MMIS system has incorporated innovative features and advancements that provide the foundation for future growth and evolution of HIT and Alaska's Medicaid program.

The MMIS is currently undergoing the certification process as of the time of this SMHP update; it is anticipated the certification process will be completed in 2018.

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 new MMIS 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.

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. Planning efforts for the MITA 3.0 SS-A are in progress and DHSS is currently working with CMS on next steps. All progress relative 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 achievement of MU and increasing HIE participation.

A.9.1 HIE Initiatives

The HIE initiatives include efforts described below.

A.9.1.1 *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 EHR Incentive Payment 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 meaningful use requirements
- Assisting EPs in moving forward through Meaningful Use

Moving forward toward the final years of the EHR Incentive Payment Program, the focus of these efforts will be exclusively 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.

A.9.1.2 *Environmental Scan*

To gain additional insight and develop a more well-informed understanding of the current "As-Is" landscape of health information technology, including EHR adoption and usage and health information exchange within Alaska, a project was undertaken by DHSS to conduct an updated environmental scan. The environmental scan was completed in December 2017, and an overview of the findings of that scan may be viewed in Section A.1.1 of this SMHPU. Information and insight obtained from the environmental scan is being used to help inform and develop the "To-Be" goals which are being defined and will be documented in the Health Infrastructure Plan that is currently under development.

A.9.1.3 *Personal Health Record (PHR)*

DHSS received HITECH funding to support the onboarding of Medicaid recipients to PHRs available within the HIE. The requested funds will be utilized to enhance the ability of patients to access their own health care data in an electronic format that supports MU CQMs including the EP Core Measure: Electronic copy of health information. Medicaid PHR/Blue Button (or similar) implementation supports this functionality.

The PHR will not collect CQMs or interface to public health registries. However, it will provide short and long-term value to providers by assisting them in achieving MU. The total number of individual patient portal accounts that have been created is 298.

A.9.1.4 *Medicaid Claims Feed to the HIE*

Alaska plans to integrate the MMIS claims data into the HIE, allowing Medicaid recipients to view their Medicaid claims information in a portal and access it through a Blue Button (or similar) download. Additionally, this initiative will benefit providers by assisting them in achieving MU by helping them meet View, Download, and Transmit (VDT) requirements.

This Medicaid PHR/Blue Button (or similar) approach allows providers to meet VDT requirements without having to create individual patient portals. This supports providers in achieving MU. Medicaid eligible population will benefit by being able to obtain their Medicaid claim information along with access to their PHRs.

This initiative will require contractor assistance from Xerox, LLC, to complete required MMIS changes as well as Alaska's HIE service provider, Orion Health, to implement the necessary HIE updates. The DHSS IT Planning Office will coordinate the efforts of the three vendors.

A.9.1.5 *CQM Reporting*

CQMs track the quality of services provided by EPs, EHs, and CAHs. CQM reporting supports improved health outcomes, processes, patient safety, and the ability of patients to make informed healthcare choices.

Providers participating in the EHR Incentive 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 MU must submit CQMs electronically.

Providers have had the capability to report CQMs electronically to the Alaska SLR since early 2013. CQM reporting via the HIE initiative will allow providers to submit data to Alaska in one location. Alaska will continue the design and development of a CQM reporting feature for EPs and EHs to have the ability to directly report and submit patient level data as QRDA I to the HIE to support their meaningful use attestations for the incentive program.

Project objectives include

- Implementing CQM reporting in the HIE
- Interfacing CQM data to the SLR to support EHR Incentive Program MU attestations
- Providing additional HIE functionality that providers can leverage, supporting the HIE sustainability model and improving the richness of the HIE data and functionality
- Ensuring privacy and security standards are met
- Providing the ability to report patient and aggregate level data

A.9.1.6 *Behavioral Health HIE Onboarding*

Developing a comprehensive and cohesive information technology system is a crucial element in assessing 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.9.1.7 *AKAIMS*

The AKAIMS is the current statewide electronic health record, and is additionally responsible for housing data that is stored and aggregated from EHRs across the state. The 2015 Final Rule

established core measures for Meaningful Use related to the HIE. The implementation of the AKAIMS project will provide another potential attestation source for ensuring that meaningful use is met by providers 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. 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.

The onboarding activities of the initiative will be completed in a phased approach, beginning with approximately three behavioral health provider organizations being targeted for onboarding in the initial fiscal year of implementation. Following the initial implementation, onboarding activities will increase which each subsequent year. The initiative will assist with onboarding a total of 50 Behavioral Health providers.

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

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

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.9.1.8 *Prescription Drug Monitoring Program*

DHSS will connect the Alaska HIE to the statewide Prescription Drug Monitoring Program (PDMP) database. The implementation of this initiative and the ability to onboard additional providers to the PDMP will give 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 will also encourage cooperation and coordination among local, state, and federal agencies. Coordination of care activities will be improved as scheduled drug information will now be 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.

This initiative will provide Alaska with the ability for EPs and EHs to connect to the PDMP solution and submit data as a specialized registry to meet meaningful use attestation requirements regarding submissions to registries.

Below is a listing of high level tasks that will be 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
    - Phase 1: Medicaid Providers (Approximately 30,000 providers)
    - Phase 2: Remaining Providers Statewide (Approximately 3,400 more providers)

A.9.1.9 *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 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
- Develop and implement the process of splitting STD/HIV messages from other EPI messages
- Onboard with the statewide HIE
- Perform testing activities

A.9.1.10 *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 the 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 anticipated registries to be made available for electronic submission by providers include

- 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

The above listed registries will be in addition to the following existing registries already available for electronic submission by providers:

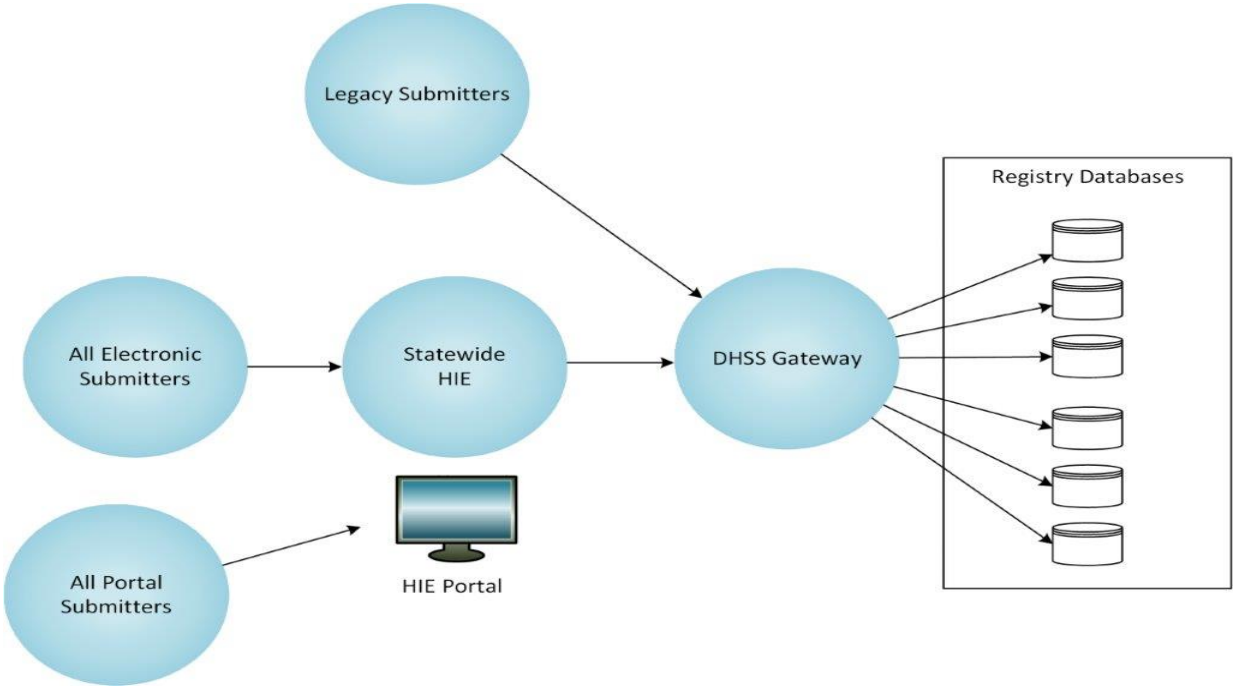
- Lead ELR – currently available to hospitals only
- Cancer Registry
- AKSTARS – reportable disease registry
- BioSense – syndromic surveillance reporting
- Electronic Lab Results reporting – hospitals only

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. Funding was requested for the implementation of Microsoft's Dynamic CRM tool, which operates on SQL Server and has the required functionality to provide robust reporting and programming methods. 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 data store, which will store and parse the data for the individual registries, offering a streamlined and efficient method of submission.

A.9.1.11 *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 such as the Medicaid Claims Data Feed to the HIE and the CQM reporting to the HIE. 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 MU 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.

Because the MCI contains data on almost all Alaskan citizens, further development of the MCI will enable DHSS to receive patient level data for CQM and/or public health interfaces.

Ongoing development of the MCI will provide short and long-term value to providers through de-duplication of client data. An enhanced MCI will support creation of a unique client identifier for each individual. This will allow correlation of all known instances of client data and records for each client and will reduce duplicate entries and allow tracking of participation data for Medicaid providers and recipients across DHSS systems and programs. This supports improved coordination of services for Alaska's Medicaid program.

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
- Automation of the updated version of the dataset from beta solution
- Inclusion of data from MMIS and Vital Stats along with the opportunity to bring in new feeds from other DHSS systems

A.9.1.12 *myAlaska Authentication*

Currently, the myAlaska platform is a solution which provides a multifunctional universe for statewide activities including, but not limited to, issuance of benefits, retirement, and identity verification of state employees. myAlaska Authentication aligns with the State of Alaska's HIE approach and Medicaid Reform initiatives by leveraging myAlaska as the user authentication and identity management tool for the HIE. The Enterprise IT Roadmap identifies the need for a shared or enterprise solution for identity verification/validation. Through this implementation, the DHSS will leverage the current myAlaska solution as a single sign-on platform, offering significant cost savings to the state. The DHSS intends to explore shared funding opportunities with additional departments within the Alaska DHSS to support other use cases of the myAlaska application.

To be HIPAA compliant, the solution must be upgraded with additional functionality and security components. DHSS will implement SafeNet to be used in conjunction with the myAlaska tool. This will enable the implementation of multifactor authentication and allow the myAlaska portal to become the single sign-on engine for the DHSS and statewide HIE.

Implementation of myAlaska authentication for the HIE will support providers in achieving MU electronically because their identity will be authenticated via myAlaska and managed by the

DHSS MCI, in conjunction with the myAlaska tool. Alaska intends to use myAlaska as the only means for user authentication and electronic submission of MU by providers.

myAlaska Authentication for the HIE will provide the following value to providers:

- Simple user authentication for all of DHSS using a single source
- Reduction in overhead costs

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 a 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**:**

- Number of Alaskans with online access to health care records and health care education resources
- Percentage of providers who attest to meeting MU 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 January 31, 2018, over 40,000 Alaskans have qualified for health coverage under Medicaid expansion. Medicaid expansion was particularly important in Alaska because 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 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: 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 EHR Incentive Program Specific Proposed Regulation

The new final regulations, began with program year 2017, include

- Removes the mandate for the EP/EH to submit a signed original attestation to the EHR office. They will be able to upload it to the SLR
- Mandates 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
- Updates 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's procedures

A.13 HIT/E Activities Across State Borders

The HealtheConnect Alaska has completed connectivity with the eHealth Exchange and currently planning to engage with Carequality and CommonWell Health Alliance. Engagement with these national networks will facilitate interoperability and health information exchange beyond the Alaska 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.9.1.11.

