STATE OF ALASKA

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

STATE MEDICAID HIT PLAN UPDATE (SMHPU)

VERSION 3.0

December 2016

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EXECUTIVE OVERVIEW

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

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 for Health Information Technology (ONC) detailing the development of an economical, sustainable HIE in Alaska. In March 2010, the DHSS entered into a cooperative agreement with the ONC to create an HIE in Alaska. In April 2010, DHSS contracted with the Alaska eHealth Network (AeHN) to be the non-profit governing board that will procure and manage Alaska's HIE. In November 2010, Alaska eHealth Network contracted with Orion Health Inc. to implement the Software as a Solution (SaaS) Health Information Exchange solution for Alaska.

The establishment of the non-profit governing board has established a foundation of collaboration and coordination that has brought a diverse group of stakeholders together to advance Alaska's HIE. Development of Alaska's HIE resulted in the culmination of over ten years of statewide and regional health information exchanges and concepts created in the National Health Information Network (NHIN)and enhanced through ARRA stimulus. Today, Alaska's Health HIE provides clinical data to over 2,000 providers in 40 organizations. 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.

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 AeHN 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 AeHN include Alaska State Medical Association (ASMA); Alaska Hospital Association (AHA); Alaska Primary Care Association (APCA); Federally Qualified Health Centers (FQHCs); 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 current MMIS Replacement Project. The initial MITA SS-A did not include all of the elements to support development of this SMHP and as a result, a 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.

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 implementing and administering Alaska's EHR Incentive Program, including:

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

The ultimate goals for the State of Alaska are to ***improve access to health care and quality of health care for Alaskans***. The DHSS vision for the future of HIT is a multi-year vision that consists of existing and planned projects and initiatives that will significantly contribute to Alaska's health care transformation. By leveraging implementation of new technologies such as a modernized MMIS, extending web based access to providers and members, EHRs, and HIE networks, DHSS 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

DHSS submitted and received approval for the State Medicaid Health Information Technology Plan (SMHP) in November 2010 and the related Implementation Advance Planning Document (IAPD) in November 2010. The Centers for Medicare & Medicaid Services (CMS) approved the Alaska EHR Incentive Payment Program to "go live" in December 2010, and Alaska's State Level Registry was opened to receive attestations in January 2011.

An SMHP update was submitted in February 2013 addressing the 2013 program year changes and Stage 2, as delineated in the 42 Code of Federal Regulations (CFR) 495.302 - 495.306 revised on September 4, 2012. A subsequent SMHP update was submitted in October 2014 addressing the revisions mandated by the 2014 Flexibility Rule.

CMS issued the 2015 – 2017/Stage 3 rule on October 16, 2015, effective on December 15, 2015. Alaska submitted an SMHP Addendum and the required State Level Registry (SLR) screen changes that were subsequently approved by CMS, and the 2015 – 2016 changes were implemented.

This SMHP update consolidates all of the previous updates and addendums, as well as updating information to reflect the current status of the Alaska Electronic Health Record Incentive Program.

Background

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

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

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.

Use of MITA Principles and Methodology

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

During the planning phase, business areas reviewed the regulatory requirements for submission of the SMHP published in the Final Rule at §495.332 and in CMS guidance for developing the SMHP published on April 29, 2010. The project team then reviewed each SMHP business process to determine if the standard MITA business process would apply to develop a concept of operations for the Alaska EHR Incentive Payment Program. As shown in **Error! Reference s ource not found.**, all MITA business processes were reviewed, and where feasible, an approach

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

was adopted to integrate the Alaska EHR Incentive Payment Program business process into DHSS's corresponding standard MITA business process.

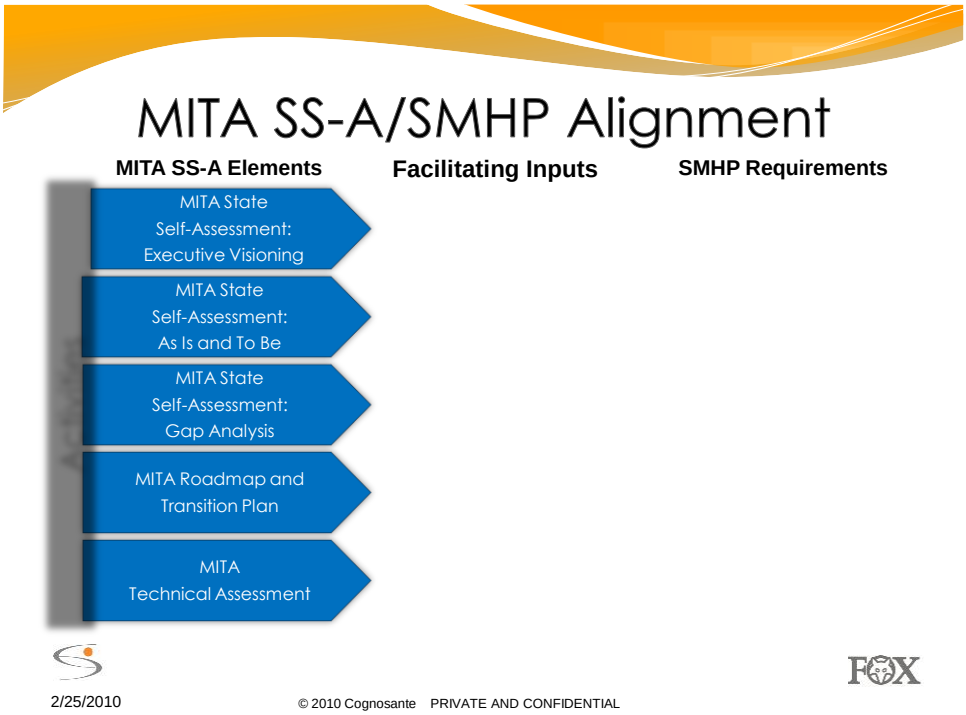


Figure 1 – MITA SS-A to SMHP Alignment

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

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 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 2017, the results of which will be included in the next Alaska SMHP update.

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' ability to actively participate in and contribute to their families, schools, places of employment, and communities.

While progress has been achieved in the past five years, 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 recently implemented 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 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.

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 health care information and services for beneficiaries
- Simplified interaction with the health care infrastructure for providers
- Improved health care outcomes measured by increased usage of performance criteria
- Evolving use of modern information technology to improve the delivery of health care 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 health care

This SMHP describes the DHSS near and long term goals to meet the above objectives by leveraging the successes achieved thus far and enhancing the overall capability for electronic sharing of health information, as well as utilizing the data in an effort to realize improved health care 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 Certified EHR Technology (CEHRT) among the provider population, augmented by the implementation of the statewide HIE. DHSS planning incorporates the progress made thus far to further enhance the capabilities of providers to increase electronic interoperability and to increase the number of providers participating in and utilizing the benefits of the program.

There are 26 hospitals in Alaska, 22 of which are eligible for the Medicaid EHR program. Of the 22 eligible hospitals, one has not been able to meet the patient volume requirements. The state has 13 hospitals currently identified by the Flex Monitoring Team as Critical Access Hospitals (2015). There are no Rural Health Clinics in Alaska (CMS, 2015), and 29 Federally Qualified Health Centers 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 % 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	Total
Total Providers Paid (number) AIU	61	240	198	167	72	**738**
Total Amount Paid AIU	$1,296,250	$5,057,502	$4,207,500	$3,506,250	$1,530,000	**$15,597,502**
Total Providers Paid (Number) MU	0	39	25	332	292	**688**
Total Amount Paid MU	$0	$331,500	$209,667	$3,271,084	$2,966,500	**$6,778,751**
Total Amount Paid	**$1,296,250**	**$5,389,002**	**$4,417,167**	**$6,777,334**	**$4,496,500**	**$22,376,253**

* Financial data includes recoupments resulting from audits

Eligible Hospitals	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	Total
Total Hospitals Paid (number) AIU	5	12	3	1	0	**21**
Total Amount Paid AIU	$2,817,708	$9,094,291	$972,250	$303,530	-$416,181	**$12,771,598**
Total Hospitals Paid (number) MU	0	4	4	13	8	**29**
Total Amount Paid MU	$0	$2,259,886	$2,058,191	$5,141,864	$1,263,961	**$10,723,903**
Total Amount Paid	**$2,817,708**	**$11,354,177**	**$3,030,441**	**$5,445,394**	**$847,780**	**$23,495,501**

* Financial data includes adjustments resulting from audits

Attestations by Provider Type	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	Total by Provider Type
Physician	39	185	186	368	254	**1032**
Nurse Practitioner	17	51	19	83	70	**240**
Dentist	0	18	12	18	19	**67**
Optometrist	0	0	0	0	0	**0**

Pediatricians	0	6	1	2	0	**9**
Physician Assistants	1	6	4	5	8	**24**
Acute Hospitals	5	16	7	14	8	**50**
Children's Hospitals	0	0	0	0	0	**0**
Total by Calendar Year	**62**	**282**	**229**	**490**	**359**	

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, the enhanced capability for electronic exchange of information is very important. The Certified Electronic Health Record Technology combined with the implementation of the Alaska statewide HIE has enabled expanded data sharing so critical for the smaller communities.

A.1.1 Environmental "As-Is" Scan

Information from two separate surveys conducted in 2009 and 2010 was used to determine the "As-Is" state of adoption by Medicaid eligible providers.

DHSS anticipates conducting another Environmental Scan within 2017, as recommended by CMS guidance. The funding for the Environmental Scan has been approved by CMS and DHSS has procured a vendor to conduct the scan. The results of the new scan, as well as the considerations revealed by a new scan, will be included in the next AK SMHP update.

For further information regarding the scans conducted in 2009 and 2010, please see Appendix A (EPs) and Appendix B (EHs)

A.2 Telecommunications and Broadband Access.

A.2.1 United States Department of Agriculture (USDA) Community Connect

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

A.2.2 Federal Communications Commission (FCC) Pilot Project

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

The FCC contract is currently complete. Funding through this source of revenue required a 15-percent match for each year of the contract. The ANTHC had submitted a proposal for 2008 that included funding for 231 facilities statewide. A contract was established with GCI and Structures to design an infrastructure under Phase 1 of the project which was completed in October 2009. Phase 2 of the project was to procure and deploy equipment for the implementation of the statewide infrastructure. The RFP for Phase 2 was publicly posted in July 2011, but there were no further efforts to pursue this project, and the project was closed in 2013.

A.2.3 Universal Services Administrative Company/Universal Services Fund

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

The High Cost Program ensures that consumers in all regions of the nation have access to and pay rates for telecommunications services that are reasonably comparable to those services provided in urban areas. The Low-Income Program is designed to ensure that quality telecommunications services are available to low-income customers at just, reasonable, and affordable rates. The Rural Health Care Program is designed to provide reduced rates to rural health-care providers (HCPs) for telecommunications services and Internet access charges related to the use of telemedicine and telehealth. The Schools and Libraries Program commonly known as the "E-Rate Program," provides discounts to assist most schools and libraries in the United States to obtain affordable telecommunications and Internet access.

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

A.2.4 Broadband Internet Access in Alaska

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

New fiber optic cable is currently being installed in the Arctic that will expand 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 this past summer (2016). The new cable is being 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 will be the first fiber optic cable through the Northwest Passage.

The Terra projects, detailed below, were consolidated with other initiatives collectively called the Alaska Broadband Task Force. The Task Force website, which can be seen at http://www.alaska.edu/oit/bbtaskforce/homepage.html highlights the success of the initiatives. The TERRA Project (managed by GCI) is expected to cover 84 communities in Alaska by the end of 2016. GCI most recently expanded into the communities of Noorvik, Golovin, and Buckland.

A.2.5 Terra-Southwest Project

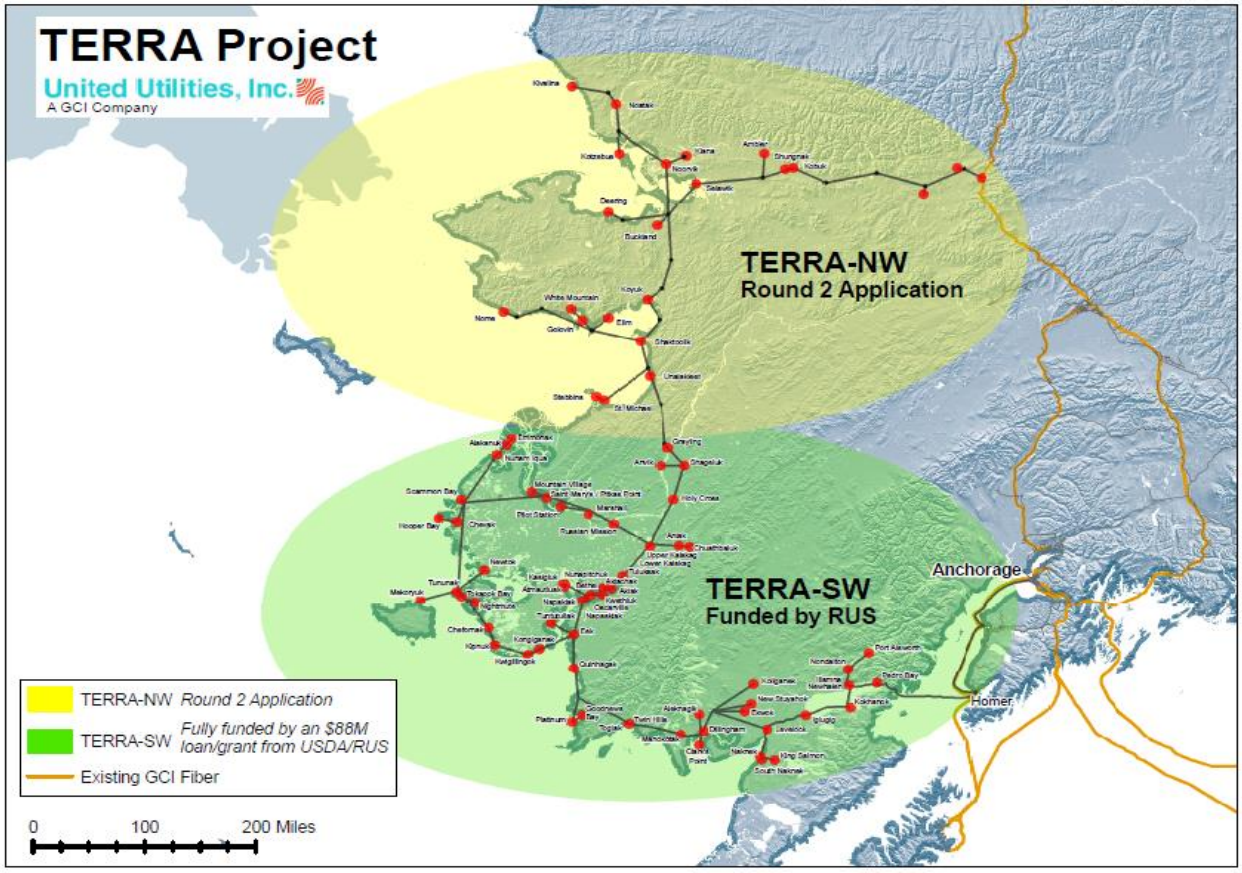
The Terra-Southwest ("TERRA-SW") Project, serves 9,089 households and 748 businesses in 65 covered communities. A key benefit of the project is that it serves public/non-profit/private community anchor institutions and entities, such as regional health care providers. Included in this effort was the construction of Alaska's first truly statewide mobile wireless network, which will seamlessly link urban and rural Alaska for the first time in the state's history.

A.2.6 Terra-Northwest Project

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.

See TERRA Project Map below.

Figure 2 – TERRA Project Map



A.3 New HRSA Grants

The Alaska Primary Care Association recently obtained a grant for a Quality Improvement Network project.

The Alaska Quality Improvement Network (AQulN), Alaska's Health Center Controlled Network (HCCN) is comprised of 10 Participating Health Centers from across the state of Alaska. As a program of the Alaska Primary Care Association (APCA), the AQulN will be housed in the Alaska Center for Healthcare Quality (ACHQ), a division of the APCA. AQulN will be 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 staff from the Alaska Center for Healthcare Quality.

Upon receipt of the HCCN Program award from HRSA, AQulN will undertake competitive procurement of a vendor contract to develop and implement a data warehouse for the network. The data warehouse would receive routine, periodic data feeds from each

Participating Health Center's Electronic Health Record (EHR). The data warehouse would be query-able by APCA and Participating Health Centers - for their own health center data for use with quality improvement and population health management purposes, and for comparisons to other Participating Health Centers. A set of reports from the data warehouse would be pre-formatted, for regular reporting requirements, desired data points, and set performance measures, but reports will also accommodate special data queries. Procurement is anticipated to be completed by January of 2017, when the connections with individual Participating Health Centers will begin to be constructed. AQulN forecasts onboarding two Health Centers in project year 1, and four in each of years 2 and 3. Costs for those connections are requested in the project budget.

The overall purpose of the AQulN is Quality Improvement for better health outcomes, increased patient and family engagement, and lower costs. As the health care market demands better performance and a focus on population health, Alaska's Health Centers recognize the need to own their data, and be able to respond to that data for improvement in value, efficiency, and effectiveness. The data warehouse 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. And, as Alaska explores alternative payment methodologies, the AQulN will position Health Centers to be able to participate in value-based pay. The Alaska Department of Health & Social Services just released a report on improving the Medicaid Program. It 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.

APCA proposes to operate and manage the AQulN program through its Alaska Center for Healthcare Quality (ACHQ) with onsite and remote-delivered technical assistance. 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, AQulN staff will implement and adapt successful best practices from HCCN, data analytics, and clinical care coordination experts.

A.3.1 Federally Qualified Health Clinics and Rural Health Clinics

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 Rural Health Centers (RHCs) in Alaska. No HRSA grants have been issued to Alaska's FQHCs.

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

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

A.3.2 Rural Health Information Technology Grants

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

Table 1 – Rural HIT Grants

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

A.3.3 Community Health Center Planning Grants

HRSA distributed additional Patient Protection and Affordable Care Act (PPACA) funds for organizations to become community health centers in September 2011. The funding helped these organizations plan for the development of a comprehensive primary care health center, so that they can provide care for some of Alaska's most vulnerable populations and potentially create more high-quality jobs in the future for their communities. These awards fund community-based entities seeking to provide a more comprehensive range of primary health care services and or expand their services to a larger community. Grantees submitted final reports in November 2012.

