



STATE MEDICAID HEALTH INFORMATION TECHNOLOGY PLAN (SMHP)

**Alabama Medicaid Agency
in Partnership with Health Information Exchange
Advisory Commission**

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1. PURPOSE, SCOPE, TIME FRAME, CONTENT AND STAKEHOLDER ENGAGEMENT

1.1. PURPOSE

The Alabama State Medicaid Health Information Technology Plan (A-SMHP) provides the activities the Alabama Medicaid Agency will engage in over the next 5 years relative to implementing Section 4201 Medicaid provisions of the American Recovery and Reinvestment Act (ARRA) Alabama has provided explicit plans for the immediate (up to 18 months) activities and set the framework for the remaining time with the intention to update the A-SMHP at least annually to assure the it supports the necessary I-APDs.

1.2. SCOPE

Section 4201 of the ARRA provides 90% FFP HIT Administrative match for three activities to be done under the direction of the State Medicaid Agency (SMA):

- *Administer the incentive payments* to eligible professionals and hospitals;
- *Conduct adequate oversight of the program*, including tracking meaningful use by providers; and
- *Pursue initiatives to encourage the adoption of certified EHR technology* to promote health care quality and the exchange of health care information.

Alabama's SMHP provides the state's plan related to:

- paying the incentive payments (100% FFP), including how the state will identify eligible providers, connect to CMS's National Level Repository (NLR) for efficient and effective data flow, design, develop and implement the ASMA State Level System, and initiate the provider appeal function (90% FFP for systems and administration);
- monitoring providers (90% FFP for systems and administration), including start and stop dates of payments, tracking payments for continued retention of eligible status and appropriate audit functions; and
- making the Alabama Health Information Exchange Strategic/Operational Plan (AHIE S/OP) (submitted to ONC at the end of July) and the A-SMHP sections in the same chapters in the same book (90% FFP for systems and administration with an appropriate cost-allocation plan for the design, development,

implementation and operations that are not Medicaid related and do not serve Medicaid enrollees).

The Strategic/Operational Plan process and document and the A-SMHP are dependent on and provide opportunities for each other. They also provide an integrated, long-term sustainable effort with the State Health Information Technology (HIT) Coordinator, Kim Davis-Allen, housed in the Medicaid Agency. She has been tasked by the Governor to implement and manage the State Strategic/Operational Plan. This approach assures: the SMHP dovetails with other State-wide HIE planning initiatives; Medicaid activities are coordinated with the Regional Extension Centers (RECs); Medicaid enrollee and provider needs are addressed in the decision making process; and electronic exchange of information in a meaningful way becomes a sustainable way of operations. Alabama's extensive Medicaid population and expanded provider network has resulted in a core principle that it MUST work for Medicaid to work for all.

Appendix 8.1, which is the Alabama Health Information Exchange State Strategic/Operational Plan (AHIE S/OP) that was submitted to ONC July 2010, provides the activities the state intends to accomplish to create a state gateway to the NHIN and act as the "hub" for the exchange of information within and connecting outside the state. This plan will be funded through ONC, Medicaid, suitable state matching and other funding as appropriate.

Appendix 8.2 provides the previously completed State Medicaid MITA Self-Assessment. The A-SMHP is built off both the MITA Self-Assessment and the AHIE S/OP. The A-SMHP supports the AHIE S/OP and indicates the level that can be established at this time which of the activities will have significant funding through A-SMHP and I-APDs that will follow to develop new systems within the expanded Medicaid Management Information System (MMIS) or enhance systems that already exist within the MMIS system of systems. The end goal is to address Medicaid in context of systemic system wide changes that result in improved cost management, efficient and effective administration, and quality health care and health care delivery. This will be accomplished through incremental but important changes. As this is an evolving and developing process, other activities related to HITECH implementation will be identified and incorporated in future A-SMHP updates and I-APDS. Anticipated sources of funding include HITECH (multiple sources) as well as MMIS funding through the authority provided under CHIPRA and the Patient Protection and Affordable Care Act (PPACA).

1.3. TIME FRAME

The A-SMHP time horizon is five years with considerable more detail provided for the immediate (up to 18 months) activities. With an intense focus on providing the urgent infrastructure (human and technical) to support the first two responsibilities of the state related to meaningful use incentive payments, the Alabama State Medicaid Agency (ASMA) is actively engaging in the third responsibility as a core leader and member of the AHIE Advisory Commission. The A-SMHP provides the basis for the initial I-APD to fund the two initial activities while setting the stage for those that will follow. Because Alabama will be testing this fall and plans to “go live” the first quarter of calendar year 2011 as a volunteer Testing Group with the CMS National Level Repository (NLF), approval of funding must be authorized and awarded promptly.

Alabama intends to update the A-SMHP as necessary but at least annually with the first update expected October 2011 to match the federal fiscal year and align with the AHIE S/OP time lines and implementation. In addition, mid-year updates will be provided to assure that the A-SMHP supports the necessary I-APDs that may need to be submitted prior to an annual update.

1.4. REQUIRED vs. OPTIONAL CONTENT

The A-SMHP has addressed all appropriate required and optional questions in the following sections using the format provided by CMS to assure consistency and ease in review. In line with CMS’s State Medicaid Director letter, Alabama intends to leverage existing efforts to achieve the vision of interoperable information technology for health care, including QTool. The priorities for the state are enormous, complex and inter-dependent in a time of immense budget constraints and huge policy transformational activities, both federally mandated and optional. The A-SMHP seeks to identify and address the most immediate of the priorities without dismissing the need to begin on some of the more major efforts related to: insurance reform (Health Insurance Exchanges) impacts on MU quality measurement; mental health and public health infrastructure renovation to assure more accurate and appropriate Medicaid payment while addressing MU quality reporting; and Medicaid expansions that will bring more enrollees and providers into the Medicaid system. All of these changes will have momentous impacts on Medicaid.

As CMCS Director Cindy Mann continues to say, “2014 is now”. Alabama is listening and is seeking the funding for the infrastructure support (human and technical) to make the transition smooth and beneficial to enrollees and providers.

1.5. STAKEHOLDER ENGAGEMENT

As indicated in Appendix 8.1, AHIE S/OP, Medicaid has engaged stakeholders within and outside the State and Federal government in the development of a common vision of how Medicaid's provider incentive program will operate in concert with the larger health system and statewide efforts. With Medicaid Commissioner Carol Steckel as chair of the AHIE Advisory Commission (along with the State Public Health Director as the Vice-Chair) and Executive Sponsor for the A-SMHP, and the Medicaid Agency staffing the joint initiatives, the AHIE Advisory Commission (used for both the AHIE S/OP and the A-SMHP) was able to engage with Governor appointed leaders for providers, advocates, Regional Extension Center (RECs) and Universities engaged in HIT education.

The AHIE Advisory Commission is also the steering committee for project oversight of the A-SMHP and resulting activities. The AHIE work groups reflecting the five domains prescribed by ONC (Governance, Finance, Technical Architecture, Business and Technical Operations, Legal/Policy) provided advice and HIT oversight for the A-SMHP as well as the AHIE. To assure a patient centered focus, Alabama expanded the five work groups to include a work group specifically on Communications and Marketing (See Section 3 in Appendix 8.1 for details)

Economies of scale have resulted as key personnel overlap between efforts related to Medicaid MTG (QTool), MITA Self-Assessment (Medicaid Agency), Broadband (ADECA), and REC (University of Alabama). Coordination has also been discussed in the context of how technical assistance will be provided to health care providers, how trained professionals from workforce development programs will be utilized to support statewide HIE, and how plans to expand access to broadband will inform ongoing state planning. A special center of attention for workforce development has been the Historic Black Colleges in Alabama and the role they potentially can play.

The Environmental Scan was designed to generate the "as is" state for both the AHIE S/OP and the A-SMHP, including explicit questions related to meaningful use status and plans. Based on the data collected and multiple workgroup and Commission meeting discussions, Alabama has developed the A-SMHP with targets and measurable outcomes, as explained in the following sections. In addition, the Medicaid assessments for meaningful use and Alabama Medicaid and CHIP policy development have been at the forefront of each policy and implementation decision.

Inter-state issues have been highlighted through Alabama Medicaid's leadership in the Southeast Regional Collaboration for HIT and HIE (SERCH) through which Medicaid agencies are addressing numerous consumer and provider concerns. For instance, the states of Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North

Carolina, South Carolina, Tennessee and Virginia have completed activity grids to determine where they align in policy, approach and issues so they can move forward in a coordinated, structured way to address issues. Table 1 illustrates the type of information that has been collected and used by the SERCH states in their cross-state Medicaid efforts. Information has also been collected on types of statewide HIE being developed in the state (hybrid, federated, centralized), core services to be provided through HIE, EMR options (hosted, licensed, free or at low cost, not at all), use of State HIE as a Condition of Meaningful Use (MU), State partners and coordinated efforts, provider eligibility for MU definition and measurement, and MU Provider Enrollment Process and relationship to MMIS. In addition, information has been collected on MU reporting (including system certification and provider attestation), audit and validation of provider payments, making payments and use of MMIS as part of process, methods to ensure MU components are in place (building, procuring, endorsing), and planned or completed work on components of a system of systems for meaningful use. This would include eligibility, registries, personal health records and medication management infrastructure. All the SERCH tables are updated as additional information is obtained.

Table 1: SERCH States HIT/HIE Activity Grid

State, Website	HIE Awardee & Amount	MTG/Area Medicaid Transformation Grant	REC Awardee & Amount	CMS PAPD/IAPD and Amount
Alabama www.medicaid.alabama.gov	Ala Medicaid Agency, \$10,564,789	Yes \$7.6 -- HIT	USACHSI \$7.5 million	PAPD - \$269,000
Arkansas www.hitarkansas.com/	AR Dept of Finance and Administration , \$7,909,401	Yes \$285,513 – eligibility \$1.4 – Quality and Health Outcomes	AK Foundation for Medical Care \$7.4 million	PAPD - \$815,000
Florida www.fhin.net	Agency of Health Care Admin., \$20,738,582	Yes \$1,737,861 – eRx \$11.3 m -- CHIPRA	Health Choice Network, Inc :\$8.5 million (partial state)	P-APD \$1.69 m
Georgia	GA Dept. of Community Health,	Yes \$3,929,855 – HIT	National Center for Primary Care, Morehouse School of	P-APD \$3.17 m

State, Website	HIE Awardee & Amount	MTG/Area Medicaid Transformation Grant	REC Awardee & Amount	CMS PAPD/IAPD and Amount
	\$13,003,001		Medicine \$19.5 million	
Kentucky http://www.chfs.ky.gov/os/goehi/	Cabinet for Health and Family Services , \$9,750,000	Yes \$4,987,583 – HIT	Greater Cincinnati HealthBridge \$9,738,000 UK Research Foundation \$6,005,467	P-APD [\$2.6 m]
Louisiana	LA Health Care Quality Forum \$10,583,000			
Mississippi	State of Miss., \$10,387,000	Yes \$1,688,000 – HIT. \$1,750,700 – Fraud, Waste		
North Carolina	NC Dept of State Treasurer, \$12,950,860	Yes \$1,019,950 – Quality & Health Outcomes \$9.3 m -- CHIPRA	North Carolina Area Health Education Centers Program \$13.5 million	
South Carolina	Dept of HHS \$9,576,408			P-APD \$1.48 m
Tennessee www.tn.gov/eh/health	State of Tennessee, \$11,664,580	Yes \$674,204 – eRx	QSource \$7.25 m	P-APD \$2.7 m

In addition, Alabama has been engaged in ONC State HIE activities with a team of engaged public and private providers and stakeholders. One example is the Alabama

BCBS, which has been a strong Commission partner and engaged in both in-state and across-state discussions. In addition, Alabama continues to participate in the National Governor Association (NGA), Southern Governor Association, National Association of State Medicaid Directors/National Association of Medicaid Directors (NASMD/NAMD) and other national activities in a leadership role including the *State Level HIE Consensus Project*, *State Alliance for eHealth*, *State Health Policy Consortium*, *NASMD Multi-State Collaborative* and *AHRQ Medicaid Medical Directors Learning Network*.

The A-SMHP Landscape follows the same format as the AHIE S/OP Environmental Scan: current “*as is*” landscape assessment, a “*to be*” vision of the State’s HIT future, and a “*road map*” of specific actions necessary to implement the incentive payments program with the broader HIT “*road map*” (Section 2 of Appendix 8.1) Alabama has responded directly to each of the CMS questions related to how Alabama plans to implement the section 4201 provisions in context of the AHIE (e.g., the State Medicaid agency is the HIT Point of Contact for both the AHIE S/OP and A-SMHP as well as the subsequent implementation and operation).

2. SMHP SECTION A: ALABAMA’S “AS IS” HIT LANDSCAPE

Standard: As indicated in the survey results as presented in Section 3 of Appendix 8.1 (AS/Ops), Alabama used a multifaceted approach to its environmental scan that included the readiness of providers for meaningful use through an assessment survey of providers, interviews with State Agencies and information through informal mechanisms, including AHIE workgroup discussions. The environmental scan survey of providers was geared to gain a baseline on information needed for the AHIE and Medicaid MU.

The Alabama state IT infrastructure requirements for networking services are established through Department of Finance; however, there is not a statewide defined architecture.

Methodology: The actual environmental scan survey tool (Appendix 5.2 in Appendix 8.1) and the survey results are provided in detail in the AHIE S/OP. The survey, titled “ELECTRONIC HEALTH INFORMATION EXCHANGE AND CAPABILITY TO PARTICIPATE IN MEDICARE OR MEDICAID “MEANINGFUL USE” INCENTIVES SURVEY”, provides critical information to the Alabama Medicaid Agency (AMA) that is needed for AMA to provide financial incentives to certain providers to convert their paper records to an electronic format and begin exchanging health information electronically. The questions in the on-line environmental scan were designed to include required information such as providers’ movement toward implementation of electronic health records as well as their ability to become meaningful users of certified health information technology.

To avoid confusion and improve validity in the responses, the following definitions were provided to the providers to be used in their responses:

Electronic Health Record (EHR): An electronic record of health-related information on an individual that conforms to nationally recognized standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization.

Electronic Medical Record (EMR): An electronic record of health-related information on an individual that includes patient demographic and clinical health information, such as medical history and problem lists that is available to only one individual hospital or provider and is not shared between entities.

Process: No specific provider information from the Environmental Scan was publicly released; however, since part of the federal funding from ONC included technical assistance through the REC and Medicaid to help providers select and implement the meaningful use of electronic health records (EHRs), providers were allowed to self-

identify their practice so that, if needed, either the REC or Medicaid could follow up to assess needs as the year progresses. Since the submission of the AHIE S/OP, the state has pursued multiple approaches to gaining additional information related to provider readiness to use health information in a meaningful way.

- For instance, the Alabama Academy of Pediatrics completed a targeted survey in the largest county and was able to determine that 8 of the 28 pediatricians have EMRs.
- Surescripts also completed an analysis regarding e-prescribing that indicates that showed that from 2007 to 2009 the Alabama physicians routing prescriptions went from 330 to 1221 and the number of community pharmacies activated for e-prescribing went from 790 to 1041. In 2009, total prescriptions routed electronically in Alabama were approximately 2.2 Million with 14% of total prescriptions represented by renewal response. Using SureScripts data to determine the baseline of physician’s utilizing e-Prescribing in Alabama, the percentages of Alabama providers routing prescriptions electronically at year-end were: 5% in 2007, 9% in 2008, and 18% in 2009.ⁱ SureScript’s State Progress Report on Electronic Prescribing, indicated that Alabama had an overall blended rate of 86% for all (not just Medicaid) community pharmacies in 2009.ⁱⁱ An increase is also anticipated with the activation of an e-prescribing portal as a part of the MMIS by the end of 2011.

Goals and Tracking Progress

Activity	Current State (December 2009)	Goal (July 2011)	Goal (July 2012)	Goal (July 2013)
Eligible Professionals use of e-Prescribing	18%	25%	50%	75%
Routing of Prescriptions	7%	20%	40%	75%
Pharmacy Access	86%	To Be Determined*	To Be Determined	To Be Determined

*more research is needed to determine why the 14% are not current participating

- The Federal government’s incentive program for the meaningful use of certified EHR technology includes an optional or “menu” measure for incorporation of structured lab results into EHRs. For an EP, eligible hospital, or critical access hospital to meet Stage 1 meaningful use requirements, more than 40% of all

clinical lab tests results ordered for patients admitted to its inpatient or emergency department during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.

Alabama began the landscape assessment by identifying each laboratory operating in the state, using data collected from the Clinical Laboratory Information Act (CLIA) website and state data. Although there are over 3,700 labs in the state, Alabama Medicaid claims data indicates there are 176 laboratories actively billing for Medicaid services. Using the list of unique organizations based on license numbers, Alabama plans a survey of laboratories that seeks information on their current ability and plans to: (1) Produce and deliver structured lab results electronically, and (2) The data content and transmission standards deployed. From this baseline, Alabama also will determine the percentage of results electronically delivered. We expect to begin the survey process in December 2010 to send to labs by March 2011 in order to assure the infrastructure is in place regarding labs that is required for providers to meet meaningful use. AHIE fully plans to leverage any national work done by other states or communities of practice.

Further data analysis is needed to cross reference the list of CLIA approved labs and billing labs to determine why such a discrepancy in numbers. Issues to be considered include billing versus performing, volume in both numbers and dollars and current reporting capability.

Task	Timeframe
Data Analysis	December 2010
Identification of Targeted Providers	January 2011
Contracting/Terminology Standards	April 2011
Integrated into AHIE	July 2011

- The federal government’s incentive program for the meaningful use of certified EHR technology includes but core and menu measures for patient care summaries:
 - As part of the core measure set for Stage 1 meaningful use requirements, EPs, eligible hospitals and CAHs must perform at least one test of certified EHR technology’s capability to electronically exchange key clinical information (for example, problem list, medication list, medication

allergies, diagnostic test results), among providers of care and patient authorized entities.

- As part of the Menu Set measures for Stage 1 of meaningful use requirements, the EP, eligible hospital or CAH who transitions their patient to another setting of care or provider of care must provide a summary of care record for more than 50% of transitions of care and referrals.

Goals and Tracking Progress

Activity	Current State (October 2010)	Goal (July 2011)	Goal (July 2012)	Goal (July 2013)
Number of hospitals currently using EHR technology that is EXCHANGING information	To Be Determined by March 2011	To Be Determined	To Be Determined	To Be Determined
Number of EPs using EHR technology that is EXCHANGING information	To Be Determined by March 2011	To Be Determined	To Be Determined	To Be Determined
Number of Hospitals using certified technology	To Be Determined by March 2011	To Be Determined	To Be Determined	To Be Determined
Number of EPs using certified technology	To Be Determined by March 2011	To Be Determined	To Be Determined	To Be Determined

AHIE will track provider adoption of EHRs and Qualified Organizations' capabilities to transport summary care records.

- In the absence of a Health Information Exchange in Alabama, there is no mechanism for secure messaging and there is no provider registry that will allow provider to identify and interface with each other for purposes of meaningful use.

In addition to the initial environmental scan, AHIE conducted a follow-up telephone survey (please refer to Appendix C: Survey Results) of Medicaid-enrolled providers which produced 1,001 responses. Of those providers responding to that survey, 35% (354/1,001ⁱⁱⁱ) indicated current use of electronic

health records and thus have the potential to take advantage of secure messaging with other providers through the AHIE, when operational.

While the process for determining further detailed answers regarding providers' readiness for the Medicaid incentive program and their ability to use health information in a meaningful way continues, the state is actively working with ONC to receive final approval of the AHIE S/OPs with the intent to provide the necessary infrastructure for secure messaging and a provider registry in 2011 to assist providers meet the MU requirements. Therefore, the Alabama Medicaid is simultaneously moving forward with the information it has while expanding the state's knowledge base. While significant detail is provided from the multiple sources documented in Section 3 of the AHIE S/OP (Section 3 of Appendix 8.1), the state also contracted with Alabama State University to do a targeted telephone follow-up survey of five questions with specified providers in September 2010 to further determine level of EHR adoption and participation in the meaningful use incentive payment program.

In addition, the state is investing in an animated website where the state will provide information to providers' questions related to MU. It is the intent of the state to go back to physicians to ask them what questions they want answered related to signing up and getting incentive payments. The website, which will continue to be funded by Medicaid, will be a dissemination tool for a core set of documents as it migrates away from the Medicaid specific web to a broader site (onehealthrecord.alabama.gov); but it will also remain a vehicle for obtaining further detailed information on the "as is" state of providers. For example, as further clarification has been obtained from CMS regarding the inclusion of e-prescribing, additional and/or variations on previously requested information is desired. A mechanism for obtaining this additional information will be this website, the RECs (as indicated in the AHIE S/OP) and the next AHA national hospital survey, which will again provide Alabama specific information.

2.1. What is the current extent of EHR adoption by practitioners and by hospitals?

Information was drawn from several sources: Alabama-specific data gathered through the American Hospital Association (AHA) national survey; an Alabama initiated survey of specified providers, collection of information from subject matter experts, and data from various state associations. Details of the information are provided in Appendix 8.1.

An example of the information collected related to hospital EHR adoption is provided as a result of the 2009 AHA survey which investigated how hospitals and health systems were utilizing information/data sharing. Based on the data from the survey, the number of responding hospitals within the state that have a computerized system, which allows for electronic clinical documentation, ranged significantly. Most either had the capability

across all hospital units, or had the interest but not the resources to consider implementation. This makes resources a major consideration for the state in working with the hospital providers. Physician notes were the least likely to be captured and managed through a computerized system, while patient demographics, medication lists, lab and consultant reports, and radiology reports and images were most likely implemented across all units. To a degree this validates the viability of electronic data sources for medication lists, lab and radiology reports and patient demographics, which will be important for both AHIE and providers' access to meaningful use incentives. However, the variance between hospitals is not minimal.

The use of Computerized Provider Order Entry (CPOE) is very important when determining readiness of eligible hospitals for meaningful use incentives. The survey data relating to Alabama hospitals CPOE capability varied appreciably as well, but the vast majority indicated they were considering implementation but did not have the resources. A significant amount of hospitals indicated they did not have CPOE in place and were not considering it. Almost the opposite was true however, when it came to the responses provided relating to the use of decision support systems.

Most hospitals indicated that they either had a decision support system fully implemented across all units or they did not have the resources but were considering implementation. Almost all hospitals focused on drug related alerts with less than half having clinical guidelines fully implemented across all units.

In relation to supporting meaningful use, the information gleaned from this survey indicates that a majority of the responding hospitals' electronic systems establish a current medication list upon admission, track when the patient is in the hospital and provide the updated list upon discharge. However, when it comes to automatically extracting data from the hospital EHRs to report Hospital Alliance quality measures, most respondents indicated that they did not have that particular capability. Another requirement for meaningful use is the use of a certified EHR system and, although the regulation has only recently been related regarding a process to establish an interim certification body, the fact that about a third of the reporting hospitals are already using systems certified by the Certification Commission for Health Information Technology (CCHIT) is promising. Unfortunately the number of hospitals that said they were not certified or did not know if they were certified was split fairly equally, identifying another focus area for the Regional Extension Center (REC) in Alabama and AHIE.

Since the AHA survey was focused on hospitals in Alabama, a broader provider self-assessment was completed in May and June 2010. The survey incorporated questions that will help the state and the REC address the exchange of information in a meaningful way, including Medicare/Medicaid meaningful use related questions regarding Medicaid providers' readiness for EHR. The biggest quality issue of the

information received is the small number of respondents and the gap in types of providers that responded.

Almost 70% of the responders to the questionnaire indicated they were anticipating participating in the Medicare/Medicaid adoption incentive program. However, MU and the participation rate for a significant number of the responders will be problematic as they do not serve a sufficient number of Medicaid enrollees to qualify. Based on the information obtained through the survey, administrative activities such as insurance verifications and claims submissions are routinely performed electronically; however, e-prescribing and providing summary care information (two critical components of MU incentives and core to statewide HIE) are not currently routinely done as electronic activities. Even where Alabama providers are using computers, they are being used for filing claims, scheduling, plan inquiries, staff calendars and links to managed care plans.

For providers in the state who responded to this survey who already use EHRs, nearly 70% had their EHRs for at least two years. Most users have sought CCHIT certified systems, but those certifications were obtained prior to the new evolving yet to be defined certification requirements so it is unknown what their compliance status will be once the regulations are finalized. In addition, simply having a system does not mean it is being utilized in a meaningful way. One potential sign of usage in a meaningful way is the ability to generate reports in order to manage specialized populations. Per the responses of providers who currently use EMR/EHR, they are able to generate reports about major clinical areas for children and adults, including asthma, cancer, CPD, congestive health failure and depression. However, the caveat is that the providers who were most likely to respond are also the providers who are mostly likely already engaged in the transformation to electronic based administrative and clinical business operations.

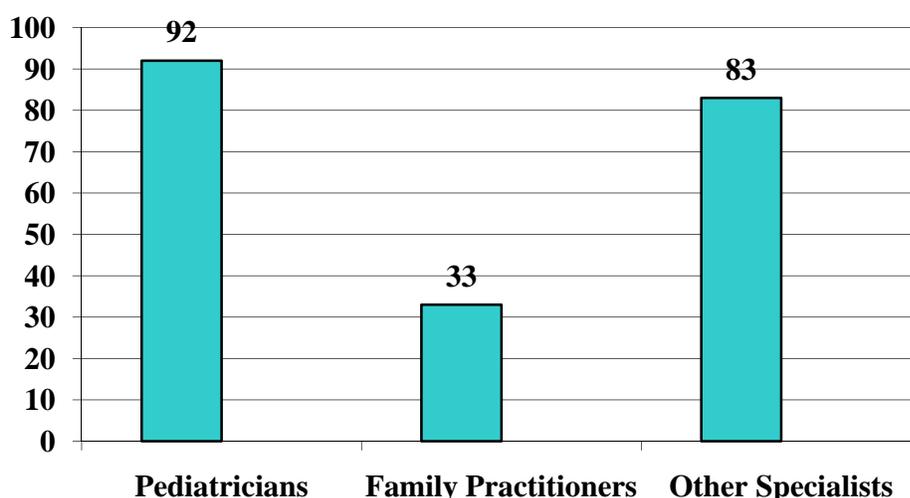
2.1.1. How recent is this data? The AHA survey was completed in 2009 and the Alabama specific hospital and provider survey was completed in 2010. Additional information has been and continues to be added as it is obtained.