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" of the system and the scope of the system, DPH has not been successful in acquiring grant awards to improve the product. DPH is participating in a forum with the VacTrAK vendor to identify opportunities to collaborate on solution alternatives.

VacTrAK contains both a graphical user interface and a database which is accessible through the Internet. Vaccination records are stored and maintained at a central database 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 MU 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 15 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.

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)

The Alaska LIMS system supports two state labs via two separate LIMS databases; one in Fairbanks and one in Anchorage. Separate lab databases are maintained due to bandwidth limitations between the two labs. The only data that is shared is patient and provider demographic information. DPH has leveraged a CDC grant to connect the two state labs to the CDC sending HL7 standard transactions.

In 2012, a review was conducted to determine the status of Alaskan labs’ capability of enabling electronic lab data submission. The study found that there where differing capabilities and incompatibilities between the various lab systems in the state. The study looked at various methods for electronic lab data submission; including Direct Secure Messaging, a Lab Hub solution, and a robust HIE solution. It was determined that the use of Direct Secure Messaging would offer the least costly, quickest, and easiest method to enhance submission of lab data. Additionally, the statewide HIE is able to accept Direct Secure Messaging.

Provider acceptance has been slow since most EHRs do not have Direct Messaging capability built in. The Alaska Department of Public Health recognizes the limitations and is exploring additional options to support electronic submission of lab data to include: lab results being requested and returned via the HIE, cloud faxing for lab results instead of utilizing the postal service, and billing for lab services.

A.14.6 Vital Statistics

Alaska has implemented a new Vital Statistics system called EVRS. The system would be able to interface with the HIE, but HIE access would diminish the current revenue stream that sustains this system and agency. Implementing an HIE interface would require development of additional capability to charge requestors for the information. An HIE interface with EVRS is unlikely until the revenue issue is resolved.

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 (PHIN MS). The system securely sends and receives encrypted data over the Internet to public health information systems using Electronic Business Extensible Markup Language (ebXML) technology. 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 anticipated program timeframes 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 assisting providers that participate; improving electronic CQM reporting 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 CQM and Public Health reporting
- Improving access to the Personal Health Record and single sign-on access
- 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, like the modernized MMIS, 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
  - Enhance secure web-based Beneficiary information, communication, outreach and tracking
  - Provide enhanced provider online search capabilities
  - Improve service delivery through Interactive Voice Response (IVR) and Voice Over Internet Protocol (VOIP) technologies, where possible
  - Design and implement online capabilities to enhance quality consumer-directed access to care
  - Develop a strong Medical Home model delivery system
  - Increase collaboration between all state payers and providers
  - Streamline Point-of-Service functions (e.g. Smart Cards)
  - Fully develop e-Prescribing functionality
- Simplified interaction with the Health Care infrastructure for Providers
  - Credentialing:
    - Single credentialing organization and standard forms for all payers for the State of Alaska
    - Adopt nationally recognized provider credentialing process
    - Interface to the NPI database
  - Web-based Access:
    - Enhance secure web-based provider enrollment, maintenance, communication, and tracking that is available for provider self-service
    - Provide online data submission with real-time claims tracking of approvals, denials, and other status reporting
    - Provide web-based physician/provider quality and cost reporting
    - Provide a secure web-based care management systems option

        - Enhance web-based prior authorization function
        - Enhance web-enabled claims processing functionality
        - Improve eligibility coordination and knowledge sharing between agencies and business partners
    - Enhanced Technology Supports:
        - Streamline Point of Service functions (e.g. Smart Cards)
        - Support and accommodate electronic signatures
        - Provide for data interchange with Data Warehouse
        - Facilitate move to total electronic claims
        - Interface with future EHR and PHR system functionalities
        - Fully develop e-Prescribing functionality
- Improved Health Care outcomes measured by increased usage of performance criteria
    - Create clear outcomes and expectations for providers to address pay for performance and quality of care
    - Incentivize providers to use quality preventative care
    - Utilize HIE/HIT to improve health care quality and safety
    - Develop and expand innovative approaches to prevention
    - Develop a comprehensive statistical profile for delivery and utilization patterns
- Evolving use of modern information technology to improve the delivery of healthcare
    - 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 (TPL) functionality
        - Fully develop e-Prescribing functionality
        - Enhance pre-payment and post-payment pattern analysis
        - Provide contractor system supports to improve efficiency of contracting process
    - Coordination of Care
        - Develop enhanced interfaces to existing registries
        - Develop strong Medical Home model delivery system
        - Interface with future EHR and PHR system functionalities
    - Optimization of Care

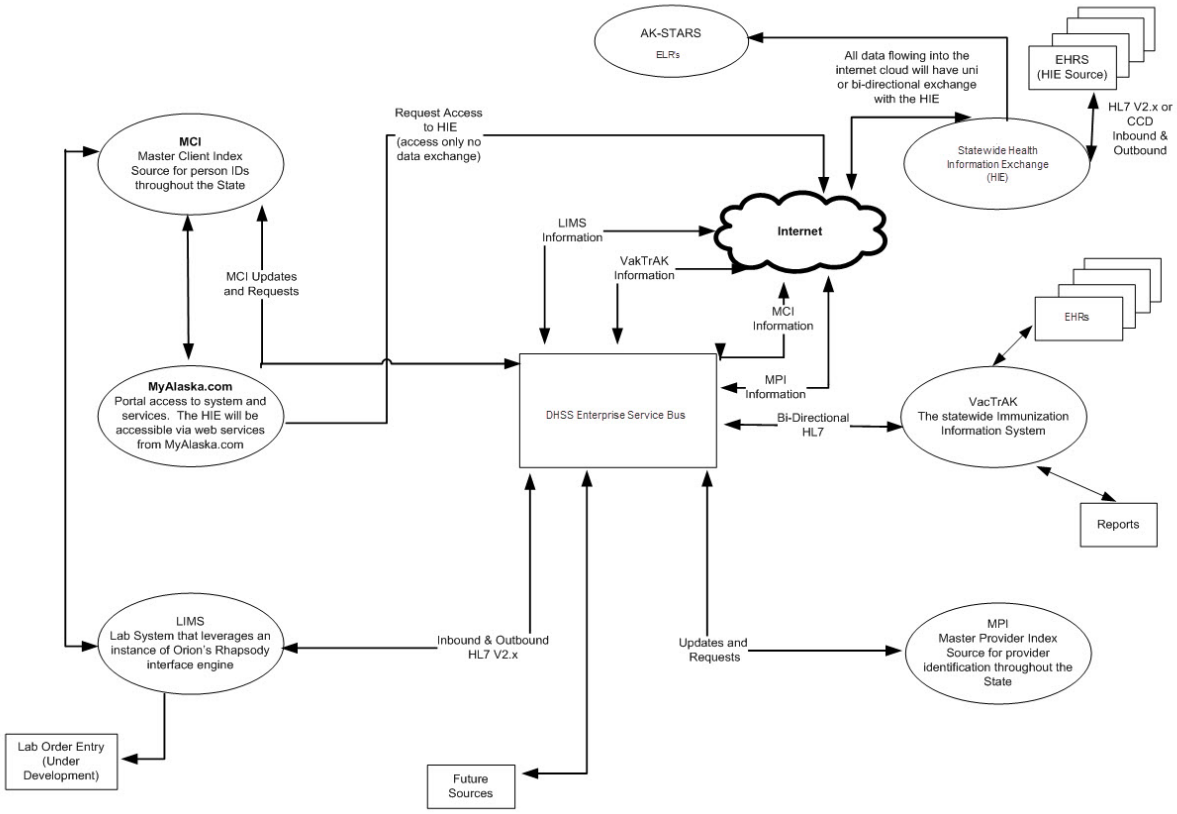
        - Provide secure, web-based assessment tool for waiver, senior, and disability functions
- Improve service delivery through IVR and VOIP technologies where possible
    - Provide clear and accurate Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and tracking
    - Explore health care literacy program to reduce Emergency Department (ED) use by Medicaid population
    - Implement Statewide HIE to improve episode of care management
    - Develop and expand innovative approaches to prevention.
    - Streamline Point-of-Service functions (e.g. Smart Cards)
- Integrated medical service delivery model that includes high quality Medicaid providers
    - Encourage and promote retention of quality Medicaid providers
    - Explore healthcare literacy program to reduce ED use by Medicaid population
    - Implement Statewide HIE to improve episode of care management
    - 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 the multiple vendors is committed to modernizing and maintain 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 will be able to issue new accounts within 72 hours of receiving the notarized identification form which is a significant decrease from the current 2-4 weeks with Orion Health. Additionally, Inpriva regularly uploads accounts to the national direct registry to facilitate secure directory access for all participants.

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. The following describes the relevant national data standards for health and data exchange and open standards for technical solutions that have been incorporated:

B.2.3.1 *Continuity of Care Document (CCD)*

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

B.2.3.2 *HL7*

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

Alaska's immunization registry and disease reporting repository currently support HL7 standard messages.

B.2.3.3 *Secure Internet Messaging*

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

B.2.3.4 *XML*

Extensible Markup Language (XML) will be used for ease of search and messaging. For more information, see the Journal of the American Medical Informatics Association, Volume 13, Number 3, May/Jun 2006, p. 289+. "An XML-based System for Synthesis of Data from Disparate Database".

B.2.3.5 *Logical Observation Identifiers Names and Codes (LOINC)*

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

B.2.3.6 *SNOMED*

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

B.2.3.7 *National Council for Prescription Drug Program*

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

B.2.3.8 *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 ensures 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 EHR Incentive Program payments and electronic submission of CQMs. Currently, Alaska is exploring ways to capture CQM data, both

from SLR submission as well as directly into the statewide HIE. The CQM Reporting via the HIE initiative will allow providers to submit data to Alaska in one location. Alaska will continue the design and development of a CQM reporting feature to allow EPs and EHs to directly report and submit patient level data as QRDA I to the HIE to support their meaningful use attestations for the incentive program.

Project Objectives include

- Implementing CQM reporting in the HIE
- Interfacing CQM data to the SLR to support EHR Incentive Program MU attestations
- Providing additional HIE functionality that providers can leverage, supporting the HIE sustainability model and improving the richness of the HIE data and functionality
- Ensuring privacy and security standards are met
- Providing the ability to report patient and aggregate level data

B.2.4.1 *Integration of Clinical and Administrative Data*

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

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

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 has begun the initial stages of a DPH Modernization process to evaluate each of the various existing registries to identify the upgrades needed for participation with data exchange. As of this writing, the proposed process is on hold for evaluation by DHSS Public Health. 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.

Activities necessary to support this goal are

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

Goal #3 – Improve provider participation.

Activities necessary to support this goal are

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

Goal #4 – Improvement in Population Health Outcomes.

Activities necessary to support this goal are

- Define specific Target Population Health measures, many of which are aligned with the MU clinical quality measures
    - Examples include
        - Diabetes prevention and monitoring
        - Heart Disease and cancer monitoring, education, and prevention

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

Activities necessary to support this goal are

- Promote the use of the existing HIE Patient Portal that should provide patient access to
    - Medical History, including Immunization History
    - Prescription List
    - Health Education
- Integrate the Patient HIE Portal with myAlaska, the primary web portal for Alaskans
- Incorporate the Medicaid claims data from the MMIS to share claims data with Medicaid recipients

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

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

very interested in gaining access to accurate prescription lists and medical records to improve treatment outcomes.