Table 2 - Alaska's Community Health Center Planning Grants

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

The Alaska Community Health Integrated Network (ACHIN) project was conceived as a single EHR network of nine Community Health Centers. None of the Health Centers had adopted an EHR at that point. The network decided to implement NextGen. The project was complex and comprehensive: the servers for seven of the sites were hosted at the APCA, and the EHR data was collected from all sites. APCA hired both IT and billing/coding staff to handle those tasks for the nine Health Centers.

The project did get implemented and worked roughly according to plan until the grant funding ran out. The nine Health Centers withdrew from the network for a variety of reasons, including the escalating cost of maintaining NextGen, and the high costs of purchased services at APCA without the benefit of funding.

The project ended in late 2013.

In 2016, all 29 Community Health Centers in Alaska have adopted, implemented, and are using ONC-certified EHRs. Many have achieved levels one and two of Meaningful Use, and almost half are now PCMH-recognized and utilizing at least some of the patient data from their respective EHRs for care planning.

A.3.4 Community Health Center Medical Home Grants

HRSA announced that 904 community health centers nationwide received funds to support an initiative that focuses on enhancing the quality and coordination of healthcare services through the patient-centered medical home.

These funds were made available under the PPACA, considered supplemental funding that provided upfront assistance to existing health centers as they try to achieve recognition as a patient-centered medical home. Activities include care planning, support for team-based models of service delivery, and system upgrades.

Table 3 - Community Health Center Medical Home Grants

Award Year	Organization	Location	Amount
2011	Anchorage Neighborhood Health Center	Anchorage, Alaska	$35,000
2011	Bethel Family Clinic	Bethel, Alaska	$35,000
2011	Bristol Bay Area Health Corporation	Dillingham, Alaska	$35,000
2011	Interior Community Health Center	Fairbanks, Alaska	$35,000
2011	Council of Athabascan Tribal Government	Fort Yukon, Alaska	$35,000
2011	Southeast Alaska Regional Health Consort	Juneau, Alaska	$35,000
2011	Manillaq Association	Kotzebue, Alaska	$35,000
2011	Bristol Bay Borough	Naknek, Alaska	$35,000
2011	Seldovia Village Tribe	Seldovia, Alaska	$35,000
2011	Peninsula Community Health Services of Alaska, Inc.	Soldotna, Alaska	$35,000

2011	Sunshine Community Health Center, Inc.	Talkeetna, Alaska	$35,000
2011	Iliuliuk Family and Health Services, Inc.	Unalaska, Alaska	$35,000
2014	Bethel Family Clinic	Bethel, Alaska	$250,000

A.3.5 Beacon Community Grant

No Beacon grants have been awarded in Alaska at this time.

Alaska had submitted an application for a grant to address connectivity of telehealth and telehome with EHRs to provide a complete picture of coordinated care for use by providers.

A.3.6 Tri-State Children's Health Improvement Consortium (T-CHIC)

Alaska, in partnership with Oregon and West Virginia, received $2,231,890 for the first year of a five-year grant that will total $11,277,361. Alaska, will receive approximately $750,000 per year for five years. The Quality Demonstration project, funded by CMS, tested the combined impact of patient-centered care delivery models and health information technology in improving the quality of health care for children and adolescents enrolled in Medicaid and Denali Kidcare (CHIP). The three States worked together to develop and validate quality measures, improve infrastructure for electronic or personal health records utilizing health information exchanges, and implement and evaluate medical home and care coordination models.

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

The T-CHIC quality measures comply with the Pediatric Recommended Core Clinical Quality Measures as recommended by CMS. Examples of the CQMs to be used by the Medicaid and CHIP programs include Appropriate Testing for Children with Pharyngitis, Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents, and Use of Appropriate Medications for Asthma.

As of 2014, Alaska had reported on 15 of 24 CQMs, Practices reporting on the subset of CQMs demonstrated improvement between calendar 2012 and 2013, including:

- Adolescent immunizations
- BMI
- Developmental screening
- Well child visits
- Linked to Plan-Do-Study-Act (PDSA) cycles

T-CHIC has supported infrastructure changes, pushing child measure to the top. Grantees have found the CHIPRA measures to be more valuable than the Medical Home Index: Revised Short Form (MHI-RSF).

In July 2015, Alaska reported that it helped its three participating practices enhance their medical home features. The practices—each one a federally qualified health center—vary by size and location (frontier, rural, and urban). The State worked with the practices in two main ways. First, it hired practice facilitators to support the practices in implementing features of the patient-centered medical home (PCMH) model—a primary care model intended to improve care coordination, access to services, and patient engagement. The practice facilitators also helped the practices to implement quality improvement (QI) activities. Second, the State used a learning collaborative model to educate the practices on PCMH and provide a structure and process through which the practices could learn from each other.

With an annual grant of $110,000 to $250,000 from the CHIPRA quality demonstration, the practices—

- **Improved care coordination for children with special health care needs.** Having learned from the State about the goals and key components of care coordination, all three practices decided to use CHIPRA quality demonstration funds to hire care coordinators. The care coordinators followed up with caregivers of children who received the services they needed. Care coordinators also linked caregivers with community resources, including parent support groups and food assistance. The practices valued the care coordinators highly, although they sometimes found it challenging to integrate the care coordinators into their workflows. For example, care coordinators were not assigned to specific care teams in a practice, so care coordinator support was not always integrated into a patient's care plan.
- **Raised their medical home index scores.** All three practices reported increases in their Medical Home Index scores from 53 in 2012 to 67 in 2014. One practice was also recognized as a medical home by The Joint Commission; another was recognized by the National Committee for Quality Assurance (NCQA); and the third is applying for NCQA recognition for its satellite sites (its primary site is already recognized).

Alaska continued to pursue its CHIPRA quality demonstration until August 2015 under a grant extension approved by CMS.

Alaska's activity is detailed in reports contained at the following T-CHIC website:

http://dhss.alaska.gov/dph/HealthPlanning/Pages/tchic.aspx

A.4Veterans Administration and Indian Health Service Facilities

A.4.1 Veterans Administration and Department of Defense

The Veteran's Administration (VA) has used EHR technology for more than seven years. In 2003, the VA was the largest single medical system in the United States, providing care to over 4 million veterans, employing 180,000 medical personnel, and operating 163 hospitals, over 800 clinics, and 135 nursing homes. About a quarter of the nation's population is potentially eligible for VA

benefits and services because they are veterans, family members, or survivors of veterans. In response to this significant demand, the VA has developed Veterans Information Systems and Technology Architecture (VistA) the largely internal EHR to be an open-source, highly integrated, and interoperable EHR system.

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

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

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

A key barrier to HIE participation for the VA and DOD was noted in a report mandated by the Affordable Care Act (Section 5104) submitted to Congress September 2010. Report to Congress of the Interagency Access to Health Care in Alaska Task Force, p 4: "There is a need for improvements in health information technology, building on a long history of innovation and practice that sets the Indian Health Service (IHS) (and ANTHC), VA, Department of Homeland Security (US Coast Guard) and DOD in Alaska apart as leaders in telemedicine. However, the interconnectivity necessary for coordination of care through electronic health information exchange is lacking. Historically, Federal agencies have not had coordinated mechanisms for paying for participation in integrated health information systems nor have they developed clear policies that will permit participation."

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

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). The AI/AN National REC will assist Tribal health providers with achieving meaningful use of Electronic Health Records (EHRs). NIHB is expected to reach all Indian tribes to support EHR deployment and meaningful use implementation: an objective that could impact approximately 3,000 providers in

35 states at over 500 individual tribal provider sites. The Alaska Native Tribal Health Consortium (ANTHC) was an active participant in the development of the grant proposal.

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.

A.4.4 Tribal HIE Participation

Alaskan Indian Health Services (IHS) facilities and clinics have been active participants with the HIE. The Alaska Native and Tribal Consortium is a member of the AeHN Board of Directors; 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 entities 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 on the HIE to enable EPs to share data. Please see Section A.9.6 for further details.

A.5 Stakeholder Engagement With HIT/E Activities

A.5.1 Stakeholder Engagement

Senate Bill 133, 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, health care leaders, and payers who actually participate in the delivery of healthcare services. Additionally, there are a number of Operational Workgroups, including:

- Legal Workgroup
- Technology Workgroup
- Clinical Workgroup

The mandated membership of the board and the formation of the Advisory groups in conjunction with the Operational Workgroups demonstrates Alaska's commitment to including all stakeholders involved with HIT and HIE activities.

A.5.2 Stakeholders Meeting Meaningful Use

The combination of the recently implemented Medicaid Expansion and the enactment of Alaska Senate Bill 74, 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:

- 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 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 make State lab results, immunization records, vital statistics, client and provider information available to HIE participants and exchange new lab requests, immunization administration, and reportable disease events with the respective state systems from Alaska HIE participants. Integrating these systems will allow eligible Alaska medical providers to become meaningful users of their EHRs
- Upgrades to the Division of Behavioral Health (DBH) AKAIMS database to connect directly to the HIE to allow for the transmission of data that supports EPs' and EHs' abilities to achieve meaningful use for the transition of care 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 EPs' and EHs' ability to achieve meaningful use.

These activities will enhance providers' abilities to meet Meaningful Use while increasing participation with the statewide HIE.

A.6 SMA 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 health care stakeholders.

DHSS recognizes that Alaska has a large number of health care 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 Health Information Exchange (HIE) Governance

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

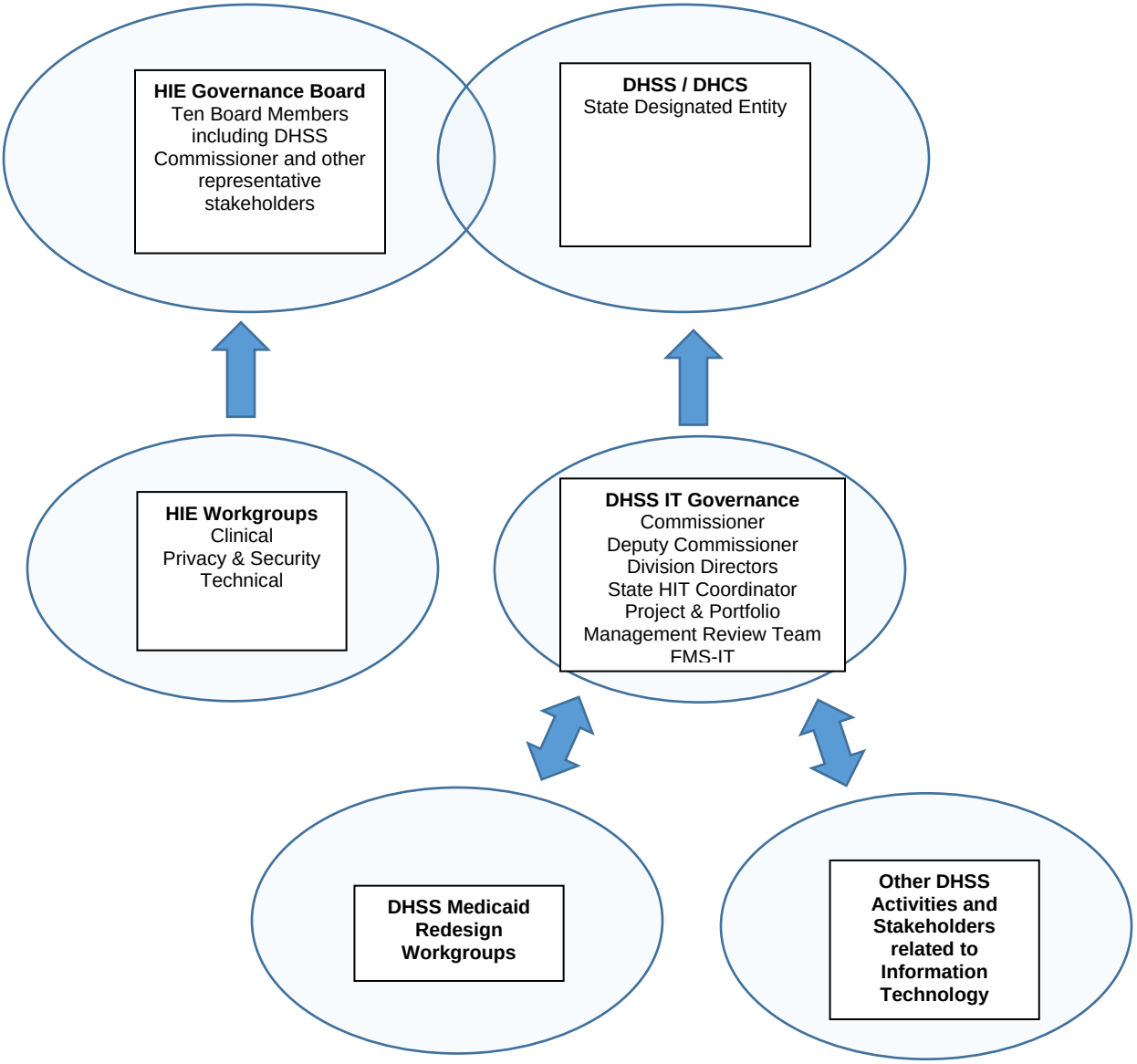
The Alaska HIE Governance Model describes a health information organization that is consistent with federal and state guidance. The Alaska HIE complies with Alaska not-for-profit regulations and is a qualified 501(c)(3) entity with a Board of Directors made up of key stakeholders from the community and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

The 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 monthly 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), Alaska Health Care Commission (AHCC), AeHN, and DHSS are depicted in the graphic in Figure 3 below.

Figure 3 – Alaska State Designated Entity Organization Structure



A.7.1 HIE Board of Directors

The HIE Board of Directors positions are filled by volunteers from the stakeholder groups as shown in the table below. Board representation is defined by Alaska Senate Bill 133. The DHSS

Commissioner is responsible for ensuring the HIE Board of Directors meets Senate Bill (SB)133 requirements. The Commissioner, or a DHSS Commissioner appointed representative, is a voting member of the board.

Table 4 – HIE Board of Directors

Affiliation	Officers	SB 133 Required Areas
Fairbanks Memorial Hospital	President	Hospital and Nursing Home Facilities
Blue Cross / Blue Shield	Secretary	Health Insurers
Alaska Communications Services	Treasurer	Employers or Businesses
Alaska Primary Care Association	Vice President	Community-Based Primary Care Providers
University of Alaska	Non-voting Liaison Member	Liaison to the Board of Regents of the University of Alaska
Allergy, Asthma and Immunology Center of Alaska, LLC	Member	Private Medical Care Providers
LaTouche Pediatrics	Member	Private Medical Care Providers
Alaska State Hospital and Nursing Home Association	Member	Hospital and Nursing Home Facilities
Providence Hospital	Member	Hospital and Nursing Home Facilities
Alaska VA Healthcare System	Member	Federal Health Care Providers
Alaska Department of Health & Social Services	Member	Commissioner DHSS
Alaska Community Mental Health Services	Member	Health Care Consumers
Alaska Native Tribal Health Consortium	Member	Alaska Tribal Health Organizations

A.7.2 Alaska eHealth Network (AeHN)

AeHN 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 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 plus monetary support from strategic partners, including the Alaska Federal Health Care Partnership, the Alaska Native Tribal Health Consortium, Premera Blue Cross/Blue Shield, Providence Alaska Medical Center, and the Alaska Division of Health and Social Services. The Alaska RHIO was renamed and reorganized as AeHN in 2008.

AeHN has as its mission: “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”. Alaska eHealth Network (AeHN) is a carefully planned solution to better communicate vital medical information electronically – facilitating coordinated patient care, reducing duplicative treatments, and avoiding costly mistakes. AeHN 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.

In 2009, Alaska DHSS contracted with the AeHN 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. Today, AeHN provides clinical data to over 2,000 providers in 40 organizations. In addition, AeHN acts as the conduit for public health reporting, sending immunization, syndromic surveillance, and reportable laboratory data to DHSS from connected organizations.

Over the course of the last ten years, AeHN's predecessor organization, the Alaska Telehealth Advisory Council (ATAC, 1996-2005), and subsequently, AeHN 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 AeHN.

A.7.3 Alaska Regional Extension Center

In 2010, the AeHN received $3,632,357, from the ARRA to establish one of 60 nationwide health information technology Regional Extension Centers (REC) in addition to the contract to provide the nonprofit governing board to procure and manage the HIE. The Alaska REC provides technical assistance to eligible doctors and hospitals that select and implement electronic record systems, helping them to achieve widespread meaningful use of Health Information Technology (HIT) and to promote electronic health record utilization for every citizen of Alaska. The federal funding allowed AeHN to establish an HIT REC that helps Alaska's healthcare providers learn to select and use EHRs. 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. AeHN 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.