2.1.2. Does it provide specificity about the types of EHRs in use by the State's providers? Although anecdotal information about types of EHRs is known, no EHR is a certified EHR based on the MU requirements, so the state chose to not request that information through the survey. It is the intent of the REC to collect and share that information with the Alabama Medicaid.

2.1.3. Is it specific to just Medicaid or an assessment of overall statewide use of EHRs? The survey was broader than Medicaid but providers were asked specifically about their "intent" related to Medicaid incentive program. In addition, the analysis provided in Section 3 of Appendix 8.1 (AHIE S/OP) directly addresses likelihood of responders to be eligible for MU incentives.

2.1.4. Does the SMA have data or estimates on eligible providers broken out by types of provider? The major responders to the Alabama specific survey were physicians (pediatricians, family and other specialists); the vast majority of them Medicaid providers. In addition, information was also obtained from FQHCs, physicians in community mental health clinics, dentists and optometrists; all who are eligible for meaningful use. Charts are included in that provide data based on type of provider.

Figure 1 Percentage of Physicians Who Qualify for Medicaid Adoptive Incentive



2.1.5. Does the SMA have data on EHR adoption by types of provider (e.g. children’s hospitals, acute care hospitals, pediatricians, nurse practitioners, etc.)? Alabama has 3 critical care hospitals: Red Bay Hospital, Washington County Infirmary and Randolph County Hospital. The state has one Children’s hospital and one women’s and children’s hospital that will qualify as children’s hospitals and has multiple acute care hospitals (all who responded to the AHA survey providing Alabama specific information). Data is also provided in Section 3 of Appendix 8.1 that separates pediatricians from other physicians but nurse practitioner data is not readily available.

2.2. To what extent does broadband internet access pose a challenge to HIT/E in the State’s rural areas? Did the State receive any broadband grants?

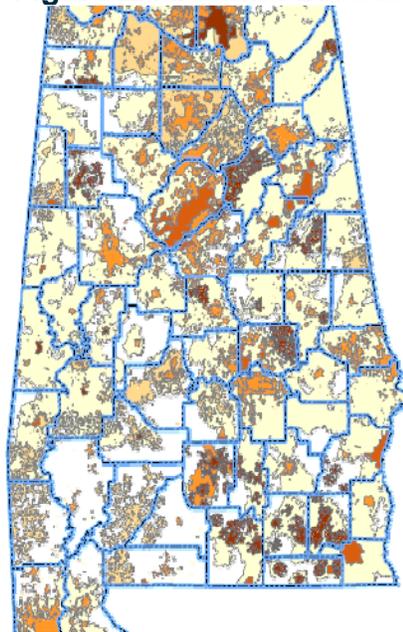
The Department of Commerce’s National Telecommunications and Information Administration (NTIA) awarded Alabama a grant to fund broadband mapping and

planning under NTIA's State Broadband Data and Development Grant Program. The award was made to the Alabama Department of Economic and Community Affairs (ADECA) for approximately \$1.4 million for broadband data collection and mapping activities over a two-year period and approximately \$463,000 for broadband planning activities over a two-year period, bringing the total grant award to almost \$1.9 million.

ConnectingAlabama is the lead Agency in Alabama for coordination of broadband activities. One of their first accomplishments was the mapping of Alabama to identify underserved areas. This type of information is valuable to the HIE Commission in determining priority needs including system design issues, beta site testing, and connectivity for clinical data issues. The work of the HIE Commission and ConnectingAlabama is closely aligned. A representative from the Alabama Medicaid Agency is being appointed to the Regional boards. Part of the purpose of the regional boards is to work within communities to create awareness of broadband capabilities which include healthcare support and demand.

Currently the initiative is working to survey existing service providers to identify and map where broadband service exists across the state – and to identify where there are under-served areas - particularly in rural Alabama. It is also working with governmental, community and industry leaders from across the state to articulate a clear vision for Alabama's broadband future and to develop (and fund) regional technology adoption and growth strategies addressing the needs of communities in all sixty-seven (67) counties

Figure 2. Alabama Broadband



Note: Broadband density indicated by colored areas

2.3. Does the State have Federally-Qualified Health Center networks that have received or are receiving HIT/EHR funding from the Health Resources Services Administration (HRSA)? Please describe.

Fifteen Alabama Health Center Grantees were awarded a total of \$13,956,035 through the Recovery Act Capital Improvement Program (CIP). These grants can be used to support construction, repair and renovation, purchase new equipment or HIT systems, and adopt and expand the use of electronic health records. The Alabama Primary Health Care Association (APHCA) that represents Federally Qualified Health Care Centers (FQHCs) throughout the state is a sitting member on the Alabama HIE Commission and serves as the co-chair of the Business and Technical Operations workgroup. This level of involvement ensures coordination between the ARRA Capital Improvements funding work of the Health Information Exchange.

In March 2009, three centers in Alabama received funds in excess of \$3.25 million to expand access. The funding will result in new primary care centers in Montgomery, Mobile and Gadsden areas. In July 2009, an additional \$13,956,035 in capital improvement grants was awarded for Alabama community health centers. The grants will help address pressing capital improvement needs in health centers, such as construction, repair, renovation, and equipment purchases, including health information technology systems.

Through the APHCA leadership, several initiatives that support Alabama's HIT vision are underway including the above mentioned capital improvement programs and EHR deployment system. FQHCs are high volume historical providers in the State. It is anticipated that linkages will occur between the FQHCs either on an individual basis or through regionalization of their efforts and the statewide AHIE system.

In June 2010, Whatley Health Services in Tuscaloosa, Alabama also received \$645,875 as part of the announced \$83.9 M in grants to help networks of health centers adopt EHRs and other HIT systems. The funds are part of the \$2 B allotted to HRSA under ARRA to expand health care services to low-income and uninsured individuals through its health center program.

2.4. Does the State have Veterans Administration or Indian Health Service clinical facilities that are operating EHRs? Please describe.

As stated in the AHIE S/OP (Section 1 of Appendix 8.1), the AHIE Advisory Commission has identified the need to outreach to VS and IHS but has not made a decision at this time regarding whether to exchange information with federal health care providers including but not limited to Veterans Affairs (VA), Department of Defense (DoD) and Indian Health Services (IHS) in the initial implementation phase.

Alabama Medicaid has had a long standing working relationship with the Native American Nations in Alabama. The health care delivery system is an IHS system rather than tribal managed so efforts will continue to be coordinated with and build off the IHS initiatives. Future plans to incorporate connectivity to such federal entities require that they must sign an agreement with NHIN in order to be able to exchange data with federal agencies; therefore AHIE is designing the Alabama agreements to align with DURSA. Plans are to pursue agreements with the federal agencies, starting with CMS for Medicare, during the implementation phase.

Alabama has a traditional working relationship with the Poarch Band of Creek Indians located in southwest Alabama. This tribe is a historical Medicaid provider enrolled as an FQHC and as a medical home provider. The State will ensure that tribal leaders are aware of HIT activities and coordination will ensure that tribal members are included in exchange planning.

2.5. What stakeholders are engaged in any existing HIT/E activities and how would the extent of their involvement be characterized?

A core principle for Alabama has been throughout the AHIE S/OP and A-SMHP has been the engagement of a broad set of stakeholders as indicated in the AHIE S/OP (Appendix 8.1). The state has sought to gain buy-in from stakeholders and the community by operating in a transparent way that built off the involvement of providers, consumers, payers and purchasers, public and private. This process was used in the MTG and has proven to be a successful tool as evidenced by the development and implementation of QTool.

The Alabama Advisory Commission launched workgroups charged with supporting the development and implementation of the AHIE S/OP and A-SMHP. In addition to enabling broader participation by interested stakeholders, the workgroup structure enabled specific expertise to be focused and engaged in addressing issues and overcoming barriers to HIE and MU in Alabama.

As documented in the Environmental Scan, the engagement of all stakeholders, including educational institutions, was extensive, explicit and ongoing as it will continue to be going forward. A mindful effort was put forth to engage stakeholders external to the state as well as internal. One such example as further explained in Section 3 of Appendix 8.1 is the coordination efforts through Alabama Medicaid with other states in the southeast region (SERCH). SERCH has been instrumental in bringing key issues to the forefront so that Alabama is addressing issues across state borders versus in a singular approach

2.6. Does the SMA have HIT/E relationships with other entities? If so, what is the nature (governance, fiscal, geographic scope, etc) of these activities?

Governance: AMA staffs the Statewide AHIE Advisory Commission, along with its workgroups for the Five Domains plus One, and will provide the staff support to the AHIE. The State HIT Coordinator and staff, as state employees, will administratively report to the Governor through the Medicaid Agency but will functionally report directly to the Advisory Commission. The Advisory Commission plans to create an initial set of exchange rules for the AHIE, Health Information Organizations (HIOs) within the state and individual entities connecting with the statewide exchange. It is the intent of the state to abide by and harmonize with the rules being established through the ONC certification requirements, NHIN certifications and standards, CMS meaningful use (MU) specifications and/or existing regulations (e.g., HIPAA). Enforcement of the rules will become the responsibility of an existing regulatory authority (e.g. Department of Public Health). The governance model can be found in Figure 2 in Appendix 8.1.

Finance: As the AHIE is part of the AMA, Medicaid funding is an integral part of the financing mechanism for the AHIE. The AHIE S/OP provides detailed information related to the budget and the inter-connectivity but separation of the Medicaid and ONC funding. The Alabama HIT Office, will implement financial policies, procedures and controls to maintain compliance with generally accepted accounting principles and all relevant OMB circulars.

The Finance activities and approaches to activities for FFY 2010 through FFY 2013 and how they relate to Medicaid are provided in the Table 5 in Section 2.5.2 of Appendix 8.1. The proposed overall four year summary financial budget and annual budgets are provided in Tables 8-12 in Section 2.5.2 of the appendix, but will be adjusted as the state moves from planning to actual execution and results of procurements and implementation activities defined.

In addition to coordination within the state through the AHIE, AMA is aligning its efforts with other states in the southeast region. Through the Southeast Regional Collaboration for HIT and HIE (SERCH), comprised of 11 states (Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee and Virginia), Alabama is looking for ways to leverage resources on areas such as consent models, DURSAs, collective bargaining for contracted services such as medication management, lab interfaces and the general sharing of knowledge. SERCH has been instrumental in bringing key issues to the forefront so that Alabama is addressing issues across state borders versus in a singular approach.

Technical Infrastructure: The AHIE, which is part of the MMIS system of systems, is envisioned as the gateway for individual or group entities (primary providers, pharmacies, EMTs, hospitals, clinics, organized health systems, payers, consumers for Personal Health Records (PHRs) and government institutions), within the state to connect with other state HIEs and Medicaid agencies, federal agencies, and the NHIN. The AHIE model, which is built off the NHIN model, is provided in Figure 3 in the AHIE S/OP.

Core clinical functional service components of the AHIE are needed in order to assist providers in meeting the MU requirements including: laboratory ordering and results delivery: electronic prescribing, and clinical information exchange.

Technical and Business Operations: The initial focus of the AHIE Business and Technical Operations workgroup centered on what is needed to support providers in obtaining and retaining meaningful use incentives and how the state can carry out oversight, while assuring adequate payment with limited additional burden on providers.

A major cross-cutting area led by the Business and Technical Operations Workgroup was the coordination with Medicaid and the State Medicaid HIT Plan (SMHP). Since

the Alabama Medicaid Agency is the lead agency for the Advisory Commission and is the support infrastructure for the Strategic/ Operational Planning process, coordination with the SMHP and the environmental scan required for both the SMHP and the HIE Strategic Plan was smooth and uneventful. While CMS and ONC have stated that the State Strategic/Operational Plan and the SMHP are “chapters in the same book,” Alabama has treated them as sections in the same chapters assuring that each activity, operational concept and policy is reviewed from both vantage points. This approach has increased the viability of successful and meaningful exchange and use of health information for the delivery of care, consumer engagement and state/federal oversight. With the State Medicaid Commissioner the Chair of the Advisory Commission, the possibility of the content in the HIE Strategic/ Operational Plans not addressing the needs of the Medicaid population and providers became a non-issue. All Medicaid required sign-off was accomplished as part of the formal Strategic/Operational Plan development process.

Policy and Legal: In order to identify and determine whether the Alabama laws or standards conflict with one another, conflict with federal law or regulations or create a barrier to MU, the state has been working with other state policies, including conducting a survey of Alabama’s border states (FL, GA, MS and TN) to determine where common ground exists and to identify where Alabama policy changes may need to be pursued.

The Communications and Marketing : The workgroup developed a comprehensive Communication and Marketing plan to address core messaging audiences that were identified, including but not limited to hospitals, physicians, laboratory/x-ray entities, pharmacies, providers of ancillary services, other providers, rural health clinics, patients/consumers, payers, purchasers, state agencies, health professional school, general public and the federal and state government. The core messages developed through audience specific research are included in Section 3.2.6 of Appendix 8.1.

2.7. Specifically, if there are health information exchange organizations in the State, what is their governance structure and is the SMA involved? ** How extensive is their geographic reach and scope of participation?

In close alignment with the SMHP, the Advisory Commission’s strategy was to provide AHIE as a patient-centered HIE by leveraging the capacity already developed by integrated and/or large health care systems, regional/sub-regional HIOs, and community based entities and providers to connect health care providers to improve the quality and efficiency of health care in Alabama. AHIE must also provide direct connectivity to those providers not part of a health system or regional HIO. Further, AHIE will support public health and vital statistics data needs. *“Governance of the AHIE*

is described in Appendix 8.1, Section 2.5 of the A-HIE S/OP. In addition, Figure 6 in Section 3.4 of the SMHP reflects the governance structure.

2.8. Please describe the role of the MMIS in the SMA's current HIT/E environment. Has the State coordinated their HIT Plan with their MITA transition plans and if so, briefly describe how.

Alabama completed the state's MITA Self-Assessment in December 2009 and submitted it in February 2010. The state has traditionally equated MMIS to the claims processing (Fiscal Agent HP) and decision support systems, but has moved to the expanded MMIS terminology including all the systems that support Medicaid provider and enrollee activities, including the evolution of the current eligibility system which is run in-house at this time. The claims processing system will connect to the Alabama HIE, but they are both parts of the MMIS (see "To Be"). The claims processing system will also connect to the eligibility system, which is also envisioned as being a part of the MMIS. Eligibility is completed by state employees so there is no county enrollment/eligibility system.

Alabama completed the state's MITA Self-Assessment through a contract with Fox, Inc. Submitted February 2010; other state agencies were involved in the MITA Self-Assessment. The state completed the MITA Self-Assessment prior to the engagement of the state in the AHIE S/OP and A-SMHP. The involvement of CHIP was limited to interfaces. Alabama intends to amend the MITA Self-Assessment to address MU. The ASMA has governance for updating the MITA Self-Assessment that includes a quarterly meeting process with the eight separate business areas. All amendments to the MITA Self-Assessment will be reviewed through this process before submission to CMS.

Two separate APDs have been submitted: one for procurement of the new claims processing system (claims management) and one for a revised recipient subsystem (member management). Planning stages have already begun (IV & V APD already submitted to CMS) for the expanded recipient system. In addition, Alabama is in the process of addressing 5010 and ICD-10 with the intent to meet federal implementation requirements of January 2012 for 5010 and October 2013 for ICD-10. Alabama's P-APD for ICD-10 has been approved, but the I-APD has not been submitted.

Reporting requirements for ARRA and ongoing Medicaid are through the current financial reporting systems and are compliant with all federal requirements. This will not change in the "To Be" environment.

2.9. What State activities are currently underway or in the planning phase to facilitate HIE and EHR adoption? What role does the

SMA play? Who else is currently involved? For example, how are the regional extension centers (RECs) assisting Medicaid eligible providers to implement EHR systems and achieve meaningful use?

ARRA offers an unprecedented opportunity for Alabama to make giant steps forward in adoption of electronic HIT. With federal incentive money potentially available later this year for Medicaid providers who can demonstrate “meaningful use” of electronic health records (EHRs), Alabama Medicaid is simultaneously working on its State Medicaid HIT Plan (SMHP) and appropriate I-APD related to Medicaid’s three direct responsibilities under ARRA HITECH. The state is working diligently to address both the readiness of providers to exchange information and the readiness of providers to use IT in a meaningful way so that Alabama providers can access the full meaningful use incentive payments and avoid any potential future penalties.

The capacity to host an EMR was considered but the decision was made that the HIE should not host such a solution itself. The HIE will work with the REC to provide a hosted solution without significant cost to enhance the potential for some smaller providers to benefit from meaningful use incentives. Details on the various activities are provided in the AHIE S/OP. The state is working with the REC, which will provide to its priority providers one interface at no cost, to determine the feasibility of providing connectivity to the A-HIE proposed provider registry and secure messaging to facilitate provider’s ability to meet MU requirements.

In addition, ASMA is pursuing a reimbursement strategy linking the state’s medical home strategy with MU as an additional incentive for providers to serve Medicaid enrollees and potentially improve their population percentages; thus increasing the likelihood that they will meet the population percentage criteria. As indicated in the “Dear State Medicaid Director Letter”, Alabama intends to design a well-defined, developmental and time limited project with the specific goal of enabling eligible Medicaid providers who qualify or who potentially could qualify with a small increase in Medicaid population to achieve meaningful use of certified EHR technology.

Beginning April 1, 2011, Alabama will implement an enhanced Primary Care Case Management (PCCM) program, building upon the existing infrastructure by establishing regional networks within local systems of care designed to achieve long-term quality, cost, access, and utilization objectives in the management of care for Medicaid recipients. Alabama will continue to operate the original PCCM program; however, primary care providers in select areas of the state will become members of a regional network. All primary care providers are paid fee for service. Initially the regional networks will be in pilot counties covering approximately 60,000 patients. Each network will have an administrative entity that contracts with the state. Both the networks and the primary care providers are paid a per member per month (pmpm) payment.

The networks will provide population health management by furnishing preventive services and information; systematic data analysis to target recipients and providers for outreach, education, and intervention; monitoring system access to care, services, and treatment including linkage to a medical home; monitoring and building provider capacity; monitoring quality and effectiveness of interventions to the population; supporting the medical home through education and outreach to recipients and providers, and facilitating quality improvement activities that educate, support, and monitor providers regarding evidence based care for best practice/National Standards of Care.

Networks will provide disease management through advocating for high risk, high acuity recipients to ensure that recipients receive appropriate evidence based care and educating recipients about disease states and self management. Population management, disease management and medical coordination of treatment and prevention will be provided to recipients enrolled with a network provider.

Networks and providers will receive increases in the pm/pm for subsets of populations that are high risk; high acuity, high cost, and may have complex co-morbid conditions so that enhanced care management services can be provided. In addition to the services stated above, enhanced services include but are not limited to comprehensive and integrated package of high risk screening/assessment, triage, and referral, hospital transitions, pharmacy review, medication reconciliation, inpatient and ED diversion with care management across the continuum of care. Alabama intends to submit a State Plan Amendment to address Medicaid reimbursement and will work with CMS to determine if an I-APD will be needed to support the reimbursement enhancement.

The state is also considering options to engage pharmacies, including reimbursement methodologies, because the role of pharmacies in the successful operation of e-prescribing is significant.

2.10. Explain the SMA's relationship to the State HIT Coordinator and how the activities planned under the ONC-funded HIE cooperative agreement and the Regional Extension Centers (and Local Extension Centers, if applicable) would help support the administration of the EHR Incentive Program.

Continued coordination with Medicaid and ONC various grant and cooperative agreements has been a core principal of Alabama's efforts. Key personnel overlap between efforts related to Medicaid MTG (QTool), MITA Self-Assessment (Medicaid Agency), Broadband (ADECA), and REC (University of Alabama). Coordination has also been discussed in the context of how technical assistance will be provided to

health care providers, how trained professionals from workforce development programs will be utilized to support statewide HIE, and how plans to expand access to broadband will inform ongoing state planning.

The Alabama HIT Office will be responsible for the daily operation of the AHIE as well as implementing the strategic and business plans outlined by the Advisory Commission initially and then the Operating Commission at the appropriate time. The State HIT Coordinator will direct the HIT Office. The State HIT Coordinator and staff, as state employees and contracted staff, will administratively report to the Governor but will functionally report directly to the Commission. The placement of this position maximizes resources in that this person will be responsible for coordinating statewide efforts as well as overseeing operation of the exchange.

The HIT Office will oversee day-to-day operations of the AHIE through the management of the sub-divisions of Administration, HIE Operations, and Meaningful Use. The Administration sub-division will be responsible for the management of the HIE describing the financing and sustainability, marketing and communication, and reporting. The Operations sub-division will be responsible for management of the HIE including compliance of technology, operating standards, contractual oversight of the exchange, connectivity needs and coordination and oversight of other state agencies e-Health activities. The Meaningful Use sub-division will be responsible for the development, implementation and coordination of the meaningful use program and will coordinate outreach activities to educate provider regarding the program. The Alabama HIT Office will also be responsible for coordinating the Alabama HIE alignment with NHIN. It is anticipated that the HIT Office in handling its responsibilities for compliance of technical/operating standards including privacy/security issues will seek to mirror federal requirements.

The HIT Coordinator will work to solicit cooperation among state community stakeholders, state agencies, and federal partners as providers migrate to HIE connectivity. The Key Staff and roles are provided on Table 6 in Appendix 8.1

2.11. What other activities does the SMA currently have underway that will likely influence the direction of the EHR Incentive Program over the next five years?

Per the P-HIT-APD, all the planning activities required to timely and effectively implement the MU infrastructure, including connectivity to the NLR, design, development and implementation of the State Level Soystem, enhancing the claims processing and provider tracking systems capability, adding a provider appeals capability, and outreach to providers.

2.12. Have there been any recent changes (of a significant degree) to State laws or regulations that might affect the implementation of the EHR Incentive Program? Please describe.

No. The AHIE Legal and Policy workgroup is in the process of sourcing and analyzing legal information related to privacy and security, interoperability, Medicare and Medicaid, and the development of relevant policies and procedures. Key areas of research include identification and determination whether the Alabama laws or standards conflict with one another, conflict with federal law or regulations or hinder the mission of Alabama's HIE; understanding of other state policies regarding HIE, including conducting a survey of Alabama's border states (FL, GA, MS and TN) to determine where common ground exists and to identify where Alabama policy changes may need to be pursued.

The necessary tasks related to legislative requirements, privacy and security, exchanges with other states, policies and procedures, oversight and risk mitigation that the state will complete as well as the timeframe and responsible entities are provided in Table 13 and Table 14 in Section 2.5.6 of Appendix 8.1.

2.13. Are there any HIT/E activities that cross State borders? Is there significant crossing of State lines for accessing health care services by Medicaid beneficiaries? Please describe.

Alabama Medicaid is a key participant in Southeast Regional Collaboration for HIT and HIE (SERCH). Through SERCH, 11 states (Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee and Virginia) are looking for ways to leverage resources on areas such as consent models, DURSA, collective bargaining for contracted services such as lab interfaces and the general sharing of knowledge. SERCH has been instrumental in bringing key issues to the forefront so that states are addressing issues across state borders versus a soloed approach. SERCH states met face-to-face on May 26, 2010 and established a priority list for their coordinated activities. As a result of the meeting in which over 80 attended including federal partners, the following have been identified as priority areas: lab exchange, implementation of the MU incentive program, patient consent policies and common privacy policies and procedures. SERCH meets on a weekly basis as a forum for sharing ideas, knowledge and resources. A key topic is discussed with a state taking the lead each week. Participants include HIT Coordinators, REC project managers, Medicaid staff and other state representatives including Governor Office representatives

In order to improve both state and national coordination, Alabama participates in the National Governors Association (NGA), Southern Governors Association and the National Association for State Medicaid Directors/National Association for Medicaid Directors (NASMD/NAMD) and other national activities in a leadership role, including the following:

- *State Level HIE Consensus Project:* Advisory Commission Chair, Carol Steckel, the HIT Coordinator, Margaret McKenzie, along with other members of the AHIE Advisory Commission have participated in national meetings sponsored by ONC to gain knowledge from ONC and other states in the areas of governance, finance, business operations, monitoring and remediation, and financial sustainability. Participants from the Advisory Commission have accessed webinars.
- *State Alliance for eHealth:* Advisory Commission Chair, Carol Steckel is a member of the State Alliance for e-Health and has played a key role in the discussion of the Medicaid and operational parameters that impacts Alabama and all states working with staff of the NGA Center for Best Practices that support the e-Alliance.
- *State Health Policy Consortium:* Privacy and security are significant consumer and provider perceived issues and have the potential to de-rail EHR implementation. Alabama has participated in the HISPC effort; however, there is no Alabama state HISPC report to build off of. Alabama is participating in ongoing RTI sponsored webinars and educational opportunities, as well as workgroups, to continue to address privacy and security issues.
- *NASMD Multi-State Collaborative:* Advisory Commission Chair Carol Steckel is Chair of the NASMD Multi-State Collaborative, which was initiated in response to state Medicaid agencies seeking to work across state lines on MTG HIT initiatives. Through web-based learning opportunities, these states continue to work with CMS, HRSA, AHRQ, ONC to efficiently and effectively address activities from a Medicaid perspective related to the exchange of health information and meaningful use of certified EHRs.
- *AHRQ Medicaid Medical Directors Learning Network:* Alabama's Medicaid Medical Directors, Dr. Robert Moon and Dr. Mary McIntyre, both AHIE workgroup members, are active participants in the national learning network which provides a forum for clinical leaders of the State Medicaid programs to discuss their most pressing needs as policymakers and to help them find and use relevant AHRQ products and related evidence to address these concerns. The focus of their meeting in Arizona in April was the role of Medicaid in the State Strategic/Operational Plans. Dr. Moon facilitated the discussion.