Alaskans will have the opportunity to participate in the Alaska HIE through the patient portal. It is anticipated that the HIE patient portal will include an educational component that will focus on preventative care and chronic disease management.

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 the myAlaska portal, the PHR initiative, and 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. The MMIS is undergoing Certification as of this writing; but 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 EHR IT system to attest for the Provider Incentive Payment. 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 EHR Incentive 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 CEHRT. 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 processing is described in Section C.

B.4 HIE Governance

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

The Medicaid program, along with DHSS, are represented in the existing advisory structure/organization and are involved in statewide issues relative to the HIE. Medicaid and DHSS also participate in meetings held by the HIE Stakeholder Group.

B.5 Encourage Provider Adoption Strategies

Alaska is focusing on enhancing the HIE functions and capabilities to expand the statewide HIE. Alaska requested and was 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 of the HIE, providers will be encouraged to meaningfully use CEHRTs and begin exchanging data electronically, furthering achievement of MU and increasing HIE participation.

B.5.1 HIE Initiatives

Section A.9.1 describes in detail current and planned HIE initiatives, which include

- Upgrade underlying HIE technology from Orion Health platform to future state & transition existing interfaces to new platform: installing and configuring the Mirth Integration Engine, returning the NextGate eMPI solution for more robust patient matching, and then transition all existing interfaces (CDC, IZ, ELR, CH) and data feeds (ADTs, ORUs, and CCDs) from the Orion Health platform to the new platform.
- Implement consent policy and Master Client 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.
- 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.
- Add Prescription Drug Monitoring Program (PDMP) access via Single sign-on: connect with Alaska's PDMP using Dr.First data feeds (which will be connected using HL7 compliant connectivity). Future connections to the Appriss Health gateway will be considered using fees from subscribing organizations, not HITECH APD funds.
- Migrate Direct Secure Messaging: implement TigerText in addition to the new Inpriva Direct Secure Messaging solution and migrate 6500+ users to the new secure messaging platform.
- Integrate Alaska Psychiatric Institute's 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 API connections to EHRs.
- Implement 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.
- Implement Ambra Image Exchange: connect the HIE with Ambra Image Gateway to allow for subscribing organizations to see images completed at other facilities.
- HIE Onboarding Support will continue for behavioral health providers, tribal providers, and partner tribal providers.
- Medicaid Claims Data Feed project will occur after DHSS's MMIS has been certified and evaluated to determine best method to share claims data.
- Enhancement of the Personal Health Record
- eCQM Reporting to the HIE
- AKAIMS to further support Meaningful Use

- 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.
- Public Health System Modernization to increase opportunities for Meaningful Use Public Health reporting

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 the 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 MPI 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 CDR 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)

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 EHR Incentive Program, and informing them that 2016 is the last year to begin participation. Outreach efforts are now focused on Stage 3 and 2018, and for providers to continue to meet Meaningful Use. The outreach will focus on the reduced MU requirements in which started in 2015 and may enable providers to successfully attest for Meaningful Use where previously they may have had issues. 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 the larger Medicaid populations.

B.6 FQHCs with HRSA HIT/HIE Funding

Alaska's FQHCs do not receive additional HRSA funding. 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 the rule changes for 2015–2017, and the subsequent beginning of Stage 3 in 2018 along with the provision that providers will need to upgrade their CEHRTS to the 2015 Edition, represents significant change for providers.

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.

A few specific examples where DHSS serves 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.

In FY16, public education has been provided to prevent and reduce opioid misuse and abuse through the launch of the state's first opioid public education website, in partnership with the DHSS Public Information Team.

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 EHR Incentive Payment Program. In addition to the previously-established SB 133 creating the HIE, Alaska has recently implemented new laws impacting HIT, HIE, and healthcare delivery in Alaska.

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/

Alaska has recently expanded Medicaid, and as of January 31, 2018, over 40,000 Alaskans have qualified for health coverage under Medicaid expansion. Medicaid expansion was particularly important in Alaska because previously single citizens or married couples without dependent children did not qualify for Medicaid.

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 otherwise assisting providers in meeting the increased Medicaid population. Specific steps to achieve these goals are detailed in subsequent sections of this SMHP.

B.10.2 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 include

- 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 healthcare 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.

B.11 Other Issues to be Addressed

SB 74 has 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 (HTS) 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. HTS is approximately halfway through the scope of work which consists of internal and external stakeholder meetings and strategic planning sessions to establish the “As-Is” and “To-Be” environment, and the results of this work will inform future state HIT initiatives.

C. ACTIVITIES NECESSARY TO ADMINISTER AND OVERSEE THE ALASKA EHR INCENTIVE PAYMENT PROGRAM

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

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

The Office will leverage existing 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 will be employed as part of the pre-verification process for each program year for the EHR Incentive Payment Program. All providers are manually checked for sanctions before being enrolled in Alaska Medicaid. Once a month, the 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 EHR Incentive Payment office of providers who are sanctioned and 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 is 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 another state or territory in the United States.

C.2 Verification of Hospital Based Providers

When providers register for the EHR Incentive Payment 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 EHR incentive payments are made to an eligible provider, 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 EHR Incentive Payment 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 the provider's CEHRT is certified.

The IT Planning Office applies additional controls to ensure that the payments are made to an eligible provider. This process includes examination of the following resources to determine if each provider application appears on the lists:

- US DHHS Office of the Inspector General (OIG) 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 the prepayment validation DHSS 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 EHR 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 EHR Incentive Payment Program through emails, job aids, and updated provider manuals with each CMS Final Rule announced. Our outreach plan includes

- Sharing information for program year 2018 with an email list of EPs, EHs, and organization representatives shortly after the Notice of Proposed Rule Making (NPRM) for 2015-2017/Stage 3 was announced. Our ongoing plan is to send out quarterly email updates to providers and organization representatives regarding the Medicaid EHR Incentive Payment 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 EHR Incentive 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
- Creating radio, TV, and social media spots for the Medicaid EHR Incentive Program
- Contacting relevant provider associations to develop partnerships and to link our information on their webpages, including
    - Sending introductory email from EHR program staff
    - Asking to submit EHR-related articles to their newsletters
    - Requesting to have a link to our EHR 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 EHR Incentive Payment Program.

C.4.1 Verifying EP Patient Volume

EPs will need to meet patient volume thresholds to be eligible for incentive payments. The Alaska patient volume thresholds are calculated using as the numerator the individual EP's total number of Alaska Medicaid encounters in any consecutive 90-day period in the previous full calendar year, or in the most recent 12-month period preceding attestation, or any consecutive 3-month period greater than or equal to 90 days. The denominator is all patient encounters for the same individual professional over the same selected time period.

EPs who work predominantly in FQHCs or RHCs may meet "needy individual" volume requirements when the clinical location for over 50 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 EHR Incentive Payment.

DHSS will encourage providers to establish the group patient volume for an organization using the Medicaid group or clinic enrollment criteria (as identified in the Alaska MMIS) or by the Tax Identification Number of the group. There may be multiple groups or clinics within one given Tax Identification Number. Groups shall not include ancillary services such as nursing or pharmacy services in their Medicaid group patient volume. The group patient volume will be determined only by the eligible professional patient encounters.

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 clinical 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 FQHC in order to be considered as an FQHC for the purposes of the Medicaid EHR Incentive Payment Program. In June 2011, CMS revised this policy and will allow any such tribal clinics to be considered as FQHCs for the Medicaid EHR Incentive Payment 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 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.

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 EHR Incentive Payment Program since program inception. These include

- CMS Final Rule in October 2015 addressing criteria for Stage 3 and Modifications to Meaningful Use in 2015-2017 for the EHR Incentive Program.
- CMS Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Final Rule which established the groundwork for the Medicare Quality Payment Program (QPP)
- Finalized the QPP in October 2016, which included modifications to the EHR Incentive Payment 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,

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 Incentive Payment Program required to allow Eps, EHs, and CAHs to attest to Modified Stage 3 MU OPPS and QPP.

EPs will complete the SLR MU Modified Stage 2 attestation process indicating

- The 10 Objectives and Objective Measures
- 9 Core or Alternate Core Clinical Quality Measures, including numerator and denominator or exclusion for each

EHs will complete the SLR MU attestation process indicating

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

The real-time notification of MU doesn't occur until the provider saves the data. All saves are stored. The SLR will flag multiple entries for the same measure as an exception.

Coordination with Medicare, as well as other states, is accomplished via the D16 NLR transaction. After DHSS approves a provider for 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 MU requirements.

EHs not in their first year of MU 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 EHR incentive payments will attest to MU through the SLR as described above.

C.7.2 2015-2017 Modifications and Stage 3-Optional Stage 3 Attestation

In the Stage 3 rule (80 FR 16772), in order to allow all providers to successfully transition to Stage 3 of the EHR Incentive Payment Program, CMS proposed to allow flexibility for the EHR Incentive Programs in 2017 changing the reporting period to a full calendar year timeframe. A transition period allowed providers to establish and test their processes and workflows for Stage 3 of the EHR Incentive Programs prior to 2018.

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

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.

Alaska chose not to allow first time MU attesters the option for Stage 3 in 2017.

C.7.2.1 *State Level Registry System Change – EP Option to Attest to Stage 3 in 2017*

Changes were made to the initial MU page in the SLR to allow provider to report on either Stage 3 or Stage 2 objectives for 2017. When 2017 Stage 3 MU Objective option is selected, the EP is presented with a summary of 2017 Stage 3 Objectives. From the summary page, the EP can navigate to any specific Stage 3 Objective. The table below shows objective name and sequence that differed from Stage 2 objectives in 2017:

Stage 3 Objective
Protect Patient Health Information
Electronic Prescribing (eRx)
Clinical Decision Support
Computerized Provider Order Entry (CPOE)
Patient Electronic Access
Coordination of Care
Health Information Exchange
Public Health and Clinical Data Registry Reporting

Upon advancing from the selection page to the detailed MU pages, each Stage 3 Objective displays with the 2017 Objective, measure text, and relevant exclusion criteria per the final rule. Five Public Health measure options display for EP in 2017 under the Stage 3 selection option. 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.

Validations that prevent Stage 3 section options from displaying are as follows:

- Stage 3 MU option is disabled for providers that do not have a 2015 edition CEHRT validation on EHR Certification Page in the SLR. In this scenario, EPs can only attest to Stage 2 objectives and measures.
- Stage 3 MU option is disabled for EPs that have not successfully demonstrated MU in a prior year. Validation is based on B6 data and/or prior year(s) attestation data in the SLR

When 2017 Stage 2 MU Objective option is selected, the EP is presented with a summary of 2017 Stage 2 Objectives. From the summary page, the EP can navigate to any specific Stage 2 Objective. There are two objectives with measure text changes or threshold changes per the final rule:

- Objective 8: Patient Electronic Access
- Objective 9: Secure Electronic Messaging

C.7.2.2 *State Level Registry System Changes - EH Option to Attest to Stage 3 in 2017*

On the initial MU page in the SLR, EHs attesting for 2017 MU are presented with a selection option to report on either Stage 3 Objectives or to report on Stage 2 Objectives.