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

- Education and Outreach activities such as quarterly newsletter releases, website updates, media/press releases, and participation in professional association meetings
- 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

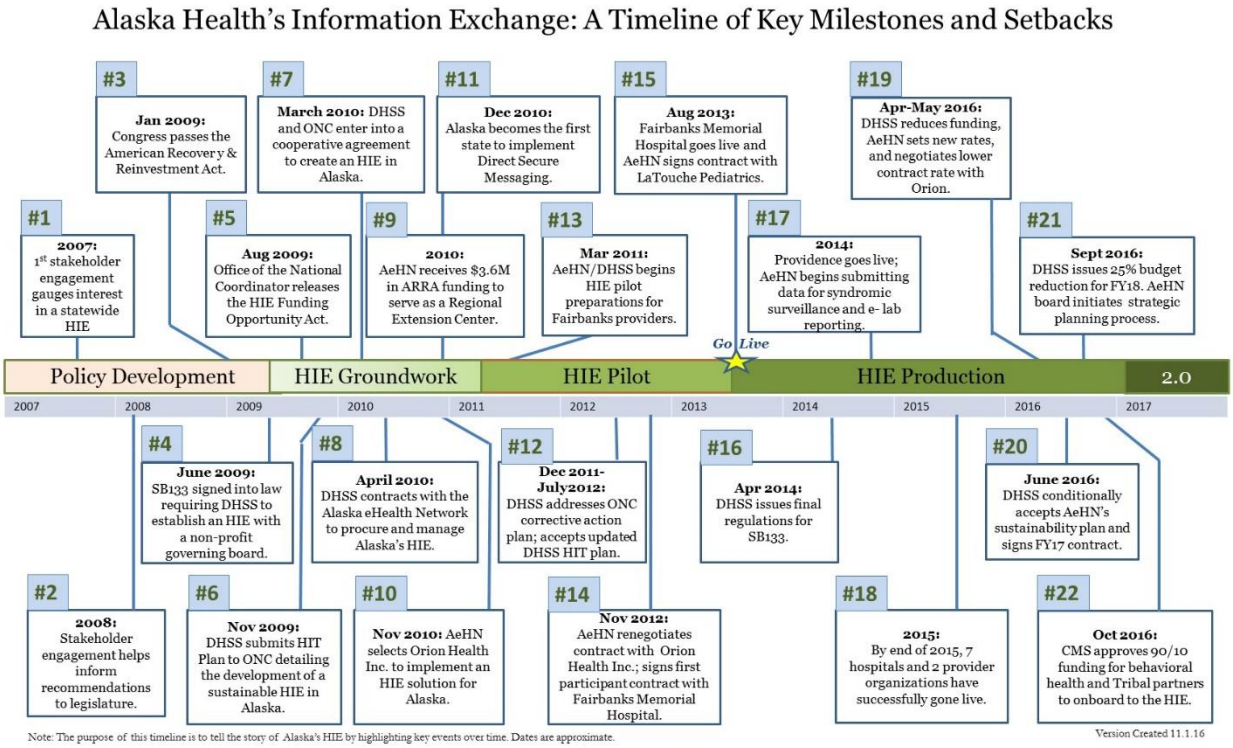
- Coordination with other states through Communities of Practice (CoP) groups providing opportunities for sharing "best practices" for provider outreach
- Coordination with Alaska's tribal REC to ensure best practices are shared across Alaska. The National Indian Health Board (NIHB) was awarded a National REC grant in April 2010
- Webinars and presentations targeting HIE participation and EHR adoption

While ONC funding for the REC activities ended in April 2016, the REC will continue to provide services to providers using the HIE.

A.7.4 Health Information Exchange Acquisition

AeHN coordinated an effort to develop HIE product requirements, write a Request for Proposal (RFP), evaluate responses, and select an HIE vendor. This process included over 80 participants representing various provider and payer entities. Eight responses to the RFP were evaluated, 4 vendors were selected to deliver technical and workflow demonstrations based on specific pre-defined criteria, and Orion Health was the selected vendor. Orion provides HIE, clinical portal and patient portal services. AeHN uses NextGate as the statewide Master Patient Index.

AeHN deployed the health information exchange and direct secure messaging technologies using a hosted, software-as-a-service model. AeHN launched a pilot program in February 2011 with one hospital and two clinics participating in the exchange of authorized medical information. The pilot and associated user acceptance testing was completed in early September 2011. AeHN began connecting additional Alaska providers in December 2011, and has over 2,000 users and 40 organization participants today.



A.7.5 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.

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

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

- Increase Patient Privacy and Security in exchanging Medical Records - 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 AeHN agreements and procedures.

A.7.6 Alaska Health Care Commission

In addition to SB 133 passed in 2009 to establish the statewide health information exchange, SB 172 passed in 2010, establishing the Alaska Health Care Commission (AHCC). The Commission had initially been established at the beginning of 2009 by then Governor Palin under an Administrative Order. The AHCC was created to address growing concerns over the condition of Alaska's healthcare system and to serve as the state health planning body. The AHCC was chartered to provide recommendations to the governor and the legislature on a comprehensive statewide health care policy to address quality, accessibility, and availability of healthcare for all citizens of the state.

The AHCC recommended the following Core Strategies for Health Care Transformation:

I. Ensure the best available evidence is used for making decisions
II. Increase price and quality transparency
III. Pay for value
IV. Engage employers to improve health plans and employee wellness
V. Enhance quality and efficiency of care on the front-end
VI. Increase dignity and quality of care for seriously and terminally ill patients
VII. Focus on prevention
VIII. Build the foundation of a sustainable health care system

For each Core Strategy, the Commission developed a body of more specific policy recommendations for implementation by the Governor, legislature, and state agency commissioners. A copy of a summary document that briefly describes the Core Strategies and lists all of the policy recommendations is available online at:

http://dhss.alaska.gov/ahcc/Pages/Reports/default.aspx

Under the eighth Core Strategy – to build the foundation of a sustainable health care system – are a series of policy recommendations related to strengthening the health information infrastructure (included on pages 10-13 in the document linked above). HIT-related recommendations that have since been adopted include:

- Policies related to the statewide health information exchange and electronic health record adoption
- Mandatory participation by health facilities in the Hospital Discharge Database
- Development of a web-based data system for public health information

Other HIT-related recommendations made by the Commission that have not yet been adopted include creation of a statewide All-Payer Claims Database, and certain system and reimbursement supports for expanding the use of telemedicine.

The Alaska Health Care Commission was defunded in 2015 and is no longer active.

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 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 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 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 2016.

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, a number of 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 (8) business areas. The MITA SS-A Update sessions revisited the As Is and To Be business processes and included a reassessment of MITA maturity levels.

Additionally, FOX completed a Technical Assessment of the systems that are currently supporting the Alaska Medicaid Enterprise.

A.8.2 MITA SS-A Vision and To Be Roadmap

Alaska requested and received funding in FFY 2016 to procure and implement a commercial off the shelf solution. DHSS will be conducting a MITA SS-A 3.0 for the HIT environment in early 2017.

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 planned HIE initiatives include 10 efforts described below.

A.9.1.1 *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. 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 has developed targeted onboarding campaigns particularly focused on the following activities to assist with increasing the ability for EPs and EHs to achieve meaningful use:

- Onboarding providers to the HIE to support meaningful use reporting
- Identifying EPs that may be eligible, but have not begun the Medicaid EHR Incentive Payment Program
- Assisting EPs in moving forward through Adopt/Implement/Upgrade and through Meaningful Use

A.9.1.2 *Environmental Scan*

An environmental scan will be conducted. The DHSS will collaborate with partners to develop a hybrid delivery methodology for survey execution. An online survey tool to survey the Alaska's health information technology environment will be utilized along with a paper based survey to ensure that all target audiences are engaged. Additionally, DHSS, in cooperation with the key stakeholder organizations, will field the survey and collect the survey responses. Alaska DHSS will utilize the results of the environmental scan to develop a HIT strategic roadmap which will contribute to DHSS's overall Enterprise IT Strategic Framework.

Additionally, as part of the environmental scan, an internal As-Is and To-Be assessment of the DHSS HIT infrastructure will be completed. Following completion of the HIT assessment, the

development of the HIT roadmap will be completed, supporting an increase in interoperability and coordination of care amongst department organizations.

Project Objectives include:

- Development of environmental scan survey tool
- Deployment of survey tool and collection of responses
- Analysis of environmental scan data
- Development of HIT Strategic Roadmap

A.9.1.3 *Personal Health Record*

DHSS received HITECH funding to support the onboarding of Medicaid recipients to the personal health record (PHR) 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.

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 Critical Access Hospitals (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. 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.

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 on 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 Alaska Automated Information Management System (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 Department of Behavioral Health (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 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 3 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 Department of Health & Social Services 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 behavioral health IT 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 *DPH 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/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 sexually transmitted diseases (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 electronic laboratory reportable (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*

In order to support meaningful use and provide specialized registries for EPs and EHs to collect reports electronically, the modernization initiative is to give EPs and EHs the tools to improve the coordination of care, the transition of care, and the availability of specialty registries, increasing the number of providers attesting for and meeting meaningful use requirements.

The 2015 – 2017/Stage 3 rule expanded the requirements for Public Health Reporting. The reporting requirements include:

A.9.1.10.1 Eligible Professional (EP)

Eligible Professional Meaningful Use Objective 10 covers reporting requirements to public health agencies and requires the EP to be *"in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice."* There are three measures defined as follows:

- Measure 1 - Immunization Registry Reporting: The EP is in active engagement with a public health agency to submit immunization data.
- Measure 2 – Syndromic Surveillance Reporting: The EP is in active engagement with a public health agency to submit syndromic surveillance data.
- Measure 3 – Specialized Registry Reporting: The EP is in active engagement to submit data to a specialized registry.

A.9.1.10.2 Eligible Hospitals (EH)

Public health reporting is covered under Objective 9 for EHs and requires *"The eligible hospital or CAH is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice."* There are four measures defined for EHs:

- Measure 1 – Immunization Registry Reporting: The eligible hospital or CAH is in active engagement with a public health agency to submit immunization data.
- Measure 2 – Syndromic Surveillance Reporting: The eligible hospital or CAH is in active engagement with a public health agency to submit syndromic surveillance data.
- Measure 3 – Specialized Registry Reporting: The eligible hospital or CAH is in active engagement to submit data to a specialized registry.
- Measure 4 – Electronic Reportable Laboratory Result Reporting: The eligible hospital or CAH is in active engagement with a public health agency to submit electronic laboratory reportable (ELR) results.

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, 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
- PRISM – HIV/AIDS reporting

The above listed registries will be in addition to the existing registries available:

- 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 is 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 Master Client Index (MCI) with registries, and can support the DHSS Enterprise Service Bus (ESB) which already supports integration with the statewide HIE.

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

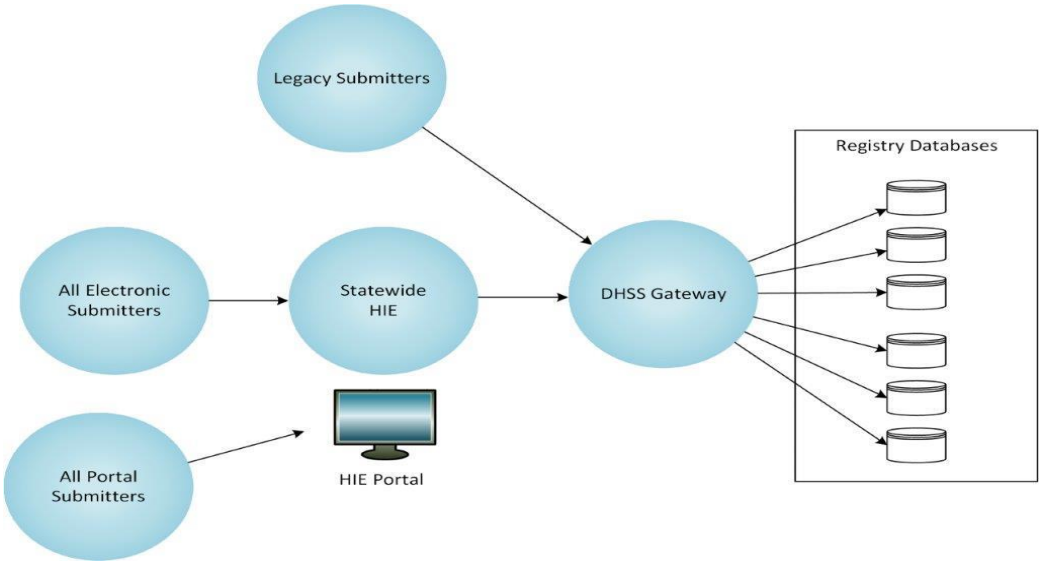


Figure 4 - DHSS Gateway

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*

Alaska Medicaid is expanding its support for the continued design, development, and implementation of modifications to the statewide Master Client Index 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 Client Services Dashboard 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 Client Services Dashboard, 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.

In addition, this project provides functionality to create unique client identifiers that will enable DHSS to track participation data for Medicaid Incentive Program Eligible providers 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 of upgraded MultiVue environment
- 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 opportunity to bring in new feeds from other DHSS systems to provide further value to MCI and data

A.9.1.12 *myAlaska Authentication*

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.

DHSS intends to explore shared funding opportunities with additional departments within the Alaska DHSS to support other use cases of the myAlaska application.

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. This initiative will allow the DHSS to connect the myAlaska solution to the statewide HIE and begin utilizing the functionality for user authentication.

In order 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:

1. Percentage of providers connected to the HIE for Direct Exchange
2. Percentage of providers connected to the HIE for Query based Exchange
3. 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**:**

1. Number of Alaskans with online access to health care records and health care education resources
2. 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.9.3 Alaska Medicaid Expansion

Alaska has recently expanded Medicaid, and as of September 20, 2016, nearly 23,000 Alaskans have qualified for health coverage under Medicaid expansion. There has been $120,000,000 in new Federal revenue designated for Alaska since May 31, 2016, due to Medicaid expansion. Medicaid expansion was particularly important in Alaska because single Alaskans or married couples without dependent children were not possible to qualify for Medicaid under any circumstance under the previous rules.

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

A.9.4 Senate Bill 74

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:

- 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.10 SMA Relationship with State HIT Coordinator

Alaska has a State HIT Coordinator working directly for the DHSS Commissioner who is ultimately responsible for our state's 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 AeHN Board of Directors and other work groups to ensure efficiency and effectiveness of planning efforts.

A.11 Other Activities

The activities that will influence the direction of the EHR Incentive program include the recently implemented Medicaid expansion and the enacted Senate Bill 74. Both of these are detailed in the next section.

A.12 State Laws and Regulations

A.12.1 Alaska Medicaid Expansion

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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 address 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.

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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

There is a proposed regulation, currently undergoing public comment, impacting the Provider Incentive Payment Program.

The new regulations, beginning in 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

A.13.1 Tri-State Children's Health Improvement Consortium (T-CHIC)

Alaska, in partnership with Oregon and West Virginia, received $2,231,890 for the first year of a five-year grant that will total $11,277,361. Alaska, will receive approximately $750,000 per year for five years. The Quality Demonstration project, funded by CMS, tested the combined impact of patient-centered care delivery models and health information technology in improving the quality of health care for children and adolescents enrolled in Medicaid and Denali Kidcare (CHIP). The three States worked together to develop and validate quality measures, improve infrastructure for electronic or personal health records utilizing health information exchanges, and implement and evaluate medical home and care coordination models.

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

The T-CHIC quality measures comply with the Pediatric Recommended Core Clinical Quality Measures, as recommended by CMS. Examples of the CQMs to be used by the Medicaid and CHIP programs include Appropriate Testing for Children with Pharyngitis, Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents, and Use of Appropriate Medications for Asthma.

As of 2014, Alaska had reported on 15 of 24 CQMs, Practices reporting on the subset of CQMs demonstrated improvement between calendar 2012 and 2013, including:

- Adolescent immunizations
- BMI
- Developmental screening
- Well child visits
- Linked to Plan-Do-Study-Act (PDSA) cycles

T-CHIC has supported infrastructure changes, pushing child measure to the top, Grantees have found the CHIPRA measures to be more valuable than the Medical Home Index: Revised Short Form (MHI-RSF).

In July 2015, Alaska reported that it helped its three participating practices enhance their medical home features. The practices—each one a federally qualified health center—vary by size and location (frontier, rural, and urban). The State worked with the practices in two main ways. First, it hired practice facilitators to support the practices in implementing features of the patient-centered medical home (PCMH) model—a primary care model intended to improve care coordination, access to services, and patient engagement. The practice facilitators also helped the practices to implement quality improvement (QI) activities. Second, the State used a learning collaborative model to educate the practices on PCMH and provide a structure and process through which the practices could learn from each other.

With an annual grant of $110,000 to $250,000 from the CHIPRA quality demonstration, the practices—

- **Improved care coordination for children with special health care needs.** Having learned from the State about the goals and key components of care coordination, all three practices decided to use CHIPRA quality demonstration funds to hire care coordinators. The care coordinators followed up with caregivers of children who received the services they needed. Care coordinators also linked caregivers with community resources, including parent support groups and food assistance. The practices valued the care coordinators highly, although they sometimes found it challenging to integrate the care coordinators into their workflows. For example, care coordinators were not assigned to specific care teams in a practice, so care coordinator support was not always integrated into a patient's care plan.
- **Raised their medical home index scores.** All three practices reported increases in their Medical Home Index scores from 53 in 2012, to 67 in 2014. One practice was also recognized as a medical home by The Joint Commission; another was recognized by the National Committee for Quality Assurance (NCQA); and the third is applying for NCQA recognition for its satellite sites (its primary site is already recognized).

Alaska continued to pursue its CHIPRA quality demonstration until August 2015, under a grant extension approved by CMS.

Alaska's activity is detailed in reports contained at the following T-CHIC website:

http://dhss.alaska.gov/dph/HealthPlanning/Pages/tchic.aspx

A.13.2 Western State Consortium/National Association for Trusted Exchange (NATE)

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

The National Association for Trusted Exchange (NATE) was established from the Consortium in 2013.

Alaska successfully piloted a trial program assigning case managers to provide additional help to support Medicaid clients that were “super utilizers” of emergency services. In the pilot, the case managers helped clients navigate the healthcare delivery system, and as a result of better matching care needs with the delivery environment, successfully demonstrated significant cost savings without reducing quality of outcomes. This pilot was very successful for the initial 1,000 volunteer Medicaid clients. Alaska proposes to add voluntary clients and, specific to this National Strategy for Trusted Identities in Cyberspace (NSTIC) pilot, enhance the program by providing both the client and their case manager with access to health information maintained by the Alaska statewide health information exchange (HIE) – Alaska eHealth Network (AeHN). The NATE pilot will use the AXN to extend and expand the Alaska program by federating and deploying multi-factor authentication methods to “step-up” the strength of existing credentials of the case managers and their clients.

Today, the system employed by Alaska’s case managers is operated by the State while AeHN is operated by an independent public-private entity. There is currently no facile method for case managers to authenticate into AeHN. Alaska proposes to demonstrate the applicability of the NSTIC Identity Ecosystem Framework (IDEF) in reusing credentials already established in the State operated system for case managers to permit appropriate access to PHI via the AeHN.