2.14. What is the current interoperability status of the State Immunization registry and Public Health Surveillance reporting database(s)?

The Department of Public Health has been instrumental in ensuring that the information provided through the AHIE is comprehensive and meets provider needs in making clinical decisions. Areas of coordination include the immunization registry, disease surveillance and reporting and integration of their clinical data into the exchange.

DPH runs the county health departments in 65 of the 67 counties in Alabama. These local agencies have pieces of EMRs but not complete ones. (The two counties that operate independently, Jefferson and Mobile, do have EMRs). DPH is looking for assistance to adopt EMRs and EHRs and hopes that the development of AHIE and meaningful use activities will provide the support needed. The local agencies concentrate on the care provided in a few areas including case management, family planning, WIC, and home health. Statewide DPH provides 215,000 family planning visits per year, 400,000 homecare visits per year, and 1.3 million hours of EDW/Lifecare services per year. ADPH is the largest Medicaid Home Health Agency in the state. DPH provides almost no primary care outside of Jefferson and Mobile counties.

DPH's interest in development of the AHIE is to improve quality and reduce costs. DPH also believes the AHIE would greatly improve its disease surveillance capacity. In addition, the Department runs a large clinical laboratory that processes specimens for newborn screening, disease control activities, family planning and other public health needs. In addition, it is well on its way to having a modern laboratory information system through SMHP efforts. The state envisions this becoming a part of the AHIE, which would greatly assist epidemiological studies.

DPH also maintains a claims-based, immunization registry that is on-line and was recently upgraded. This immunization registry could interface with the new AHIE. Enhancements to the immunization registry may be pursued under the SMHP to give an additional consumer view to the data. DPH also participates in case management systems with the Medicaid Agency. There is strong evidence that women who receive case management services while participating in a family planning program are less likely to have an unplanned pregnancy. The case management system needs to be integrated into the AHIE to gain the full benefit of the program.

Other HIT efforts identified by DPH with state HIE strategy and operational as well as Medicaid State HIT planning implications include the need for a hybrid solution for integration and interoperability of Alabama Public Health Systems that has all the characteristics of AHIE and could possibly be a gateway to the AHIE; an upgrade of the

web based immunization system to allow for real time bi-directional exchange of data on Service Oriented Architecture; connectivity to AHIE of their case management system, ACORN; updating the technical architecture of their clinical system, PHALCON, and integration of their multiple isolated systems.

As DPH is responsible for the Laboratory Information Management System for Alabama, the coordination with the Epidemiology and Laboratory Capacity Cooperative Agreement Program (CDC) will be managed through the Department's representation on the AHIE. As HIT infrastructure support is part of both their HIV-AIDS and the Elderly and Disabled Medicaid Home and Community Waiver information system roles, the Department will also engage as appropriate in the coordination with the Assistance for Integrating the Long-Term Care Population into State Grants to Promote Health IT Implementation (CMS/ASPE) and the HIV Care Grant Program Part B States/Territories Formula and Supplemental Awards/AIDS Drug Assistance Program Formula and Supplemental Awards (HRSA).

2.15. If the State was awarded an HIT-related grant, such as a Transformation Grant or a CHIPRA HIT grant, please include a brief description.

The goals of the Alabama Medicaid Transformation Grant were to change the way Medicaid does business by simplifying provider access and use of information at the point of care. This has been achieved by developing a real-time, claims-based electronic health record for provider use to improve patient health outcomes and create a system that allows state agencies and providers to share information electronically to improve patient health and control costs. A clinical support tool using care management data has also been developed to enable providers to improve care choices and better manage their patients, especially those with chronic illnesses.

Figure 3 TFQ Pilot Counties



QTool is being offered, still at no cost, to all Alabama providers. QTool is viewed as a learning tool to help providers gauge the impact electronic medical records can have on a practice, including workflow issues. There are currently 189 web based locations representing over 500 users with an additional 106 users that are directly interfaced through the provider's existing EMR system. Alabama does not anticipate seeking certification for QTool. QTool is not a full-fledged EMR in that it does not contain core elements such as the ability to document clinical services. The State plans on offering QTool through the end of September 30, 2011. This timeframe anticipates a transitional period for providers to obtain certified EMR/EHR technology that can be used towards achieving MU. Outreach will continue to providers with a clear delineation of the availability of the QTool timeframe. Since it is a web-based, free application there is not a cost to the provider for implementation, so even short term implementation can be worthwhile. QTool will be a learning tool for both providers and the State in moving towards certified systems and the achievement of meaningful use.

QTool through its current interoperability with existing systems supports Alabama vision for a statewide Health Information Exchange. Due to Alabama contracting laws, the State cannot "leverage" in a traditional sense the work to date by just continuing the existing contracts. The State can, however, use existing relationships, interfaces and

most importantly, lessons learned for a successful implementation of a more comprehensive exchange. To facilitate the transition, the original stakeholders for the development and implementation of QTool are many of the same individuals working on our Alabama Health Information Exchange Advisory (A-HIE) Commission and workgroups. This knowledge base has allowed the State to move quickly through the decision making process. All involved see QTool and the subsequent comprehensive exchange as a means to helping providers begin the process of meaningfully using health information technology.

The state has built on, and benefited from, the years of work of the state and stakeholders under the Medicaid Transformation Grant (MTG). The credibility established related to transparency, stakeholder engagement, patient involvement and resource commitment through the MTG process and outcomes have allowed the participants to build trust in each other and the process to move into uncharted territory. In addition, key personnel overlap between efforts related to Medicaid MTG (QTool), MITA Self-Assessment (Medicaid Agency) and AHIE.

3. SMHP SECTION B: ALABAMA'S "TO BE" LANDSCAPE

- 3.1. Looking forward to the next five years, what specific HIT/E goals and objectives does the SMA expect to achieve? Be as specific as possible; e.g., the percentage of eligible providers adopting and meaningfully using certified EHR technology, the extent of access to HIE, etc.

"To Be" Future State of Statewide HIE: The AHIE Advisory Commission's approach is to provide a valuable information exchange that will be easy to navigate and timely in its response to queries in order to encourage voluntary participation. The AHIE Technical Workgroup acknowledges that a critical access hospital and small physician groups may require integration from scratch with AHIE acting as the HIE platform while other entities will provide NHIN messaging capabilities and C32 CCD exchange. Institutional connections (nodes) will vary with at least one hospital system using its own HIO for CCDs, e-prescribing, lab orders/results via NHIN gateway or similarly specified protocols.

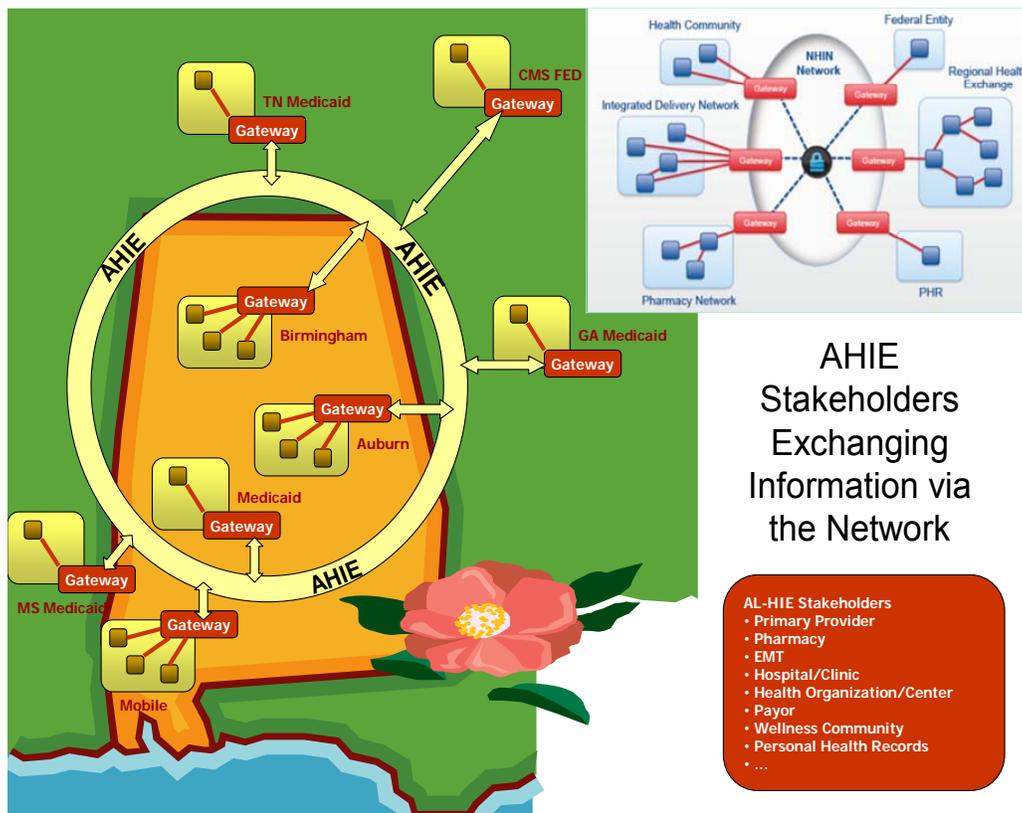
Building off the NHIN model, the AHIE is envisioned as the gateway for individual or group entities (primary providers, pharmacies, EMTs, hospitals, clinics, organized health systems, payers, consumers for Personal Health Records (PHRs) and government institutions), within the state to connect with other state HIEs and Medicaid agencies, federal agencies, and the NHIN. Since there is no established mechanism today for providers to identify and communicate clinical information in a secure manner between them, the baseline for this component is zero. Once the capability exists, the goal is to get providers to use it. Consistent with the other components, the state will initially seek to increase by 25% each year the first two years. If the metrics is not met, the state will look at ways to increase participation or consider other alternatives by year two in order to prevent barriers to providers reaching meaningful use.

In order to minimize the number of queries, which should be speedy, performed by a user of the system and assure the data is standardized, timely, high quality and assembled into an integrated record across episodes of care, the AHIE will abide by the ONC transport and content standards (technical, semantic and process). For example, transport of data to and from electronic destinations will require the use of general industry recognized transport types (e.g., Internet Protocol Version 6) and authorized recipients' technical capability (e.g., EHR, fax, or printer). Standards will support various statewide HIE services, privacy and security policies (e.g., patient consent or special procedures for sensitive information), and connection to the Nationwide Health Information Network (NHIN). The statewide HIE will be built on NHIN Connect and

NHIN Direct standards to enable both intra- and inter-state health information exchanges. Participants of the statewide HIE, generally through their associated health IT vendor(s), are expected to adhere to the national standards as they are finalized by ONC.

The AHIE model follows in Figure 4. (Figure 3 in the AHIE S/OP in Appendix 8.1)

Figure 4 AHIE Exchanging Information



“To Be” Future State of MU Identification, Validation, Payment, Audit and Appeals HIT: To improve the continuity of data/information, relationships and management through efficient, effective and interoperable IT technical infrastructure and business and technical business operations, Alabama has determined to contract with an outside vendor for the Medicaid EHR Incentive Program at the state level. A web-based approach will provide a system to capture and track provider application, evaluate eligibility, and collect attestations, in order to make timely incentive payments to qualifying providers (EPs and EHs) for the adoption, implementation or upgrade of certified EHR-systems. The system will be built to interface with the NLR) as well as capture and document appeal decisions.

3.2. What will the SMA’s IT system architecture (potentially including the MMIS) look like in five years to support achieving the SMA’s long term goals and objectives? Internet portals? Enterprise Service Bus? Master Patient Index? Record Locator Service?

“To Be” Future State of Statewide HIE to Support the Exchange of Information for Meaningful Use: The technical functionality, required to support the meaningful use of information by Medicaid and Medicare Incentive Program providers, will be available through the AHIE, which is provided below. While the functionality is created for and supports MU providers, the technical infrastructure will exist for use for other Medicaid providers and other public and private providers as needed. The following table provides the technical infrastructure and core functions as updated to clarify the core functionality to assure providers in Alabama can be successful in meeting meaningful use. This table was updated to support ONCs vision as to how the Exchange can support meaningful use.

Table 2: AHIE Technical Functionality
Core HIE Services: Phase I
<p>Provider Registry/Directory: The proposed design calls for a centralized provider registry that will allow providers to register into an account, update, and interface with other providers through a secure web-interface. The provider directory capability will include information from one or more sources that will have the ability to identify provider (individuals or organizations), The directory will include specific levels of security, including authentication and access controls and necessary firewalls. The provider directory and secure web-based service will include both technical functionality and administrative functionality. The provider directory creates a webservice for providers to log in or to interface with through their EHR. Through this web service, which will be based on NHIN standards and protocols. Each provider will have an account interfaced with a robust provider directory that enables secure, authenticated messaging. This service will allow providers to exchange basic health information through direct messaging or email attachments. The provider directory will be populated with information from Medicaid, Blue Cross and Licensure (both as a source of information and as a checkpoint). The provider directory will update per provider “hit” with the most current e-mail from the initiator who has logged in through his/her account.</p> <p>The administrative functionality will include and support the establishment and management of the provider “account”, communication and coordination with Regional Extension Center (REC) to educate providers on how to fully utilize the state’s web service, and assuring the Medicaid “meaningful use” providers the mechanism needed to receive the appropriate incentives. The web service will include administrative and technical validation of the eligibility of the provider to participate [authentication], validation of their status as a provider [data sources to include: Medicaid, BCBS, and licensure boards], and agreement to comply with the</p>

Table 2: AHIE Technical Functionality

privacy and security rules of engagement through an agreement that aligns with the national DURSA agreement.

Secure Messaging: Using the other core functionalities including role based access and management, message and data validation, privacy and security (encryption and signed data user agreement-DURSA), monitoring and auditing, secure messaging will be provided.

System Administration: Standard administration services such as user provisioning, security and access control,

Privacy: The system should support the privacy of protected health information according to HIPAA, relevant state laws and applicable policies, including how system protects, enables and enforces patient privacy both the controls and any procedures to protect patient protected health information.

Security: Support for the “Four A’s”: authentication, authorization, access, and audit. In addition, support for messaging, system, and network security protocols. System must support immutability of audit entries as it relates to access and disclosure of patient health information (PHI) and supports and/or provides two-factor authentication.

Logging: Levels and logging of transactions and transaction types including but not limited to NHIN / HHS standards, IHE auditable events and debugging or event tracing

Monitoring: Support for internal system monitoring, load balancing and network monitoring of services availability. Additionally, support for operational, business-driven, reliability, availability and serviceability monitoring. Any specialized rules or methods that detect unusual clinical, access, or other HIE functional events based on the clinical services. Examples include specialized rules your system utilizes to detect clinical gaps in care, drug seeking or shopping behavior, or other surveillance type functions based on the transactions traversing the network.

Reporting: Support for operational, audit trail, and management reports, including but not limited to: access metrics, usage metrics, consent adherence, transactions, ad hoc reporting, Also parameters for supports for reporting generation and customization.

Core HIE Services: Phase II

Patient Registry: The proposed design calls for a centralized patient registry. Functionally, this is often referred to as an MPI/RLS, enabling matching and location of patient information anywhere in the network.

Consent Registry: Based on the access consent policy that Alabama utilizes, patient consent policies need to be linked and accessible in order to operate in an NHIN exchange model. These consent policies should provide a consistent source of a consumer’s preferences, thereby enabling patient engagement and provider access to clinical information. The registry should be able to connect to existing consent registries and provide a consent registry if one is

Table 2: AHIE Technical Functionality

not available.

Web Services Registry (UDDI): The registry contains endpoints for statewide Web services, stored in an NHIN compatible registry. The registry is able to point to other HIO registries or serve as the main lookup vehicle for any endpoints and nodes across the network.

Role Based Access and Management: Required for security and authorization as described in the NHIN messaging platform and may require additional specificity to meet Alabama privacy and security policies. The intersection of user roles as defined by the user directory and trust models in the proposed solution should be provided.

Terminology Management (HITSP C83 / C80 Support): This is required to enable uniform transport of the CCDs. As many existing interfaces are not compliant with the terminology standards described in the existing HITSP specifications, solutions should clearly describe how to handle the challenge of semantic interoperability between systems.

Integration and Message Transformation: Integrated Healthcare Enterprise (IHE) Profile Support (PIX) Manager, XDS Registry, XDS Repository, etc.): Support for the NHIN messaging platform which generally requires support for various IHE profiles, specifically the use of PIX/PDQ for patient identification and the use of XDS profiles for document indexing and retrieval; in addition, the use of cross community profiles including XC.

Core HIE Services: Phase III - TBD

The AHIE technical workgroup also defined the clinical functional services requirements, which are included in the following table for Phase II.

Table 2: Potential Future Functionality

Laboratory Ordering and Results Delivery: Push and pull lab orders and results to Alabama providers for integration into EHRs. The system must integrate with labs, lab hubs, or other sources of leveraged laboratory connections, receive and process discrete digital laboratory results data (PDF versions are not acceptable) and route or otherwise make those results available to provider systems; laboratory ordering capabilities are also of interest

- Integration with labs via HL7 2.5 or similar interface (such as via HITSP or

Table 2: Potential Future Functionality

NHIN constructs).

- LOINC coding/translation of results.
- Bi-directional interface to reference labs.

ELECTRONIC PRESCRIBING (E-PRESCRIBING): THE SYSTEM SHALL PROVIDE CONNECTIVITY TO MULTIPLE SOURCES OF MEDICATION HISTORY, FORMULARY, AND ELIGIBILITY, AND RESPOND TO QUERIES FROM PROVIDERS FOR SUCH INFORMATION. PROVIDE A STATEWIDE INTERFACE FOR E-PRESCRIBING TRANSACTIONS.

- Connect to Surescripts and application e-prescribing networks.
- Connect to payer systems for medication history.
- Provide connectivity and query response capabilities to provider EHRs based on NHIN messaging platform or other broadly accepted standard protocols.
- Service to enable new connections to new sources of medication history that arise, such as hospitals, outpatient surgical centers, and outpatient treatment facilities.

CLINICAL INFORMATION EXCHANGE: ENABLE MEMBERS OF THE STATEWIDE HIE TO EXCHANGE KEY CLINICAL INFORMATION BETWEEN THEIR EHR SYSTEMS.

- Accept and route CCD and/or CCR payloads between any providers connected.
- Translation or aggregation between proprietary formats and CCD or CCR formats.
- Endpoint system interoperability (e.g. delivery to EHRs, PHRs, or other systems).
- Secure Messaging

Patient Summary Record: The ability to create, transmit, receive and interpret patient care summaries can enhance a wide range of health services, including continuity of care, accurate diagnosis and treatment, and patient and care giver engagement

FUNCTIONALITY FOR ELIGIBILITY AND AUTHORIZATION UNIFICATION: PROVIDE A SINGLE POINT OF CONNECTIVITY TO ALL PAYORS IN ALABAMA VIA MULTI-PAYER PORTAL OR OTHER MEANS TO ENABLE DAY CERTAIN ELIGIBILITY TRANSACTIONS (INCLUDING AUTHORIZATION) FROM A PROVIDER TO ANY PAYORS WITHIN THEIR PRACTICE AREA.

- Connect to all payers in Alabama and enable conducting eligibility transactions by 270/271 transactions or equivalent allowing day certain eligibility determinations.

Table 2: Potential Future Functionality

- Route eligibility requests from provider EHRs and/or practice management systems to appropriate payers and return results to provider EHRs and/or practice management systems, accounting, and/or billing subprograms.

Potential Web Based EHR Solution: EHR alternative viewing capability for all clinical services; this should require only standard web browsers.

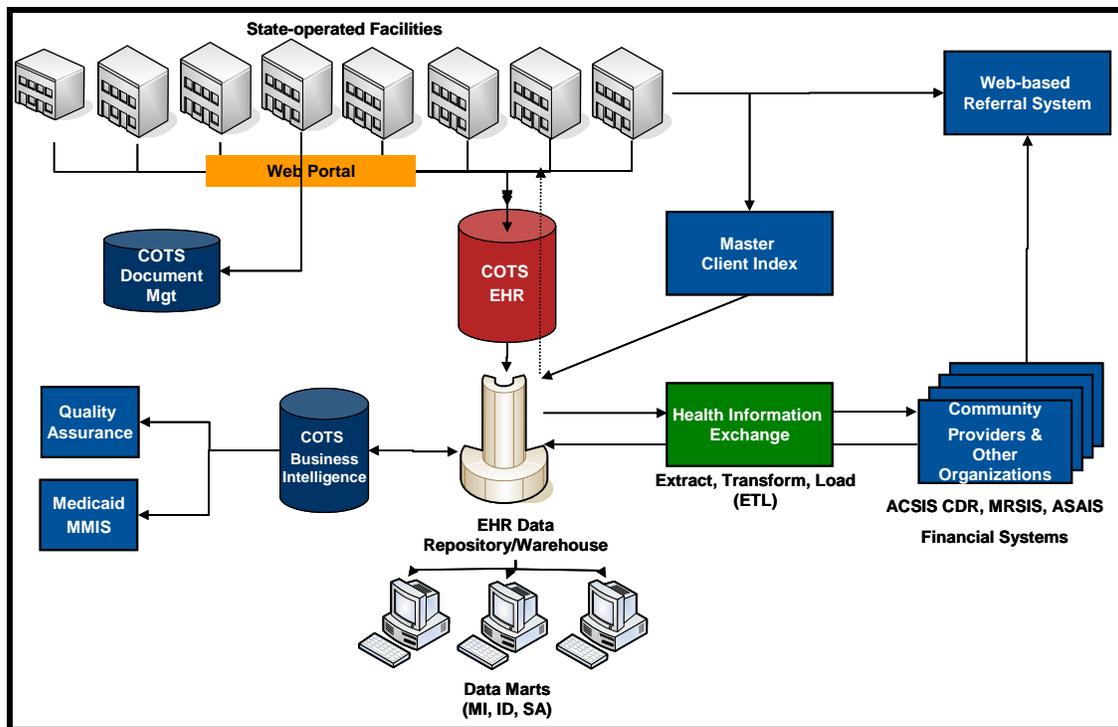
The AHIE, by the end of FFY 2011, intends to implement as a core component secure messaging, including role based access and management, privacy and security, monitoring and auditing. Existing services will be leveraged to the extent possible by continuing discussions with Blue Cross/Blue Shield.

“To Be” Future State of MU Identification, Validation, Payment, Audit and Appeals HIT:

A web based application will support NLR interfaces and data exchanges and Alabama requirements for determining and issuing eligible provider incentive payments will seek to avoid state variation to improve administration across states. The application will have both a provider facing and a user support component (for use by the State Medicaid Healthcare Program Office (SMHPO)).

In addition to the work on the AHIE, Alabama is seeking to move to MITA Level 3 and Level 4 for Medicaid behavioral health activities as well as prepare for Stage 2 of MU, which is anticipated to include more mental health quality measurements. The state will submit a separate I-APD for the HIT to support that transition. The schematic for the data warehouse system architecture to support the future Medicaid MH MU Quality Measures follows in Figure 5.

Figure 5 Architecture to Support the future Medicaid MH MU Quality Measures



Note: The state data infrastructure grants have been used to fund the analysis and design in preparation for development so the system will support Medicaid but be able to support non-Medicaid funded services and non-Medicaid funded enrollees.

3.3. How will Medicaid providers interface with the SMA IT system as it relates to the EHR Incentive Program (registration, reporting of MU data, etc.)?

Alabama is considering using its current Fiscal Agent to continue to handle provider registration as an EP or EH consistent with the role of the FA in relationship to provider enrollment on an ongoing basis. CMS and AMA will have information on registration for EHR incentive programs available on each website (see previous response).

Since initial declaration and registration must be through the NLR, Alabama will interface through the process and technical infrastructure identified in the previous question. In addition, EPs and EHs are required to use certified EHRs, so cross validation with ONC' listing of certified EHRs is required. As soon as CMS provides further guidance on "connectivity" with the ONC site, the technical infrastructure will be put into place to fully utilize the centralized, secure web site. In addition, the State intends to collect email address and other information that is necessary to support secure messaging and a provider registry as well as the information necessary for the attestation process.

Alabama considered the MAPIR collaborative effort and intends to use a web based application that will support National Level Repository (NLR) interfaces/data exchanges and state requirements for determining and issuing eligible provider incentive payments. The application will have both a provider facing and an A-SMA user support component.