When 2017 Stage 3 MU Objective option is selected, the EH is presented with a summary of 2017 Stage 3 Objectives. From the summary page, the EH can navigate to any specific Stage 3 Objectives. The table below shows objective name and sequence that differs from Stage 2 objectives in 2017:

Stage 3 Objective
Protect Patient Health Information
Electronic Prescribing (eRx)
Clinical Decision Support
Computerized Provider Order Entry (CPOE)
Patient Electronic Access
Coordination of Care
Health Information Exchange
Public Health and Clinical Data Registry Reporting

Upon advancing from the selection page to the detailed MU pages, each Stage 3 Objective displays with the 2017 objective, measure text, and relevant exclusion criteria per the final rule.

Six Public Health measures options display for EH in 2017 under the Stage 3 selection option. 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 objective data from the C5 received in 2017. 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.

Validations occur that prevent Stage 3 section options for the following reasons:

- Stage 3 MU option is disabled for EPs that do not have a 2015 edition CEHRT validation on EHR Certification Page in the SLR. In this scenario, EHs can only attest to Stage 2 objectives and measures.
- Stage 3 MU option is disabled for EHs that have not successfully demonstrated MU in a prior year. Validation is based on B6 data and/or prior year(s) attestation data in the SLR.

When 2017 Stage 2 MU Objective option is selected, the EH is presented with a summary of 2017 Stage 2 Objectives. From the summary page, the EH can navigate to any specific Stage 2 Objectives. There is one EH objective with measure text changes or threshold changes per the final rule:

- Objective 8: Patient Electronic Access

C.7.2.3 *Related Program Changes*

Alaska will be updating the Provider Manual (with 2017 screen guidance), the Provider Outreach Page, and the Meaningful Use webpages with relevant information to 2017. The prepayment verification checklist will be updated to reflect the changes. There will also be, at a minimum, quarterly listserv emails sent out to the EP/EH contacts with updates to the Alaska Medicaid EHR Incentive Program.

C.7.2.4 *Related Policy Changes*

There are no state policy or regulation changes.

C.7.2.5 *Audit Strategy*

Modifications to the Alaska Audit Strategy for 2017 and Stage 3 were submitted and approved in early 2018. Program Year post-payment audits will not begin until 2019.

C.7.3 Program Year 2017 MU Requirements

In 2017, all providers are required to attest to a single set of MU objectives and measures; for both EPs and EHs there are eight objectives. Specifically, for 2017, CMS proposed providers may either repeat a year at their current stage or move up stage levels. Additionally, for 2017, a provider may not move backward in their progression and providers who participated in Stage 1 in 2016 may choose to attest to the Stage 1 objective and measures, or they may move to Stage

2 or Stage 3 objectives and measures for an EHR reporting period in 2017. Providers who participated in Stage 2 in 2016 may choose to attest to the Stage 2 objectives and measures or move to Stage 3 objectives and measures for an EHR reporting period in 2017. However, under no circumstances may providers return to Stage 1.

C.7.3.1 *System Changes*

The Alaska SLR has been modified for the changes required for Modified Stage 2 for program year 2017. Included also is editing to verify the provider is attesting to the appropriate program year.

C.7.3.2 *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 2018 screen guidance), the Provider Outreach Page, and the Meaningful Use webpages with relevant information to 2018. The prepayment verification checklist will be updated to reflect the changes. There will also be, at a minimum, quarterly listserv emails sent out to the EP/EH contacts with updates to the Alaska Medicaid EHR Incentive Program.

C.7.3.3 *Audit Strategy*

Modifications to the Alaska Audit Strategy for 2017 and Stage 3 were submitted and approved in early 2018. Program Year post-payment audits will not begin until 2019.

C.7.4 OPPS Rule

C.7.4.1 *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.7.4.2 *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 returning MU providers.

C.7.4.3 *Related Program Changes*

Alaska will be updating the Provider Manual (with 2017 screen guidance), the Provider Outreach Page, and the Meaningful Use webpages with relevant information to 2017. The prepayment verification checklist will be updated to reflect the changes. There will also be, at a minimum, quarterly listserv emails sent out to the EP/EH contacts with updates to the Alaska Medicaid EHR Incentive Program.

C.7.5 Modifications to Measure Calculation Timeframe

There are changes to the measure calculations policy, which specifies 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, 2017, but does not have to occur within the 90-day period.

C.7.5.1 *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 calendar year 2017. Additionally, the SLR displays an attestation statement at the EHR Reporting Period page that numerator and denominator data is in the reporting period. On each MU objective page, providers are required to enter data in numerator and denominator fields specific for applicable MU 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 meet the MU objective when all measure(s) meet the threshold(s).

C.7.6 Medicare Quality Payment Program (QPP)

C.7.6.1 *Updates to Definition of Meaningful EHR User*

This section includes updates that include demonstration of supporting information exchange and prevention of information blocking.

C.7.6.2 *System Changes*

For program year 2017, the SLR displays two attestation statements on the EHR Certification page. These statements are related to supporting providers with the performance of CEHRT

(SPPC). Providers are required to select a check box indicating their confirmation they engaged in SPPC activities as stated by the rule. A second check box is optional to select. Selection of this checkbox indicates their confirmation of engagement in surveillance of health information, as stated by the rule.

On the same EHR Certification page, the SLR displays an attestation statement related to the support for health information exchange and the prevention of information blocking. Providers are also required to select a check box indicating their confirmation they engaged in prevention of 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.7.7 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.7.7.1 *System Changes*

Please see system changes for Section 3.1 for information on changes for this section.

C.7.8 Policy Changes

As the program matures, the IT Planning Office continues to refine the 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.7.9 Recent Changes in State Laws or Regulations

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

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

A regulation change has been 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 EHR Incentive 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.

Changes have been made, effective with the beginning of program 2015:

- Updated the verification process to validate
  - Active Medicaid participation
  - License and sanctions
  - Encounters
  - CEHRT
  - Meaningful Use
  - Attestation Agreement
  - 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 MU definition.

C.8.1 Allowed Attestation Grace Period

DHSS will allow EPs to submit their EHR Incentive Payment Program attestation up to 60 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 2011 is 60 days, EPs can select either a 90 day or greater period from calendar year 2011 or a 90 day or greater period within the 12 months preceding the attestation date to demonstrate patient volume for program attestation until February 29, 2012.

DHSS will allow EHs to submit their EHR Incentive Payment 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 2011 to demonstrate Medicaid patient volume for program attestation until December 31, 2011.

DHSS appreciates that extensions of grace periods beyond 60 days in the new calendar year requires CMS approval.

C.9 Verify Providers Use of CEHRT

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

C.10 Collection of MU 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 EHR Incentive 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 MU must submit CQMs electronically.

In early 2013, providers began reporting CQMs electronically to the Alaska SLR. The proposed CQM Reporting via the HIE initiative will allow providers to submit data to Alaska in one location. Alaska will continue the design and development of a CQM reporting feature to allow EPs and

EHs to directly report and submit patient level data as QRDA I to the HIE to support their meaningful use attestations for the incentive program.

Project Objectives include

- Implementing CQM reporting in the HIE
- Interfacing CQM data to the SLR to support EHR Incentive Program MU attestations
- Providing additional HIE functionality that providers can leverage, supporting the HIE sustainability model and improving the richness of the HIE data and functionality
- Ensuring privacy and security standards are met
- Providing the ability to report patient and aggregate level data

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 Medicaid provider's patients who have their high blood pressure and diabetes 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 EHR Provider Incentive 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.

The SLR features include

- Secure provider log-in
- Self-service review and edit of providers' demographic information
- Role-based screens for providers and Agency staff
- Facilitation of providers A/I/U or Meaningful Use 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 EHR Incentive 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. A copy of the approved IAPD is attached to this updated SMHP.

C.13 IT Timeframe for Systems Modification

The changes for program 2017 and Stage 3 were completed by the first quarter of 2017. The changes for the total switch over to Stage 3 were implemented in early 2018.

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

DHCS has rebuilt the state's Medicaid claims processing and payment system. 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 {ACS}) 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 new 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 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 progressive MMIS system has incorporated innovative features and advancements that provide the foundation for future growth and evolution of HIT and Alaska's Medicaid program.

The new MMIS is currently undergoing the Certification process as of the time of this SMHP update; it is anticipated the Certification process will be completed by the end of 2018.

Anticipated changes for the MMIS related to HIT/HIE include development of a claims feed to the HIE, a feed of the MMIS claims to the HIE, and a modified interface to support the MCI effort.

Both initiatives were included in Alaska's recently approved IAPD. A copy of the IAPD is included with this submission.

C.18 Addressing Provider Questions Regarding the Incentive 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 EHR Program Staff. The staff also responds to phone call from providers.

In addition, 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.

C.19 Appeal Process for the Incentive Payment Program

The appeals policy details the steps a provider may take if an EHR Incentive 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 EHR Incentive 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 EHR Incentive Payment appropriation it originated from. The documents accompanying these monies are created in the EHR Incentive 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 EHR Incentive 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 EHR Incentive Program eligible providers will be reported on a separate line on the CMS 64 (Management and Administrative Reporting (MAR) 1060/1062 reports) report. This report will be reviewed for accuracy and deficiencies.

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

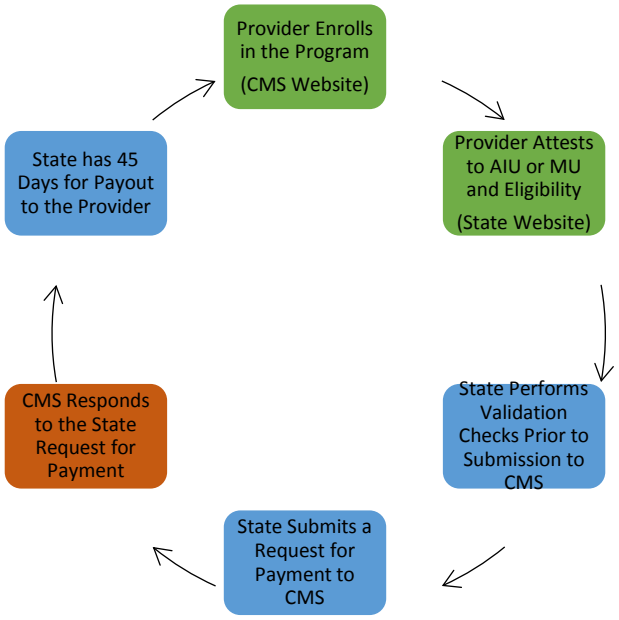
At this point, automated and manual validation checks are performed and a decision regarding enrollment is reached. This decision is transmitted to the NLR within 24 hours. The timing for the manual validation check is variable depending on the submitted number of attestations.

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 – Incentive Payment Issue Process.

Figure 7 – Incentive Payment Issue Process



C.22 Assuring Medicaid Payments are Paid Directly without Deduction

Payments issued by the EHR Incentive Payment 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 (PMF) 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 payment of $21,250 in their first year, with the exception of Pediatrician's qualifying with a 20%-29% patient volume. In subsequent years, each EP will receive the full payment of $8,500, with the exception noted above.

Per §495.310, an EP may not begin receiving payments later than calendar year 2016. Payment after the first year may continue for a maximum of five years. EPs may receive payments on a non-consecutive, annual basis. No payments may be made after calendar year 2021. In no case shall 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 EHR Incentive Payment 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.

Please refer to Appendix C for a detailed description of the Alaska EH Incentive Payment Calculation.