Although AeHN has a personal health record (PHR) service offering, it has proven difficult to use traditional means to efficiently credential the Medicaid client so that they may access their PHI via the AeHN. Alaska is unique, in that many residents are registered with the state in order to receive Permanent Fund Dividend Checks – a benefit to residents related to the investment earnings of mineral royalties, and this program has enabled the creation of a statewide Alaskan Person Registry. Over the course of this pilot, the team will develop a mechanism that would use the antecedent information about the beneficiary already held by the State to support the creation of a strong credential for the individual to access his/her health information via AeHN.

Enabling the beneficiary to access the AeHN with enhanced security and privacy by leveraging the capabilities of the AXN to validate attributes provided by the beneficiary supports second factor authentication and reuse of the State’s existing Alaskan Person Registry as an identity provider (i.e., federating an existing user credential).

This approach facilitates establishing a relationship between a case manager and a beneficiary such that, when a case manager accesses the Alaskan HIE, they are authorized to access data only for beneficiaries who have consented to allow their case manager's access to their health information. Further, Alaska has existing agreement forms that are signed by the beneficiary to grant Alaskan case management staff access to their PHI as part of the process of volunteering for the program. Ideally, this would be accessed and agreed to using the credential created above.

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, and physicians, nurses, and other medical personnel can view, edit, and update the records from any computer with an Internet connection. For clinics with existing electronic systems, VacTrAK staff can establish a data exchange process that sends batch data directly to VacTrAK from an electronic medical record, or from a practice management or billing system. 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 (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.

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.

The anticipated registries to be made available for electronic submission by providers include:

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- 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
- PRISM – HIV/AIDS reporting

The registries listed above will be in addition to the existing specialized registries available:

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

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 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 health care in Alaska.

B.1.1 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 second half of the anticipated program timeframes we will continue reaching 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 health care and assure quality of health care for Alaskans. Specifically, the mission of the DHSS is to promote and protect the health and well-being of all Alaskans. DHSS's overall goals continue to drive increases in provider participation with EHRs and improvement in the quality of care, patient safety, and health care outcomes.

We will encourage providers to meaningfully use EHRs by facilitating provider-to-provider communication and electronic data exchange; broadening Public Health Reporting options, offering assistance for providers to participate; improving electronic CQM reporting, and including 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 Repository and myAlaska portals, and improving the overall performance of the HIE.

B.1.2 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 health care 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 health care 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 health care 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 recently-implemented, 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 health care system that places individual Alaskans, their families, and communities at the center of their health care 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 Health Information Technology includes the following six components and related strategies:

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

    - Enhance secure web-based Beneficiary information, communication, outreach and tracking
    - Provide enhanced provider 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

2. Simplified interaction with the Health Care infrastructure for Providers

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

- Web-based Access:
    - Enhance secure web-based provider enrollment, maintenance, communication, and tracking that is available for provider self-service
    - Provide online data submission with real-time claims tracking of approvals, denials, and other status reporting
    - Provide web-based physician/provider quality and cost reporting
    - Provide a secure web-based care management systems 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 Personal Health Record (PHR) system functionalities
    - Fully develop e-Prescribing functionality

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

    - Create clear outcomes and expectations for providers to address pay for performance and quality of care
    - Incentivize providers to use quality preventative care
    - 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

4. Evolving use of modern information technology to improve the delivery of health care

    - Administrative Efficiencies:
        - Improve contract administration
        - Provide automated federal reporting
        - Enhance automated reporting capabilities
        - Improve financial reporting capacity including data pulls, details, and definitions
        - Simplify and automate creation and management of edits and audits
        - Develop and automate the rate setting process
        - Support and enhance capabilities to access federal rebate programs
        - Provide for data interchange with Data Warehouse
        - Develop and expand innovative approaches to prevention

- Reduce duplication of effort 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)

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

   - Encourage and promote retention of quality Medicaid providers
   - Explore health care literacy program to reduce 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

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

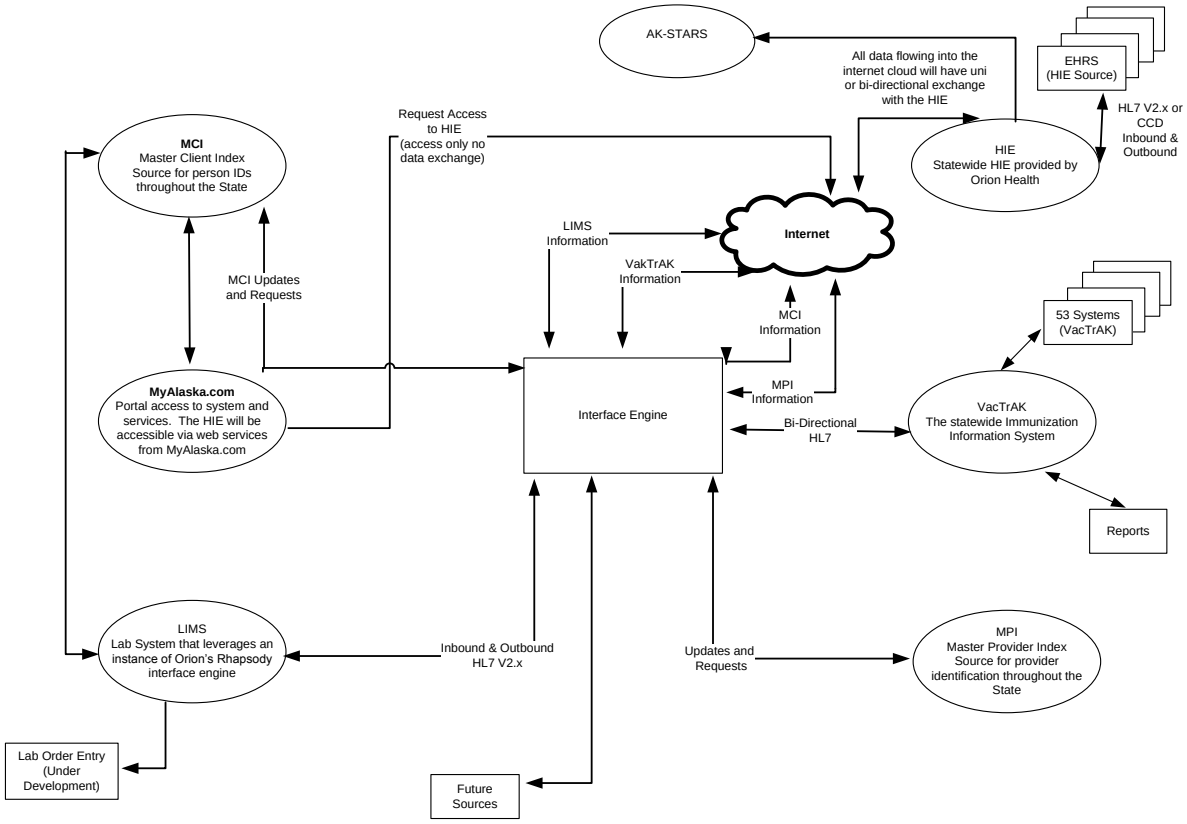
   - Develop strong Medical Home model delivery system

B.2IT 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. The Figure below

depicts the anticipated initial integration of the immunization registry (VacTrAK), the state lab system (LIMS) and the repository supporting state-defined reportable diseases (AK Stars). In addition, the figure highlights the state MCI and Master Provider Index (MPI) that will be made available to the HIE infrastructure via the interface engine.

Figure 5 - Anticipated Logical Architecture



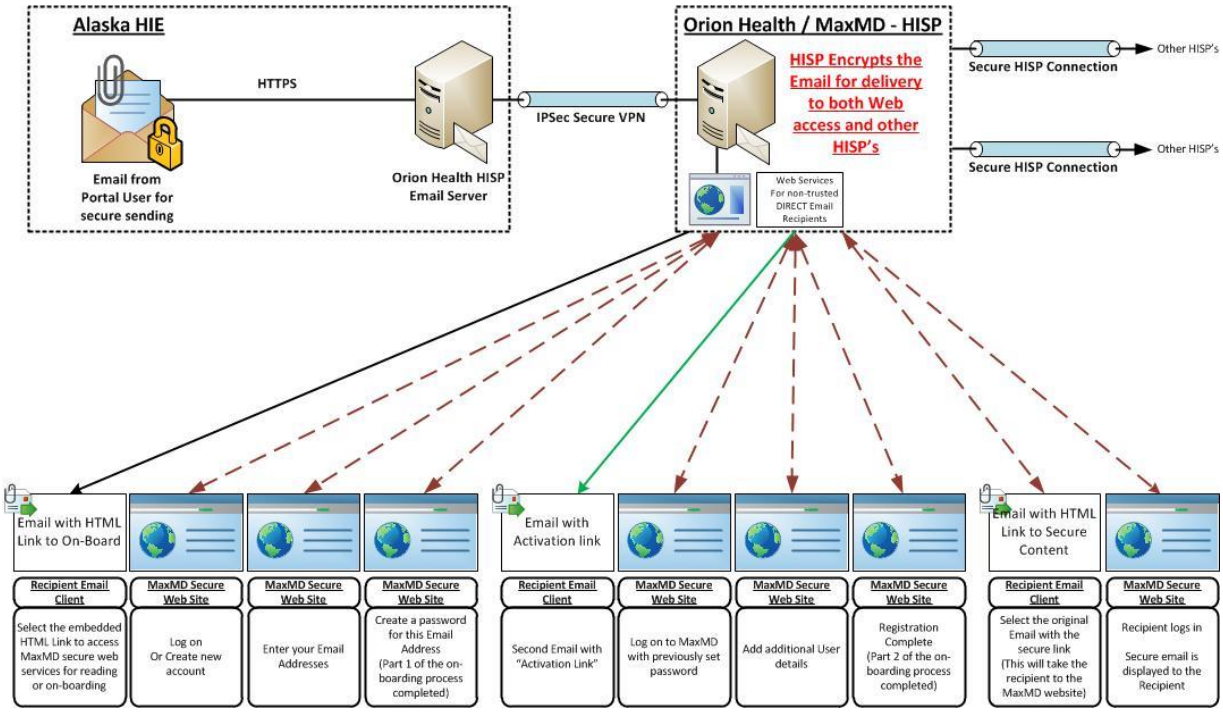
B.2.1 Data Sharing Components of Alaska HIT solutions

The Alaska HIE is the centerpiece of data sharing in Alaska. The Alaska HIE implementation has evolved over time with increased participation and as Alaska HIT systems are integrated with the HIE. The sections below describe some of the essential components of the HIE infrastructure.

B.2.2 Direct Project Implementation

AeHN, through its vendor Orion Health, has provided the means by which all participants in the continuum of care can communicate in a secure electronic environment across the state of Alaska. Important clinical history can be sent to any location with internet access, regardless of whether they have an EHR. The Figure below depicts the Direct Project standards implementation in Alaska to support the simple distribution of clinical history and referral information.

Figure 6 – Direct Project Standard Implementation



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 are currently available to Alaska HIT 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 SOAP (Simple Object Access Protocol). HL7 content will be sent within the "body" of a SOAP message with standard SOAP message headers and SOAP wrappers. The SOAP standard is defined at http://www.w3.org/TR/soap/.

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. Orion Health uses the Rhapsody™ Integration Engine to manage electronic messaging. This solution leverages SSL and encryption, and hashing algorithms. The Concerto™ Clinical Portal is responsible for the encryption of authentication information based upon Remote Authentication for Dial-In User

Service (RADIUS) authentication protocol. This is a widely-used protocol in network environments.

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

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

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 undergoing review by DHSS IT Governance.

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

Alaska is currently developing a RFP for an Outreach/Marketing Plan to increase provider participation in the program and enhance the number of providers continuing through the program to become, and remain, meaningful users. During 2016, the last year EPs can begin the attestation process, the focus was no new provider registration. DHSS also developed guidance targeting dental providers to inform them of their ability to meet the 2015, and beyond, meaningful use objectives.

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; with enough clinical data to demonstrate improvements in quality oversight and measurement initiatives. 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 SMA IT Systems

Access to the Alaska Medicaid Management Information System 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 SMA 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 SMA 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 NLR, also has an automated real-time interface with CHPL to verify an attested provider's Certified Electronic

Health Record Technology (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 are 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 describe in detail the planned HIE initiatives, which includes:

- HIE Onboarding Support
- Conduct an Environmental Scan
- Implement Medicaid Claims Data Feed
- Enhance Personal Health Record capability
- Medicaid Claims feed to the HIE
- CQM Reporting to the HIE
- Behavioral Health HIE Onboarding
- AKAIMS to further support Meaningful Use
- Connection to the statewide Prescription Drug Monitoring Program
- DPH PRISM System Development as a specialized registry
- Public Health System Modernization to increase opportunities for Meaningful Use Public Health reporting
- MCI Enhancements to support enhanced Meaningful Use submissions
- myAlaska Authentication to enable single sign on

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 they can begin participation. After 2016, outreach effort will focus on preparation for Stage 3 in 2018, and for providers to continue to meet Meaningful Use. The outreach will focus on the reduced MU requirements starting in 2015, which may enable providers to successfully attest for Meaningful Use where previously they may have had issues. Also, we will 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 DHHS, 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 Alaska Primary Care Association (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.

FQHC 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 (or, optionally in 2017), 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 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 May 31, 2016, nearly 18,000 Alaskans have qualified for health coverage under Medicaid expansion. There has been $120,000,000 in new Federal revenue to Alaska since May 31, 2016 due to 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

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 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.

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 has recently issued a RFP 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.

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

This section includes a high-level description of 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 pre-verification process for each program year for the EHR Incentive Program. All providers are manually checked for sanctions before being enrolled in Alaska Medicaid. Once a month, CMS sends a file that is run against the provider file to check for any new sanctions. CMS also sends letters when 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/CBPLSearch.aspx?mode=Prof

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

When providers register for the EHR Incentive 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% 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% 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 Certified EHR Technology, including supporting hardware and interfaces needed for meaningful use, without reimbursement from an eligible hospital or a Critical Access Hospital (CAH), and
- Uses such Certified EHR Technology in the inpatient or emergency department of a hospital (instead of the hospital's Certified EHR Technology)

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 a number of 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:

- USDHHS 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.2.2 2014 Flexibility Rule

The 2014 Flexibility Rule accommodated providers who were not able to implement a 2014 Edition CEHRT, and were able to use either a 2011 CEHRT or a combination 2011/2014 CEHRT. Impacted providers were able to attest Stage 1 2013 or 2014 measures depending on which CEHRT edition they were using. The changes were implemented for program year 2014. The 2014 Rule was only in effect for the 2014 program year, and is no longer applicable for subsequent program year attestations.

C.3 Provider Communication

DHSS has developed a Communications Plan for informing providers, the public, external agencies, and the media on progress made toward implementation of the EHR Incentive Program. This Plan also includes details for sharing communications internally within the DHSS organization. Please see Appendix F for the detailed Communication Plan

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. We anticipate an increase in our outreach efforts as we enter 2016, the last year EPs are able to attest for the first time. Our outreach plan includes:

- Sharing information for program year 2015 with an email list of EPs, EHs, and organization representatives shortly after the 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 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/) in February 2016.
- 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 brochure for exhibit tables at local health-related conferences and for presentations at health-related organizational meetings
- Contacting potential eligible providers for the incentive program before the end of program year 2016
    - Identifying and contacting potential providers by securing list of all eligible provider types and their contact information from Alaska's Medicaid Fiscal Agent
    - Reviewing and contacting providers on the NLR and AK SLR who have not completed the registration or attestation process
- 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 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% of his/her total patient encounters over a period of 6 months in the prior calendar year occurs at an FQHC or RHC. To be identified as a "needy individual," patients must meet one of following criteria: (1) received medical assistance from Alaska or the Children's Health Insurance Program; (2) were furnished uncompensated care by the provider; or (3) were furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

DHSS will allow clinics or group practices to use the practice or clinic patient volume and apply it to all 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; and

- 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 the services 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 health care facilities owned and operated by American Indian and Alaska Native tribes and tribal organizations ("tribal clinics") with funding authorized by the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended) must be reimbursed as Federally Qualified Health Center (FQHC) in order to be

considered as an FQHC for the purposes of the Medicaid EHR Incentive 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 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: (1) received medical assistance from Alaska or the Children's Health Insurance Program; (2) were furnished uncompensated care by the provider; or (3) were furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

C.7 AIU verification

Verification of the providers or hospitals eligible for the EHR Incentive Program are as follows:

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

Providers and hospitals that are currently *not* eligible for the Alaska EHR Incentive Program include Behavioral Health (substance abuse and mental health) providers and facilities and long-term care providers and facilities.

DHSS verifies the provider NPI, billing NPI/TIN, and group NPI/TIN, if applicable. Furthermore, DHSS reviews for valid license and the absences of sanctions.

The attested CEHRT is verified by a real-time transaction to the ONC CHPL site and by documentation submitted by the provider demonstrating that they have contracted to acquire, have acquired, or have implemented the attested CEHRT. Documentation can include a contract or purchase order for the CEHRT; or screen prints from the CEHRT showing data has been entered into the CEHRT.

C.8 Verification of Meaningful Use

The SLR has been modified to accommodate Stage 1 and Stage 2 Meaningful Use attestation, as well as the 2013 modifications mandated by the 2014 Stage 2 Rule, and the changes required by the 2014 Flexibility Rule. The SLR was approved by CMS for the 2015–2017 Rule changes. The screen shots for 2015 were made available to CMS for approval. Xerox has developed a prototype for review of the screen shots affording a view of the screen functionality. The prototype can be made available upon request if a review of the screen changes are desired.

Stage 1 and Stage 2 Meaningful Use screens and processes have been presented in earlier version of this SMHP. However, the 2015–2017/Stage 3 will move all providers to the modified Stage 2 (2015–2017) and to Stage 3 in 2017–2018. Unlike previous rule changes where providers

may have been at different points in MU scheduling, the new rule brings all providers to the same point in MU. As such, we will remove the Stage 1 and Stage 2 topics and present the 2015 Modified Stage 2.

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.8.1 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.8.2 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.