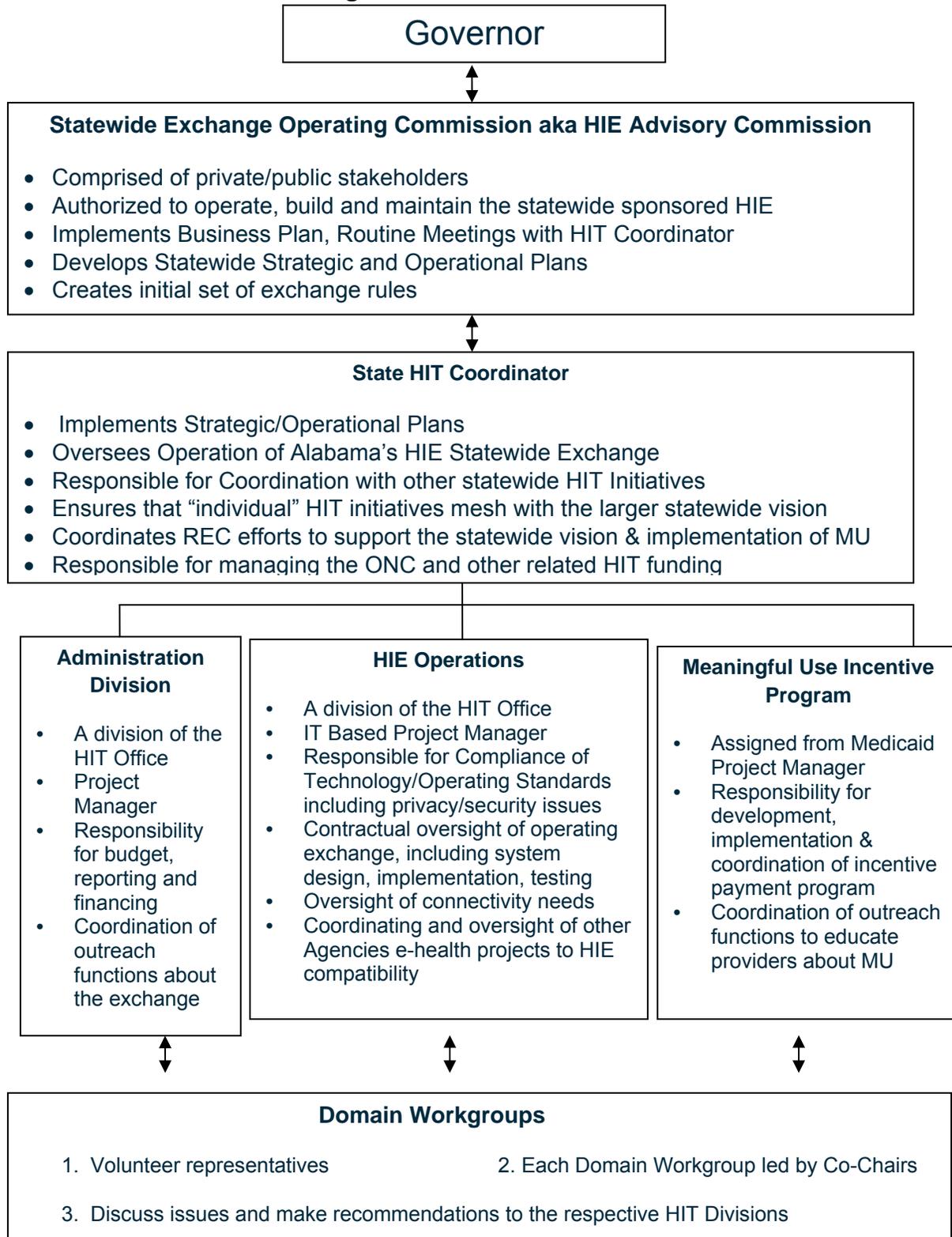
A provider must be actively enrolled with Medicaid (MA) in order to apply for MA incentive payments; therefore the NLR will be the “master” of the required provider application information (e.g., NPI). Provider required fields entered by the provider initially at the NLR will need to be modified at the NLR rather than at the State level.

A provider application is not ready for payment until the application is complete and the NLR and the state web based system have verified no duplicate payments have been made. When Alabama informs the NLR that a payment is ready to be made and the NLR has approved payment, the provider applicant record will be “locked” and the provider cannot switch programs or states for that payment. Back end financial processing of incentive payments will leverage existing MMIS processes such as 1099s, remittance advices, eBatch files will be retrieved from the NLR to begin application processing. As the NLR will have required fields and edits to insure those required fields are error free, the NLR will start the data source. A-SMA will also use the listing of federally certified systems that will be available on a federal government website as another data source for validation of eligibility.

3.4. Given what is known about HIE governance structures currently in place, what should be in place by 5 years from now in order to achieve the SMA’s HIT/E goals and objectives? While we do not expect the SMA to know the specific organizations will be involved, etc., we would appreciate a discussion of this in the context of what is missing today that would need to be in place five years from now to ensure EHR adoption and meaningful use of EHR technologies.

In Alabama the development and governance of the AHIE has been under the auspices of ASMA; thus the details of the proposed interim-and long-term governance structure involves and is explicitly understood in relationship to this effort by the Medicaid Agency Director and staff. As explained in Section 2 of the AHIE S/OP (Appendix 8.1), the “*To Be*” *Future State* governance model for the AHIE as currently envisioned by the Advisory Commission is as shown on the following page in Figure 6.

Figure 6: AHIE Governance



Alabama HIT Office: The Alabama HIT Office will be responsible for the daily operation of the AHIE as well as implementing the strategic and business plans outlined

by the Advisory Commission initially and then the Operating Commission at the appropriate time. The State HIT Coordinator will direct the HIT Office. The HIT Office will oversee day-to-day operations of the AHIE through the management of the sub-divisions of Administration, HIE Operations, and Meaningful Use. The Administration sub-division will be responsible for the management of the HIE describing the financing and sustainability, marketing and communication, and reporting. The Operations sub-division will be responsible for management of the HIE including compliance of technology, operating standards, contractual oversight of the exchange, connectivity needs and coordination and oversight of other state agencies e-Health activities. The Meaningful Use sub-division will be responsible for the development, implementation and coordination of the meaningful use program and will coordinate outreach activities to educate provider regarding the program. The Alabama HIT Office will also be responsible for coordinating the Alabama HIE alignment with NHIN.

Table 3: Key Staff and Roles	
Key Staff	Roles
HIT Coordinator	<p>Provide leadership, direction, management and coordination of the State HIT office, in order to ensure timely accurate and complete information and knowledge is available for the provision of health care services and policy decisions.</p> <p>Primary contact with the Governor's Office, the Operating Commission, and the Medicaid Agency</p> <p>Coordinate cooperation with state agencies engaged in promoting the adoption of state HIT systems and e-health initiatives to insure all AHIE requirements and standards are identified for health information exchange.</p>
HIE Operations Manager	<p>Coordinate the efforts set forth in the state to develop and implement a statewide HIE based on the criteria set forth by the ONC and as further defined by the Advisory Commission and workgroups</p>
Meaningful Use Project Manager	<p>Coordinate the efforts set forth by CMS for the implementation and adoption of meaningful use criteria by eligible providers in the Medicaid system</p>
Reporting/Accounting	<p>Coordinate the multiple reporting and accounting requirements that must be met through the various funding sources as well as</p>

Table 3: Key Staff and Roles	
Key Staff	Roles
Analyst	work to identify additional funding opportunities.
Administrative Support	Coordinate and track the various work of other individuals

Initial-Interim Statewide Exchange HIE Advisory Commission: After careful evaluation and productive discussions, the State of Alabama established a multi-tiered governance framework. The current Statewide AHIE Advisory Commission, along with its workgroups will continue until authority for a permanent governance structure is in place with the Medicaid Agency providing ongoing staff support. This approach mitigates risk to the federal and state government as it allows the effort to move forward using current authority, while more permanent authority can be established. As the authority for the Advisory Commission is not time limited, the state has the ability to continue to act under its current authority until replaced with a long-term governance structure. In addition, Alabama will retain the current domain workgroups to maintain the involvement of all the various stakeholders groups as the state proceeds to confront issues, adopt strategies, and develop solutions of all e-health challenges.

Decisions that remain include:

- State oversight of any organization that exchanges information with the HIE (who, how and under what statutory requirements);
- Operational details, such as procurement specifications and processes; and
- Regulatory oversight of HIOs that don't participate in the HIE.

3.5. What specific steps is the SMA planning to take in the next 12 months to encourage provider adoption of certified EHR technology?

The ASMA as a part of the AHIE has a detailed communications plan for engagement of providers, the state legislature and other stakeholders to assure the HIT infrastructure is in place through the AHIE to support EPs and EHs efforts to meet MU requirements by July 2011. The Communications and Marketing Workgroup has developed a comprehensive Communication and Marketing Plan, which can be found in Appendix

8.1 Section 2. The core messaging audiences are hospitals, physicians, laboratory/x-ray entities, pharmacies, providers of ancillary services, other providers, rural health clinics, patients/consumers, payers, purchasers, state agencies, health professional school, general public and the federal and state government. The inclusion of health professional schools is critical and often missed.

Based on the feedback from the core messaging audiences and Advisory Commission, the following “One Health Record” logo was selected (Figure 7). The critical message for providers is that the goal is not the incentive – the incentive is the tool to reach the goal – a more efficient, effective health care delivery system.

Figure 7: Selected Logo



The Technical and Business Operations also has a targeted short-term and longer-term strategy as depicted in the following table to assure the state completes Group 1 testing with CMS’ NLR in order to assure payment is available to EPs and EHs at the earliest feasible date. With the same goal in mind, the Legal/Policy Workgroup is focusing on multiple areas, but targeting a DURSA agreement as a top priority. In addition the state is considering some additional targeted activities.

Table 4: Business and Technical Operations Activities/Approaches		
Activity	Year	Approach
RFI	2010	An RFI was issued by the state to help define the core functionality and additional functionality as will be required through the state procurement process was identified earlier in Table 2. There were 21 responses to the RFI, which provided validation to the Technical Infrastructure’s workgroup proposed approach.
RFP	2010	The drafting of the RFP is in process with a goal of releasing the RFP in early 2011 as the focus has shifted to supporting core components required for meaningful use, including secure messaging and provider registry.
SMHP	Sept – Dec	Medicaid is concurrently developing and submitting the State Medicaid HIT Plan (SMHP) to assure alignment in process and timing.

Table 4: Business and Technical Operations Activities/Approaches		
Activity	Year	Approach
	2010	
Group Testing CMS NLR	Fall 2010- Winter 2011	Alabama has been authorized to be a Group testing cohort for the CMS National Level Repository with the goal of the state able to launce their EHR Incentive Program by the end of the first quarter of calendar year 2011. Testing will occur this fall and may overlap with the beta testing for the AHIE. When and where that occurs, efforts will be initiated to bring together the efforts and limit unnecessary intrusion and demands on the providers seeking to comply with MU timelines and requirements.

3.6. ** If the State has FQHCs with HRSA HIT/EHR funding, how will those resources and experiences be leveraged by the SMA to encourage EHR adoption?

The Alabama Primary Health Care Association (APHCA) that represents Federally Qualified Health Care Centers (FQHCs) throughout the state is a sitting member on the Alabama HIE Commission and serves as the co-chair of the Business and Technical Operations workgroup. This level of involvement ensures coordination between the ARRA Capital Improvements funding work of the Health Information Exchange. Through the APHCA leadership, several initiatives that support Alabama’s HIT vision are underway including the above mentioned capital improvement programs and EHR deployment system. FQHCs are high volume historical providers in the State. It is anticipated that linkages will occur between the FQHCs either on an individual basis or through regionalization of their efforts and the statewide AHIE system.

3.7. ** How will the SMA assess and/or provide technical assistance to Medicaid providers around adoption and meaningful use of certified EHR technology?

Alabama Medicaid will leverage the work of the AHIE and the continued use of the contract consults that supported the state in the development of the A-SMHP and the AHIE S/OP. In addition, the state has named the Medicaid lead as the HIT Coordinator and authorized the hiring of a MU Manager to focus totally on this effort.

The REC will have a contract with Alabama State Medicaid Agency (ASMA) to provide technical assistance (TA) to Medicaid providers specifically related to Meaningful Use (MU) activities. The scope of work is currently being negotiated but will focus on education and outreach to non priority providers. The contract will be negotiated the

first quarter of calendar year 2011 and will initially be for one year in order to evaluate the value with options to extend. A copy of the contract will be provided to CMS Regional Office (RO) upon finalization. The REC will not provide any audit functions for ASMA as a part of this contract.

The Alabama Hospital Association intends to provide support again for the national AHA follow-up survey and will provide the information to the AHIE to further target the communication plan is already in play. In addition, the REC has committed to working with the AMA in identifying providers who are in the position to pursue their MU incentive and to also identify providers who are in need of additional TA.

Since engagement with Medicare is important to many of the providers, the state has plans to begin conversations with Medicare regarding the inclusion of Medicare data in the AHIE.

3.8. ** How will the SMA assure that populations with unique needs, such as children, are appropriately addressed by the EHR Incentive Program?

Alabama has represented the CHIP program on the IOM Pediatric Quality Measures effort and the AHRQ quality measurement process under the CHIPRA legislation and has worked at the national and local level to integrate the MU quality measurement process and results with the requirements on the state to report quality measures for children. The two Medical Directors from ASMA have also provide leadership roles on the AHRQ funded Medical Directors Learning Network, where they have led targeted efforts to leverage the reporting for providers and the state.

While the focus this year for the state is AIU, the ASMA is cognizant of the need to address the quality measures for the first year of meaningful use. The state does not intend to require additional measures or mandate optional measures at this time, but dependent on the results as the providers move forward, the option could be considered in the future.

3.9. If the State included in a description of a HIT-related grant award (or awards) in Section A, to the extent known, how will that grant, or grants, be leveraged for implementing the EHR Incentive Program, e.g. actual grant products, knowledge/lessons learned, stakeholder relationships, governance structures, legal/consent policies and agreements, etc.?

As indicated in Section A, Alabama Medicaid is involved in multiple efforts within the state and across the nation. As a part of SERCH, the state is working collaboratively with other states on a DURSA agreement; through PA's lead the state is working with other states with the same fiscal agent to leverage the fiscal benefit of development of the IT infrastructure once instead of multiple times; through the MITA effort, the state has looked to cross-state and public/private lines of business; and through the Medicaid Collaborative, addressed technical and business operations as well as technical infrastructure. Section 2 of Appendix 8.1 provides significant detail regarding each of these activities, most which are still in process.

3.10. Does the SMA anticipate the need for new or State legislation or changes to existing State laws in order to implement the EHR Incentive Program and/or facilitate a successful EHR Incentive Program (e.g. State laws that may restrict the exchange of certain kinds of health information)? Please describe.

Although the state is not anticipating the need for legislation, the state is determining whether the administrative code will need to be amended. The AHIE workgroups are in the process of sourcing and analyzing legal information related to privacy and security, interoperability, Medicare and Medicaid, and the development of relevant policies and procedures related to the AHIE. The development of a privacy and security framework will guide the actions of all health care-related persons, entities and individuals that participate in the AHIE network for the purpose of electronic exchange of individually identifiable health information. Therefore, it is essential that the state's privacy and security framework adhere to the privacy principles set out by the state, as well as the privacy principles provided by the Department of Health and Human Services, and must be accepted by all stakeholders in order to ensure the public trust.

The Legal and Policy Workgroup spent significant time discussing and defining the parameters and questions to be answered concerning the legal framework under which the state HIE and state government will facilitate HIE. The legal framework has been discussed in the context of a policy framework that transitions from the current governance structure to the permanent governance structure -- a method for moving the state, private purchasers/payers, providers and consumers through the process without encountering gaps in funding, leadership, or implementation, including risk mitigation strategies and operational processes.

An overarching principle is to align with Medicare and federal standards and only deviate if there is a state law or state imperative that prohibits alignment. In such cases, the HIE, if appropriate, will pursue adjustments in state law and/or regulation to allow for the alignment with the federal approach. This will make inter-state and connectivity with

NHIN not only more viable, but less expensive. Areas of particular focus include privacy, security, standards defined in the interim ONC regulation, Medicaid and Medicare requirements and the development of policies, procedures and legal agreements related to HIE.

Additional core legal/policy principles for the AHIE include: adherence to applicable federal laws (HIPAA, FERPA, 42CFR Part II for Substance Use Treatment), openness, transparency and accountability such that patients can have confidence in the system; due regard for equality and equitable treatment; “do no harm”; personal autonomy of the patient, and a balance between the rights of the individual and the rights of the community.

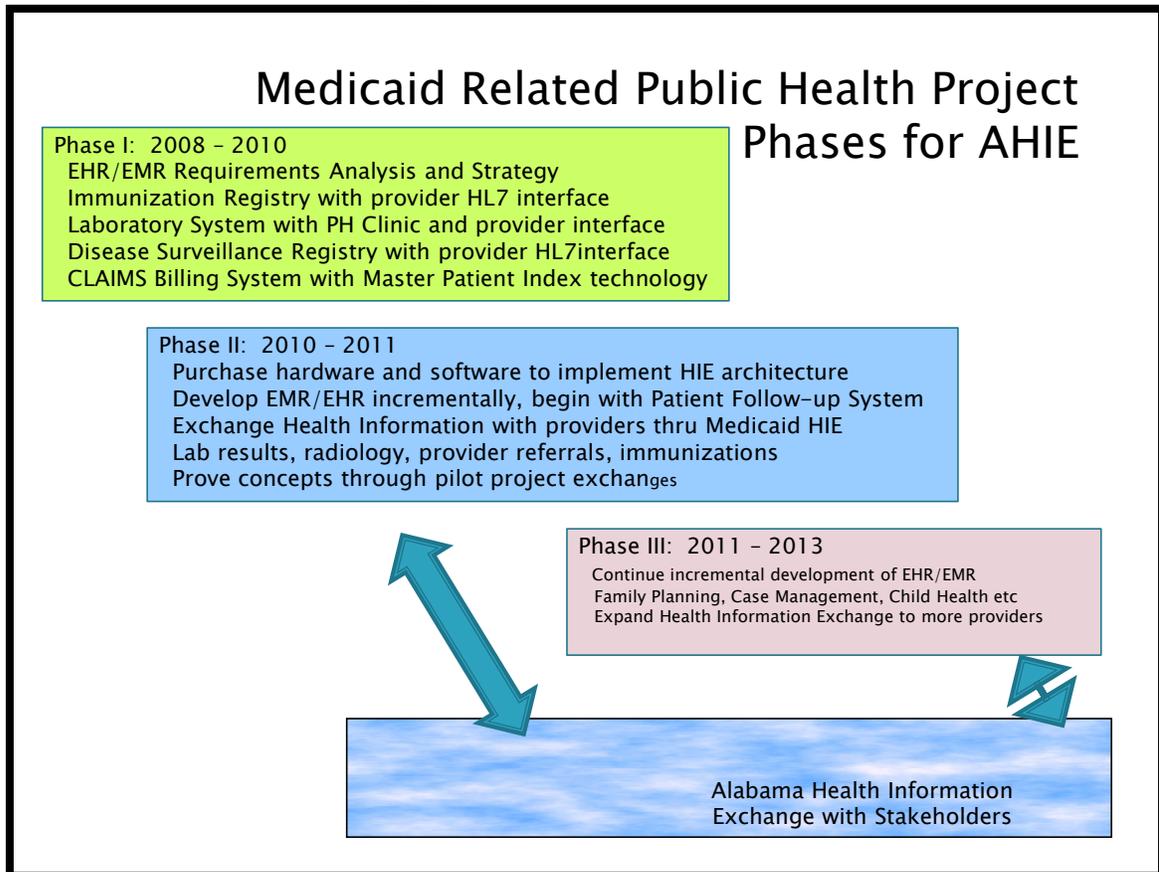
The workgroup also identified strategies to assure alignment with the principles that establish policies and procedures that result in: completion of thorough planning prior to implementation; periodic review of legal/policy implications; implementation and execution in a timely and professionally competent manner; a fair process for patients and providers in a non-discriminatory manner; design and execution that reflects respect for the person and dignity of the patient; adequate representation for those with diminished capacity; confidentiality and security of personal health information; and compliance with both the letter and spirit of the law.

Please include other issues that the SMA believes need to be addressed, institutions that will need to be present and interoperability arrangements that will need to exist in the next five years to achieve its goals.

The state has taken a very expansive view of this process and although targeting initial efforts of implementation, the state is seeking to fully utilize the authority to deal with upfront issues of health care delivery, including eligibility and enrollment, so accurate determinations of MU eligibility can result. In addition, as the state and providers move to MU activities, such as reporting of quality performance measures, additional focus will be stressed on substance use privacy regulations, quality issues for individuals with health disparities, including adolescents, and new payment and service delivery oversight needs. The inclusion of public health and mental health is already prevalent, but the renovation of their infrastructure will play a more demanding role in the years ahead.

Public Health has with ASMA, developed a specific plan, which is provided in the following figure. Public Health intends that trauma reporting, lab reporting, hospital required reporting, and other state and federal reporting will be through the AHIE in addition to service delivery activities.

Figure 8 Public Health Plan



4. SMHP SECTION C: ACTIVITIES NECESSARY TO ADMINISTER AND OVERSEE THE EHR INCENTIVE PAYMENT PROGRAM

One of the stated priorities of the AHIE Advisory Commission in the AHIE S/OPs was to “support the meaningful use of EHRs throughout the State and facilitate health care providers’ ability to qualify for Medicare and Medicaid incentive payments by aligning the Strategic and Operational Plans with the SMHP” (Section 1 of Appendix 8.1).

From a consumer and provider operational view the vision is straightforward, simple and understandable, “One Health Record” - Health Information Technology (HIT) to support health care and health care delivery transformation. From a technological, legal and operational infrastructure outlook, the AHIE is standardized, interoperable, evolving and inclusive of Medicaid and all public programs.

The vision for the AHIE is to strengthen Alabama’s health care system through the timely, secure and authorized exchange of patient health information among health care providers that results in multiple views but one longitudinal patient record and supports the connectivity required for providers to receive incentive payments under the MU provisions. A second explicit principle of the AHIE is to create immediate access to critical health information for patients, providers and payers to ensure health information is available to health care providers at the point of care for all patients, which is why Medicaid is center to the AHIE rather than simply aligned with it. The outcome for Medicaid is administrative efficiencies and clinical effectiveness, including reduction of medical errors, avoidance of duplicative procedures and better coordination of care by linking the full continuum of providers — public and private, physicians, clinics, labs and medical facilities. The outcome for Medicaid providers includes the necessary infrastructure to fully benefit from the MU incentives.

While there are other key principles, the third one that directly positively impacts Medicaid providers is the assurance that the interoperability will be inter- as well as intra-state through the development of an enterprise approach for Alabama that is aligned with the National Health Information Technology Network (NHIN) guidelines. Using NHIN guidelines guarantees compliance with Section 4201 of the Recovery Act requires that incentive payments be used for the adoption and use of “certified EHR technology,” which (pursuant to section 1903(t) (3) (A) of the Social Security Act (the Act) and by definition) must be certified as meeting standards adopted under section 3004 of the Public Health Service (PHS) Act.

ASMA has taken ONC National Coordinator and CMS leadership seriously and has made the patient in the center, built from what the state has today, created a bold vision

but an implementation plan that is incremental starting with infrastructure (policy, technical and operational) to support MU incentive payments, fostered innovation, but balanced that with the need to “watch out for the little” through plans to contract with the REC for Medicaid specific support beyond the RECs responsibilities under their ONC contract.

Process: ASMA will comply with the CMS guidance as it is provided to ensure that eligible professional and eligible hospital have met Federal and State statutory and regulatory requirements for the EHR Incentive Payments. The 6 core activities of the program implementation are:

Program implementation activities



In addition, Alabama has already required for the AHIE and thus Medicaid, the use of NHIN standards, services and policies. The technical specifications for the AHIE mimic NHIN’s specifications.

Table 5: Proposed Medicaid Electronic Health Record (EHR) Incentive Process in the First Year

NLR Processing
The provider applicant enters information on NLR.
Information sent ASMA via a daily batch file.
ASMA retrieves daily batch files from the NLR
ASMA system may reject an entire file based on some parameters and if so file resolution will be required with NLR.
Upon receipt of file, ASMA system performs edits on SSN, CCN, State Code Program Type is MA, duplicate checking, determining whether the provider is present in the Medicaid Management Information System (MMIS) Provider file. If edits are not passed, then the record will be suspended for: resolution of individual records with NLR (e.g., duplicates incorrect state code), ASMA to research, and exclusions sent from NLR for investigation by Program Integrity.
If edits are passed, email to the applicant will be generated with instructions on how to begin the application process. Suspended records will also generate an email to the provider that indicates the reason for the suspense (provider not enrolled, etc.) and who to contact.

Provider Applicant Verification

The provider will access via an Internet portal. The provider must be an enrolled Medicaid provider and have registered to use the provider portal. Information on the website will instruct providers that they must be enrolled and how to do so. If the NPI on the records received from the NLR does not match a record in the MMIS, then the provider will be emailed and instructed to contact ASMA to enroll

Enrolled providers who are not a HITECH provider type (Physician, Dentist, Hospital, etc.) on the MMIS enrollment file will not be able to access provider portal. If the enrolled provider has a valid logon id and provider type, a link will be presented for the provider to access system.

The system will use the NPI associated with the logon ID or any service location associated with the logon ID to search for a match. If a match is found, the provider has been verified and will proceed to enter the application. If no match is found, then the provider will be given an error message indicating that there is no match for this record from the NLR. They will be instructed to contact the NLR.

Provider enters the registration fields at the NLR. If information confirmed, provider will proceed. If information is not confirmed, the record will be suspended as incomplete and the applicant will be directed to the NLR to fix the information. Provider confirms information obtained from the NLR including:

- NPI
- Provider Name
- Business Address/Phone
- Personal TIN
- Payee TIN
- Payee Address
- Agency (Medicare/Medicaid)
- State (if Medicaid)
- Legal Entity Name
- Payee Legal Entity Name
- CCN for hospitals
- Provider Type
- Email Address (if provided by NLR)
- Most recent ICD information

Provider Applicant Eligibility Determination

Alabama Medicaid provider status eligibility will be determined as a first step. Providers must be currently enrolled and eligible Alabama Medicaid providers in order to be eligible for MU through ASMA. The MU system will have a feed to the current MMIS provider subsystem and will check for current status related to required ownership, control, relationship and criminal conviction information. While the NLR will audit against the national data bases, the Alabama system will audit against the current Medicaid provider system to assure eligibility. If a provider is not eligible for Medicaid, has been suspended or denied for any purpose, the MU system will deny,

send notice and terminate further action.