C.26 Contractors Role in the EHR Incentive Program

Alaska's MMIS and Fiscal Agent vendor is Xerox; 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

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.

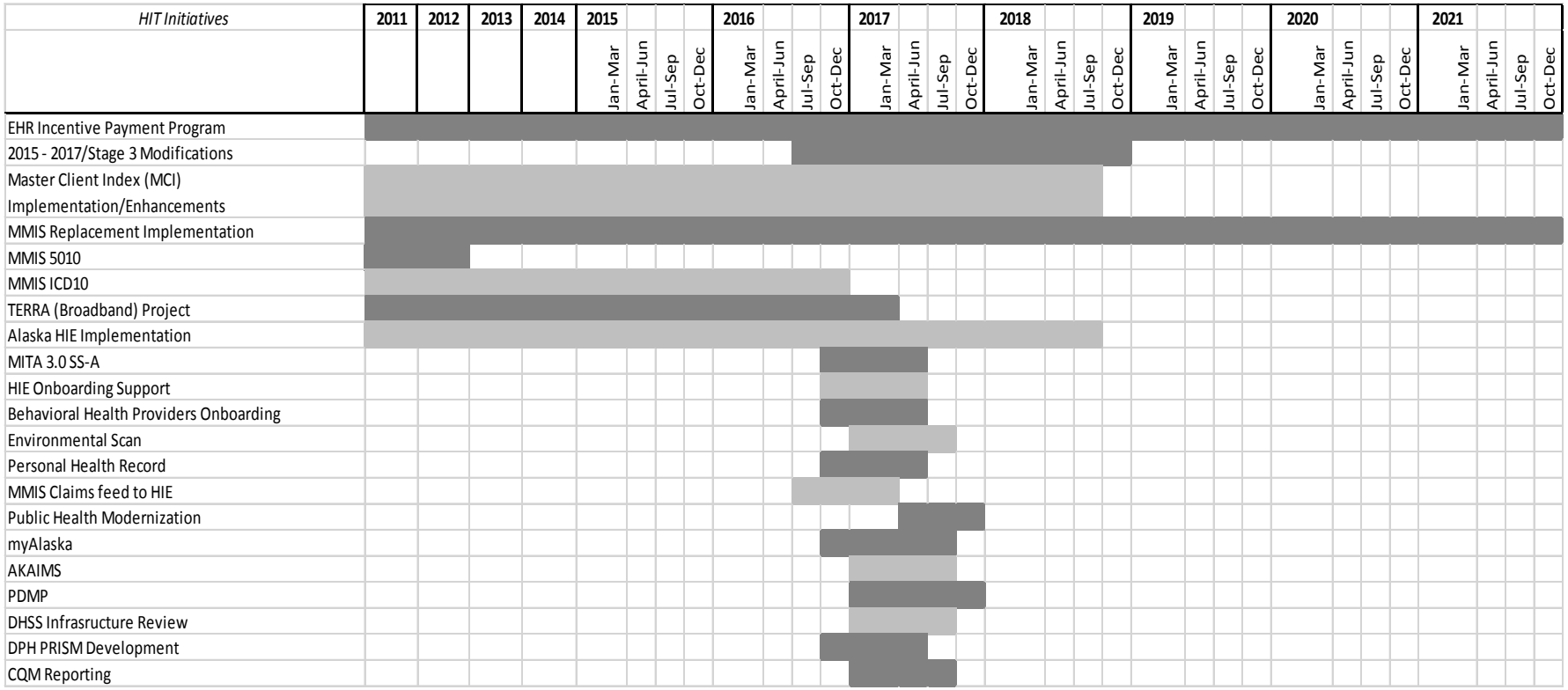
E.1 Alaska Vision for Moving from "As Is" to "To Be" HIT Landscape

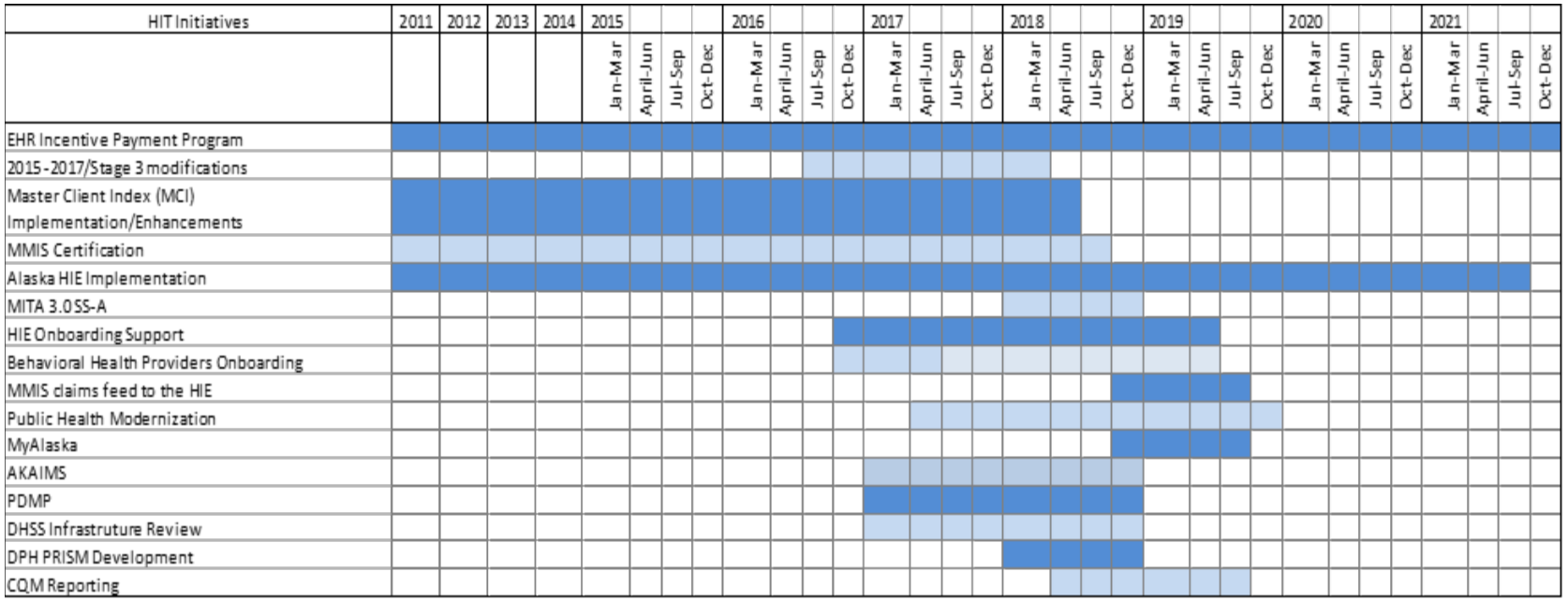
The Medicaid Health Information Technology Roadmap is a high-level plan to address the current state of the Alaska Medicaid EHR Incentive Payment Program and future Medicaid HIT/HIE goals. The roadmap contains high-level steps DHSS will take to continue administering the Medicaid EHR Incentive Payment Program and fulfill Medicaid's HIT/HIE goals and objectives. The Roadmap is not meant to be a static plan, but 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 graphical DHSS pathway is shown on the following page as Figure 8 – Alaska's "As-Is" and "To-Be" Roadmap:

Figure 8 – Alaska's "As-Is" and "To-Be" Roadmap




HIT Initiatives
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
Jan-Mar
April-Jun
Jul-Sep
Oct-Dec
EHR Incentive Payment Program
2015-2017/Stage 3 modifications
Master Client Index (MCI) Implementation/Enhancements
MMIS Certification
Alaska HIE Implementation
MITA 3.0 SS-A
HIE Onboarding Support
Behavioral Health Providers Onboarding
MMIS claims feed to the HIE
Public Health Modernization
MyAlaska
AKAIMS
PDMP
DHSS Infrastruture Review
DPH PRISM Development
CQM Reporting

E.1.2 Alaska's Pathway Narrative

Initiative	Current State	Future Activity
EHR Incentive Program	The EHR Incentive Program activities began in January 2010 with the PAPD and will continue through final provider payments in 2021. The agency has responded to the change mandates 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 EHR Provider Incentive Program until its anticipated end date of 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 Incentive program, such as Behavioral Health providers, enabling increased opportunities to meet Meaningful Use as well as enabling data sharing across all providers involved in patient care.

Initiative	Current State	Future Activity
SLR 2015-2017/Stage 3 Modifications	The current SLR has been in place since the beginning of the DHSS Provider Incentive Plan program. It has been continuously modified for 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 will be implemented for program 2017, including the optional Stage 3, and for Stage 3 in 2018. Other changes, such as the recently released Hospital Outpatient Prospective Payment System (OPPS) changes, will be implemented as required. 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 Alaskan citizens.	Alaska Medicaid is furthering its support for the continued design, development, and implementation of modifications to the statewide MCI to improve activities for EPs and EHs trying to achieve meaningful use across the State of Alaska. 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 MU 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. 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 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 progressive MMIS system has incorporated innovative features and advancements that provide the foundation for future growth and evolution of HIT and Alaska's Medicaid program. The new MMIS is currently undergoing the Certification process as of the time of this SMHP update; it is anticipated the certification process will be completed by the end of 2018.	There are MMIS initiatives planned to support HIT/HIE, including importing MMIS claim data into the HIE. The MMIS will continue to be modified as required.
MMIS 5010	5010 was implemented in the MMIS for the January 1, 2013, deadline.	No further activity is planned; although if further changes are required they will be implemented.
MMIS ICD-10	ICD-10 modifications were implemented in the MMIS for the October 1, 2015, deadline.	No further activity is planned; although if further changes are required they will be implemented.

Initiative	Current State	Future Activity
Terra (Broadband) Project	The TERRA project, begun in 2010 with a US Department of Agriculture Rural Utilities Services grant, extended terrestrial broadband service to remote areas of Alaska. The project has since been consolidated with other broadband initiatives under the Alaska Broadband Task Force.	The TERRA-Southwest ("TERRA-SW") Project, serves 9,089 households and 748 businesses in 65 covered communities. The TERRA-Northwest ("TERRA-NW") Project delivered end-to-end middle mile terrestrial broadband service, for the first time, from the Internet backbone in Anchorage to the almost 4000 households and 300 business in 20 rural Tribal communities scattered across more than 8000 square miles in the Norton Sound and Kotzebue regions, some of the most remote and economically and socially disadvantaged rural regions of the United States. The TERRA Project (managed by GCI) covering 84 communities in Alaska was completed at the end of 2016. GCI most recently expanded into the communities of Noorvik, Golovin, and Buckland. The broadband initiatives have largely been implemented.

Initiative	Current State	Future Activity
Alaska HIE Implementation	In 2009, Alaska DHSS contracted with the HealtheConnect Alaska to procure and manage Alaska's HIE grant program, and to assist the State in establishing HIE capability among health care providers and hospitals in Alaska. 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, Alaska's HIE provides clinical communication pathways to over 470 provider organizations and more than 3000 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 achievement of MU 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. It is anticipated the MITA 3.0 SS-A will be completed in 2018 the results of which 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 EHR Incentive Payment 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 dated Environmental Scan in late 2017. The scan survey included questions to help fully 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 response will be used in the creation of the Health Information Infrastructure Plan that is being developed 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.
Personal Health Record	There is currently PHR capability in the statewide HIE.	DHSS will onboard Medicaid recipients to the HIE enabling them to access their own health care data.