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

The regulation additions have been implemented and published under the title "Electronic Health Records Incentive Program 7AAC165", as required by state statute. The regulation revisions were effective on January 20, 2013. The revisions were in place prior to issuing 2013 incentive payments to providers.

A regulation change has been proposed for program Year 2017 to:

1. Remove the requirement for an EP and EH to submit a hardcopy of the attestation that is already uploaded to the SLR and,

2. 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.9 Proposed Changes to Meaningful Use Definition

Alaska does not intend to propose changes to the MU definition.

C.9.1 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.10 Verify Providers Use of CEHRT

Providers attesting to AIU are not required to be using the technology; but they must demonstrate they have either a purchase order, contact or other documentation indicating the will acquire a 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. AIU and MU providers must include the CMS Certification ID of their CEHRT, which will be verified against the ONC CHPL site.

C.11 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.12 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 (MU) attestation
- Submission of completed forms to State Medicaid entities
- Messaging to providers from State Medicaid entities
- Payment history log
- Initiation portal for providers' appeals
- 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.13 IT System Changes for the EHR Incentive Program

Alaska initially implemented the capability for AIU and Stage 1 attestation in January, 2011. Subsequent changes were made based on CMS rule changes, such as the Stage 2 changes from the 2012 rule, which included Stage 1 changes and eligibility changes in program year 2013.

The 2014 Flexibility Rule accommodated providers who were not able to implement a 2014 Edition CEHRT, and we able to use either a 2011 CEHRT or a combination 2011/2014 CEHRT. Impacted providers were able to attest Stage 1 2013 or 2014 measures depending on which CEHRT edition they were using. The changes were implemented for program year 2014. The 2014 Rule was only in effect for the 2014 program year, and is no longer applicable for subsequent program year attestations.

Changes were made to accommodate changes for program year 2015 and 2016 based on the 2015–2017/Stage 3 Rule issued in October 2015 and finalized in December 2015. Changes for program year 2017 are pending, as well as changes required for Stage 3, which will be optional for providers in 2017 and mandated for 2018.

The proposed changes for the 2012 rule (including 2013 changes) were submitted to CMS via a SMHP update; the changes for the 2014 Flexibility Rule and the 2015–2016 changes were submitted to CMS via an addendum and accompanying screen shots. All of the changes were approved by CMS prior to the changes being implemented.

The 2015–2016 screen shots are available on request.

Alaska anticipates submitting changes for program year 2017 and Stage 3 by the end of 2016, with implementation occurring in early 2017. Funding was requested and approved on October 2016 for FFY 2017. A copy of the approved IAPD is attached to this updated SMHP.

C.14 IT Timeframe for Systems Modification

It is anticipated the changes for program 2017 and Stage 3 will be completed by the first quarter of 2017. The changes for the total switch over to Stage 3 only have not been developed yet; but we anticipate the changes to be implemented in early 2018.

C.15 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.16 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.17 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, including reminders that 2016 is the last year EPs can 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. This information can assist a provider in making the decision to participate and guide them as they prepare to participate. 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.18 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 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 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 2016.

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.19 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 Frequently Asked Questions (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.20 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 of 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.20.1 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 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.21 Assurance and Accountability of Federal Funding

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

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.21.1 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.21.2 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.22 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, that 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.

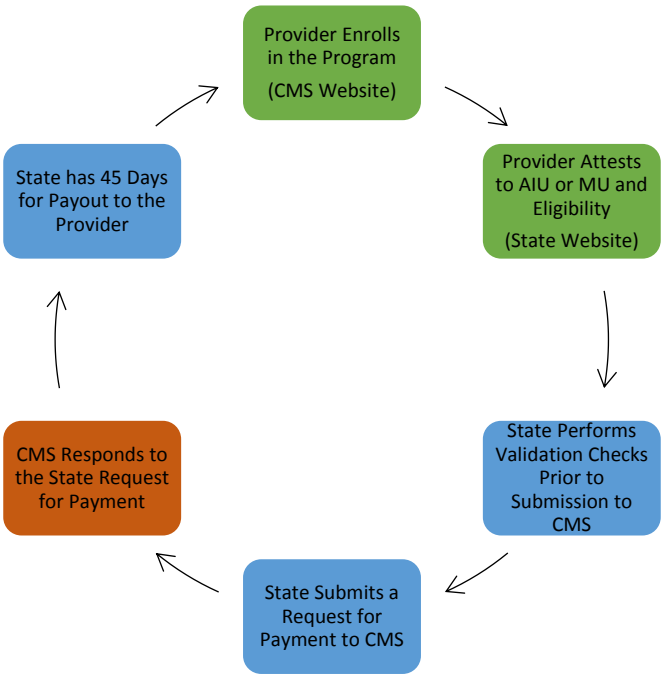
At this point, automated and manual validation checks are performed and a decision regarding enrollment is reached. This decision is transmitted to the NLR within 24 hours. The timing for the manual validation check is variable depending on the submitted number of attestations.

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:

Figure 7 – Incentive Payment Issue Process



C.23 Assuring Medicaid Payments are Paid Directly Without Deduction

Payments issued by the EHR Incentive 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.24 Payments to Entities Promoting the Adoption of CEHRT

This topic is no longer required to be addressed.

C.25 Incentive Payments Disbursed Through Managed Care Plans

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

C.26 Payment Calculations Consistent with Regulations

The pre-payment verification process assures that only those Alaskan providers eligible for the incentive payment meet the requirements for payment prior to issuing payments. Also, the post-payment audit process conducts a risk assessment to identify providers that may not met all standards and are chosen 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.26.1 Provider Payment Calculations

C.26.1.1 *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 payment in excess of the maximum $63,750. The SLR will ensure that payments are not made after 2021 and that the participation is limited to six years as well as the maximum payment amount.

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

Some providers may have difficulty producing data for a 90-day period due to capabilities of their software and other entity reporting requirements. DHSS will allow EPs to use any representative 90 day, 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.26.1.2 *Eligible Hospital (EH) 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 day, 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.26.2 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.26.3 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 D for a detailed description of the Alaska EH Incentive Payment Calculation.

C.27 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.28 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.

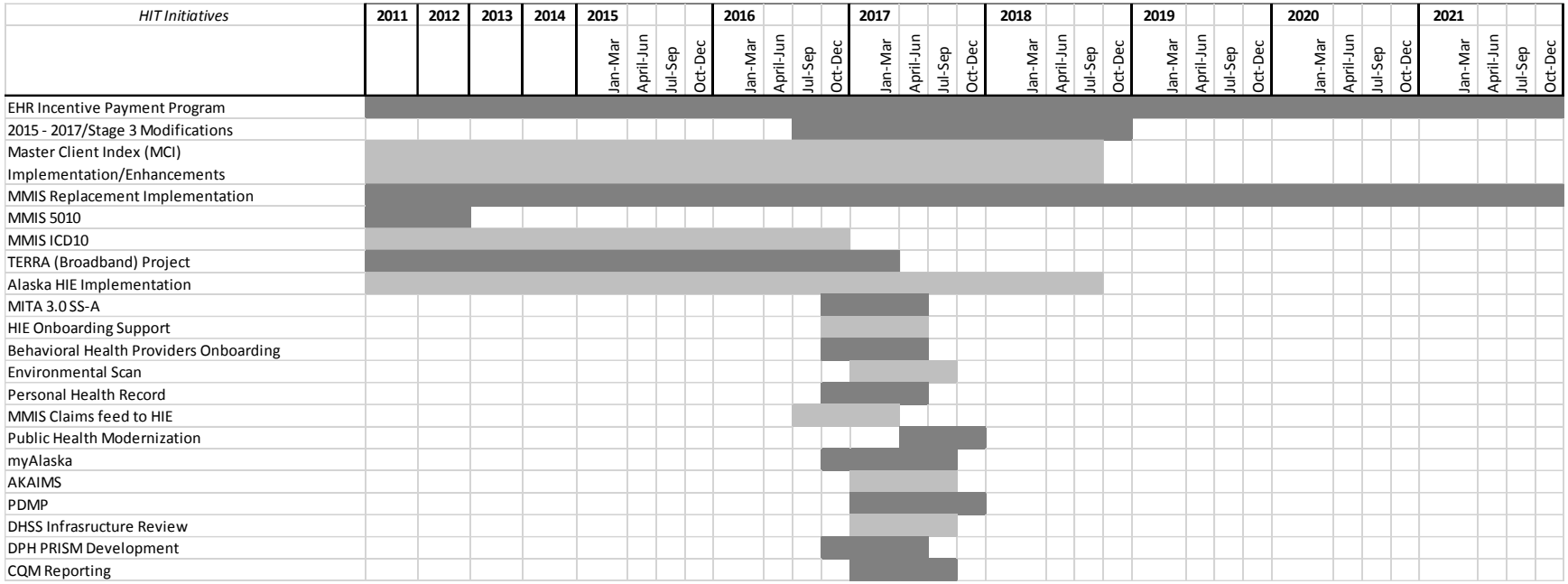
E.1 Alaska Vision for Moving from "As Is" to "To Be" HIT Landscape

The Medicaid Health Information Technology Roadmap is a high-level plan to address the current state of the Alaska Medicaid EHR Incentive Program and future Medicaid HIT/HIE goals. The roadmap contains high-level steps DHSS will take to continue administering the Medicaid EHR Incentive 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:

Figure 8 - Alaska's "AS-IS" and "TO-BE" Roadmap



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 2012. 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.
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 20102	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,

Initiative	Current State	Future Activity
	Rule, the changes for 2014 Flexibility, and the 2015 and 2016 program year changes for the 2015 – 2017/Stage 3 Rule.	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
MMIS Replacement Implementation	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 Fiscal Agent (FA) and state staff. Alaska Medicaid Health Enterprise is a sophisticated, web-enabled	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.

Initiative	Current State	Future Activity
	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 2016.	
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.
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

Initiative	Current State	Future Activity
		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) is expected to have covered 84 communities in Alaska by the end of 2016. GCI most recently expanded into the communities of Noorvik, Golovin, and Buckland. The broadband initiatives have largely been implemented.
Alaska HIE Implementation	In 2009, Alaska DHSS contracted with the AeHN 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. AeHN launched a pilot program in February 2011 with one hospital and two clinics participating in the exchange of authorized medical information. The pilot and associated user acceptance testing was completed in early September 2011. AeHN began connecting additional Alaska providers in December 2011 and today has over 2,000 users and 40 organization participants	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.
MITA 3.0 SS-A	DHSS completed its initial Medicaid Information Technology Architecture (MITA) State Self-Assessment (SS-A) in 2008 to support the MMIS	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

Initiative	Current State	Future Activity
	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.	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 2017, 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.
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.

Initiative	Current State	Future Activity
Environmental Scan	In 2008, Alaska DHSS completed a MITA SS-A using MITA Framework 2.0 and created a plan for moving the MMIS forward to its envisioned To Be state. The 2009 MITA Technical Assessment was reviewed following the identification of the Business and Technology gaps and functionality needs to fill the gaps. The information was leveraged and integrated into the statewide HIT Landscape to promote statewide cost-effective and efficient use of HIT, where feasible. The same iterative MITA planning process was used, beginning with an environmental scan, to assess the As Is readiness of Alaska providers and identify gaps.	An environmental scan will be conducted in 2017. The DHSS will collaborate with partners to develop a hybrid delivery methodology for survey execution. An online tool to survey Alaska's health information technology environment will be utilized along with a paper based survey to ensure that all target audiences are engaged. DHSS, in cooperation with the key stakeholder organizations, will field the survey and collect the survey responses. Alaska DHSS will utilize the results of the environmental scan to develop a HIT strategic roadmap which will contribute to DHSS's overall Enterprise IT Strategic Framework.
Personal Health Record	There is currently Personal Health Record (PHR) capability in the statewide HIE.	DHSS will onboard Medicaid recipients to the HIE enabling them to access their own health care data.
MMIS Claims Feed to the HIE	There is currently Personal Health Record (PHR) capability in the statewide HIE.	Alaska plans to integrate the MMIS DW 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

Initiative	Current State	Future Activity
		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.
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.	Through this implementation, the 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.
AKAIMS	The Alaska Automated Information Management System (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 Department of Behavioral Health (DBH) to develop a robust reporting database which will import and store the AKAIMS minimal data set, along with the minimal data set sent

Initiative	Current State	Future Activity
		from provider agencies through the statewide HIE to increase coordination of care. Although AKAIMS has been operational since 2003, this initiative also focuses on upgrading and developing the system to allow for HL7 transactions, ensuring HIPAA compliance. The onboarding activities of the initiative will be completed in a phased approach, beginning with approximately 3 behavioral health provider organizations being targeted for onboarding in the initial fiscal year of implementation. Following the initial implementation, onboarding activities will increase with each subsequent year.
Prescription Drug Monitoring Program (PDMP)	The current PDMP is a stand-alone solution.	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 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	Alaska has recently issued an RFP to review the DHSS

Initiative	Current State	Future Activity
	healthcare delivery. Also, the recently implemented Medicaid expansion has demonstrated a need to give healthcare providers assistance with increased patient loads.	infrastructure for ways to accommodate 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.
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	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

Initiative	Current State	Future Activity
	year of MU must submit CQMs electronically. Providers have had the capability to report CQMs electronically to the Alaska SLR since early 2013.	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

It is Alaska's plan to continue enhancing provider EHR adoption and MU rates annually 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 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 $23.5 million.
- Eligible Professionals –As of calendar year 2015, Alaska issued EHR incentive payments to over 738 unique EPs and 1,426 EP incentive payments for a total of nearly $22.4 million.
- Outreach activities will continue to assure that at least:
  - 50% of EPs attesting in the program will meet MU for 2 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 60 provider organizations in calendar 2017 (and 90 providers in 2018). There are currently twelve (12) hospitals live, nine (9) hospitals onboarding, seven (7) provider organizations live,

seven (7) provider organizations onboarding, one (1) payer onboarding to Alaska's HIE.

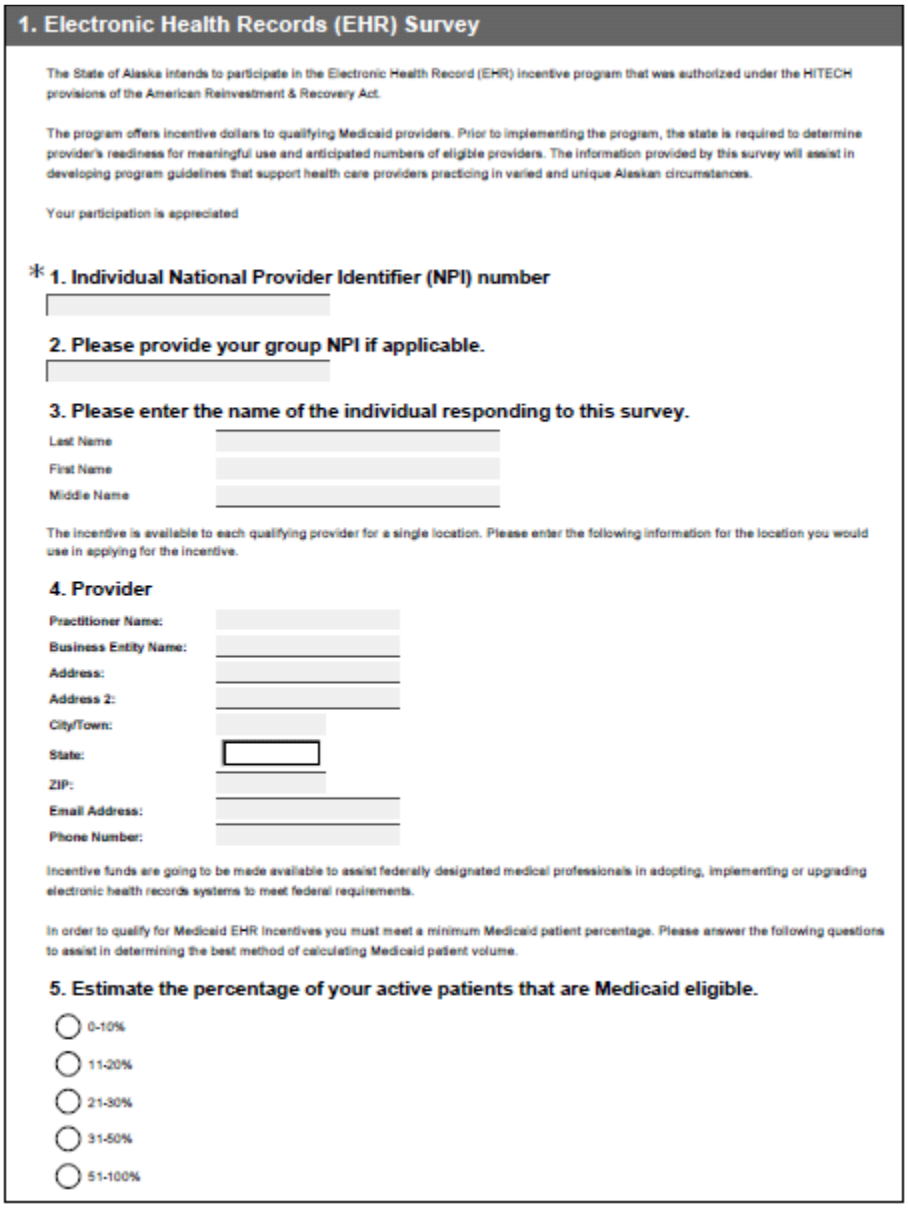
- Implement 20 new providers/users in the Event Notification Service. There are currently 8 providers using Notifications.
- Add 200 licensed professionals using query based exchange. There are currently 640 licensed professionals with active query accounts.
- Implement single sign-on with 2 EHR vendors 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 2013 and has an approved audit plan for program year 2014. 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



1. Electronic Health Records (EHR) Survey

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

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

Your participation is appreciated

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

2. Please provide your group NPI if applicable.

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

Last Name
First Name
Middle Name

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

4. Provider

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

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

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

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

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

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

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

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

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

Other (please specify)

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

- ◯ Yes
- ◯ No

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

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

10. Does your practice setting use an EHR?

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

3. EHR Readiness

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

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

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

Other (please specify)