Eligibility will be determined based on MA (or needy individuals) as a percentage of the applicants' total patient population.

Applicant confirms HITECH provider type (and Pediatrician if applicable). If the provider does not indicate any types, the application will be considered incomplete, and the provider will need to contact ASMA. If the provider type entered by the applicant does not match the provider type on the MMIS file, the provider information will be placed on a report.

Applicant indicates specialties in which they are board certified (drives Meaningful Use data parameters): 15 Board specialties associated with quality measures are provided. "Other" and "None" are also valid selections. If "Other" is selected, provider will need to explain via entry in a text box.

Hospital-based provider – (Yes/No) Upon completion of the application, a process will determine whether 90% of claims submitted by the provider are in an Inpatient or ER setting. Those in which 90% of the claim volume is in an IP or ER setting will be considered hospital-based even if they answer the question "No". A screen/report showing claim volume will be generated for auditing purposes

- If Yes, suspend
- If No, proceed to FQHC/RHC

At completion of the application: System will determine if claim volume is more than 90% of services performed in an IP or ER setting

- If Yes - Suspend
- If No – Approve for payment (if error free)

Practicing Predominately in FQHC/RHC: (more than 50%): provider indicates yes or no. If yes, provider applicant will provide the name(s) of the FQHCs/RHCs sites. If provider is full-time employee of an FQHC/RHC, he will so indicate. The FQHC/RHC will validate through a listing to the state of all full-time employees/contractors. If there is a match, the numerator and the denominator for the FQHC/RHC from the first quarter of the year prior to the payment year will determine eligibility of the provider. If the provider is less-than full-time, the provider will indicate days/time per week per FQHC/RHC site(s). If more than 50% of time, state will validate with FQHC/RHC providers percentage of time and total percentages across sites. If greater than 50%, then the numerator and the denominator for the FQHC/RHC from the first quarter of the year prior to the payment year will determine eligibility of the provider. If total needy individuals percentage for the FQHC/RHC is 30% or greater, the provider will proceed to attestation.

If provider does not practice predominantly in an FQHC/ RHC, the provider enters the Medicaid population from all their locations and if the percentage is over 30% (20% pediatrician), the provider moves to attestation. If less than the required percentage, the applicant does not meet the threshold requirement and is suspended/rejected. Provider applicant will not be able to proceed.

Provider Applicant Attestation

If the applicant cannot confirm information on all of the questions then the application is considered incomplete and flagged for suspense for manual review.

An email is sent to the provider applicant indicating that the application is suspended and that they can contact A-SDMA:

- Confirmation of registration / request for specific state Medicaid incentive program at the NLR
- Confirmation of EP provider applicant NOT pursuing payment in another state
- Confirmation of no sanctions pending against provider applicant
- Confirmation of compliance with HIPAA laws for electronic data
- Confirmation of license to practice in state.
- Confirmation of Adoption, Implementation, or Upgrade
 - Adopt (Acquiring or installing system): Is system certified? Yes – proceed No – flag for suspense
 - Is it certified EHR technology (drop down of certified systems provided by CMS): applicant selects a system in drop down – Proceed; if not suspend
 - Did organization perform a readiness assessment? (data collection only): Yes or No - proceed
- Implementation: same process as Adopt up to implementation tasks then indicate task. you've completed in the last year – If applicant selects from drop down – proceed and if Other or suspend
- Upgrade: same as adopt
- Document Sources of funding (non state/local government) for payment calculation.
- Provider applicant will be required to report any other sources of funding for use in incentive payment calculation.

Confirmation of category of entity that payment is being assigned:

- Self
- Hospital
- FQHC/RHC
- Group Practice
- Other (required to enter information in text box) – flag for suspense to Medicaid HIT for outreach (manual review for final application approval)
- Confirmation of voluntarily assigning payment to the entity indicated on the information from the NLR and entity is an Alabama Medicaid enrolled provider.
 - Yes – proceed
 - No – *assignment will not be authorized. Provider can indicate another Medicaid provider to assign payment or receive the payment himself/herself.*

Provider Applicant Payee Determination

Once eligibility and attestation is completed, provider will be required to validate payee information.

: As part of the state registration process, the provider will indicate to whom the payment will be assigned. The provider will be required to supply the NPI or TIN for the entity to whom the assignment is being made. It will be required that the entity to whom the assignment is being made is registered in the Alabama MMIS system.

Provider applicant NPI/Payee TIN combination from the NLR to determine if:

- If provider applicant has assigned their payment to an Alabama Medicaid enrolled provider
- Using NPI/Payee TIN combination to determine whether that relationship is contained within the MMIS and can be used for payment purposes:
- If Yes – continue and prompt the user to complete the provider application.
 - If No –
- If provider applicant has not assigned their payment:
- Continue to “Payment Determination”

Application Submittal Confirmation/Digital Signature

Display all of the NLR information (same as displayed in “Provider Verification” process)

Present the entire application to the provider applicant for final confirmation:

- Allow changes. If changes are made then perform editing based on the changes and process accordingly at the state site only.
- If application is error free, prompt provider applicant to FINISH and indicate further changes will be able to be made.
- Require provider applicant digital signature and preparer digital signature (under attestation).
- Allow printing of completed application including digital signature
- Save finalized application and lock record from further updating by provider applicant.

Payment Determination and Confirmation

If application is approved for payment, application sent to NLR for confirmation of payment:

- If NLR returns duplicate payment: Flag to deny payment – send email to provider applicant indicating payment has already been made and they should contact the NLR with any questions.
- If NLR returns exclusions: Suspend to Program Integrity for review and send email to provider applicant indicating additional information received from NLR and that the information is being reviewed.
- If approved:
 - Flag record as “Ready for Payment”
 - Send email to provider indicating payment has been approved and that they can expect payment in approximately XX days.
 - Lock record from internal users.

Payment Generation Utilizes MMIS Gross Adjustment (GA) process

Automatically generate financial transaction from the records that are “Ready for Payment” and feed into Medicaid Financial Cycle.

- Will contain unique gross adjustment reason code for identification
- Process in Medicaid Financial cycle
- Payment method (paper, EFT) will be driven from provider enrollment file
- Remittance Advice will indicate Medicaid provider incentive payment

Upon completion of payment cycle: Record payment transaction including pay date

Alabama started as a Group 1 state to connect with the National Level Repository (NLR) but is now planning to connect prior to the end of the first quarter in calendar year 2011 so the timeline is tight and the need for CMS approval of the SMHP and I-APD quickly cannot be overstated. The process as the state currently understands it is as follows in Table 6, which provides a summary of the CMS and ASMA processes to complete the work, the resource needs, the federal funding anticipated with expected due date, and the action steps the state anticipates will be needed to address the processes. For purposes of the Table and following responses eligible providers are noted as “EPs” and eligible hospitals are noted as “EHs”.

Table 6: NLR Process and Systems/Human Resource State Impact/Need
***EH = Eligible Hospital * EP = Eligible Provider**

Process		Alabama Impact/Needs		90/10 HIT FFP		Date	Action Steps
CMS	Alabama Medicaid Agency (ASMA)	Systems	Human Resources	Yes	No		
NLR will inform Alabama of new Medicaid registrations. NLR will send ASMA a batch feeds of new EPs and EHs that signed up for HITECH and selected		Ability to receive the new Medicaid registration data into a data warehouse and eventually into the provider data base within the current MMIS structure	MU Project Mgr. & MMIS Coordinator Mgmt & contractor oversight IT resource ASMA Contract	Y		DDI by 1/1/11 I-APD 8/10 SMHP prior to 9/30/10 Testing with	I-APD SMHP submitted Contract Amendment to Current MMIS Contract AP

Process		Alabama Impact/Needs		90/10 HIT FFP		Date	Action Steps
CMS	Alabama Medicaid Agency (ASMA)	Systems	Human Resources	Yes	No		
<p>Medicaid</p> <p>CMS maintains: NLR and Taxpayer Identification Number (TIN) which may be the EPs social security number to which the EP or EH wants the incentive payment made. For EHs, their CCN.</p> <p>The information collected in the NLR includes: Name, NPI, business address, and business phone of each EP or EH.</p> <p>NLR will confirm to ASMA the status of the providers' unique identifiers (i.e., the NPI and the CCN).</p> <p>CMS will store the history of information & on an ongoing</p>		<p>Connectivity to NLR</p> <p>Ability to accommodate the hospital methodology</p>	support for I-APD			<p>NLF 10/10</p> <p>Batch Daily 1/1/11</p>	<p>Develop P & Ps</p> <p>Communication/Marketing through workgroup to affected providers and stakeholders</p> <p>Joint communication and training through REC</p> <p>Determine if any laws/reg must be amended & do so</p> <p>Update state legislature in fall</p> <p>Work through SERCH on process for cross-state patient Medicaid count and</p>

Process		Alabama Impact/Needs		90/10 HIT FFP		Date	Action Steps
CMS	Alabama Medicaid Agency (ASMA)	Systems	Human Resources	Yes	No		
basis allow providers to change programs and states.							possibility of cross state use of denominat or
	<p>ASMA completes registration of EHs and EPs : Yr 1 Adopt, Implement, Upgrade for 90 days:</p> <p>EHs (FY) and EPs (CY):</p> <ul style="list-style-type: none"> • Medicaid only EHs • Medicare and Medicaid EHs • Medicaid EPs • Medicare EPs – not eligible for Medicaid EP status <p>ASMA will check for:</p> <ul style="list-style-type: none"> • Sanctions • Exclusions in the last exclusions check or dead. 	<p>Edits and audits in MMIS system</p> <p>Web portal to submit information from provider to ASMA and reverse</p> <p>Inclusion of data elements in provider subsystem</p>	<p>ASMA policy and IT staff</p> <p>FA Contract</p> <p>Potential REC staff</p>	y		<p>Implementatio n within 3 months of 1/1/11</p> <p>Testing NRL Fall 10</p> <p>Testing with provide rs Fall 10</p>	<p>-APD</p> <p>Contract Amendmen t to Current MMIS Contract</p> <p>Develop P & Ps</p> <p>Communic ation/Mark eting through workgroup</p> <p>Joint communica tion and training through REC</p> <p>Determine if any laws/reg must be amended & do so</p> <p>Update state legislature in fall</p>

Process		Alabama Impact/Needs		90/10 HIT FFP		Date	Action Steps
CMS	Alabama Medicaid Agency (ASMA)	Systems	Human Resources	Yes	No		
	<ul style="list-style-type: none"> Hospital-based Provider is eligible to participate (NP, dentist, physician, acute care or children's hospital, etc.) and is licensed appropriately (e.g., NP is a licensed NP, not an RN) <input type="checkbox"/> Has the provider met AIU? Provider is using certified EHR technology 						
	<p>Alabama complete registration of EHs and EPs : Yr 2 MU for 90 days</p> <p>EHs (FY) & EPs (CY):</p> <ul style="list-style-type: none"> Medicaid only EHs 	<p>Edits and audits in MMIS system</p> <p>Web portal to submit information from provider to ASMA and reverse</p>	<p>ASMA policy and IT staff</p> <p>FA Contract</p> <p>Potential REC staff</p>	y		<p>Implementation within 6 months of 1/1/11</p> <p>Testing NRL Spring</p>	<p>-APD</p> <p>Contract Amendment to Current MMIS Contract</p> <p>Develop P & Ps</p> <p>Communicate</p>

Process		Alabama Impact/Needs		90/10 HIT FFP		Date	Action Steps
CMS	Alabama Medicaid Agency (ASMA)	Systems	Human Resources	Yes	No		
	<ul style="list-style-type: none"> Medicare and Medicaid EHs Medicaid EPs Medicare EPs – not eligible for Medicaid EP status <p>Sample re-verified :</p> <ul style="list-style-type: none"> Patient volume requirements continue to be met EP Practices predominantly in non-hospital Has the provider met MU? Measure submission to confirm MU Provider is using certified EHR technology 	Inclusion of data elements in provider subsystem				11 Testing with providers as needed Spring 11	<p>ation/Marketing through workgroup</p> <p>Joint communication and training through REC</p> <p>Determine if any laws/reg must be amended & do so</p> <p>Update state legislature in fall</p>
	Alabama complete registration of EHs and EPs:	Edits and audits in MMIS system	AMA policy and IT staff	y		Implementation within 9	-APD Contract Amendmen

Process		Alabama Impact/Needs		90/10 HIT FFP		Date	Action Steps
CMS	Alabama Medicaid Agency (ASMA)	Systems	Human Resources	Yes	No		
	Payment Yr 3 MU for year EHs: <ul style="list-style-type: none"> • Medicaid only EHs • Medicare and Medicaid EHs • Medicaid EPs • Medicare EPs – not eligible for Medicaid EP status Sample re-verified : <ul style="list-style-type: none"> • Patient volume requirements continue to be met • EP Practices predominantly in non-hospital • Patient volume requirements • Practices predominantly Sample re-	Web portal to submit information from provider to AMA and reverse Inclusion of data elements in provider subsystem	FA Contract Potential REC staff			months of 1/1/11 Testing NRL Fall 10when determined by CMS	t to Current MMIS Contract Develop P & Ps Communication/Marketing through workgroup Joint communication and training through REC Determine if any laws/reg must be amended & do so Update state legislature in fall

Process		Alabama Impact/Needs		90/10 HIT FFP		Date	Action Steps
CMS	Alabama Medicaid Agency (ASMA)	Systems	Human Resources	Yes	No		
	verified : <ul style="list-style-type: none"> • Patient volume requirements continue to be met • EP Practices predominantly in non-hospital • Has the provider met MU? • Measure submission to confirm MU or AIU • Provider is using certified EHR technology • Notification to NLR and provider that the provider is excluded or so far eligible. 						

Process		Alabama Impact/Needs		90/10 HIT FFP		Date	Action Steps
CMS	Alabama Medicaid Agency (ASMA)	Systems	Human Resources	Yes	No		
	<p>ASMA to inform the NLR of the final eligibility of EPs and Hospitals that selected Medicaid.</p> <p>ASMA will send the NLR the eligibility of new Medicaid providers that have requested registration into HITECH.</p>	Ability to receive daily batch	<p>ASMA policy and IT staff</p> <p>FA Contract</p> <p>Potential REC staff</p>	Y		Batch Daily Starts 1/1/11	<p>I-APD</p> <p>Contract Amendment to Current MMIS Contract</p>
NLR sends ASMA information submitted by the hospital via the CMS Attestation Module.	<p>Alabama completes verification of attestation by provider through sample of providers:</p> <p>Numerator: Medicaid or MN</p> <p>Denominator: Book of Business public/private</p> <p>Compare N/D to Reg required for provider type and determine if</p>		<p>Program Integrity at ASMA and Provider Enrollment staff at FA to determine appropriate N/D and validate a sample</p>	Y		Batch Daily Starts 1/11	<p>I-APD</p> <p>Contract Amendment to Current MMIS Contract</p> <p>Develop provider enrollment form; create data and verification request from providers and establish policies and</p>

Process		Alabama Impact/Needs		90/10 HIT FFP		Date	Action Steps
CMS	Alabama Medicaid Agency (ASMA)	Systems	Human Resources	Yes	No		
	meets requirements. For cross-states validate with other states listed by provider.						procedures
	ASMA actions for denials: <ul style="list-style-type: none"> Determine denial or closure based on basis of ineligibility (not an eligible provider), not able to demonstrate IAU or MU, has not reported quality measures, etc. Send notice of denial to provider. Send provider appeal rights. Implement appeal process. 	Systems for provider appeals process- does not currently exist	Program Integrity at ASMA and Provider Enrollment staff at FA	y		Prior to 1/11	Determine components appealable Adjust internal state appeal process to add new process Establish P & Ps internally and externally

Process		Alabama Impact/Needs		90/10 HIT FFP		Date	Action Steps
CMS	Alabama Medicaid Agency (ASMA)	Systems	Human Resources	Yes	No		
	<ul style="list-style-type: none"> Post-appeal decisions incorporated into ASMA system and notification back to CMS. 						
	Alabama to check NLR for incentive payments already made to provider.	Adjustment to current MMIS and connect to NLR capacity		Y		Batch Weekly Start 4/1/11	I-APD Contract Amendment to Current MMIS Contract
ASMA will communicate back to the NLR and the NLR will store this info: <ul style="list-style-type: none"> Whether an EP or eligible hospital is a meaningful EHR user or adopted, implemented, or upgraded The remittance date and amount of any incentive 	ASMA makes payment: EP Limits Payment Yr 1 = \$21,250 EP Payment after yr 1 = \$8500 Start date of incentive payment for provider specific stop date ASMA calculates payment for each provider: <ul style="list-style-type: none"> Hospitals: 	Capability to address when EP reassigns incentive payment to employer or entity they have contractual relationship with.	FFA contract	y		1/11	ASMA assumes that as soon as AMA indicates to CMS intent to pay that the record is "locked" down at the NLR so that no other states can make payments as AMA will pay weekly and only be reporting to

Process		Alabama Impact/Needs		90/10 HIT FFP		Date	Action Steps
CMS	Alabama Medicaid Agency (ASMA)	Systems	Human Resources	Yes	No		
payments made to an EP or eligible hospital	<p>formula described in reg. EPs:</p> <ul style="list-style-type: none"> • AAC/NAAC process described in regulation • System edits against sanctions/ death files before payment • MMIS disburses payment to TIN – states validates TIN • MMIS creates report to notify NLR that a payment was made to EH or EP and amount. Alabama's understanding is that ASMA will provide the 						CMS monthly based on this scenario.

Process		Alabama Impact/Needs		90/10 HIT FFP		Date	Action Steps
CMS	Alabama Medicaid Agency (ASMA)	Systems	Human Resources	Yes	No		
	<p>following to the NLR: provider eligibility daily; payment determination batch – weekly; after payment monthly.</p> <ul style="list-style-type: none"> • MMIS creates reports for internal management • Reports to Finance for Drawdown (37/64) • MMIS creates Payment History By Provider 						
	<p>Initiates tracking of provider:</p> <ul style="list-style-type: none"> • Continued eligibility as a provider annually • Start date of incentive payment for provider 	MMIS adjustments	FFA contract and AMA staff	Y		Prior to 1/11	I-APD Contract Amendment to Current MMIS Contract

Process		Alabama Impact/Needs		90/10 HIT FFP		Date	Action Steps
CMS	Alabama Medicaid Agency (ASMA)	Systems	Human Resources	Yes	No		
	specific stop date						
NLR to send AMA the cost report data elements utilized by CMS to determine Medicare hospital payments.	ASMA receive and utilize data			Y		Batch Monthly Starts 4/1/11	I-APD Contract Amendment to Current MMIS Contract
	ASMA. Federal and state fiscal reporting • 37 and 64		AMA and Financial staffing FFA	y		Fall 2010	I-APD Contract Amendment to Current MMIS Contract
	ASMA oversight of e-prescribing	TBD – See AHIE S/OP	TBD	Y		Summer 2011	I-APD
	ASMA involvement in structured lab and clinical exchange	See AHIE S/OP	TBD	Y		Summer 2011	I-APD & AHIE RFP
CMS Quality Reporting Mechanisms	ASMA Quality Report: Design and Implementation of reporting measures, oversight and feedback to providers based on the electronic specifications	Expanded MMIS capability				2011	-APD Contract Amendment to Current MMIS Contract AHIE RFP and

Process		Alabama Impact/Needs		90/10 HIT FFP		Date	Action Steps
CMS	Alabama Medicaid Agency (ASMA)	Systems	Human Resources	Yes	No		
	provided by CMS (See Table 3 below)						contractor
	ASMA. to inform the NLR of incentive payments made to Medicaid Hospitals and EPs. Batch Monthly	Expanded MMIS capability		Y			I-APD Contract Amendment to Current MMIS Contract
	ASMA determine if any MCO implications and if so implement adjustments	TBD	ASMA Staff	Y		Fall 2010	Policy analysis and contract amdts if appropriate
	Obtain initial and ongoing state budget match for FFP	Expanded MMIS capability	ASMA and Financial Staff	Y		Prior to begin of FFY	State Plan Amendment for EPs and EHs and fiscal impact submitted to CMS

4.1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

Standard: ASMA requires and verifies Medicaid providers are properly licensed/qualified providers, have not been sanctioned, and comply with other Medicaid provider enrollment requirements related to ownership, control, relationship and criminal

conviction before they are enrolled in the program. ASMA issues provider contracts to physician applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*. As per program integrity requirements, review is done at specified times as well as when provider behavior results in a review in compliance with federal Medicaid requirements.

In addition, CMS has validated that if the provider is dead or excluded and also enrolled in Medicare, the provider will be stopped at the NLR level and not allowed to proceed. While this will not address providers not enrolled in Medicare, it will provide an additional means to prevent enrollment of a subset of providers. Excluded providers who show up in the DMF will be allowed to proceed but will be flagged as ineligible to attest at the NLF until the issues are resolved. Alabama will track against the exclusion information to the state from the NLR.

Alabama understands that CCN and NPI will be verified at the NLR but there is no verified taxonomy associated with the NPI so it will be the responsibility of the state to address this.

Methodology: Alabama Medicaid cross-checks the OIG's website for list of excluded providers and maintains an updated list of providers excluded from participation in Alabama Medicaid. To further protect against payments for items and services furnished or ordered by excluded parties, all current providers and providers applying to participate in the Medicaid program are required (Alabama Medicaid Provider Manual, Chapter 7, Sections 7.3.1 and 7.3.2) to determine whether their employees and contractors are excluded individuals or entities.

Process: In addition to CMS' checking for exclusion in PECOS, the Master Death File (MDF) and the Medicare Exclusions Data, ASMA will review providers for sanctioning consistent with current program integrity requirements and methodologies. As the first step for provider enrollment is verification of eligibility to be a Medicaid provider, not sanctioned by Medicare, and/or not excluded by any other state Medicaid program, this step will have been completed prior to review for MU Incentive Payments. The Medicaid system also has edits in place to assure a payment is not issued to a provider who is sanctioned after enrollment.

As providers who are eligible for MU Incentive Payments are a subset (physicians, nurse practitioners, certified nurse-midwives, dentists and physicians assistants in a FQHC/RHC) of all eligible Medicaid providers in the state, provider enrollment processes and ongoing program integrity activities will be maintained for those that cover this group of providers. ASMA understands that the physician assistants must be

leading an FQHC to be eligible, not just working in a FQHC. The provider enrollment file will provide this level of information.”

It is not anticipated that additional actions would be implemented as review for sanctioning is a core program integrity activity in the Alabama Medicaid Program. Alabama already does both pre and post audit activities as a part of their ongoing program integrity activities for the Medicaid Program.

4.2. How will the SMA verify whether EPs are hospital-based or not?

Hospital based as defined in the final regulation is an EP who furnishes 90 percent or more of his or her covered professional services in a hospital setting in the year preceding the payment year. For Medicare, this will be calculated based on the Federal FY prior to the payment year.

Standard: AMA will also use Federal FY prior to the payment year for consistency between programs. The hospital-based exclusion is defined as “90% or more of their covered professional services is in either an inpatient (POS 21) or emergency room (POS 23). The hospital-based exclusion does not apply to the Medicaid-EP qualifying based on practicing predominantly at a FQHC or RHC.

Methodology: A setting is considered a hospital setting if it is a site of service that would be identified by the codes used in the HIPAA standard transactions as an inpatient hospital, or emergency room setting. The codes are: 21 for inpatient hospital and 23 for emergency room – hospital.

Process: Alabama will match any decision made by Medicare if Medicare has made a determination and that information is readily available through the NLR. For all others ASMA will exclude all hospitalist and ER physicians through an analysis of the previous FFY’s claims from providers enrolled in the system as hospitalists or ER physicians. From the claims data, ASMA will identify the percentage of claims from the provider that are for services provided in a hospital or emergency room as defined by CMS. A provider will indicate yes or no. Either way, upon completion of an application, a process will determined whether 90% of claims submitted by the provider are an inpatient or ER. Those in which 90% are in IP or ER will be considered hospital-based even if they answer question no. A report showing claim volume will be generated for use by the staff for auditing purposes. If provider indicated hospital-based, the process stops. If the provider indicates no, the worker will proceed to the next question regarding FQHC/RHC status. At completion of the application the system will determine if claim volume is greater than or equal to 90%. If yes the application is suspended and if no, the payment is approved. Appropriate notification will be sent at that time and provider appeal rights will be granted. AMA will not exclude providers predominantly

practicing at a FQHC or RHC so the state will identify by location and enrollment data for those appropriate providers and assure that edits are in place to allow payment for this subset of providers.

4.3. How will the SMA verify the overall content of provider attestations?

Standard: Alabama plans to implement a risk-based auditing approach with pre- and post sampling process to prevent making improper Medicaid EHR Incentive payments and to monitor the program for potential fraud, waste, and abuse.

Methodology: For 2011, ASMA will focus staff resources to auditing functions related to validating:

- Provider eligibility in 5 areas: credentialing, sanction status, hospital-based status, practicing predominately in FQHC/RHC and eligible professional or institution type.
- Patient volume through use of claims data.
- Adopt, implement, or upgrade (AIU): since CMS does not anticipate that States will audit meaningful use in 2011 as all eligible Medicaid providers can receive an EHR incentive payment for AIU in their first participation year, the focus will be on the “a” and the “u”, which will require validation against the ONC list of certified EHRs.