Initiative	Current State	Future Activity
MMIS Claims Feed to the HIE		Alaska plans to integrate the MMIS Decision Support System into the HIE, allowing Medicaid recipients to view their Medicaid claims information in a portal and access it through a Blue Button (or similar) download. Additionally, this initiative will benefit providers by assisting them in achieving MU by helping them meet View, Download, and Transmit (VDT) requirements without having to create individual patient portals.
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.

Initiative	Current State	Future Activity
myAlaska	Currently, the myAlaska platform is a solution which provides a multifunctional universe for statewide activities including but not limited to issuance of benefits, retirement, and identity verification of state employees.	DHSS will leverage the current myAlaska solution as a single sign-on platform, offering significant cost savings to the state. DHSS intends to explore shared funding opportunities with additional departments within the Alaska DHSS to support other use cases for the myAlaska application.

Initiative	Current State	Future Activity
AKAIMS	The AKAIMS is the current statewide electronic health record, and is also responsible for housing data that is stored and aggregated from EHRs across the state.	The implementation of the AKAIMS project will provide another potential attestation source for ensuring that meaningful use is met by providers 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.

Initiative	Current State	Future Activity
Prescription Drug Monitoring Program (PDMP)	The current PDMP is a stand-alone solution.	DHSS will connect the Alaska HIE to the statewide PDMP database. The implementation of this initiative and the ability to onboard additional providers to the PDMP will provide them with real-time, point-of-care electronic access to patient data. This initiative will give Alaska's EPs and EHs the ability to connect to the PDMP solution, submit data as a specialized registry, and meet meaningful use attestation requirements regarding submissions to registries.
DHSS Infrastructure Review	Senate Bill 74 has provided state funding to reform healthcare delivery. Also, the recently implemented 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 HTS to conduct this review and analysis and work is currently underway.	The infrastructure review and analysis which is currently underway will be completed and a Health Information Infrastructure Plan (HIIP) will be created based upon the findings of this review. The HIIP will serve as a guide to determine the activities necessary to increase interoperability within the state.

Initiative	Current State	Future Activity
DPH PRISM Development	The current Department of Public Health PRISM system is the HIV/STD reporting system. The PRISM system does not have any mechanism for receiving HL7 messages.	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/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 achieve meaningful use through a specialized registry and would reduce the administrative burden of the current manual submission process.
CQM Reporting	Providers participating in the EHR Incentive 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 MU must submit CQMs electronically. Providers have had the capability to report CQMs electronically to the Alaska SLR since early 2013.	The CQM Reporting via the HIE initiative will allow providers to submit data to Alaska in one location. Alaska will continue the design and development of a CQM reporting feature for EPs and EHs to have the ability to directly report and submit patient level data as QRDA I to the HIE to support their meaningful use attestations for the incentive program.

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

As 2016 marked the final year in which providers could begin participation in the EHR Incentive Payment Program, moving forward, a great deal of focus was 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 EHR Incentive 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 EHR Incentive Payment Program website.

E.3 Annual Benchmarks for SMA Goals

E.3.1 Annual Benchmarks for EHR Incentive 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 22 hospitals meet the Medicaid eligibility requirements. Hospital incentive payments have totaled close to $25 million.
- Eligible Professionals – As of calendar year 2017, Alaska issued EHR incentive payments to 2,083 unique EPs for a total of nearly $30 million.
- Outreach activities will continue to assure that at least
    - 50% of EPs attesting in the program will meet MU for two program years prior to program's end
    - 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 Health Information Exchange goals are as follows:

- Expand the number of organizations sharing data in the Alaska HIE by increasing the onboarding of provider organizations in calendar 2018. There are currently 12 hospitals live, nine hospitals onboarding, seven provider organizations live, seven provider organizations onboarding, one payer onboarding to Alaska's HIE.
- Implement 20 new providers/users in the Event Notification Service. There are currently eight providers using Notifications.
- Add 200 licensed professionals using query based exchange. There are currently 640 licensed professionals with active query accounts
- Implement single sign-on with two EHR vendors and the HIE.
- Continue to identify strategies for CMS funding for the Medicaid share of HIE activities pursuant to the requirement detailed in the SMD letter of 2/29/16, including but not limited to

  - Implement infrastructure or services to support care coordination and interoperability for Medicaid providers
  - Advance opportunities for the exchange of electronic health records with other care providers such as ophthalmologists, dentists, and other specialists
  - Expand interoperability with public health systems
  - Expand database collection to include claims data and other data elements for use in risk factor analysis
  - Identify and build additional smart notifications with input from case managers and providers
  - Incorporate prescription fill/refill data from pharmacies
  - Include link to images in radiology reports
  - Provide usage reports to individual organizations
  - Advance statewide data analytics capacity
- Develop specifications for and implement enhancements to existing HIE infrastructure services to support future care coordination and data analytics services.

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 is currently completing audits for program year 2015 and has an approved audit plan through Stage 3 MU. The team has completed risk assessments and begun actual audit work on those selected for program year 2014. The team reports on audit progress in the quarterly CMS report and on the HITECH user support interface.

APPENDIX A – EP ENVIRONMENTAL SCAN QUESTIONS

Alaska Environmental Scan

Section 1

PROVIDER/FACILITY/GROUP INFORMATION

Name of Healthcare Facility _____

Name of Provider(s) _____

Provider NPI _____

Provider Address (Street) _____

City _____

State _____

Zip _____

Are you associated with a Tribal Health Organization?

___Yes *(proceed to Section 2)*

___No *(proceed to Section 3)*

Section 2

TRIBAL ORGANIZATIONS

Which Tribal Health Organization(s) are you associated with?

___ Alaska Native Tribal Health Consortium

___ Aleutian Pribilof Islands Association

___ Arctic Slope Native Association

___ Bristol Bay Area Health Corporation

___ Chickaloon Native Village

___ Chugachmiut

___ Copper River Native Association

___ Council of Athabascan Tribal Governments

___ Eastern Aleutian Tribes

___ Kenaitze Indian Tribe

___ Ketchikan Indian Community

___ Knik Tribal Council

___ Kodiak Area Native Association

___ Maniilaq Association

___ Metlakatla Indian Community

___ Mount Sanford Tribal Consortium

___ Native Village of Chitina

___ Native Village of Ekultna

___ Native Village of Eyak

___ Native Village of Tyonek

___ Ninilchik Traditional Council

___ North Slope Borough

___ Norton Sound Health Corporation

___ Seldovia Village Tribe

___ Southcentral Foundation

___ SouthEast Alaska Regional Health Consortium

___ St. George Traditional Council

___ Tanana Chiefs Conference

___ Tanana Tribal Council

___ Yakutat Tlingit Tribe

___ Yukon-Kuskokwim Health Corporation

Section 3

PROVIDER TYPE

Which of the following best describes your healthcare facility? (Check one and proceed to section annotated)

___ Hospital (*If selected proceed to Section 4*)

___ Physician Office/Ambulatory Clinic (*If selected proceed to Section 6*)

___ Long-Term Care/Nursing Home *(If selected proceed to Section 5*)

___ Behavioral/Mental Health *(If selected proceed to Section 8*)

___ Urgent Care Clinics (*If selected proceed to Section 8)*

___ Other: _____ (*if selected proceed to Section 7*)

Section 4

HOSPITAL SPECIFIC QUESTIONS

Please provide the following information for your facility

Please provide the number of beds? _____

Number of full time equivalent Jobs? _____

Average number of ER visit annually? _____

Proceed to Section 8

Section 5

LONG TERM CARE SPECIFIC QUESTIONS

Which of the following best describes your facility?

___ Home Health

___ Nursing Home

___ Other: _____

Please provide the number of patients served annually by your facility

___ 0-50

___ 51-100

___ 101-150

___ 151 >

Proceed to Section 8

Section 6

PHYSICIAN OFFICE/AMBULATORY CARE SPECIFIC QUESTIONS

Which of the following best describes your practice?

___ Primary Care *(Proceed to Section 8*)

___ Specialty Care (*Proceed to Section 7)*

___ Multi-Specialty Care (*Proceed to Section 7)*

Section 7

SPECIALTY PROVIDER SPECIFIC QUESTIONS

What are the specialties of the providers practicing within your facility? _____ (*Proceed to Section 8)*

Section 8

AFFILIATIONS

Which of the following applies to your healthcare facility (select all that apply)?

___ Part of a larger Healthcare System

___ Part of an Independent Practice Association (IPA)

___ Federally Qualified Health Center or Community Health Center

___ Critical Access Hospital or Small Rural Hospital

___ None of the above

Please provide the names of any entities or partnerships referenced above:

_____

_____

_____

Proceed to Section 9

Section 9

PROVIDER & PAYOR MIX INFORMATION

Please indicate the number of providers (MD/DO) at this location

___ 0 - 1

___ 2 – 5

___ 6 – 10

___ 11 – 19

___ 20 +

Please indicate the number of Mid-Level Providers and CHAP/BHAPs at this location.

___ 0 - 1

___ 2 – 5

___ 6 – 10

___ 11 – 19

___ 20+

Please indicate the number of other providers not included in the questions above at this location

___ 0 - 1

___ 2 – 5

___ 6 – 10

___ 11 – 19

___ 20+

What percentage of the payor mix of your practice/facility is Medicaid?

___ 0-25%

___ 26-50%

___ 51-75%

___ 76-100%

Proceed to Section 10

Section 10

INTERNET ACCESS

What type of internet access does your practice currently have?

___ Broadband (Cable/DSL/Fiber Optic) (Proceed to Section 12)

___ Dial up (Proceed to Section 11)

___ Satellite (Proceed to Section 11)

Section 11

NON-BROADBAND INTERNET

Please indicate any barriers or obstacles that prevent you from obtaining internet access:

___ Cost

___ Lack of availability in your area

___ Lack of technical expertise

___ No perceived advantages

___ Other: _____

Do you anticipate a change in your internet access within the next year?

___ Yes

___ No

___ Maybe

If you anticipate a change in your internet access within the next year, what change are you anticipating?

_____

_____

_____

Do you consider your current internet access to be a major concern in exchanging data?

___ Yes

___ No

If yes, why is this a major concern?

_____

Proceed to Section 12

Section 12

PATIENT DATA STORAGE

Where does your patient data currently reside/How is It stored?

___ Paper charts (*Proceed to Section 24*)
___ Certified Electronic Health Record (EHR) Technology (*Proceed to Section 13*)

___ Other _____ (*Proceed to Section 13*)

Section 13

EHR VENDOR AND FUNCTIONALITY INFORMATION

Which EHR vendor do you currently use?

___ Cerner (ANMC)

___ RPMS

___ Nextgen

___ Health Fusion

___ Greenway

___ Optus

___ Meditech

___ Athena Health

___ Other: _____

Is your EHR complete or modular?

___ Complete

___ Modular

___ Unsure

Does your EHR interface with other vendors and/or technologies?

___ Yes

___ No

___ Unsure

Are you able to share information with other providers through your EHR?

___ Yes

___ No

Does the EHR have a Personal Health Record (PHR) component?

___ Yes *(Proceed to Section 14*)

___ No (*Proceed to Section 15*)

Section 14

PERSONAL HEALTH RECORD

Approximately how many patients accessed the PHR?

___ 0 – 5

___ 6 – 10

___ 11- 20

___ 21+

Of those patients who have not used the PHR, have you learned why?