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

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

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

- ◯ Yes
- ◯ No

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

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

APPENDIX B – EH ENVIRONMENTAL SCAN QUESTIONS

1. Electronic Health Records (EHR) Survey

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

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

Your participation is appreciated

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

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

Last Name
First Name
Middle Name

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

* **3. Hospital**

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

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

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

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

2. EHR Readiness

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

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

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

Other (please specify)

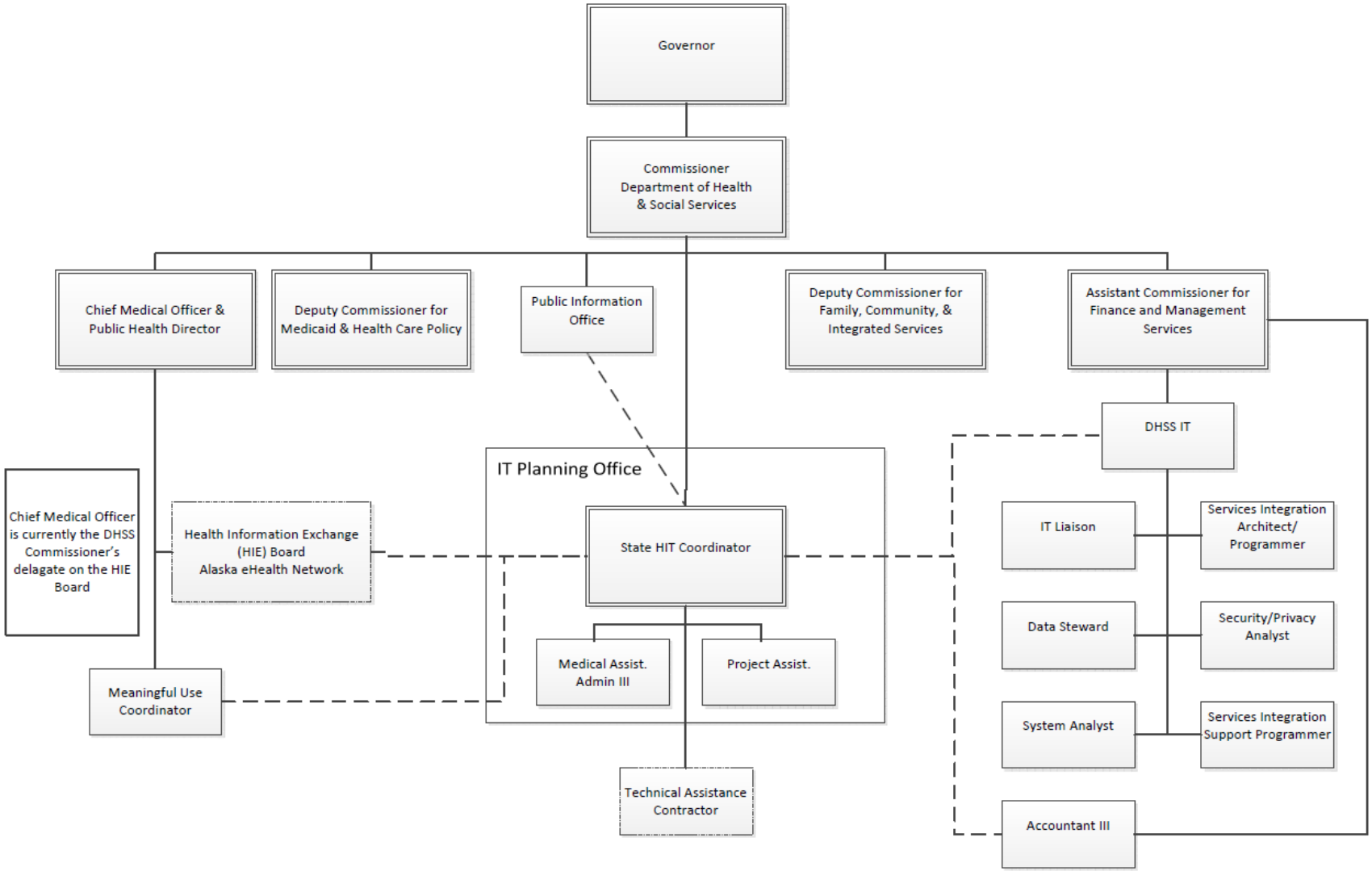
* **10. Please rate how fully you are using your EHR.**

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

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

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

APPENDIX C – DHSS ORGANIZATION CHART



APPENDIX D - 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

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.

<table>
<tr><td>Location On Cost Report - CMS 2552-96 cost report data fields or other data sources</td><td>When totals are requested for inpatient bed days and discharges, theses totals must NOT include nursery or swing bed counts.</td></tr>
<tr><td>Average Length of Stay</td><td>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="3">Prior Year Discharges Data</td><td>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>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>
</table>

Discharges	S-3, Part I, Column 15 listed as "Total All Patients", line 12-sum of acute care inpatient, or IHS HQ Reports	Lines 1 and 2 Total Discharges
Medicaid Inpatient Bed Days	State Reports	Line 3 Total Medicaid Inpatient Bed Days
Total Medicaid Managed Care Inpatient Bed Days	Alaska does not have Medicaid Managed Care Inpatient Bed Days; it is included in the hospital calculation sheet only because it is a data field in the SLR. Hospitals may enter a “0” in this field in the SLR.	Line 4 Total Medicaid Managed Care Inpatient Bed days
Total Inpatient Bed Days	IHS National IP Statistics	Line 5 Total Inpatient Bed Days
Total Hospital Charges	IHS Cost Report Summaries	Line 6 Total Hospital Inpatient Charges
Total Charity Care	IHS National IP Statistics	Line 7 Hospital Inpatient Charity Care Charges

APPENDIX E - 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)
AeHN	Alaska electronic Health Network
AeHRA	Alaska electronic Health Records Association
AHCC	Alaska Health Care Commission
AI/AN	American Indian/Alaska Native National Regional Extension Center
AKAIMS	Alaska Automated Information Management System
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

Acronym	Description
CDC:	Centers for Disease Control
CEHRT	Certified Electronic Health Record Technology
CFR	Code of Federal Regulations
CHC	Community Health Center
CHIP:	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CHPL	Certified Health IT Products Listing
CMS	Centers for Medicare & Medicaid Services
CoP	Community of Practice
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

Acronym	Description
EMR	Electronic Medical Records
EP	Eligible Professional
ePHI	Electronic Protected Health Information
EPSDT	Early Periodic Screening, Diagnosis, and Treatment Program
ER	Emergency Room
ETL	Extract, Transform, Load
FA	Fiscal Agent
FAQ	Frequently Asked Questions
FCC	Federal Communication Commission
FFP:	Federal Financial Participation
FFS	Fee for Service
FFY	Federal Fiscal Year
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

Acronym	Description
IRS:	Internal Revenue Service
IT:	Information Technology
IVR	Interactive Voice Response
LIMS	Laboratory Information Management System
LLC	Limited Liability Corporation
LOS	Length of Stay
LOINC	Logical Observation Identifiers Names and Codes
MAR:	Management and Administrative Reporting System
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

Acronym	Description
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
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

Acronym	Description
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
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
USDHHS	United States Department of Health and Human Services
VA	Veterans Administration
VistA:	Veterans Health Information Systems and Technology Architecture
VLER	Virtual Lifetime Electronic Record
VOIP	Voice over Internet Protocol
WWAMI	Washington, Wyoming, Alaska, Montana, and Idaho
X12	ANSI standard that supplies that structure to EDI transactions
XML	Extensible Markup Language

APPENDIX F – OUTREACH/MARKETING PLAN

Section 1: Executive Summary

Alaska is the largest state in the nation geographically, encompassing an area greater than the next three largest states – Texas, California and Montana – combined. Its geographical dispersion along with population diversity creates unique challenges in recruiting, educating and retaining provider participation. Despite these challenges, Alaska was one of the first states to issue an Electronic Health Record (EHR) Incentive Program payment in April 2011. As use of certified electronic health record technology (CEHRT) grows and the EHR Incentive Program continues to evolve, Alaska is seeking a strategy incorporating a variety of communication techniques to continually encourage new and existing provider participation.

To this end, Alaska has contracted with HealthTech Solutions, LLC (HTS). HTS has created a comprehensive outreach and marketing strategy with activities specific to ongoing educating of existing participating providers as well as a focus of outreach to identify and encourage potential program participants. A key reflection of the effectiveness of an outreach and marketing strategy is the ability to react and respond to the needs of the intended audience. Several key factors can be used to drive provider adoption of electronic health records and participation in the program including Alaska's recent Medicaid expansion and Alaska's Health Information Exchange (AeHN).

Program Year 2016 is the last year for providers to begin participation therefore there are specific activities to identify and encourage this initial participation. Providers do not have to participate in consecutive years but additional activities outlined are focused on encouraging program retention through increased and ongoing education and communication. Accompanying activities is the inclusion of partner stakeholders to encourage involvement in and continued support of program objectives and goals. Successful implementation of this Strategy requires a combination of coordinated efforts, working with a variety of stakeholders, and an amalgamation of communication strategies and ongoing collaboration. The strategy has been built on the acknowledgement of limited staff resources with an emphasis on employing technology and "low-touch" activities. Many activities will cast a wide-net to potential participants allowing staff to focus on individuals needing more intensive one-on-one interaction. Eligible Professionals (EPs) are the target audience however wherever and whenever to the extent possible, materials and outreach activities can be tailored towards hospitals participating in the Program.

The Strategy is augmented with lessons learned from program audits conducted by Myers and Stauffer, LLC. Myers and Stauffer has been working with the state of Alaska Department of Health and Social Services (DHSS) since the 1990s, allowing for a comprehensive understanding of the health care environment within the state. In 2012, Myers and Stauffer began providing EHR audit services to DHSS in addition to other state activities.
It is recognized that there must be sensitivity to the provider's hesitancy in initial and continued program participation. This hesitancy can be caused by a myriad of factors including provider workload issues, technology constraints, budgetary concerns, and program complexity that is

further complicated by changing program requirements. The recommended Strategy should be implemented, evaluated and

refined throughout the life of the program and align with available resources and identified participant needs.

For purposes of this document and to provide clarity, the following terms and definitions apply:

Providers: Eligible Professionals, Hospitals and Critical Access Hospitals as defined by legislation eligible to participate in the program.
EP: Eligible Professional
EH: Eligible Hospital

Stakeholders: Provider related associations; internal staff, ancillary support personnel and consumers that have an interest in program administration and impact.

The Strategy: The activities that will be conducted for purposes of education and/or outreach for Alaska's Electronic Health Record (EHR) Program.

DHHS: Alaska Department of Health and Social Services, Division of Health Care Services

SLR: State Level Repository operated by Xerox

NLR: National Level Registration/Repository

MMIS: Medicaid Management Information System

Section 2: "As-Is" Assessment

Alaska launched its program on January 3, 2011, and made its first incentive program payment in April 2011 representing 18 Eligible Professionals from one organization. Per the State, as of July 2015, Alaska has made 1,264 payments to EPs and 50 EH payments for a program total of over $44 million. CMS reports that as of July 2015, there were a reported 918 providers registered to participate in the Alaska EHR Incentive Program. The following charts reflect payments made through from the 3rd quarter of 2012 through the 2nd quarter of 2015.

Meaningful Use Incentive Program Assessment												
	Q3 2012	Q4 2012	Q1 2013	Q2 2013	Q3 2013	Q4 2013	Q1 2014	Q2 2014	Q3 2014	Q4 2014	Q1 2015	Q2 2015
EP AIU	233	299	337	348	375	499	563	579	637	693	699	748
EP MU	27	39	41	54	62	64	110	132	270	366	368	405
EH AIU	16	17	18	19	20	20	20	20	20	21	21	22
EH MU	0	14	6	6	6	8	8	13	21	21	24	29

Table 5: Alaska Program Payments

Though the Proposed Modification Rule has delayed the attestation process for Program Year 2015 applications, the change allowing all providers a 90 day reporting period for Program Year 2015 creates an opportunity for returning providers to continue in the program without having to meet program requirements for a full year. Additionally, the streamlining of Meaningful Use measures will enable providers to attest to a more focused reflection of the intent of meaningful use program.

Currently, Alaska EPs have the following participation rates as compared to the national averages:

CMS MU CoP EP Provider Participation Rates August 2015		
	National	**Alaska**
AIU to MU	40.67	38.97%
Year 2 to 3	38.55	15.3
Year 3 to 4	14.34	0
Dentists Only: Year 2 to 3	33.65	0

Table 6: CMS MU CoP, August 2015

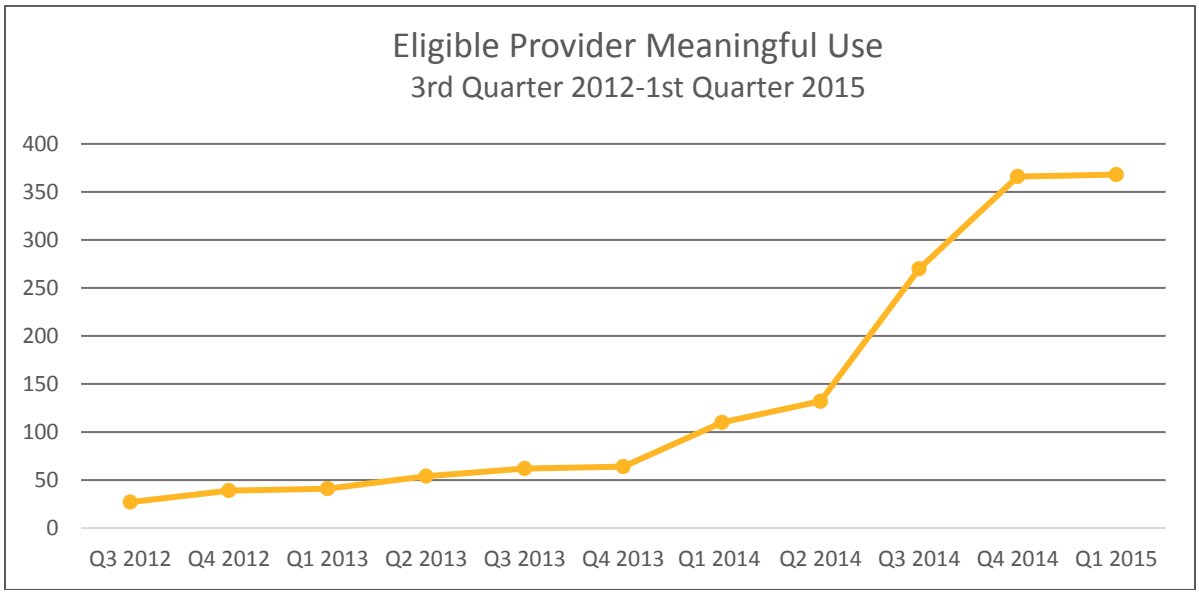


Figure 9: Eligible Provider Meaningful Use

Out of the 22 EHs with potential eligibility for the Medicaid EHR Incentive program, 21 have completed their Year 1 payment, all but 4 have completed their Year 2, and 9 have their Year 3 left to attest for (Alaska EHR Update 9/11/2015).

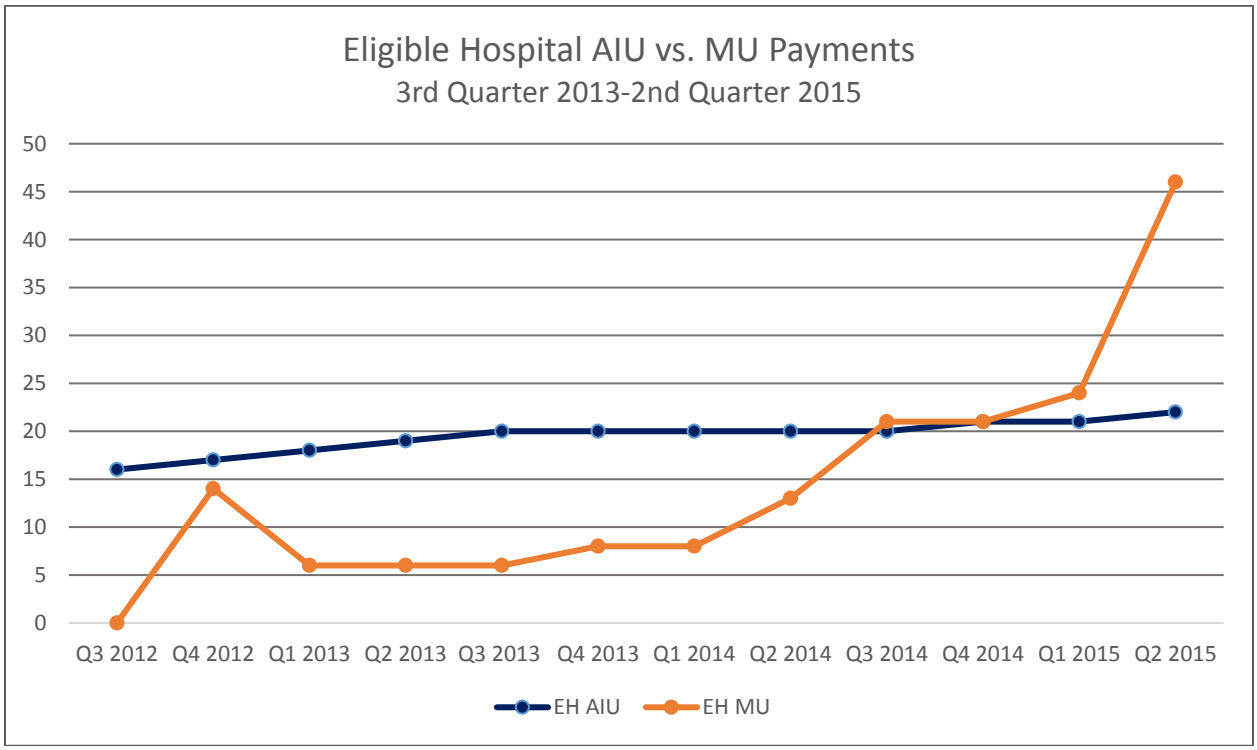


Figure 10: Eligible Hospital AIU vs. MU Payments

A. Administration

Alaska's EHR Incentive Program is supported by a knowledgeable, competent staff with responsibility for all phases of the program. It can be said that much has been done with little in terms of staff resources.