The REC will not provide any audit functions for ASMA as a part of this contract. It is the intent of ASMA to limit site visiting and use data sources to validate attestations unless there is clear reason to do otherwise. The state will expand and amend its process once it is aware of the Medicare plan for auditing and further guidance from CMS is received. ASMA will seek to leverage Medicare efforts, particularly but not solely for hospitals that are eligible for both Medicare and Medicaid EHR incentive payments. Since Medicare will not *be auditing the Medicaid only hospitals (children’s hospitals)*, and there is only one wholly functioning Children’s Hospital,, the hospital will be subject to the same auditing processes and parameters as other acute care hospitals participating in the incentive program

Process:

- The NLR will provide information about providers who have applied for the incentive program. After passing high level editing during the NLR file processing most records will be loaded into the state system. The provider will access the

state system and register to use the provider portal. If the provider is not Alabama Medicaid enrolled, the provider will be required to do so prior to registering on the system.

Enrolled providers who are not a Medicaid HITECH provider type on the MMIS enrollment file will not be able to access the enrollment system and will be directed to Medicaid via information on the provider portal and/or website. If the enrolled provider has a valid logon ID and provider type, a link will be presented for the provider to access the state system.

The system home page will have a status bar displaying the status of the provider applicant's record. The system will use the NPI associated with the logon ID or any service location associated with the logon ID to search for a match. If a match is found, the provider has been verified and will proceed to the next step. If no match is found, then the provider will be given an error message indicating that there is no match for the record from the NLF. The provider will be instructed to contact the NLR.

The Provider enters the state system and verifies the NLR information (NPI, provider name, business address/phone, personal TIN, payee TIN, payee address, Medicaid agency, Medicaid state, legal entity name, payee legal entity name, payee address, provider type and email address). Once the provider confirms the information, the provider will proceed. If the information is not confirmed, the record will suspend as incomplete and the applicant will be directed to the NLR to fix the information.

- *Provider Type:* Provider confirms HITECH provider type (pediatrician-20% threshold) If provider does not confirm type, the application will be considered incomplete and the provider will need to contact AMA. If the provider type entered by the applicant does not match the provider type in the enrollment file, the provider information will be placed on a report for provider enrollment file maintenance.
- *Credentialing:* provider indicates specialties for which they are board certified (15 board specialties associated with quality measures – other and none are also valid selections – if provider indicates other, the provider will need to explain via entry in a text box).
- *Hospital based status:* A provider will indicate yes or no. Either way, upon completion of an application, a process will determine whether 90% of claims submitted by the provider are an inpatient or ER. Those in which 90% are in IP or ER will be considered hospital-based even if they answer question no. A report showing claim volume will be generated for use by the staff for auditing purposes. If provider indicates hospital-based, the process stops. If the provider indicates no, the worker will proceed to the next question regarding FQHC/RHC status. At completion of the application the system will determine if claim

volume is more than 90% - if yes application is suspended and if no, payment is approved.

- *Practicing Predominately in FQHC/RHC:* (more than 50%): provider indicates yes or no. If yes, provider applicant will provide the name(s) of the FQHCs/RHCs sites. If provider is full-time employee of an FQHC/RHC, he will so indicate. The FQHC/RHC will validate through a listing to the state of all full-time employees/contractors. If there is a match, the numerator and the denominator for the FQHC/RHC from the first quarter of the year prior to the payment year will determine eligibility of the provider. If the provider is less-than full-time, the provider will indicate days/time per week per FQHC/RHC site(s). If more than 50% of time, state will validate with FQHC/RHC providers percentage of time and total percentages across sites. If greater than 50%, the numerator and the denominator for the FQHC/RHC from the first quarter of the year prior to the payment year will determine eligibility of the provider. If total needy individuals percentage for the FQHC/RHC is 30% or greater, the provider will proceed to attestation.

If provider does not practice predominantly in an FQHC/ RHC, the provider enters the Medicaid population from all their locations and if the percentage is over 30% (20% pediatrician), the provider moves to attestation. If less than the required percentage, the applicant does not meet the threshold requirement and is suspended/rejected. Provider applicant will not be able to proceed.

- *Patient volume:* through use of claims data:
- *Adopt, implement, or upgrade (AIU):* Adopt - if system is EHR certified proceed; if not, flag for suspense; for implementation, if certified system, proceed. Provider identifies implementation tasks completed in the last year and if none, tag for suspense, and if upgrade, same as above. The state is determining what documentation will be required for validation.

Alabama intends to do random (more intense targeted in the initial year) reviews to validate attestations. In addition, the state intends to create a document for the provider to supply the attestation that will include penalties for inaccurate information and require them to specifically state what they have done. The state will also require the actual EP to sign the authorization, which will provide program integrity to have an enhanced legal argument if action is required. Alabama will collect the certified EHR technology code as part of provider attestation for AIU, and will verify that the code is on the Office of the National Coordinator (ONC) list of certified EHR technology prior to issuing an incentive payment to that provider.

- *Provider Attestation:* Medicaid must confirm registration, no sanctions, compliance with HIPPA and confirm license to practice

- *Provider Payee Determination:* made and validated in MMIS in order to make payment.
- *Payment:* automatically generate financial transaction from the records that are ready for payment

4.4. How will the SMA communicate to its providers regarding their eligibility, payments, etc?

The State HIT Coordinator, Kim Davis-Allen, who is also project lead for the SMHP, is responsible under the governance structure for coordination with the REC efforts to support the statewide vision & implementation of MU.

Standard: Specifically related to eligibility payments, AMA is planning on using the same MMIS infrastructure it uses today for other payments to Medicaid providers, including the FA provider relations staffing, general provider training related to MU, potentially sponsorship of additional webinars, use of remittance advices, provider manuals, etc. Maximum payment the first year is \$21,250 (calendar year) with no extra bonus for health professional shortage areas. Additional years are at \$8,500 for a total of 6 years with the ability to “skip” a year. Maximum is \$63,750.

Methodology: Information related to the base line but also providing a guide to what information and how best to communicate that information was included in the environmental scan that was drawn from Alabama-specific data gathered through the American Hospital Association (AHA) national survey; an Alabama initiated survey of specified providers, a collection of information from subject matter experts, and data from various state associations. The detailed results are provided in Section 3.0 and the Environmental Scan Survey Tool is included Appendix 5.2 of Appendix 8.1.

Information related to the three core components will be included in all information provided to eligible and interested providers: use of certified EHR in a meaningful manner (e.g., e-prescribing); use of certified EHR technology for electronic exchange of health information to improve quality of health care, and use of certified EHR technology to submit clinical quality measures (CQM) and other such measures selected by the Secretary.

Focus for the first year will be to adopt (acquire), implement or upgrade to a certified EHR technology for which there is no reporting period; registration requirements; use of attestations, and compliance requirements. Additional information will be provided as requested and needed related to quality reporting, MU initial payment year requirements (90 days and use of attestation) and ongoing requirements.

CMS has already developed a number of HITECH products conveying important information about the EHR incentive programs that will be considered by Alabama for Medicaid providers in the state's HITECH communications and outreach plans that are included in the AHIE marketing and communication plan. The products will be downloaded from the CMS EHR Incentive Programs website.

Process: The RECs will take a lead as trusted source of information for providers. Effective collaboration with the Regional Extension Center (REC) in Alabama was identified as a key strategy in making the most of other ARRA funded activities. The Advisory Commission and AMA also is considering the benefit to providers and Medicaid, of additional contracted engagements with the REC through a Medicaid specific contract for purposes of assisting providers in meaningful use activities. Alabama will also incorporate to the degree appropriate the use of CMS Medicare & Medicaid EHR incentive programs fact sheets addressing EHRs and "meaningful use" as they become available.

The MU Project Manager explicitly is required to coordinate outreach functions to educate providers about re MU and that is included in the job specifications. To better prepare an effective set of messaging to the broader set of providers who will impact and be impacted by the MU of the information, Alabama has established an expansive provider and consumer communication plan. The core messaging audiences are hospitals, physicians, laboratory/x-ray entities, pharmacies, providers of ancillary services, other providers, rural health clinics, patients/consumers, payers, purchasers, state agencies, health professional school, general public and the federal and state government. The core messages developed through audience specific research are included in Section 3.2.6 of Appendix 8.1.

Since provider appeal rights are new to the process, ASMA is considering the best methodology to notify providers of their appeals related to eligibility and payment so it fits within the normal communication processes. The provider appeals process will be in place prior to the end of the first quarter in calendar year 2011 to assure ASMA can address any provider appeals related to registration, eligibility and payment. Although the appeal process does not exist today, it is in the process of being implemented and will be operational prior to the MU registration system at ASMA going live. As soon as all the details are finalized, the information will be included in all the previously identified communication efforts with providers.

4.5. What methodology will the SMA use to calculate patient volume?

This is one of the identified “risks” in the AHIE S/OPs. It is critical for the MU provider eligibility determination; yet, it requires data that does not currently exist.

Standard: Alabama is following the regulation established criteria for EPs who are not pediatricians or FQHCs/RHCs that the EPs have a minimum of 30 percent of all patient encounters attributable to Medicaid (20 percent for pediatricians) over any continuous 90-day period within the most recent calendar year prior to the reporting calendar year. For Medicaid EPs practicing predominantly in an FQHC or RHC, they must have a minimum of 30 percent patient volume attributable to “needy individuals” over any continuous 90-day period within the most recent calendar year prior to the reporting calendar year. In order to standardized and implement, the state has determine that no out of state enrollees will be included in either the numerator or denominator, no minimum number of patient volume/encounters is required, the provider can choose the 90 day period within the calendar year, and since the Alabam Medical Home initiative does not meet PCCM requirements, there will not be a separate calculation for hose providers at this time. If and when appropriate, Alabama will implement the following methodology provided in the regulation for Medicaid enrollees of Medical Homes or MCOs: $\{[\text{Total (Medicaid) patients assigned to the provider in any representative continuous 90-day period in the preceding calendar year, with at least one encounter taking place during the calendar year preceding the start of the 90-day period}] + [\text{Unduplicated (Medicaid) encounters in the same 90-day period}]/[\text{Total patients assigned to the provider in that same 90-day period, with at least one encounter taking place during the calendar year preceding the start of the 90-day period}] + [\text{All unduplicated encounters in that same 90-day period}]\} * 100$

The denominator is all patient encounters for the same individual professional over the same 90-day period as the numerator. The data source will a report run from the provider’s internal management system, which the provider will attach as as PDF to his/her submission.

Hospitals are eligible for both Medicare and Medicaid using their CMS certification number (one certification number = one hospital). An acute hospital must have a patient volume of 10% Medicaid. No out of state enrollees will be in the numerator or denominator and there is no minimum number of patient volume/encounters.

Since there is no Medicaid patient volume for Children’s Hospitals, AMA intends to assure no unnecessary barriers are established that could delay participation by Children’s Hospitals.

Methodology: $\{[\text{Total (Medicaid) patients assigned to the provider in the first quarter of the preceding calendar year, with at least one encounter taking place during the calendar year preceding the start of the 90-day period}] + [\text{Unduplicated (Medicaid) encounters in the same 90-day period}]/[\text{Total patients assigned to the provider in that same 90-day period, with at least one encounter taking place during the calendar year preceding the start of the 90-day period}] + [\text{All unduplicated encounters in that same 90-day period}]\} * 100$. The data source is the management system of the provider for the denominator and the Alabama MMIS system for the numerator. Volume is determined by paid encounter by unduplicated per date of service from practice management

Alabama is using the CMS specified definitions provided in the regulation. For instance, EP practices predominantly at an FQHC or an RHC when the clinical location for over 50 percent of his or her total patient encounters over a period of 6 months occurs at one or more FQHCs or RHCs. An EP meeting this definition would be allowed to count enrollees who are CHIP and uninsured as well as Medicaid and Medicare in their patient volume thresholds. As required by the regulation, though, Alabama will downward adjustment to the uncompensated care figure to eliminate bad debt data.

Methodology for patient volume for an EP is as follows: The FQHC shall verify that during Jan-March 3 month period for dates of services from previous calendar year for reporting year they have 30% MN patient volume then all of their EPs who practice predominately there can use that as a proxy for their own. FQHC will be contacted by state to validate providers and list all providers that are there 100%, 50-100% and less than 50% of time and % they are at that FQHC/RHC. The state will create a table that totals, by provider, their eligibility as meeting the 50% requirement. This will occur when a provider registers the system and will validate against the table.

Related to "PA led" EP, Alabama will follow the regulation definitions and make a determination from the current MMIS provider data on the eligibility of an Alabama PA: When a PA is the primary provider in a clinic (for example, when there is a part-time physician and full-time PA, we would consider the PA as the primary provider); when a PA is a clinical or medical director at a clinical site of practice; or when a PA is an owner of an RHC.

Alabama will include general short-term hospitals, cancer hospitals, and critical access hospitals that meet the Medicaid patient volume criteria. Alabama will allow clinics and group practices to use the practice or clinic management system as the data source for the denominator and the Alabama MMIS for the Medicaid patient volume (or needy individual patient volume, insofar as it applies) and apply it to all EPs in their practice under three conditions: 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.

For EHs, the methodology is as follows with the data source being the internal hospital management system for the patient days from the hospital spreadsheet: Overall EHR Amount * Medicaid Share (Overall EHR amount defined as: {(sum over 4 years of [base amt+ discharge related amount applicable for each year]) * transition factor applicable for each year} * (Medicaid Share defined as ((Medicaid inpatient-bed-days + Medicaid managed care inpatient-bed-days)/ {(total inpatient-bed-days) * (estimated total charges- charity care charges)/ (estimated total charges)})))

Process:

The state anticipates that the eligible provider will be required to utilize its existing practice management system to produce the “denominator” report defined as paid encounters unduplicated per date of service. The same parameters will be used to collect information from Medicaid MMIS. Validation of the denominator will be accomplished through the requirement for a provider to “upload” a copy of the report into the State Level Repository Validation of the numerator that includes Alabama Medicaid enrollee claims encounters handled through the current MMIS with a new report that validates for the first three month period of the previous calendar year (reporting year) *for the number of Alabama Medicaid enrollee encounters for the provider.*

Another focus area that is in process is the relationship to tribal facilities. EPs at facilities such as FQHCs, RHCs, and tribal clinics may be eligible for participation when they practice predominantly at an FQHC or RHC or meet the other patient volume requirements; therefore ASMA is determining of the methodology used for all other FQHCs/RHCs will suffice or if additional measures must be taken in relationship to tribal clinics.

Validation of the numerator that includes Alabama Medicaid enrollee encounters will handled through the current MMIS with a new report that validates for the last FFY the number of Alabama Medicaid enrollee encounters for the provider for .

For EHs the process is as follows:

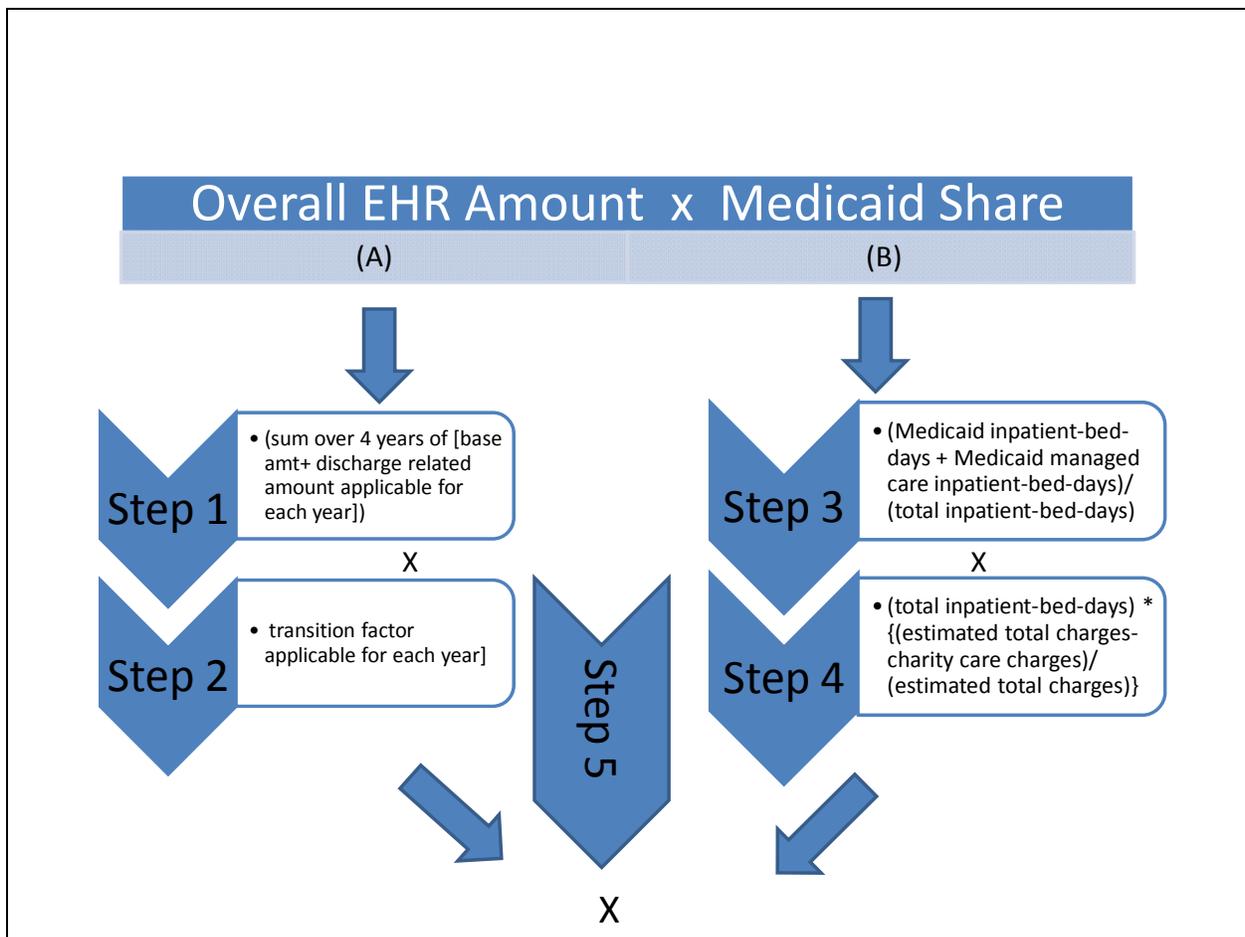
Overall EHR Amount (A):

- Definitions:
 - Discharge (1886 N2C of Final Rule): Discharge \$ Amount for All Patients (regardless of payment source)

- Initial amount: Base Amount (\$2M) + Discharge Related \$ Amount
- Year 1: Federal Fiscal Year prior to Payment Year
- Data Source: MMIS or Audited Medicaid Hospital Report (suggested: audited hospital report for comparability)

Medicaid Share (B):

- Definitions:
 - Medicaid Bed Days = Total Medicaid (not CHIP) for FFY prior to Payment Year (*AL doesn't make distinction of ER*) (S-3, Col. 5, Line 12)
 - Total Bed Days = Total Bed Days for all Payers for FFY prior to Payment Year (S-3, Part 1, Col. 6, line 12 + Col. 6, line 28)
- Data Source: MMIS or Medicaid Audited Hospital Report (suggested: audited hospital report for comparability)



4.6. What data sources will the SMA use to verify patient volume for EPs and acute care hospitals?

Standard: The data that is required to calculate patient volume is not readily available within the Medicaid and/or any state data base (provider book of business, which is needed to establish the denominator); it requires data that may be drawn from a state Medicaid data set for the numerator and data from the provider's practice management system for the denominator.

An Eligible Professional who works at multiple locations but does not have certified EHR technology available at all of them would have to have 50% of their total patient encounters at locations where certified EHR technology is available as the state must base all meaningful use measures only on encounters that occurred at locations where certified EHR technology is available

Methodology: ASMA is working through SERCH, the AHIE Advisory Commission and with CMS to finalized a process to collect the information in the least burdensome but accurate and timely way. Per earlier questions, all providers must register via the EHR Incentive Program website and be enrolled in Medicare FFS, MA, or Medicaid (FFS or managed care), have a National Provider Identifier (NPI), and use certified EHR technology. Medicaid providers may adopt, implement, or upgrade in their first year. All Medicare providers and Medicaid eligible hospitals must be enrolled in PECOS <http://www.cms.gov/EHRIncentivePrograms>. Alabama will interface with the National Level Repository through an expanded MMIS interface and providers will attest to information as indicated previously, including patient volume, licensure, MU, predominance of practice, and hospital based status. Registration requirements include: name of EP, NPI, business address and phone, TIN, Medicare or Medicaid program selection and state selection. The supporting HIT infrastructure is discussed in a previous question in this section.

Process: Validation of the denominator is a business operation process that is still being finalized. It is anticipated that the eligible provider will be required to utilize its existing practice management system to produce the "denominator" report defined as paid encounters unduplicated per date of service. The same parameters will be used to collect information from the Alabama Medicaid MMIS. Validation of the denominator will be accomplished through the requirement for a provider to "upload" a copy of the report into the State Level Repository.. Validation of the numerator, which includes Alabama Medicaid enrollee claims encounters, will be handled through a new report generated by the current MMIS that validates for the first three month period of the previous calendar year (reporting year) the number of Alabama Medicaid enrollee encounters for the

provider. The provider applicant will be required to attest to the numerator and denominator.

As indicated earlier, the need for standardized tools and specifications in order to assure the numbers can be blended is critical and one of the priorities for Alabama over the next months.

The state anticipates that the certified EHR technology will be available and listed on the ONC site this fall with registration for the EHR Incentive Program anticipated to begin no earlier than January 2011. Attestation will begin by March to April 2011.

For EHs the data source for the Overall EHR Amount (A) is MMIS or Audited Medicaid Hospital Report (suggested: audited hospital report for comparability) and the data source for the Medicaid Share (B) is also the MMIS or Medicaid Audited Hospital Report (suggested: audited hospital report for comparability).

It is the state's understanding that CMS plans to provide templates developed by CMS' TA contractor and while the state is moving forward to develop the technical infrastructure to support these activities, the state will consider any and all templates that are received timely.

4.7. How will the SMA verify that EPs at FQHC/RHCs meet the practices predominately requirement?

Standard: An EP practices predominantly at an FQHC or an RHC when the clinical location for over 50 percent of his or her total patient encounters over a period of 6 months occurs at an FQHC or RHC. Thus, AMA must determine the following:

- Does the EP practice in a setting other than the FQHC/RHC? If not, standard is met.
- If the EP practices in a setting other than the FQHC/RHC, are over 50 percent of his/her total patient encounters over a period of 6 months at the FQHC/RHC or at other locations? If at FQHC/RHC, standard is met. If not, it is not.

Methodology for Denominator: EPs must attest to their denominator and in attesting to the denominator of their total book of business, AMA will request that the EP state locations of practice, including FQHCs/RHCs and total population by location using the following definitions.

- In determining the "needy individual" patient volume threshold that applies to EPs practicing predominantly in FQHCs or RHCs, section 1902(t)(2) of the Act authorizes the Secretary to require the downward adjustment to the

uncompensated care figure to eliminate bad debt data. ASMA will downward adjust the uncompensated care figure based on Medicare cost reports or other auditable records to identify bad debts. All information is subject to audit. Needy individual is defined as one to whom Medicaid or CHIP or a Medicaid or CHIP demonstration project under section 1115 of the Act paid for part or all of the service; including premiums, co-payments, and/or cost-sharing; or services rendered to an individual on any one day on a sliding scale or that were uncompensated.

- Individuals enrolled in MCOs, prepaid inpatient health plans (PIHPs), or prepaid ambulatory health plans (PAHPs) will be included in the patient volume calculation.
- Patient volume will be determined by calculating the numerator of the EP's total number of Medicaid patient encounters in the first quarter in the preceding calendar year and the denominator is all patient encounters for the same EP over the same 90-day period. The calculation for needy individual is the same, however, includes a larger group in the definition of needy individual. Encounters is defined as services rendered on any one day to an individual where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid for part or all of the service; or services rendered on any one day to an individual for where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid all or part of their premiums, copayments, and/or cost-sharing. However, for needy patients encounters, it includes services rendered on any one day to an individual where Medicaid or CHIP or a Medicaid or CHIP demonstration project under section 1115 of the Act paid for part or all of the service; services rendered on any one day to an individual where Medicaid or CHIP or a Medicaid or CHIP demonstration project under section 1115 of the Act paid for part or all of the service; including premiums, co-payments, and/or cost-sharing; or services rendered to an individual on any one day on a sliding scale or that were uncompensated
- If the EP practices at both a Federally Qualified Health Center (FQHC) and within his or her individual practice, certified EHR technology would have to be available at the location where the EP has at least 50 percent of their patient encounters.

Where the EP states the EP is full-time at the FQHC/RHC and the FQHC/RHC confirms per the process below, the standard is met. (For auditing purposes, AMA may cross check the provider's enrollment history and claims data to determine if Medicaid has been billed by the provider outside the FQHC. If a discrepancy is found, further action will be pursued). Where the EP is less-than full time, AMA will make a determination of "predominantly at an FQHC".

Methodology for Numerator: If the EP is full-time at the FQHC/RHC, the standard will be met following the process indicated below. If the EP is less than full time but the EP can reach the 30% standard using Medicaid enrollees, no further action is required and the EP is eligible. If the EP cannot reach the 30% standard, then a determination of “predominantly at an FQHC/RHC” will be made.