___ No

___ Lack of access or computer

___ Patients not interested in visit data

___ Patients do not understand the visit data

___ Other _____

Proceed to Section 15

Section 15

ANTICIPATED CHANGES TO EHR

Do you anticipate making a change to your EHR in the future?

___ Yes

___ No

___ Maybe

If yes, what type of change are you considering?

_____

_____

_____

Proceed to Section 16

Section 16

EHR SYSTEM FUNCTIONALITY RATING

Please rate your EHR system on the following items by placing a mark in the appropriate box

Function	1. Very Unsatisfied	2. Moderately Unsatisfied	3. Moderately Satisfied	4. Very Satisfied
Clarity of Instructions/Prompts				
Accuracy & Reliability of Reporting				
Overall Reliability				
Consistency with Workflows				
Overall Satisfaction with Certified EHR Technology				

Proceed to section 17

Section 17

EHR TASKS

Please indicate the frequency in which you use your EHR to accomplish the following tasks, by placing a mark in the appropriate box:

EHR Use				
Task	**Always**	**Frequently**	**Rarely**	**Never**
Medical History				
Medical Testing Result Retrieval Consultation Report				
Clinical Documentation				
Discharge Planning				
Problem Lists				
Exchange with other facilities				
Physician Order Entry				
Identify patients due for preventive or follow-up care				
Generate Lists of Patients with particular health conditions				
Create Reports on clinical care measures for patients with specific chronic conditions				
Identification of patient-specific education resources				
Medication Reconciliation				
Secure electronic messaging				
Public Health Reporting				

Proceed to Section 18

Section 18

EHR INCENTIVE PROGRAM PARTICIPATION

Did you/Do you participate in the Alaska Medicaid EHR Incentive Payment Program?

___ Yes (*Proceed to Section 19*)

___ No (*Proceed to Section 23)*

Section 19

MEANINGFUL USE ATTESTATION

Will you attest for Meaningful Use for Program Year 2017?

___ Yes (*Proceed to Section 21*)

___ No (*Proceed to Section 20*)

___ Maybe (*Proceed to Section 20)*

Section 20

NO ATTESTATION IN 2017

If you will not be attesting to Meaningful Use for Program Year 2017, please indicate why

___ Completed all 6 years

___ Incentive not worth continuing

___ Other (if other provide description):

_____

Proceed to Section 23

Section 21

STAGE 3 ATTESTATION

Do you intend to attest to Stage 3?

___ Yes (*Proceed to Section 24)*

___ No (*Proceed to Section 22*

___ Maybe (*Proceed to Section 22)*

Section 22

NO STAGE 3 ATTESTATION

Please indicate why you are considering not attesting to Stage 3

___ Completed all 6 years

___ Incentive not worth continuing

___ Too costly to upgrade to EHR technology 2015 Edition

___ Other (if other provide description): _____

Proceed to Section 23

Section 23

NON-INCENTIVE PROGRAM PROVIDERS

If you have adopted an EHR but have not attested to Meaningful Use, please indicate why (Check all that apply)

___ Do not meet patient thresholds

___ Too time consuming

___ Not an Eligible Provider

___ Not worth the incentive amount

___ Other (if other provide description): _____

Proceed to Section 25

Section 24

NON-EHR PROVIDERS

If you **did not** adopt an EHR and did not participate in the EHR incentive program, please select the factor(s) that led to the decision to not participate:

___ Technology limitations (lack of adequate internet connectivity; lack of hardware)

___ Did not meet eligibility requirements

___ Financial limitations (lack of funds for initial investments; no return on investment)

___ Knowledge limitations (lack of knowledge of the program)

Lack of understanding of the program

___ Workflow disruption

___ Lack of support staff

IT/Technology Administrative

___ Unable to find the right EHR to meet needs

___ Other (if other provide description): _____

Proceed to Section 25

Section 25

ALTERNATIVE TECHNOLOGY

What technology do you believe may be utilized in place of the EHR to attain the same results/data?

_____

_____

_____

Proceed to Section 26

Section 26

USE OF DATA ANALYTICS

Do you utilize any data analytics (Business Intelligence/Business Analytic tools)?

___ Yes (*Proceed to Section 27*)

___ No (*Proceed to Section 28*)

Section 27

DATA ANALYTIC TOOLS

What business analytics tools do you use?

_____

_____

_____

What types of data have you analyzed?

_____

_____

_____

Have you used this tool to analyze data captured through your EHR?

____ Yes

____ No

Proceed to Section 28

Section 28

ADDITIONAL HEALTH TECHNOLOGIES

What, if any, additional health Technologies (i.e. devices, systems) do you use?

_____

_____

_____

How do you use these technologies?

_____

_____

_____

Proceed to Section 29

Section 29

DATA EXCHANGE/CONNECTIVITY

What tools do you use to facilitate electronic exchange of health information? Please select one or more options:

___ Patient Portal

___ Health Information Exchange (HIE)

___ Direct Secure Messaging

___ Other; please specify: _____

If patient portal was selected from the list above, what capabilities does the portal provide? (Select all that apply)

___ Scheduling

___ Test Results

___ Medical Records

___ Billing Information

___ Education Tools and Resources

___ Medication List - Refill Requests

___ Ability to contact physician/office staff

___ Do not offer a patient portal

___ Other, please specify: _____

Proceed to Section 30

Section 30

CONNECTIVIETY TO OTHER ENTITIES

I am currently (please select all that apply):

___ Connecting to pharmacies and labs

___ Connected to other hospitals

___ Connected to other clinics and emergency departments

___ Connected to the public health department

___ Connected to digital radiology

___ Other; please specify: _____

Proceed to Section 31

Section 31

IN-STATE REFERRALS

Do you refer or transfer patient within the state for treatment?

___ Yes (*Proceed to Section 32)*

___ No (*Proceed to Section 33)*

Section 32

IN-STATE REFERRAL INFORMATION

Please indicate if you refer patients for treatment to other in-state providers for the following specialties. Indicate all that apply, by marking if you refer to Tribal Providers, Non-Tribal Providers or Both.

Primary Reason for Transfer	Tribal	Non-Tribal	Both
Orthopedics			
Cardiology			
Emergency care-Trauma			
Emergency care-Disease			

Primary Reason for Transfer	Tribal	Non-Tribal	Both
Cancer			
Pediatric (all conditions-transfer based on age)			
Mental Health Service			
Patient Preference			
Substance Abuse			
Other _____			

What factors do you consider when you are selecting an in-state provider for a referral?

_____

Proceed to Section 33

Section 33

OUT-OF-STATE TRANSFERS

Do you refer or transfer patients out of state for treatment?

___ Yes *(Proceed to Section 34)*

___ No *(Proceed to Section 35)*

Section 34

REFERRAL STATES

Which states do you refer to? (choose all that apply)

___ Washington

___ Oregon

___ California

___ Idaho

___ Montana

___ Other: _____

Please indicate if you refer patients for treatment to out-of-state providers for the following specialties. For those referrals, indicate if you refer to Tribal Providers, Non-Tribal Providers or Both by marking the appropriate column

Primary Reason for Transfer	Tribal	Non-tribal	Both
Orthopedics			
Cardiology			
Emergency care-Trauma			
Emergency care-Disease			
Cancer			
Pediatrics (all conditions-transfer based on age)			
Mental Health Services			
Substance Abuse			
Patient Preference			
Other _____			

What factors do you consider when making a referral?

_____

Proceed to Section 35

Section 35

OUT-OF-STATE CORRESPONDENCE

Throughout the course of providing patient care do you frequently correspond with providers or healthcare entities in other states?

___ Very Frequently

___ Sometimes

___ Rarely

___ Never

Which data do you share electronically? (Please select all that apply)

___ Labs

___ Imaging

___ Medications

___ Medication allergies

___ I do not exchange information electronically

___ Other; specify: _____

___ All of the above

Proceed to Section 36

Section 36

ELECTRONIC REFERRAL SUBMISSION

When you send a referral, do you electronically send the patient record?

___ Yes

___ No

Proceed to Section 37

Section 37

RECEIPT OF RESULTS

When you send a patient record electronically for a referral do you receive an electronic record back with the results

___ Yes

___ No

Proceed to Section 38

Section 38

DISCHARGE INFORMATION & REFERRAL RECEIPT

Do you receive discharge information electronically for your patients that are in the hospital?

___ Yes

___ No

When you are referred to, do you receive electronic referral data?

___ Yes

___ No

Proceed to Section 39

Section 39

TELEMEDICINE & TELEHEALTH

Are you using telemedicine or telehealth?

___ Yes (*Proceed to Section 40*)

___ No (*Proceed to Section 41*)

Section 40

USES OF TELEMEDICINE/TELEHEALTH & HOME MONITORING DEVICES

Which technology platform are you using to deliver services via telemedicine and telehealth?

___ Store and Forward

___ Real Time “video teleconferencing”

If using Store and forward, what is the name of the store and forward platform you are using?

_____

If using video teleconferencing, which video teleconferencing platform are you using?

___ Polycom

___ Vidyo

___ Lifesize

___ Zoom

___ Other; please specify _____

Are you using telemedicine or telehealth for any of the following? (select all that apply)

___ Home monitoring

___ Providing care to patients

___ Tele pharmacy

___ Other; please specify _____

___ All of the above

When utilizing home-monitoring devices for patient care, are those devices connected to your EHR?

___ Yes

___ No

___ I do not utilize home-monitoring devices

What types of home-monitoring devices do you currently use? (Select all that apply)

___ Blood glucose meter

___ Blood coagulation meter

___ Pulse oximeter

___ Weight scale

___ Blood pressure monitor

___ Apnea monitor

___ Electrocardiogram monitor

___ Medication dispensing device

___ I do not use home-monitoring devices

___ Other

What is the estimated percentage of patients utilizing home-monitoring devices?

___ 0-25%

___ 26-50%

___ 51-75%

___ 76-100%

How do you receive results from home-monitoring devices?

___ Self-reporting

___ Telephone – Landline

___ Internet

___ Cellular

___ Other

What is your overall satisfaction level with home-monitoring devices?

___ 1 Very Unsatisfied

___ 2 Moderately Unsatisfied

___ 3 Moderately Satisfied

___ 4. Very Satisfied

Proceed to Section 41

Section 41

HEALTH INFORMATION EXCHANGE

Does your hospital or practice have an Information Technology (IT) plan as part of your overall organizational strategic plan?

___ Yes

___ No

Are you currently participating in the Alaska HIE?

___ Yes (*Proceed to Section 42*)

___ No (*Proceed to Section 43*)

Section 42

ACTIVE USE OF THE HIE

Please indicate how frequently you use the HIE for the following tasks:

Task	Never	Rarely	Sometimes	Frequently
Send information to other providers to coordinate care				
Find or request patient information from other providers				
Other, please specify:				

What additional capabilities and functionality would you like to see with the HIE? (select all that apply)

___ Assist with population health

___ Patient engagement

___ Data aggregation

___ All of the above

___ Other; please specify _____

Please select any functions of the Alaska HIE that you do not use:

___ Data Exchange

___ Patient Portal

___ Data submission to public health

___ I use all of these functions

Thank you for your participation, please submit your form.

Section 43

HIE NON-PARTICIPATION

What are the barriers that have prevented you from utilizing the Alaska HIE?

___ Technology limitations

___ Staffing limitations (understaffed/lack of understanding

___ Security Concerns

___ Financial Concerns

___ Other

If financial concerns were cited above as a barrier to utilization of the HIE, please provide additional details:

If the barriers selected above were mediated, would you consider participating in the Alaska HIE?