Beth Davidson serves as Acting State Health Information Technology Coordinator for Alaska with oversight responsibility for Alaska's Health Information Exchange as well as the Incentive Program. It is beneficial for both programs to fall under the purview of one individual allowing for shared insights, planning and program goals. JoLynn Cagle is the EHR Incentive Program Manager and Shawn Gillespese conducts prepayment review on the applications.

Program staff can be contacted either directly or there is a general email address (mailto:hss.hitinfo@alaska.gov) that is answered by program staff. Stakeholders indicated that typically JoLynn is contacted directly for assistance.

Xerox provides Alaska's attestation State Level Repository (SLR) along with a shared call center among all states utilizing the Xerox solution. There was some level of dissatisfaction expressed with the responsiveness of the call center but with the limited number of Alaska providers and scarce program resources, it is not feasible to operate a standalone call center. The call center handles primarily technical and application completion related questions. Policy and program requirement questions are to be referred to Program staff.

B. Stakeholder Conversations

Conversations were held with identified stakeholders to glean current and future program perspective. Though a series of questions were presented designed to elicit an "as-is" and "to-

be" focus on the program, the conversations were informal and participants were encouraged to discuss any and all aspects of the program. Stakeholders were asked the following questions:

1. What has worked well in the past?
2. What areas do you struggle with? Measures, application, volume?
3. Do you feel that there is enough program information? Federal level? State Level?
4. How do you like to receive your information? Email, Webinar, Website?
5. What types of information do you need to successfully participate? Workflow, understanding the measures, understanding the application process?

As expected, dependent on the stakeholder's responsibility with and level of participation in the program, responses were varied. The general consensus of stakeholders; however, was that the program was cumbersome but worked, information was available but hard to find with most information being at the national level and changing program rules. The majority of the comments dealt with the federal aspect of the program in terms of requirements. There were concerns presented however, including trying to keep up with program changes, lack of clarity on policy especially when a provider was being audited and timeliness of program information. One resounding comment was the helpfulness, professionalism and accessibility of program staff. JoLynn Cagle was mentioned several times as she is considered the "face" of the program. Conversation details by stakeholder type are contained in Table 3 below.

Type	*Summary*
State	More involved with administration side of things than actual providers; providers do not understand the difference between XEROX and state staff; need data to understand
State	Lots of moving parts. Audit issues with how cost reports originally generated. Need help understanding how the system supports the measure – not so much the measure itself. Learning curve due to huge turnover in staff. Telephone and face-to-face is best to communicate knowledge – translation gets lost in email. Lots of avenues to reach the various (220) tribes.
Provider	"JoLynn is awesome and amazing"; works closely with ONC; Xerox upload slow; goes straight to source for information; unfair to measure providers based on patient behavior; problems with HIT: infrastructure cumbersome, working on pilot that is still not in production (delayed and over budget); too much information sometimes - needs to be more streamlined; likes to know of changes and then find the information necessary.
Provider	Better contact – follow up to questions (referring to general SLR helpdesk). Have to call JoLynn. Webinars can be confusing unless straightforward. Would rather just know where information she needs and let her go get it. SLR questions do not match CMS measures – hard to match the two. Likes written information that she can access and refer to as necessary.

Type	Summary
Provider	Not so much experience – another employee helped with actual application; big learning curve; measures have to match numbers with both volume numbers and measures; 2nd year no one was successful; claims issue affecting volume (stated that the Medicaid was.5m behind in their payments due to system implementation issues); clearer delineation of requirements (federal vs state); likes soliciting input; all modes of communication are necessary; detailed step-by-step participation
Provider	Central source of attestation among 5 states. Alaska is the best. High praise for JoLynn – works very closely with JoLynn who is accessible and responsive. Best customer service. Does not use the website – just calls. Does reference CMS website quite a bit. Understanding modification rule of concern – having timely information. JoLynn is the greatest asset. Xerox is Achilles heel.
Other	A lot of frustration is due to changing program requirements at the federal level; providers do not want to participate due to audits (patient volume huge issue); great relationship with state staff – state promotes attitude of success – more than willing to work with you; volume biggest program issue – vendor interpretation – more for larger organizations and how things are billed and tracked – complex and hard; listserv for the state – listserv could be used to direct providers to key or changing requirements; federal material is geared towards Medicare; get information out more quickly; be proactive in key areas e.g. PH in modification rule; more specifics on the website; do webinars; auditing real issue for continued participation; question about application elicited long sigh – asks for more information than federal; clearer direction/affirmation when getting proxy for providers; hard to meet certain measures for rural providers; HIE frustrating – great concept – application not working out – does not meet needs – more support – vendor can't keep promises – need to see results. More communication – information about exclusions.
Other	Works closer with small hospitals; incentive dollars driving adoption of CEHRT but still very costly in terms of dollars, time and resources; biggest needs - IT trained employees and capital; HIT grant funding ending; smaller hospitals still need a lot of help in implementing and understanding; webinars helpful if controlled and focused, face-to-face allows for interaction; coordination of websites, use associations to push information to memberships; hard for hospitals to make providers change their behaviors. Tighter communication.

Table 7: Summary of Stakeholder Conversations

The findings of this qualitative research was used to formulate Strategy recommendations including successful, target and problematic areas.

C. Material Review

To gain an understanding of the efforts to date and material developed, a review of existing material was completed identifying the following documents specific to the Alaska program:

- http://dhss.alaska.gov/HIT/Documents/preparation_Checklist.pdf - Getting Started Checklist (no date)
- http://dhss.alaska.gov/HIT/Documents/Alaska%20Medicaid%20EHR%20Incentive%20Provider%20Program%20Manual%20Stage%202_2014%20v1.0.pdf – SLR Provider Manual (Updated April 2014)
- http://dhss.alaska.gov/HIT/Documents/2012_Lab_Stakeholder_Meeting_v.05.pdf – Webinar Slides (2012)
- http://ak.arraincentive.com/docs/Flexibility%20Rule%20and%20AK%20SLR%20v1.0.pdf – Flexibility Certification Rule (no date)
- http://dhss.alaska.gov/HIT/Documents/Intent%20to%20Register%20Form.docx – Intent to Register for Public Health Reporting (dated 12/23/2013)
- Immunization Registry – on boarding instructions for immunization reporting (no date)
- Electronic Lab Reporting – on boarding instructions for electronic lab reporting (no date)
- Electronic Lab Message and Testing Requirements – on boarding instructions for lab message and testing reporting (no date)
- Syndromic Surveillance – on boarding instructions for syndromic surveillance reporting (no date)
- Cancer Registry – on boarding instructions for cancer registry reporting (no date)
- http://dhss.alaska.gov/HIT/Documents/ePrescribing%20Brochure.pdf – dated
- http://dhss.alaska.gov/HIT/Documents/Resources/Meaningfuuse_Matrix.pdf - dated 2009 contains 2015 measures

It is recognized that much of this material is dated and/or developed by and in support of the Health Information Exchange.

Section 3: "To-Be" Goals and Strategy

Garnered from information from the State Medicaid Health IT Plan (SHMP), stated goals in the solicitation, and stakeholder conversations, the following goal and plan of action provides DHHS with an individual and collaborative approach to conduct outreach activities.

A. Goals and Strategies

Each of the strategies listed below are designed to promote the goal of continued program participation while seeking out potential participants. These strategies outline specific tasks to be undertaken each building upon each other.

Figure 11: Goals and Strategies

B. Timeline

Some of the recommended activities, especially in conducting outreach efforts and producing outreach material, are ongoing in nature. It is recommended that priority be given to data mining and website redesign. Knowing who your target audience is will dictate the timeline and activities for solidifying relationships, developing material and conducting outreach activities. On an ongoing basis, it is recommended that the following activities occur:

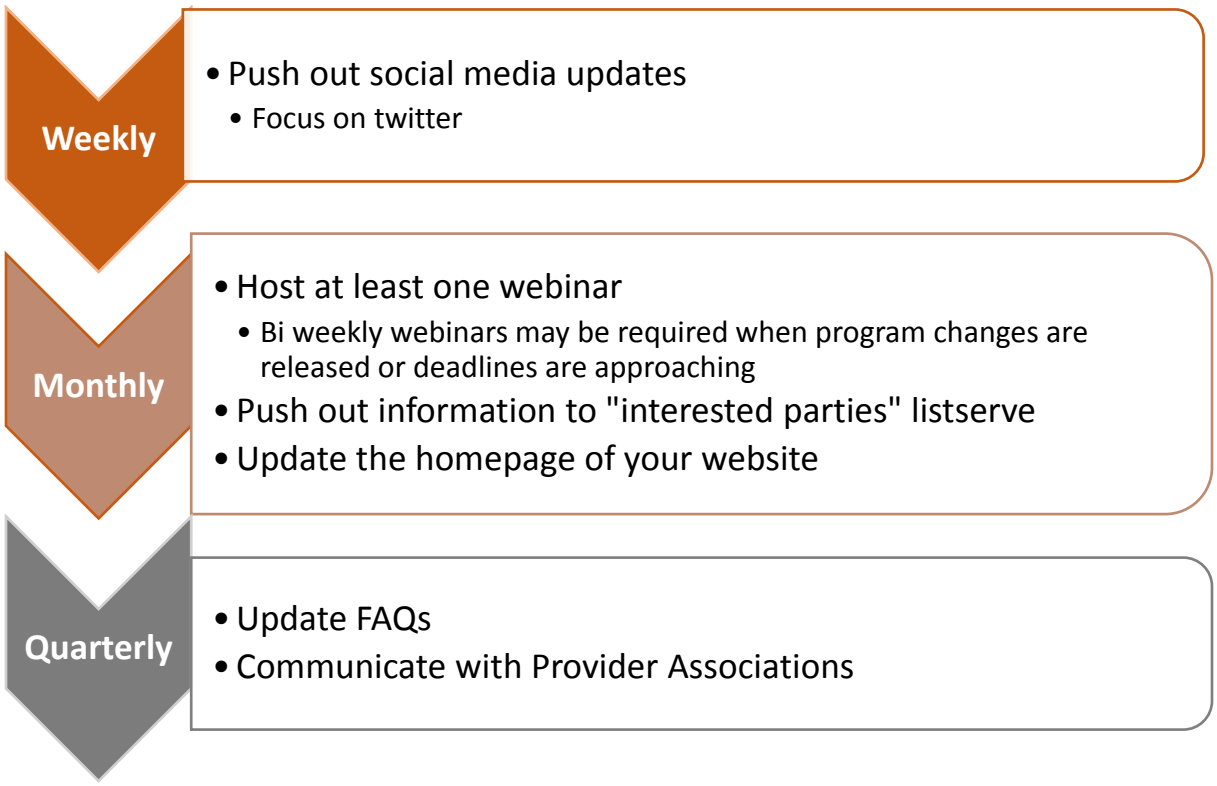
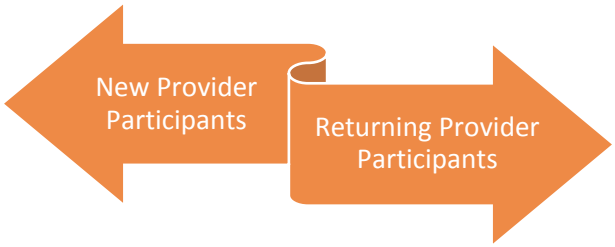


Figure 12: Timeline of Events

Section 4: Conduct Data Mining

To determine the potential for program growth and program continuation, provider identification must take a two-prong approach: new providers and returning provider participation. Data mining is a critical activity in identification. Alaska must first determine and track existing participation levels and then identify those providers that are eligible but have not registered and/or attested. Information reported via MMIS, NLR to SLR registrations, SLR reports as well as licensing, association and vendor information can also be used in identifying and tracking participants.
The data from MMIS will be used as a foundational report for comparison to other data sources for participation information. When data mining, it should be understood that the purpose is to cast a wide net of identified participants as the data elements available do not always allow for specificity to be determined on actual participation.

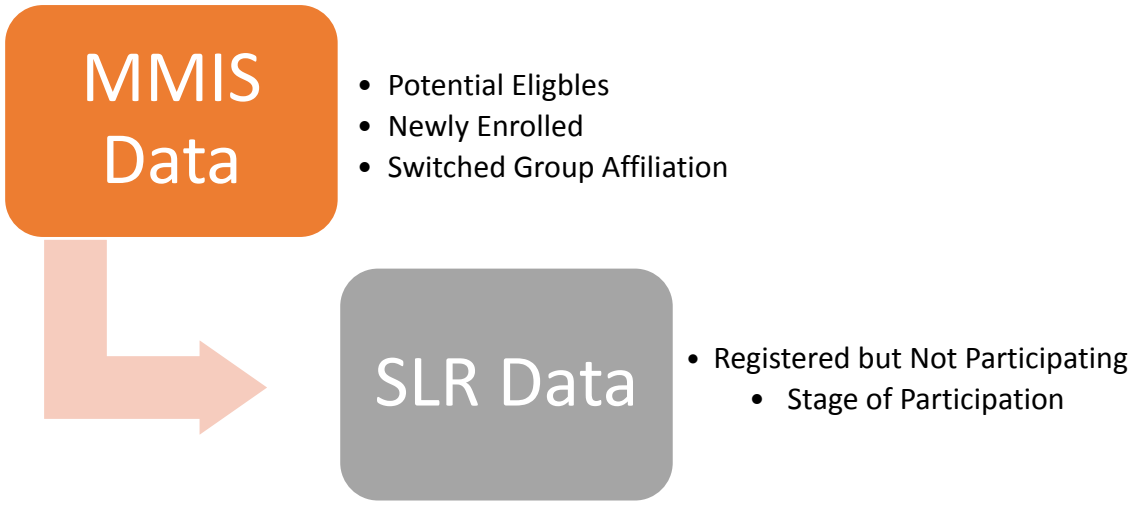


A. New Participants:

MMIS data can determine newly enrolled providers, providers who may have switched group affiliations and/or providers who qualify for the program but for a variety of reasons have decided not to participate to date.

B. Returning Participants:

SLR data should be gathered to determine provider stage of registration and/or participation. Providers should be identified by those registered but not participating or program stage beginning with Adopt, Implement or Upgrade (AIU).



C. Data Sources

The correlating identifier from each of these data sources will be the provider's NPI. Below are the recommended data elements from each source:

MMIS	SLR
NPI	NPI
Group Affiliation*	Payee/Group Information
Date of Enrollment	Email
Email Address, if available	Program Participation Years
Mailing Address	Program Participation Stages**

*Group Affiliation either by Medicaid payee number or Tax-ID
**Because providers can skip years, it must be determined what stages a provider has attested to

Table 8: Data Sources

D. Results

It is anticipated that the results of the data mining effort will be a listing of potential new participants identified through MMIS for which targeted outreach can be developed outlining the benefits of the program and how to begin the registration process. From the SLR information and dependent on whether the provider has actually begun participation, outreach material will be targeted to address basic program requirements, program benefits, specific meaningful use measures and/or an overview of program changes.

Data Mining should be conducted at least bi-annually to ensure that the target audience is being reached. After 2016, only SLR data will need to be reviewed as new providers will no longer be

eligible to begin participating in the program. For 2016 however, it is recommended that the EHR Incentive Program work with Alaska's DHS unit or fiscal agent to obtain a listing of newly enrolled Medicaid
providers on a quarterly basis. These providers could then be contacted about beginning program participation through the end of Program Year 2016.

E. Additional Data Source:

An additional source of new program participants could be determined by obtaining information from Alaska's licensing board. A listing of newly licensed providers could be used to send out general program information both about Medicaid enrollment and the program. This activity may be beneficial in light of the recent Medicaid expansion to encourage Medicaid enrollment and is recommended only if the State feels that the benefit is outweighed by the resources necessary to deploy.

Section 5: Develop Program Messaging

Best practices show that if a program or activity has a certain look, then identification with that program is more readily made by stakeholders. The EHR Incentive Program is complex, ever-changing and often viewed by providers as "just one more thing" that has to be done on a daily basis in a busy medical practice. It is important that the program have an image that can be used as a marketing tool and part of the overall strategy. A key component of the image is a consistent message and look. This will allow providers to readily identify information coming from the state and be able to trust that the information is legitimate, accurate and reliable.

F. Recommendations:

Building off the DHHS look, the existing provider facing website and AeHN, develop a logo that can be used so that providers can easily identify that the information is being provided by the Alaska EHR Incentive Program. It can be as complex as a new logo or as simple as a tag line below the existing DHSS identifier.
Examples are:

Section 6: Creation of an Interested Parties List

Having a means by which to regularly communicate with stakeholders is critical. Having a compilation of email addresses will allow program staff a regular means of communication. This list (aka listserv) can be used to send routine program updates, disseminating items of interest and even a means of inviting stakeholders to outreach events. Emails also allow for a direct communication channel to be established. If a provider is having a particular issue – then the email gives them a primary contact with whom to resolve the issue or concern.

G. Recommendations

It is recommended that the initial list be created through the SLR data mining efforts. On an ongoing basis, stakeholders can "sign" up for the listserv through the website. Elements of the listserv should include, to the extent possible, provider name, NPI, Payee NPI, contact name, contact email, county, and provider specialty. In addition to providers, other stakeholders should be included such as Provider Associations, DHHS staff, and/or entities that may be assisting providers with the application process. The capturing of this information will allow for targeted outreach campaigns as explained in Section 9.

Section 7: Solidify Partner Stakeholders Relationships

The importance and value of creating new and enhancing existing relationships with partner stakeholders cannot be overstated. Through this collaboration, synergies can be realized with those that are regularly communicating and interacting with program participants.
While the State has a mechanism by which to communicate with providers directly, it is important to identify and develop partnerships with organizations that have existing connections with both existing and new Eligible Professionals and Eligible Hospitals. Program staff currently does interact with many of these organizations, though a more formal, direct approach with tangible activities can prove beneficial.