To calculate Medicaid patient volume, the calculation is based on dividing the total Medicaid patients assigned to the EP’s panel in the first quarter of the preceding calendar year when at least one Medicaid encounter took place with the Medicaid patient in the year prior to the 90-day period plus unduplicated Medicaid encounters in the same 90-day period by the total patients assigned to the provider in that same 90-day period with at least one encounter taking place with the patient during the year prior to the 90-day period plus all unduplicated patient encounters in the same 90-day period. For the FQHC/RHC the calculation requires dividing the total Needy Individual patients assigned to the EP’s panel in the first quarter of the preceding calendar year when at least one Needy Individual encounter took place with the Medicaid patient in the year prior to the 90-day period plus unduplicated Needy Individual encounters in the same 90-day period by the total patients assigned to the provider in that same 90-day period with at least one encounter taking place with the patient during the year prior to the 90-day period plus all unduplicated patient encounters in the same 90-day period.

Process: Each FQHC/RHC in the state will be contacted annually by ASMA using the MMIS system listing of FQHCs/RHCs paid by Medicaid and asked to state for EPs within the organization the identification of those that are full-time and those who are not full-time. For those providers who are not full-time, the FQHCs/RHCs will estimate total volume of patients and their estimated “needy patients” volume using the definitions provided, and the number of encounters at the FQHC/RHC the specific EP engaged in over a specified 6 month period using the same definitions as provided above. ASMA will use the encounter count as the determining value; however, if an EP disputes the count the EP will be allowed to provide validated information to seek an adjustment.

4.8. How will the SMA verify adopt, implement or upgrade (IAU) of certified electronic health record technology by providers?

Standard: There is no EHR reporting period for demonstrating adoption, implementation or upgrading certified EHR technology by Medicaid EPs and EHs, but the entity must be registered with the NLR and select Alabama as the payment state. Since EPs/EHs can switch prior to payment, review of the NLR prior to payment will be required.

Adopting, Implementing or Upgrading: providers may receive a first year of payment if they have installed and commenced utilization of certified EHR technology (as “a qualified electronic health record (as defined in section 3000(13) of the Public Health

Service Act) that is certified pursuant to section 3001(c)(5) of such Act as meeting standards adopted under section 3004 of such Act that are applicable to the type of record involved (as determined by the Secretary), such as an ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals).” capable of meeting meaningful use requirements; or expanded the available functionality and commenced utilization of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training. For the purposes of demonstrating that providers adopted, implemented, or upgraded certified EHR technology, we proposed that Medicaid EPs and hospitals would have to attest to having adopted, (that is, acquired and installed) or commenced utilization of (that is, implemented) certified EHR technology; or expanded (that is, upgraded) the available functionality of certified EHR technology and commenced utilization at their practice site.

Methodology: ASMA will verify that providers have actually completed one of the three of adopted, implemented or upgraded certified EHR technology, patient volume, as well as other requirements. These include verifying that attestations are consistent with methodologies to combat fraud and abuse including staff training and efforts to redesign provider workflow under the definition of implementing certified EHR technology in order for providers to demonstrate progress towards the integration of EHRs into their routine health care practices to improve patient safety, care, and outcomes.

- Adopt: evidence that a provider demonstrated actual purchase/acquisition and or installation
- Implement: evidence that a provider has installed certified EHR technology and has started using the certified EHR technology in his or her clinical practice. Implementation activities would include staff training in the certified EHR technology, the data entry of their patients' demographic and administrative data into the EHR or establishing data exchange agreements and relationships between the provider's certified EHR technology and other providers, such as laboratories, pharmacies, or HIEs.
- Upgrade: the expansion of the functionality of the certified EHR technology, such as the addition of clinical decision support, e-prescribing functionality, CPOE or other enhancements that facilitate the meaningful use of certified EHR technology. An example of upgrading that would qualify for the EHR incentive payment would be upgrading from an existing EHR to a newer version that is certified per the EHR certification criteria promulgated by ONC related to meaningful use. Upgrading may also mean expanding the functionality of an EHR in order to render it certifiable per the ONC EHR certification criteria.

Process: ASMA intends to complete the initial validation of at least one of the three components of AIU which will include the following options:

- Submission of a vendor contract or proof of acquisition from providers to ensure the existence of EHR technology.
- Verification by REC of provider and staff in REC sponsored TA and training, participation in AMA sponsored training/TA and/or verification by provider of staff training from other sources.
- Verification by REC for those providers engaged with REC on implementation.

ASMA will create additional options for verification of AIU as further knowledge is gained from CMS guidance or other states' experience prior to 2011. By the end of first calendar quarter 2011, an auditing strategy will be developed leveraging the functionality of the State Level System as well as existing Program Integrity activities. An audit process will be implemented prior to the first payment of AIU in 2011. ASMA will not use the REC in any audit functions.

4.9. How will the SMA verify meaningful use of certified electronic health record technology for providers' second participation years?

Standards: In order to receive Medicaid incentive payments, providers will be required to demonstrate and ASMA will track and validate meaningful use for all periods beyond the initial option to receive incentives for AIU. In support of Alabama Medicaid and other provider's effort to reach and maintain meaningful use status, Alabama AHIE S/OPs has made e-prescribing, structured lab results and clinical exchanges as core and priorities for the AHIE. The state has set the implementation date for the AHIE to for summer 2011 to assure providers are able to comply with MU requirements. Although providers will not be mandated to use the AHIE for MU purposes, it will be the infrastructure available within the state to support the necessary exchange of health information in a meaningful way.

The state is also continuing to analyze the value of the Q-Tool, created through the Medicaid Transformation Grant. However, as it currently exists, Q-Tool does not meet the needs of the state and/or the Medicaid providers. QTool is being offered, still at no cost, to all Alabama providers. QTool is viewed as a learning tool to help providers gauge the impact electronic medical records can have on a practice, including workflow issues. There are currently 189 web based locations representing over 500 users with an additional 106 users that are directly interfaced through the provider's existing EMR system. Alabama, nor its partner vendor ACS, does not anticipate seeking certification for QTool as it is currently being used. QTool is not a full-fledged EMR in that it does

not contain core elements such as the ability to document clinical services. The State plans on offering QTool through the end of September 30, 2011. This timeframe anticipates a transitional period for providers to obtain certified EMR/EHR technology that can be used towards achieving MU. Outreach will continue to providers with a clear delineation of the availability of the QTool timeframe. Since it is a web-based, free application there is not a cost to the provider for implementation, so even short term implementation can be worthwhile. QTool will be a learning tool for both providers and the State in moving towards certified systems and the achievement of meaningful use.

QTool through its current interoperability with existing systems supports Alabama vision for a statewide Health Information Exchange. Due to Alabama contracting laws, the State cannot “leverage” in a traditional sense the work to date by just continuing the existing contracts. The State can, however, use existing relationships, interfaces and most importantly, lessons learned for a successful implementation of a more comprehensive exchange. To facilitate the transition, the original stakeholders for the development and implementation of QTool are many of the same individuals working on our Alabama Health Information Exchange Advisory (A-HIE) Commission and workgroups. This knowledge base has allowed the State to move quickly through the decision making process. All involved see QTool and the subsequent comprehensive exchange as a means to helping providers begin the process of meaningfully using health information technology.

The MMIS will be the technical support for MU and will need to be enhanced in order to do so.

Methodology: Alabama has prioritized the efforts to address AIU and first payment year infrastructure requirements, including connectivity to the NLR, for the remaining of FFY 2010 and early 2011. However, in the design and implementation of the AHIE the requirements for MU have been addressed in both the requirements noted within the RFP, which will be released August 2010, and the potential contractor’s requisite specifications. Providers will be required to demonstrate MU for the second year of payment but first year of MU for a period of 90 days under Medicaid. AMA’s MMIS will be enhanced to include the capability to track a provider’s year of entry into the Medicaid EHR incentive program to determine the correct eligibility criteria and generate the appropriate Medicaid incentive payments. It is likely that if there are provider appeals, they may happen at this time so system’s support for provider appeals will be in place prior to that time.

ASMA will continue many of the steps of Payment Year 1 (for AIU) into through the following years, but will expand responsibilities in program integrity, Fiscal Agent (FA)

contract, and MMIS operational business process, as technical capability to address the additional requirements under MU.

Process: Alabama intends to submit an I-APD that will allow the state to pay providers the Medicaid EHR incentive payments for being meaningful users of EHRs, and in 2012 begin receiving clinical quality measures data from those providers. In addition, ASMA seeks to create the infrastructure to appropriately use the data from the quality measures for ongoing management and as appropriate federal reporting, such as the aggregated, de-identified annual reporting required for children under CHIPRA. As the time line and format for sharing the clinical quality measurement data with CMS that is required under the MU provisions is not currently available, ASMA intends to seek to accommodate the parameters once known within reasonable expectations as the state is fully aware that failure to submit reports required by CMS could result in discontinued funding or disallowances.

For hospitals eligible for both the Medicare and Medicaid EHR incentive programs, CMS will collect the meaningful use measures; therefore Alabama will need the capability to collect from CMS, retain, analyze and use the information for Medicaid purposes and will not need to collect additional information. The state is awaiting further guidance from CMS on how ASMA will be able to access the MU data submitted to CMS by hospitals eligible for both Medicare and Medicaid EHR incentive payments in order for the State to meet its audit and oversight requirements.

4.10. Will the SMA be proposing any changes to the MU definition as permissible per rule-making? If so, please provide details on the expected benefit to the Medicaid population as well as how the SMA assessed the issue of additional provider reporting and financial burden.

ASMA is not proposing any changes to the MU definitions at this time.

4.11. How will the SMA verify providers' use of certified electronic health record technology?

Standard: In order to receive a Medicaid incentive payment the EHR technology must be "certified" as "a qualified electronic health record that is certified pursuant to section 3001(c) (5) of such Act as meeting standards adopted under section 3004 of such Act that are applicable to the type of record involved (as determined by the Secretary), such as an ambulatory electronic health record for office-based physicians or an inpatient

hospital electronic health record for hospitals).” The Recovery Act specifies 3 requirements: use of certified EHR in a meaningful manner (e.g., e-prescribing), use of certified EHR technology for electronic exchange of health information to improve quality of health care and use of certified EHR technology to submit clinical quality measures(CQM) and other such measures selected by the Secretary. ASMA will seek to verify compliance with all three components.

Methodology: ASMA will defer to the determination made by Medicare for hospitals to avoid duplication of effort with the exception that Medicaid will randomly review quality measures that are specific to the Medicaid/CHIP populations. For any hospital that is not seeking Medicare, AMA will use an audit process yet to be established to validate that for an EHR reporting period in a payment year the hospital is utilizing certified EHR technology in a meaningful manner, utilizing certified EHR technology that is connected in a manner that provides for the electronic exchange of health information to improve the quality of healthcare such as promoting care coordination; and is submitting information on clinical quality measures and other measures in a form & manner specified by Secretary of HHS.

For EPs, the review will require a sampling approach that addresses continued certification of the system, including upgrades as required by the ONC rule as the process moves from Stage 1 to Stage 2 to Stage 3 and as further guidance is provided. For Stage 1, ASMA will focus on whether the EP and EH were able to capture health information in a coded format, use that information to track key clinical conditions, communicate that information for care coordination purposes, and initiate the reporting of clinical quality measures and public health information. This will include the 25 objectives/measures for EPs and 24 objectives/measures for EHs that are divided into a core set and menu set. In 2011, EPs seeking to demonstrate Meaningful Use will be required to submit aggregate clinical quality measure numerator, denominator, and exclusion data to ASMA by attestation. In 2012, EPs seeking to demonstrate meaningful use must electronically submit clinical quality measures through certified EHR technology

Process: ASMA’s current understanding is that ONC is creating a list of certified electronic health record technology that Alabama will use to validate whether the EHR is certified at the most current standards under regulation. The certified ONC-Authorized Testing and Certification Bodies are anticipated to be announced this month- August 2010 and certified EHRs tested and announced fall 2010. Since previously certified products must be recertified, the timing of this process may be tight. Therefore, the state will try to make this verification process electronic, but may need to do manual verification initially if the infrastructure needed is not initially in place. It is the goal of ASMA that by the second implementation year, Alabama will have the capacity to

accept direct submission of Medicaid providers' clinical quality measures from certified EHR technology and has established a time line for the AHIE to make that a possible.

Since providers may begin attesting to being meaningful users by April 2011 and may seek payment therefore, ASMA intends to have the capability to receive the attestations prior to the April 2011 date. The random review/audit function will begin as soon as possible to avoid the potential of large "take backs" on the backend; however, it will be a sampling methodology rather than 100% review. For Medicare, CMS will begin making payments by mid-May 2011 and AMA may be later but unlikely to be earlier. The last date hospitals may register for the program and attest to being a meaningful user to receive FY 2011 payments is November 2011 and February 2012 is the last date for EP registration to receive CY 2011 payments. ASMA is working toward those deadlines.

Another component of the process over time; however, not in the initial year, will be to determine for MU if the information with respect to clinical quality measures was generated as output of an identified certified electronic health record. The actual process for doing that is yet to be determined but will be completed prior to MU reporting of quality measures in 2011.

4.12. How will the SMA collect providers' meaningful use data, including the reporting of clinical quality measures? Does the State envision different approaches for the short-term and a different approach for the longer-term?

Standard: The reporting period, which is significant for EPs and EHs because it will define the period during which the provider must demonstrate meaningful use of certified EHR technology, is significant to ASMA because that is when the state is required to validate to CMS that providers meet all of the eligibility criteria to qualify for Medicaid incentive payments, including the applicable patient volume thresholds, hospital-based requirements, and all other requirements.

Methodology: As explained in more detail in other responses, ASMA is developing administrative infrastructure (technical and human), business processes for operation, and payment and audit processes, including the capability to obtain and retain EPs' and EHs' attestations of eligibility to qualify for the Medicaid incentive payments. As multiple states are using the same FA (ACS), ASMA intends to meet with states that contract with ACS to determine if there is a uniform approach that can be used and costs less. Alabama intends to use attestation as the means of validation with a sampling of attestations for audit purposes. ASMA also intends to meet with the FA to determine if the creation of special codes on claims is feasible both short term and longer term. With the transition to ICD-10, it may be possible to address this issue as a part of that

process in the coding of the claims; however, with the significance and time constraints of 5010 and ICD-10 implementation this may not be feasible. A decision on this will be forthcoming.

As the bar for demonstrating meaningful use of certified EHR technology will rise in Stage 2 and 3 and the parameters will be established via regulations, criteria will evolve. At this time, ASMA does not intend to add additional objectives; however, the state has not made a long-term decision.

Process: While for Medicaid there is a little time as providers have the option of receiving incentive payments for AIU, the move to MU will happen prior to the end of 2011, which is not minor considering the IT infrastructure and business operations that are required at CMS, ASMA and providers. CMS for the most part will handle the input from EHRs of the quality measures, but ASMA will be responsible for EHRs and EHRs that are not serving Medicare.

ASMA is working through SERCH to identify the issues and opportunities to collect, analyze, report to CMS, and fully utilize the information for quality oversight for ongoing operations and to comply with federal requirements under CHIPRA. ASMA has also consider this as an opportunity to establish the framework for quality reporting for all Medicaid providers so when additional providers are also engaged in the electronic exchange of data in a meaningful way, the building blocks already exist.

Alabama's FA contract, upon approval of the I-APD, will be amended to input into the MMIS system requirements for monitoring meaningful use including the capacity to determine the appropriate stage of meaningful use; the appropriate incentive payment amount, depending upon the providers' payment year; ability to track a provider's year of entry into the Medicaid EHR incentive program to determine the correct eligibility criteria and generate the appropriate Medicaid incentive payments. It is the state's intent to provide as required to CMS the clinical quality measures data that will be received as of 2013. Since the format and specifications are unknown, the IT implications are not clear but will be a part of the discussions with the FA in order accommodate the transmission of the data on an annual basis at the appropriate time. Simultaneously, the state intends to receive, retain and create useful reports based on the MU data submitted to CMS by hospitals eligible for both Medicare and Medicaid in order for the State to meet its audit and oversight requirements.

4.13. * How will this data collection and analysis process align with the collection of other clinical quality measures data, such as CHIPRA?

Standards: See Tables included in Appendix 8.1.3 for Quality Measures from CMS Regulation.

Methodology: Some measures have denominators of unique patients regardless of whether the patient's records are maintained using certified EHR Technology or not and other Stage 1 measures include in the denominator only patients whose records are maintained using a certified EHR. Other measures require only a yes/no attestation. By 2012 measures will need to be reported electronically. Therefore the technical infrastructure and reporting specifications need to accommodate these variables and must be able to adjust to changes that will result in Stage 2 and 3.

Process: Alabama intends to leverage the EHR Incentive clinical quality measures to meet the state's CHIPRA reporting requirements. Although Alabama has a separate CHIP program, the state views standardization of data collection and measurement as a core principal for infrastructure development. In addition to gaining dual benefit from the reporting of these measures, the approach decreases provider burden. ASMA intends to use the four clinical quality measures that overlap: Weight Assessment Counseling for Children and Adolescents, Chlamydia Screening for Women, Childhood immunization Status and appropriate testing for children with pharyngitis. Alabama has included this work in the scope of work that will be required in the initial I-APD because of its policy significance and the need to timely compliance with CHIPRA reporting requirements.

In addition, the state has been a leader in public-private coordination of performance measurement and both ASMA Medical Directors participate in the AHRQ Medicaid Medical Directors Learning Network, which is putting forth efforts to coordinate across state lines on quality measurements for children and adults. As Alabama's Medicaid Director is also the Chair of the NASMD/NAMD Executive Committee, the state is working cross-state through the Medicaid Collaborative, the AHRQ CHIPRA Quality Measurement efforts and the NGA "Best Practices", to move forward on obesity, measures aimed at reducing disparities, child abuse, developmental delays, and efficiency measures while implementing the processes and structure required for the current Stage 1 clinical quality measures. Alabama expects that when the "administrative simplification" provisions of the health care reform legislation along with the long term care HIT provisions are finalized, additional measures that are relevant to the state will become options that the state may chose even though it has limited its current requirements to CMS established Stage 1 quality measures that are already in existence.

As indicated previously, the state has the same leadership involved in the various national efforts to benefit from lessons learned from federal initiatives, other states and private approaches.

4.14. What IT, fiscal and communication systems will be used to implement the EHR Incentive Program?

The current expanded MMIS (using the MITA expansions to incorporate all management information needs related to the Medicaid program built for and use by Medicaid enrollees, providers and administrators of the program but not exclusively or solely for Medicaid) will be the IT infrastructure for the fiscal and communication systems for implementation of the EHR Incentive Program. This is a system of systems approach with the actual Medicaid incentive payment made through the MMIS and use of the current FA. The connectivity to the NLR will be through a secure linkage with the MMIS due to time constraints and need for the provider information, provider and payment tracking, and financial/fiscal reporting to be incorporated into the current infrastructure.

The system needs for the provider appeal process have yet to be determined as the policies/procedures and workflows are still being worked out but will also be a part of the MMIS system. It may be structured as a new system within the MMIS system or it may simply be a web portal as envisioned under the AHIE S/Ops for communication to the multiple Medicaid and other stakeholders. The IT infrastructure and materials will be developed for Medicaid and used across public-public within the state and consistent with other states (Maturity Level 3-4).

4.15. What IT systems changes are needed by the SMA to implement the EHR Incentive Program?

Standard: The following figures provide ASMA's current understanding of the connectivity and technical structure based on the CMS guidance to date.

Figure 9: High-Level Overview of Data Exchanges Participation Year 1

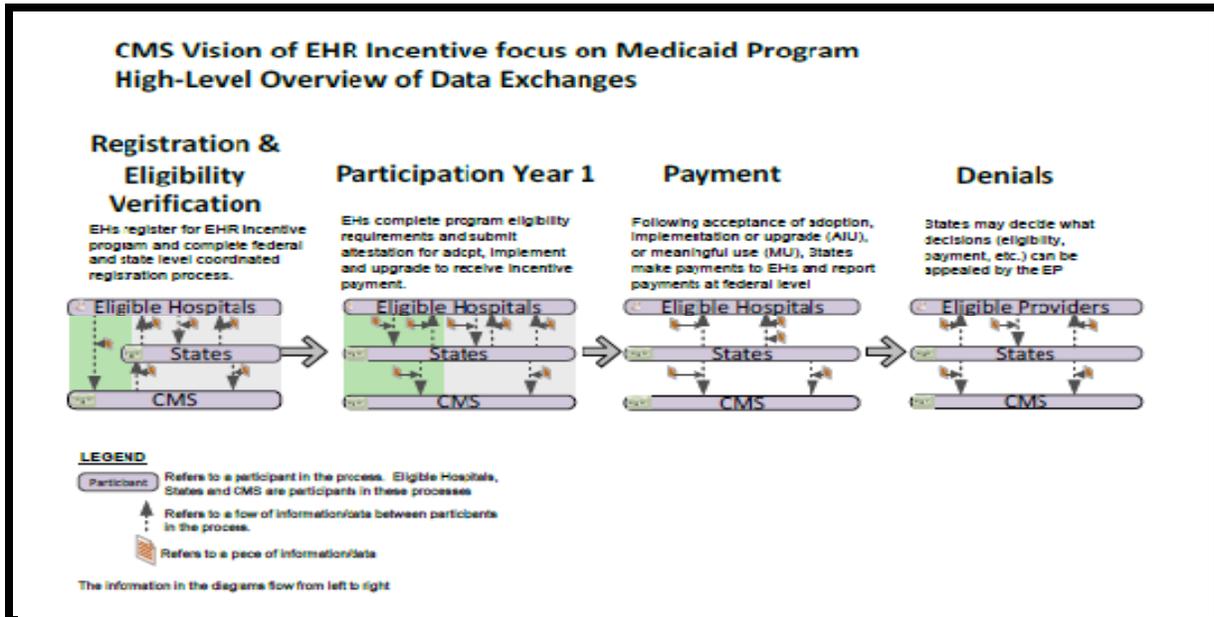


Figure 10: Eligible Hospital Registration & Eligibility Verification

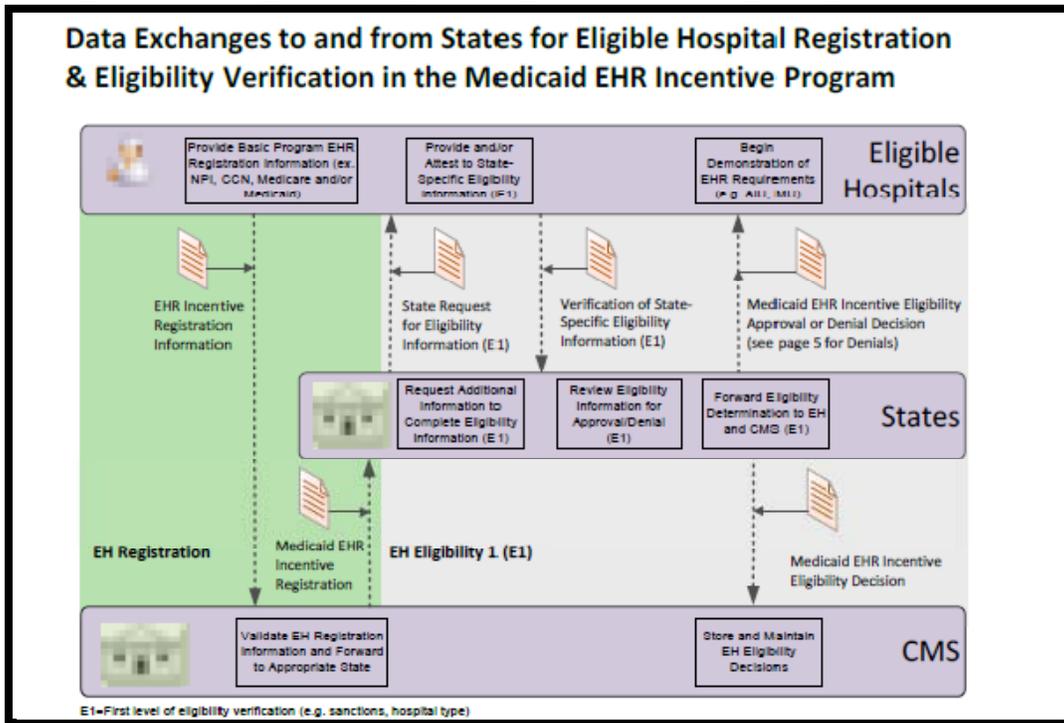


Figure 11: Data Exchanges for EH Payment

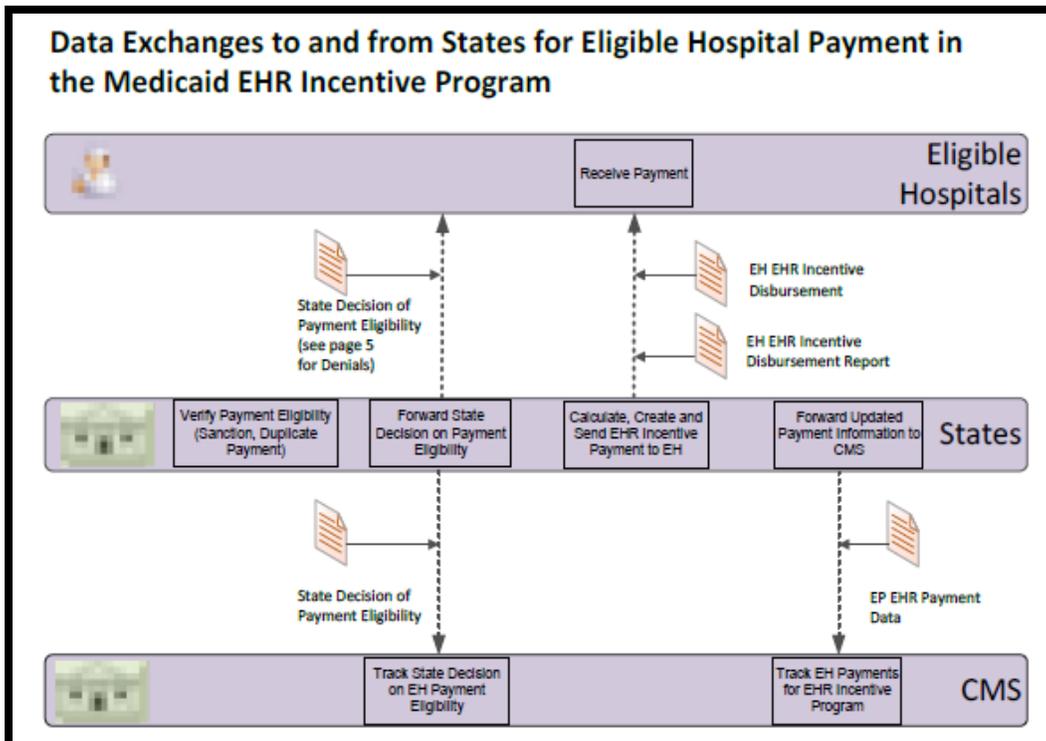
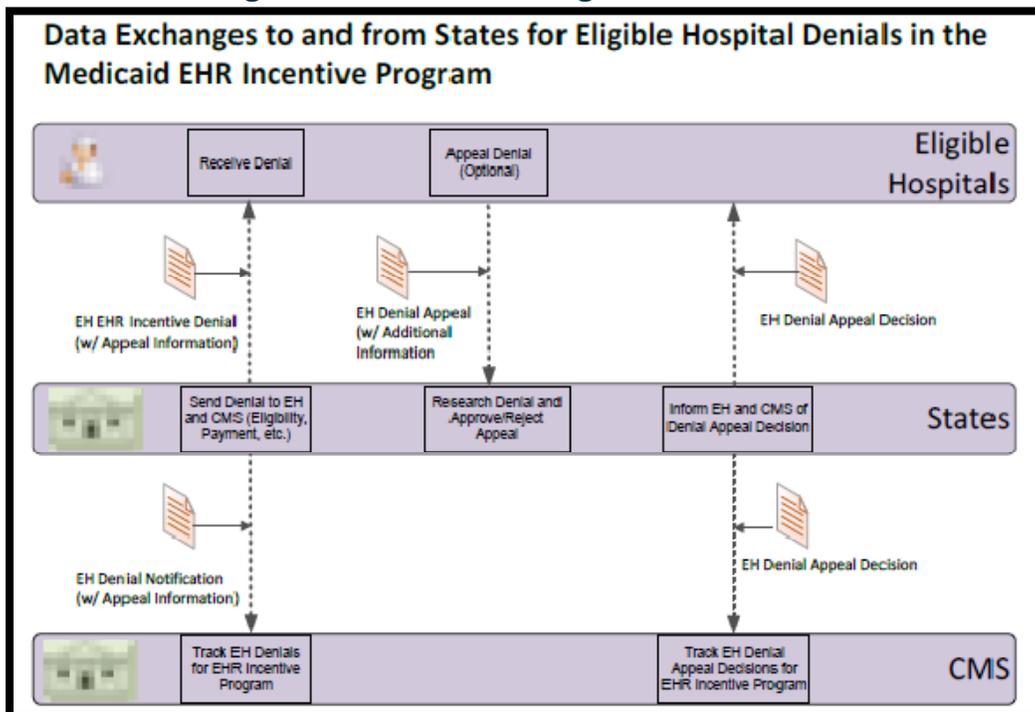


Figure 12: Data Exchange for EH Denials



Methodology: There are multiple IT systems changes needed over time, some more immediate than others. The more immediate will be included in the initial I-APD. Examples include the capacity to accommodate connectivity to the NLR for registration; capability within the expanded MMIS provider system to identify, validate and track EPs and EHs; capacity to make, track, report and audit payments and ongoing eligibility; integration of expanded web-based communication tools, including secure communications with CMS, REC and AHIE; facility to support provider appeals; ability to complete MU quality reporting and oversight, including integration with CHIPPPRA reporting requirements, and other yet to be defined needs.