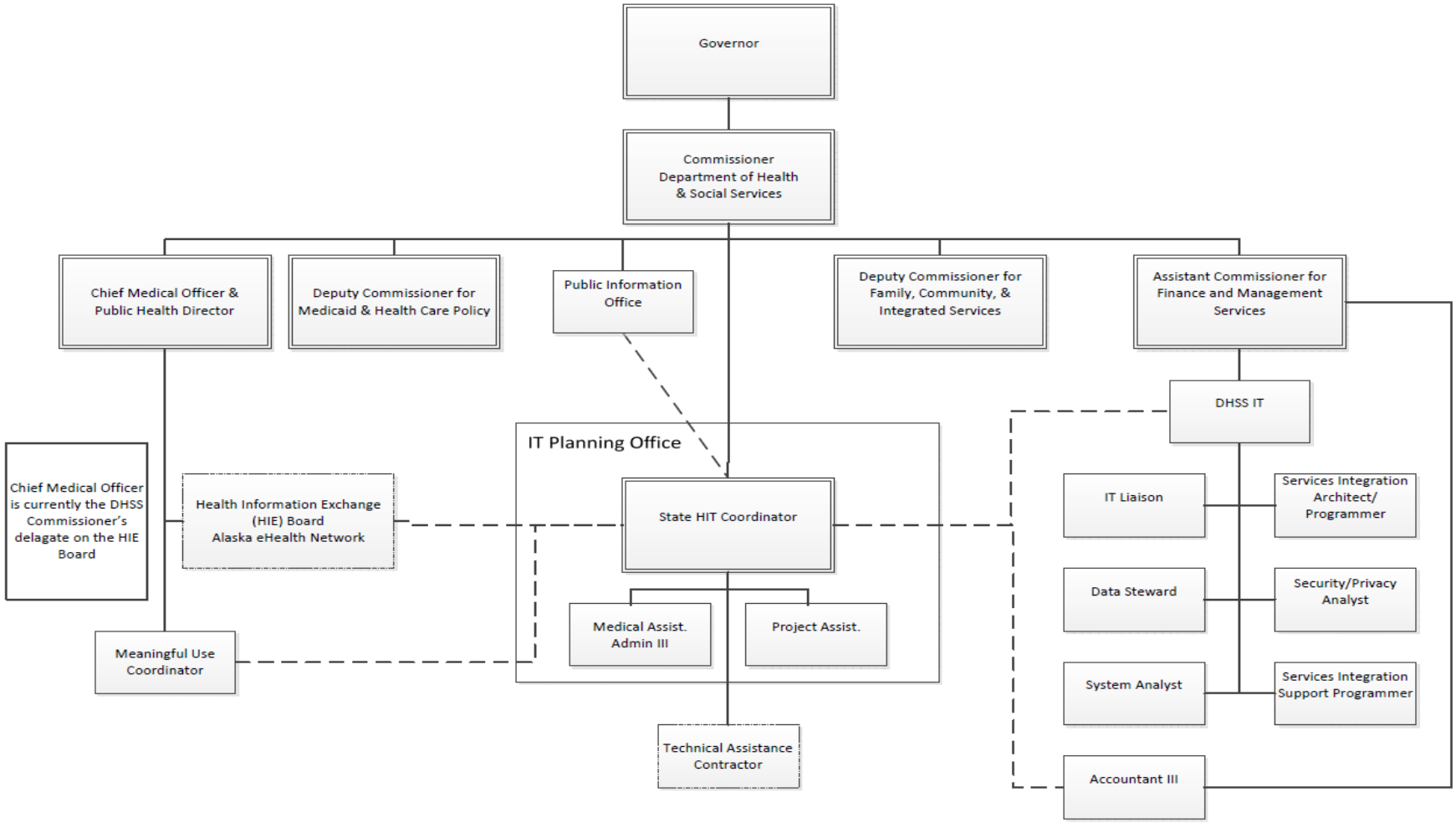
___ Yes

___ No

___ Maybe

Thank you for your participation, please submit your form.

APPENDIX B – DHSS ORGANIZATION CHART



APPENDIX C – HOSPITAL INCENTIVE CALCULATION

Enter Hospital Name

Calculation of Medicaid Electronic Health Records (EHR) Incentive Payment

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

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

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

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

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

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

> discharges are capped at 23,000 each year

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

Step 3: Compute the initial amount for 4 years

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

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

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

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

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

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

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

Hospital Tip Sheet

Confirm Medicaid Eligibility for Eligible Hospitals

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

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

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

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

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

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

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

7/15/11

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

7/15/11

Tribal Hospital Tip Sheet

Confirm Medicaid Eligibility for Eligible Tribal Hospitals

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

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

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

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

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

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

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

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

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

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

Year 4 is 2007
Year 3 is 2008
Year 2 is 2009
Year 1 is 2010</td></tr>
<tr><td>Location on Cost Report – CMS 2552-96 or other data sources</td><td>Location on SLR’s Confirm Alaska Medicaid Eligibility Page</td></tr>
<tr><td>Discharges</td><td>S-3, Part I, Column 15 listed as "Total All Patients", line 12-sum of acute care inpatient, or IHS HQ Reports</td><td>Lines 1 and 2
Total Discharges</td></tr>
<tr><td>Medicaid Inpatient Bed Days</td><td>State Reports</td><td>Line 3 Total Medicaid Inpatient Bed Days</td></tr>
<tr><td>Total Medicaid Managed Care Inpatient Bed Days</td><td>Alaska does not have Medicaid Managed Care Inpatient Bed Days; it is included in the hospital calculation sheet only because it is a data field in the SLR. Hospitals may enter a “0” in this field in the SLR.</td><td>Line 4 Total Medicaid Managed Care Inpatient Bed days</td></tr>
<tr><td>Total Inpatient Bed Days</td><td>IHS National IP Statistics</td><td>Line 5 Total Inpatient Bed Days</td></tr>
<tr><td>Total Hospital Charges</td><td>IHS Cost Report Summaries</td><td>Line 6 Total Hospital Inpatient Charges</td></tr>
<tr><td>Total Charity Care</td><td>IHS National IP Statistics</td><td>Line 7 Hospital Inpatient Charity Care Charges</td></tr>
</table>

APPENDIX D - ACRONYMS

Acronym	Description
A/I/U	Adopt, Implement, and Upgrade
AAC	Alaska Administrative Code
AAFP	American Academy of Family Physicians
AAP	American Academy of Pediatrics
ACHIN	Alaska Community Health Integrated Network
ACS	Affiliated Computer Systems (now known as Xerox)
AeHRA	Alaska electronic Health Records Association
AHCC	Alaska Health Care Commission
AI/AN	American Indian/Alaska Native National Regional Extension Center
AKAIMS	Alaska Automated Information Management System
AKSTARS	
ANMC	Alaska Native Medical Center
ANTHC	Alaskan Native Tribal Health Consortium
APCA	Alaska Primary Care Association
AQuIN	Alaska Quality Improvement Network
ARRA:	American Recovery and Reinvestment Act of 2009
ASMA	Alaska State Medical Association
ATAC	Alaska Telehealth Advisory Council
AVAHS	Alaska Veterans Administration Healthcare System
BMI	Body Mass Index
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

Acronym	Description
CHC	Community Health Center
CHIP:	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CHPL	Certified Health IT Products Listing
CMS	Centers for Medicare & Medicaid Services
CoP	Community of Practice
CQM	Clinical Quality Measure
DDI	Design, Develop, Implementation
D.O.	Doctor of Osteopathic Medicine
DHCS	Division of Health Care Services
DHSS	Department of Health and Social Services
DoD	Department of Defense
DoD VA	Department of Defense Veterans Administration
DPH	Division of Public Health
DSS:	Decision Support System
DW	Data Warehouse
ebXML	Electronic Business Extensible Markup Language
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
EH	Eligible Hospital
EHR	Electronic Health Record
ELR	Electronic Laboratory Reports or Reporting
EMR	Electronic Medical Records
EP	Eligible Professional
ePHI	Electronic Protected Health Information
EPSDT	Early Periodic Screening, Diagnosis, and Treatment Program
ER	Emergency Room

Acronym	Description
ETL	Extract, Transform, Load
FA	Fiscal Agent
FAQ	Frequently Asked Questions
FCC	Federal Communication Commission
FFP:	Federal Financial Participation
FFS	Fee for Service
FFY	Federal Fiscal Year
FQHC:	Federally Qualified Health Center
HIE	Health Information Exchange
HIMSS	Health Information Management and Systems Society
HIPAA	Health Insurance Portability and Accountability Act
HISPC:	Health Information Security and Privacy Collaborative
HIT:	Health Information Technology
HITECH:	Health Information Technology for Economic and Clinical Health Act
HL7	Health Level Seven
HRSA:	Health Resources and Services Administration
HSS IT	Health and Social Services Information Technology
IAPD:	Implementation Advance Planning Document
ICD-10:	International Classification of Diseases and Related Health Problems, 10th Revision
IHS:	Indian Health Services
IRS:	Internal Revenue Service
IT:	Information Technology
IVR	Interactive Voice Response
LIMS	Laboratory Information Management System
LLC	Limited Liability Corporation
LOS	Length of Stay

Acronym	Description
LOINC	Logical Observation Identifiers Names and Codes
MAR:	Management and Administrative Reporting System
MCI	Master Client Index
MD	Medical Doctor
MFCU	Medicaid Fraud Control Unit
MITA	Medicaid Information Technology Architecture
MMIS	Medicaid Management Information System
MPF	Master Provider File
MPI	Master Provider Index
MU	Meaningful Use
NETSS	National Electronic Telecommunications System for Surveillance
NHIN:	National Health Information Network
NwHIN	Nationwide Health Information Network
NIHB	National Indian Health Board
NLR:	National Level Repository
NNDSS	National Notifiable Diseases Surveillance System
NPI:	National Provider Identifier
NPPES:	National Plan and Provider Enumeration System
NPRM	Notice of Proposed Rule Making
OIG	Office of the Inspector General
ONC	Office of the National Coordinator for Health Information Technology
PA	Physician's Assistant
PACS	Picture Archiving and Communication System
PC Agency	Primary Care Agency
PDMP	Prescription Drug Monitoring Program
PEP	Provider Enrollment Portal
PERM	Payment Error Rate Measurement

Acronym	Description
PHR	Personal Health Record
PHIN MS	Public Health Information Network Messaging System
PI	Program Integrity
PMF	Provider Master File
POS	Place of Service
PPACA	Patient Protection and Affordable Care Act
REC	Regional Extension Center
RFP:	Request for Proposal
RHC:	Rural Health Clinic
RHIO:	Regional Health Information Organization
RPMS:	Resource and Patient Management System
R&S	Research and Support
SaaS	Software as a Service
SB	Senate Bill
SDE	State Designated Entity
SDS	Senior and Disabled Services
SLR	State Level Registry
SMHP	State Medicaid Health Information Technology Plan
SMHPU	State Medicaid Health Information Technology Plan Update
SMA	State Medicaid Agency
SMM	State Medicaid Manual
SNF/ICF	Skilled Nursing Facility/Intermediate Care Facility
SNOMED	Systematized Nomenclature of Medicine
SOA	Service Oriented Architecture
SQL	Structured Query Language
SS-A:	MITA State Self-Assessment
SSL	Secure Socket Layer

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