H. Provider Associations

Alaska's medical professionals are supported a variety of associations that can be leveraged to provide program information. The role of a Provider Association is to support their members including seeking knowledge about programs important to their membership. Providers routinely look to their professional association to provide program information that impacts their practice.
Table 5 provides a list of identified potential partnerships:

Alaska Medical Association	www.asmadocs.org
Alaska Physicians and Surgeons	www.apsdoctors.org/
Alaska Osteopathic Medicaid Association	www.nwosteo.org/AK/ or www.alaskado.org/
Alaska Medical Group Management Association	www.akmgma.org/
Alaska Chapter of the American Academy of Pediatrics	www.aapalaska.org/
Alaska State Hospital and Nursing Home Association	www.ashnha.com
Alaska Dental Association	www.akdental.org
Alaska Health Information Management Association	www.akhima.org
Alaska Primary Care Association	www.alaskapca.org
Alaska Native Tribal Health Consortium	www.anthctoday.org
Alaska Academy of Family Practice	www.alaskaafp.org/
Nurse Practitioners	https://anpa.enpnetwork.com/

Table 9: Potential Partnerships for Outreach and Marketing

I. County Medical Associations

County Medical Societies also provide an avenue for distribution of information as they meet regularly providing an opportunity for program staff to speak directly with providers and ancillary staff. It is recommended that program staff contact the Alaska Medical Association for a listing of county societies and contact information.

J. Regional Extension Center

In Alaska, the REC, Alaska eHealth Network (AeHN), provides support services for healthcare providers assisting them in the adoption of Electronic Health Records (EHRs) with the goal of helping providers achieve Meaningful Use (MU).
AeHN plays an important role in providing "boots-on-the-ground" assistance to providers in understanding, participating in and providing continued program support. As stated in AeHN's Outreach and Communication Plan:

> "Alaska, like the rest of the United States, faces challenges in addressing increasing health care costs, improving access to medical care, and ensuring and improving quality medical care for patients. Timely access to essential medical information by providers at the point of care is critical to good outcomes for the patients. The Alaska eHealth Initiative is working to address these challenges by promoting expansion of the use of Electronic Health Records by Alaska's medical providers and by establishing a statewide Electronic Health Record exchange network to support all of Alaska's health care delivery systems and to thereby provide critical information where and when it is needed."

Continued coordination will allow for an avenue of dissemination of program information while supporting statewide efforts.

K. Recommendations

The following recommendations are made to establish a working relationship and utilize the resources of these organizations in furthering program goals. It is recognized that some additional work must be done to determine the extent of collaboration and that the type of level of activity is dependent on the partner.

- Send an introductory email from Program staff explaining program purpose and provide contact information. The introductory email can explore collaboration ideas and/or specifically ask for support e.g. sending information to membership; inclusion on web, etc.
- Create a web button that will allow linkage from each Partner website to the DHHS webpage.
- Draft and submit articles for publication in newsletters (for those that publish a newsletter).
- Draft and submit text for an email campaign to be sent to the membership by the Partner. It is important this text be succinct and point the provider to more detailed program resources.
- Routinely push out information to each Partner updating on program progress and/or changes.

- Support Partner efforts as feasible by attending Association events such as annual meetings. Participation solidifies the relationship and provides a mechanism for direct contact with their memberships.
- Determine if there are local chapters by which the State and communicate with and support.

Section 8: Redesign Website

There are two websites currently in production supporting the EHR Incentive Program. Both websites provide specific and select program information serving as provider resource sites. The SLR website (http://ak.arraincentive.com) maintained by the SLR Vendor, Xerox, is standard among all states using the Xerox solution. The information contained is primarily specific to the application and the policies and procedures surrounding actual attestation. The site also contains linkage to federal resources such as the Center for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator (ONC). It is understood that the design and layout of the SLR related website is governed by a collaborative design so format and content changes are limited

The DHHS maintained website (http://dhss.alaska.gov/HIT/Pages/Default.aspx) is primarily policy specific and contains links to other Alaska Health IT initiatives such as the Health Information Exchange (AeHN).

A. Recommendations

It is recommended that the DHHS website be the principal source of provider information since it is maintained by DHHS staff and can be more readily updated with new and changing information. Conversely, it is recommended for the SLR related website that all policy related content to be linked back to the State sponsored site. This will ensure that correct and timely information is available without having to update two sites.

In reviewing the DHHS site, it is recommend that the format and content be revamped to allow providers the ability to easily, readily and quickly find relevant information. An overarching and initial change would be the inclusion of the EHR Incentive Program branding that would allow the site to be recognized as the source of information for the program.

In considering website design, information and layout must be and have:

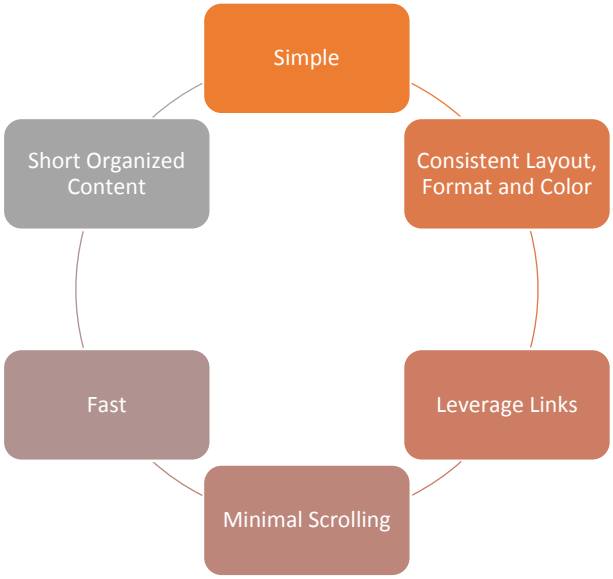


Figure 13: Website Design Considerations

When redesigning the layout and writing web copy, Alaska must keep in mind the varied needs of their stakeholders including those seeking general information, individuals trying to determine participation, active participants keeping abreast of current program requirements.
The following is a mock-up of website redesign that allows information to be laid out in such a manner that information is targeted, identifiable and easily updated to meet changing program requirements.

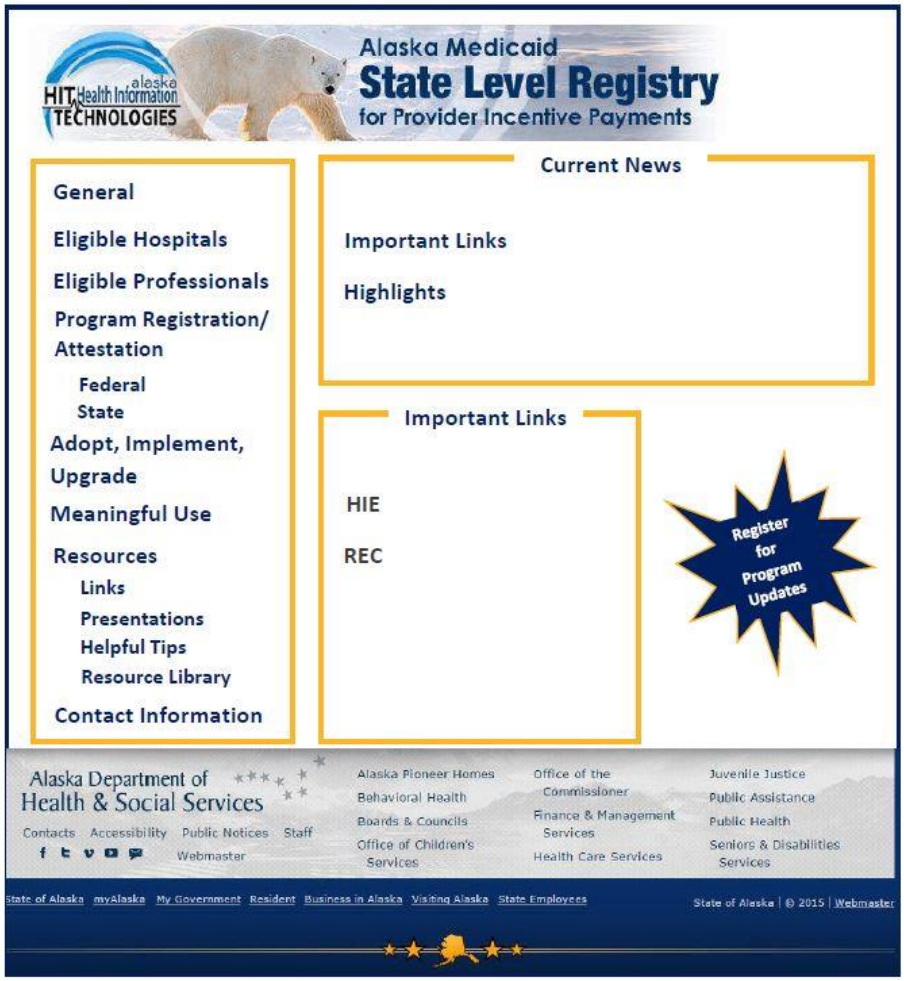


Figure 14: Website Redesign Example

B. Explanation of Website Components

- Left Side Navigation: this will allow readers to identify topics of interest. Each heading can be expanded to include specific information. Suggested headers and subheadings include:
  - General Program Information
  - Eligible Hospitals (subheadings of Eligibility and Meaningful Use Measures)
  - Eligible Professionals (subheadings of Eligibility and Meaningful Use Measures)
  - Program Registration/Attestation (subheadings of Federal and State)
  - Adopt, Implement, Upgrade
  - Meaningful Use
  - Resources (subheadings of links, presentations, tip sheets, etc)
  - Contact Information
- Current News: this should be updated regularly with current program information so that providers are encouraged to routinely visit the website. Updates could include program changes, program deadlines and/or highlight identified problem areas.

- Important Links: this should link readers to other Alaska Health IT Initiatives such as AeHN.
- Register for Program Updates: this will allow a listing to be created of interested parties so that program information can be pushed out

Information should be updated timely but at a minimum the home page should be updated monthly. Something new and catchy will encourage regular visits to the website.

Section 9: Develop Outreach Materials and Activities

Understanding and participating in the EHR Incentive Program can be a complex and time-consuming undertaking. Key components of the program can be explained through developed tip sheets, Webinar Presentations, and Frequently Asked Questions (FAQs). Program information that is clear, concise and available enables providers to access and refer to program guidance. Having developed material also allows Program staff to respond quickly to stakeholders needs.

A. Recommendations

It is recommended that a combination of materials and communication modes should be employed to reach the wide breadth of both internal and external stakeholders each with specific needs and learning styles. Outreach components should be developed building off the work done by the CMS tailored to the unique needs and focus of Alaska. Printed materials, webinars, email campaigns, social media can all be effective outreach components. The following sections highlight the recommended use of each.

Figure 15: Recommended Topics

C. Printed Material

Printed material allows stakeholders to review and retain the information for future reference. It also allows for “on demand” referral and can be easily share with others. Types of printed material should include:

1. Frequently Asked Questions (FAQs): the creation of this document can be used to highlight program policy in a short, succinct manner for reference by providers. As common topics are identified, questions can be added and revised to meet provider needs. FAQs can serve as an easy, quick reference tool for stakeholder referral. As new questions/topics are added, email notification can be used to point providers to the updated FAQs.

2. Tip sheets: The use of a tip sheet can take a complex, focused issue and break it down into a simple explanation for providers.

3. Meaningful Use Measure Chart: Though a summary repeat of the information from CMS, information about each meaningful use measure can be listed in on easy reference document. Currently the CMS Specification Sheets for Meaningful Use is structured for one measure per page, but best practices in other states indicate that providers like having a chart format for reference.

D. Webinars

An effective way to reach participants is the use of webinars that can be used to convey program information in a formatted but interactive mode. Stakeholder conversations indicated that webinars were an acceptable and even somewhat preferred form of communication. Webinars take advantage of available technology and allows for communication without the complication of scheduling and travel constraints. In addition, webinars can be recorded for "play-on-demand" needs by providers. Webinar topics can be broad in nature explaining general program policies that can be used to target potential program participants as well as specific in nature focusing on topics such as volume, meaningful use measures or changing program requirements.
It is recommended that webinars be routinely scheduled so that providers can plan accordingly and begin to realize that there is a constant and consistent source of program information. Webinar topics can be repeated and material reused as providers may need to hear program guidance repeatedly in order to gain an understanding.

E. Email Campaigns

At a minimum, monthly information should be pushed out via the listserv. In addition to appealing to a general audience or topic, emails can be tailored to fit a particular provider type, application status or location. In addition to the listserv, it is recommended that emails be pulled periodically from the SLR based on application status for outreach specific to a particular program stage.

F. MMIS Capability

In addition to the emails generated via the application process, the Agency has a Provider Alert system that allows for mass emails to be sent to even a wider range of providers. The Provider Alert system can be used to publicize events, send out updated program information and target certain provider types for program participation.
Additionally the possibility of banner messages and/or Remittance Advice (RA) messages can be explored. These messages can be short and simple n nature and point providers back to the website for information.

G. Program Newsletter

The creation and publication of a quarterly, or more frequent, newsletter can be another source of disseminating program information. The newsletter, sent via the listserv and posted to the website, can highlight program achievements, include information on the Health Information Exchange (AeHN), explain problem areas or just share information from the national perspective.

If a stand-alone newsletter is not feasible, or in addition to, information can be shared with the Provider Bulletin published by the MMIS vendor.

H. Provider Input

An initial activity to determine stakeholder needs is to conduct a simple outreach survey. Tools such as survey monkey can be used to elicit information from providers on learning modes, topics to be covered and frequency of needs. Questions to ask could include:

1. Would you attend webinars?
2. Best Time of day for webinars – morning, noon, afternoon or after 5
3. Which topics would you like covered in a webinar:
    - Meaningful Use Measures
    - Program Changes
    - General Program Overview
    - Information for Specialists
4. On which of the following program areas do you have the most questions?
    - Volume
    - Meaningful Use Measures
    - Completing the Application
5. Preferred Communication Method
    - Webinar
    - Printed

Section 10: Use of Social Media

The use of social media is becoming more prevalent in terms of reaching a large audience. Social media has been defined as a "message encouraging further action."
Social media is the collective of online communications channels dedicated to community-based input, interaction, content-sharing and collaboration social instrument of communication
DHHS currently has the following social media accounts:


4,392 followers
https://twitter.com/Alaska_DHSS


https://www.facebook.com/alaska.dhss

There are also a DHHS Vimeo and YouTube accounts established. Both of these avenues could be used to post training videos.

I. Recommendations

Program can staff can use these avenues to push out general program information as well as publicize outreach events. One focus will be to develop the number of followers on each of these sites so that a large audience can be captured. Social media icons should be included as part of presentations, tip sheets and email messages. In addition to increasing the number of subscribers, a plan for routinely pushing out information should be developed in accordance with DHHS policy. If possible, at a minimum tweets should be posted weekly. A coordinated schedule will add validity to these sites as sources of information.

Section 11: Measuring Effectiveness

The Strategy outlined does have the ability to affect provider participation through increased recognition, knowledge and presence. The decision for actual participation, either initial or continued, however is influenced by other factors such as provider perception/perspective, financial and human resource availability, practice design, practice ownership and other factors that are dictated by that moment in time.
Effectiveness of the Strategy should gauged by the process and the numbers of providers reached by each activity.

J. Recommendations

The following metrics can be used to determine if the Strategy is effective and what changes should be made to meet provider needs.

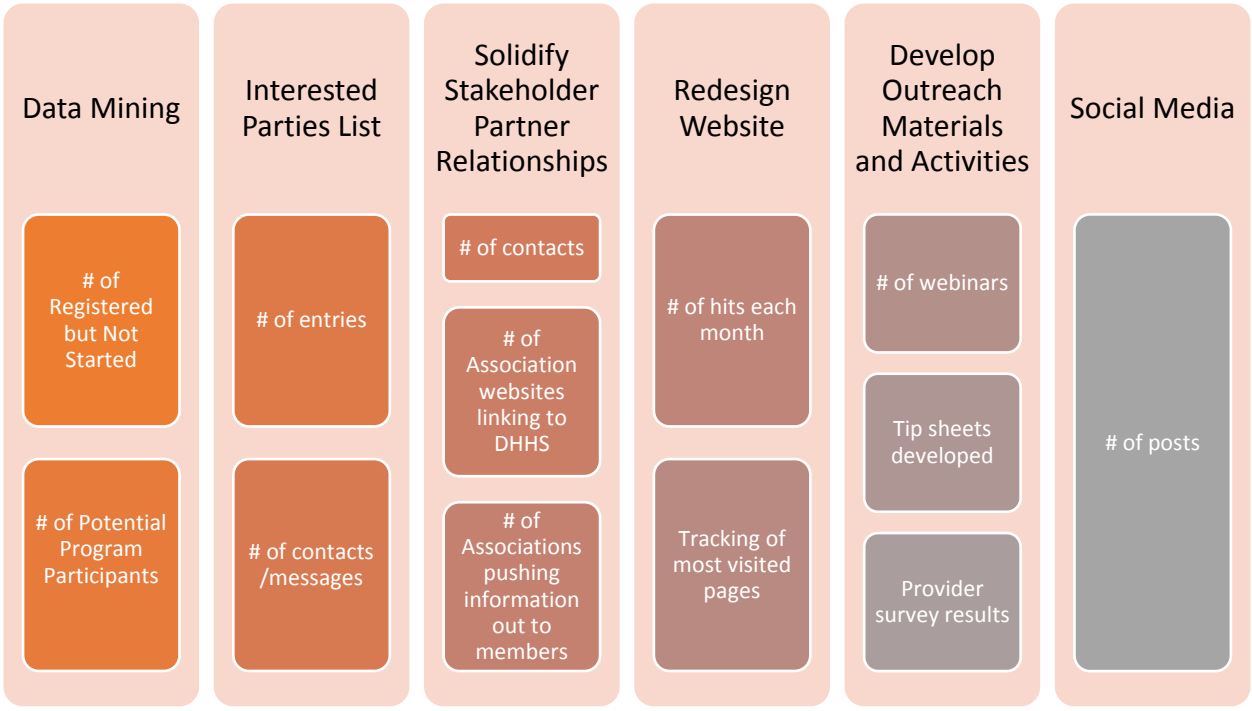


Figure 16: Metrics for Measuring Strategy Effectiveness