Process: Some adjustments may be required to the initial I-APD for details as guidance is provided related to items such as “real time interface” with the NLR and batch processing, including error handling. Additional I-APDs may be submitted, particularly related to public health and mental health, as quality reporting is further investigated; the relationship to PERM is researched and further guidance from CMS is provided.

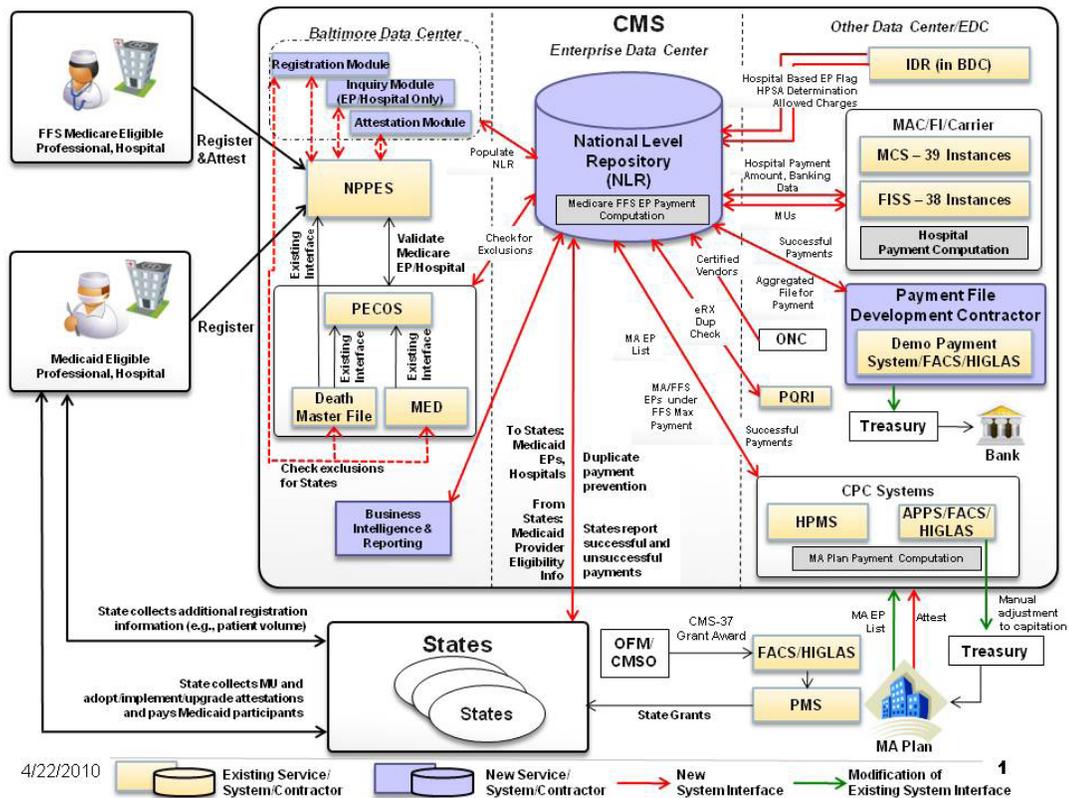
4.16. What is the SMA’s IT timeframe for systems modifications?

Alabama originally was a Group 1 state and intends to be ready to “go live” as close to 1/1/11 as possible but no later than 4/1/11. Alabama has submitted an I-APD for the initial systems modifications and staffing/administrative support for design, development, implementation, training and ongoing operation so an amendment to the FA contract can proceed in September 2010. Initial focus will be on connectivity to the

CMS NLR, since any potential EP or EH can select the State by the user designated Alabama during registration from a list of states that can participate. The state will also need to have the capacity to retain the information the NLR will provide, such as a daily batch file (registrations) that contains a record control number and transaction type values. ASMA also needs to address the official business address and provider type via NPPEs. Other interfaces include post-payment appeal batches to the NLR, PECOS and web-based communication tools. The provider appeals systems support is a part of the first I-APD and will be developed as a part of the initial systems development to assure ASMA can address any provider appeals related to registration, eligibility and payment as they are initiated.

Multiple internal MMIS system changes need to occur, along with testing and implementation. A work plan with timelines and milestones will be developed with the FA contractor as part of any contract amendment. The model with indicated interfaces as currently understood follows in Figure 14. Alabama is developing its technical infrastructure to be interoperable with this technical design and creating the technical and business operations to support this model.

Figure 13: CMS Model for Planning Purposes



4.17. When does the SMA anticipate being ready to test an interface with the CMS National Level Repository (NLR)?

AMA agreed to meet the requirements set forth and time table established by CMS for Group 1, including testing in October-December 2010 in order to launch in January; however, with the delays, Alabama is scheduled to be in Group 3 and live prior to the end of the first quarter of calendar year 2011.

Based on the current guidance from CMS, ASMA anticipates that functional testing will begin in August with North Carolina and Alabama will be ready for testing in early 2011 with “End-to-End” testing and stress testing with CMS at some level (yet to be determined) after also prior to April 1, 2011..

4.18. What is the SMA’s plan for accepting the registration data for its Medicaid providers from the CMS NLR (e.g. mainframe to mainframe interface or another means)?

Alabama intends to build off its interface experience with MSIS data and other federal reporting and will validate its decision with the FA experts prior to making a decision. However, the state anticipates it will continue its mainframe to mainframe interface, but plans to consider all options that move the state to a secure web-interface going forward.

Standard: ASMA will be ready to accept registration data from the CMS NLR on time and will have systems’ capability to obtain, retain and interface for validation with the MMIS system prior to 4/1/11 date. All data elements from the registry will be downloaded to the Alabama system including initial information related to provider eligibility as provided to CMS from the provider, including but not limited to sanction status, hospital-based status, practicing predominately in FQHC/RHC and eligible professional or institution type

Methodology: The NLR will provide information about providers who have applied for the incentive program. After passing high level editing during the NLR file processing most records will be loaded into the state system. The provider will access the state system and register to use the provider portal. If the provider is not Alabama Medicaid enrolled, the provider will be required to do so prior to registering on the system.

Process: Enrolled providers who are not a Medicaid HITECH provider type on the MMIS enrollment file will not be able to access the enrollment system and will be directed to Medicaid via information on the provider portal and/or website. If the

enrolled provider has a valid logon ID and provider type, a link will be presented for the provider to access the state system.

The system home page will have a status bar displaying the status of the provider applicant's record. The system will use the NPI associated with the logon ID or any service location associated with the logon ID to search for a match. If a match is found, the provider has been verified and will proceed to the next step. If no match is found, then the provider will be given an error message indicating that there is no match for the record from the NLF. The provider will be instructed to contact the NLR.

The Provider enters the state system and verifies the NLR information (NPI, provider name, business address/phone, personal TIN, payee TIN, payee address, Medicaid agency, Medicaid state, legal entity name, payee legal entity name, payee address, provider type and email address). Once the provider confirms the information, the provider will proceed. If the information is not confirmed, the record will suspend as incomplete and the applicant will be directed to the NLR to fix the information.

Provider Type: Provider confirms HITECH provider type (pediatrician-20% threshold) If provider does not confirm type, the application will be considered incomplete and the provider will need to contact AMA. If the provider type entered by the applicant does not match the provider type listed in the enrollment file, the provider information will be placed on a report for provider enrollment file maintenance.

Registration Summary Information: The Medicaid EHR Incentive Program registration will provide information on the date the information was originally created and updated, the name of the provider, TIN, NPI, business address, Medicaid/Medicare Program, phone number, contractor ID, hospital based (Y or N), hospital based percentage, FI/Carrier/MAC status, NPI status, OIG exclusions, death master file (Y or N), registration status, and registration status reason.

Attestation Summary Information: The Medicaid EHR Incentive Program attestation section will provide data originally submitted by calendar year.

Payment Information: Payment Summary Information, Program Year Payment Issue Date, Payment Method, Payment Address, Payment Amount, Withheld Reason, EHR Incentive Program Status.

Measurement Information: Program Year Status, Submission of Quality Measures, Cancellation Date, Number of Measures Met by Participation Year, Stage Reporting period and EHR certification number.

Figure 14: Registration Summary Information Example

Registration Summary Information
 Your Medicaid EHR Incentive Program registration was originally created on 01/11/2010. Your Medicaid registration was last updated on 02/11/2013.

Registration ID: R20100323000023 Business Address:
 Name: John Jones Marshall Jr. 12601 Fair Lakes Circle
 TIN: XXX-XX-3344 (SSN) Fairfax VA 22033-2322
 NPI: 2388284432 Phone #: (703) 227-6000

Incentive Program: Medicaid (VA)
 Contractor ID: 00904 - Virginia

+ Additional Information

Attestation Summary Information
 Your Medicaid EHR Incentive Program attestation was originally submitted on 01/11/2010 for calendar year 2011. You have also submitted your attestation information for calendar year 2012 and 2013.

+ Additional Information

Payment Summary Information
 Your Medicaid EHR Incentive Program has received a total of \$ 7,478 year to date.

+ Additional Information

Program Year	Payment Issue Date	Payment Method	Payment Address	Payment AMT	\$ Withheld	Reason	EHR Incentive Prg Status
2011	07/11/2011	EFT	12601 Fair Lakes Circle Fairfax VA 22033-2322	\$ 2,239.00	\$ 2,239.00	TBD	Payment Applied on 03/15/2011
2012	08/22/2012	EFT	12601 Fair Lakes Circle Fairfax VA 22033-2322	\$ 5,239.00	\$ 0	TBD	Payment Applied on 03/15/2012
2013	N/A	N/A	12601 Fair Lakes Circle Fairfax VA 22033-2322	N/A	N/A	TBD	Payment Process Underway

4.19. What kind of website will the SMA host for Medicaid providers for enrollment, program information, etc?

Structure: The website will be HIPAA compliant, meet the updated privacy and security requirements that will go into effect this fall following the public comment period on the proposed regulation, and meet the initial national standards as developed for Stage 1 as a part of the ONC regulations related to governance, funding and infrastructure of controlled vocabularies, value sets and vocabulary subsets.

Methodology: As is true today, the Medicaid website will have links to the interactive FA website. The website is compliant with HIPAA privacy and security requirements. It includes access to a secure site for interface and transmission of confidential data.

Process: As a part of the AHIE S/OP, Alabama has developed a structure and expansive communications plan that includes the hosting by ASMA of a website for Medicaid providers but available to all public and private providers with information on enrollment, MU program parameters, etc. (OneHealthRecord). To the degree possible

and to assure continuity and consistency of message, the portal will be the main vehicle for messaging and feedback.

Initially the site will provide information regarding MU Incentive payments and requirements, the potential to submit information from providers electronically and a view of EP and EH status. Eventually the website will be the viewing mechanism for providers and enrollees to view quality data and provide the state with requested information; however, the how and when is yet to be determined. Funding requests may be included in the initial I-APD.

4.20. Does the SMA anticipate modifications to the MMIS and if so, when does the SMA anticipate submitting an MMIS I-APD?

Yes. Alabama intends to submit an I-APD to CMS simultaneously or closely following the submission of the final SMHP. As a Group 3 state, it is critical the approval of both the SMHP and I-APD is rapid. Since the guidance from CMS is still evolving, ASMA anticipates that amendments to the I-APD may be necessary at some point, but the critical pieces for MU can be designed, developed and implemented fall 2010 in order to meet the necessary time lines. ASMA anticipates that the systems support for the Medicaid Incentive Payment system support will include both a module to the current MMIS system via a contract amendment and a new I-APD.

4.21. What kinds of call centers/help desks and other means will be established to address EP and hospital questions regarding the incentive program?

Standard: Stakeholder education and engagement have been core principals of the AHIE S/OPs and SMHP process. A priority has been involvement of providers and their associations in the planning so operational details, like call centers/help desks are not forgotten.

Methodology: Through the AHIE S/Ops, Alabama has established a MU Project Director position that will have lead responsibility for MU Incentive Activities within the HIT Office, which is located within the ASMA. (Section 3 of Appendix 8.1)

Process: The state intends to fully utilize its current call center/help desk through its FA contract. In addition, ASMA intends to contract with the REC for direct technical assistance and training for Medicaid providers seeking to become EHs and/or EPs and obtaining and maintaining MU status. Funding and approval of an I-APD to include materials and staff support for TA through the REC, FA and ASMA staff will be requested. No final decision has been made in this area.

4.22. What will the SMA establish as a provider appeal process relative to: a) the incentive payments, b) provider eligibility determinations, and c) demonstration of efforts to adopt, implement or upgrade and meaningful use certified EHR technology?

Standard: Provider appeal rights, notifications, timely process and administrative processes related to eligibility, ability to demonstrate AIU and MU, and payment as required by the CMS regulation will be in place prior to 2011. Appeal rights for providers are a new component for the Alabama Medicaid Program and the provision will require additional technical infrastructure, human resources and business processes. The provider appeals process will be in place prior to the end of the first quarter in calendar year 2011 to assure ASMA can address any provider appeals related to registration, eligibility and payment. Although the appeal process does not exist today, it is in the process of being implemented and will be operational prior to the MU registration system at CMS and ASMA going live. As soon as all the details are finalized, the information will be included all the previously identified communication efforts with providers.

Methodology: AMA intends to use its current administrative appeal process structure for provider appeals related to eligibility, demonstration AIU and MU, and payment. Implementation of the decisions will be communicated post-appeal to the provider and CMS. Basis of appeals include exclusion, imposition of sanctions, use of certified EHR technology, inability to meet and/or maintain AIU or MU, disagreements regarding payments and compliance issues, such as data reporting. The detail of that process has not been finalized nor have the parameters of what can and cannot be appealed; however that anticipated process is provided below. It is anticipated that the results will be incorporated into the payment history of the provider within the MMIS. Standardized notifications will be used, but the legal/policy workgroup of the AHIE Advisory Commission has not completed their analysis of what regulatory changes are required.

Process: Through SERCH and NGA's Best Practice efforts, AMA is seeking to identify standardized provider notifications and determine if there is any legal/regulatory reason the state cannot adopt those standardized notifications. Through previously mentioned efforts, ASMA is reaching out to other states working with the same FA (ACS) to design the technical architecture to support provider appeals consistently (and hopefully quicker). ASMA also expects further guidance from CMS. ASMA has engaged its program integrity staff, legal counsel, communication staff and MITA Team, along with the Legal/Policy AHIE Advisory Commission work group in establishing the parameters. The REC will also play a role in communicating the process to the providers. If an ASMA program integrity staff makes a determination that a provider was overpaid, a

demand letter shall be sent to the provider, at his last known mailing address as established on the provider data base in the MMIS system. If a provider designated a payee, the demand letter may be mailed to a provider's last known mailing address. If a provider disputes the amount of overpayment, a provider may initiate the administrative appeals process. A timely filed request of administrative appeal process shall stay the recoupment activities by ASMA pertaining to the issues on appeal until the administrative appeal process is final. If ASMA determines that no adjustments are required, the initial determination shall stand. If the department determines that the amount of overpayment demand should be reduced, a refund due to the provider shall be refunded to him within thirty (30) calendar days from the date of the determination.

Resolution of Provider Disputes Prior to Administrative Hearing: If a provider disagrees with a Medicaid determination with regard to an appealable issue as provided for in Section 9 of this administrative regulation, the provider may request a dispute resolution meeting. The request shall be in writing and mailed to and received by the Branch manager that initiated the department-written determination within thirty (30) calendar days of the date the provider received the notice. The department shall not accept or honor a request for administrative appeals process, or a part thereof that is filed by a provider prior to receipt of the department-written determination that creates an administrative appeal right under this administrative regulation.

A provider's request for a resolution meeting shall clearly identify each specific issue and dispute, state the basis on which ASMA's decision on each issue is believed to be erroneous, provide documentation or a summary supporting the provider's position, and state the name, mailing address, and telephone number of individuals who are expected to attend the dispute resolution meeting on the provider's behalf. Either ASMA or the provider may request the presence of a court reporter at the dispute resolution meeting. If an administrative hearing is requested, the transcript shall become part of the official record of the hearing.

ASMA will send a written response to the provider identifying the time and place in which the meeting shall be held. The provider may present evidence or testimony to support his case. A provider may submit information that the provider wishes to be considered in relation to the department's determination without requesting a dispute resolution meeting. ASMA will uphold, rescind, or modify the original decision with regard to the disputed issue and provide written notice to the provider of the department's decision. The administrative hearing process shall be used if it requires repayment of an overpayment or a provider's payments are being withheld. Information relating to the selection of the provider for audit, investigation notes or other materials which may disclose auditor investigative techniques, methodologies, material prepared for submission to law enforcement or prosecutorial agency, information concerning law

enforcement investigations, judicial proceedings, confidential sources or confidential information shall not be revealed.

4.23. What will be the process to assure that all Federal funding, both for the 100 percent incentive payments, as well as the 90 percent HIT Administrative match, are accounted for separately for the HITECH provisions and not reported in a commingled manner with the enhanced MMIS FFP?

Standard: Alabama has instituted the financial reporting requirements under HITECH for all activities and has created within the state financial accounting processes, the separate coding required to track SMHP HIT funding from enhanced MMIS funding.

Methodology: As CMS is intending to create a new line item on the 64/37, Alabama is doing the same for state budgetary reporting. In addition, all provider incentive payments will have coding for which edits/audits exist within the MMIS system so only EPs and EHs are paid, the payment amount is reported into claims history and to CMS for quarterly federal financial reporting, and the coding matches the federal specifications (not yet provided) so the correct draw down is made. Since the enhanced funding through this mechanism for administrative functions and ongoing HIT operations, reporting adjustments have been made on multiple lines of the 64/37 to address internal administrative costs, FA costs related to HIT and any additional systems implications. Alabama has assigned separate fund codes for tracking and accounting purposes (THE: health exchange TMU: meaningful use) Fund codes within the claims system to track MU payments using the establishing numbering system.

Process: ASMA is working through the CMS process to accommodate any and all changes to the federal financial reporting requirements. ASMA has already worked with ONC to comply with all HITECH reporting requirements. The I-APD will include funding needed for technical and human resources; however, it is anticipated that the addition of a "line" on the 64/37 is not the significant cost. It is the tracking by provider, by amount, by funding code will be a part of the current FA contract but will also be in the HIT - IAP . Research into the scope of the work and relationship to current MMIS is being undertaken; however, ASME will track different funding streams, including requiring the FA to track work done by the FY by funding source.

The CMS-64.10 report will include a new category for reporting 90 percent FFP match for State administrative expenses associated with HIT. The new category will be called: Health Information Technology Administration. This category is to be completed for

potentially eligible activities that are listed in Enclosure E and should not be used for MMIS 90 percent expenditures.

4.24. What is the SMA's anticipated frequency for making the EHR Incentive payments (e.g. monthly, semi-monthly, etc.)?

Frequency has not been determined, but anticipated that it will be processed through the MMIS system as a transaction. It is anticipated that EHR Incentive payments would also be processed through the MMIS and move forward through the financial department for payment. FFP drawdown will be on the same quarterly time lines as are currently used. Additional planning is underway to establish a schedule.

What will be the process to assure that Medicaid provider payments are paid directly to the provider (or an employer or facility to which the provider has assigned payments) without any deduction or rebate?

Standard: As required in regulation, Alabama attests that payments to an entity promoting the adoption of certified EHR technology, as designated by the State, will only be made if participation in such a payment arrangement is voluntary for the Medicaid EP involved, and if such entity does not retain more than 5 percent of such assigned Medicaid incentive payments for costs not related to such technology.

Methodology: There are no edits/audits in the MMIS to reduce payment and none will be initiated for this purpose. Enhancements to the MMIS will be required to allow for such a designation, create the separate payment and provide for auditing capability to support this transaction.

Process: The provider file provides the person/facility to which the provider wishes payment to be issued and the payment process will issue the payment (electronic transfer) consistent with current payment processes plus the additional scope of work related to provider appeals and payment methodology. It is possible that the 5% calculation will be done manually initially until all systems implication can be sorted through and addressee.

4.25. What will be the process to assure that Medicaid payments go to an entity promoting the adoption of certified EHR technology, as designated by the state and approved by the US DHHS Secretary, are made only if participation in such a payment arrangement is voluntary by the EP and that no more than 5 percent of such payments is retained for costs unrelated to EHR technology adoption?

Standards: Alabama attests that the entire incentive payment will be forwarded to the eligible Medicaid provider, and that no Medicaid eligible professional or hospital is required to return any portion of the incentive payment to the ASMA.

Methodology: ASMA is not aware of any requests or interest at this time for implementation of this provision, but will incorporate the necessary infrastructure in case it comes up in the future.

Process: The Medicaid provider would need to request in writing the designation of another entity TIN to receive the payment and that information included in the attestation signed by the provider. The attestation will state that designation is voluntary on part of the provider, the entity name, address (including e-mail address), and the amount. ASMA will validate the credentials of the entity designated to determine if that entity is eligible for the payment, the amount is within the regulation requirements and then issue payment through the MMIS for appropriate tracking and auditing functions to occur.

4.26. What will be the process to assure that there are fiscal arrangements with providers to disburse incentive payments through Medicaid managed care plans does not exceed 105 percent of the capitation rate per 42 CFR Part 438.6, as well as a methodology for verifying such information?

Standard: Alabama attests that disbursement of incentive payments through Medicaid MCOs will not exceed 105 percent of the capitation rate. Alabama is not a high concentration managed care state so the use of capitation payments is not significant or a priority for initial implementation.

Methodology: Alabama will put into place a business process which will be manual in nature but will use HIT where it is beneficial to assure that the total of the incentive payments through a MCO will not exceed 105 percent of the capitation rate.

Process: Since Alabama is a very low concentration Medicaid MCO state and through discussions as a part of the AHIE Commission and AHIE S/OP process has not encountered any indication of an intent to request the disbursement of incentive payments through a Medicaid MCO, this is a lower priority for the state. However, as a part of the business process development and technical design, the state will address the potential and assure mechanisms are in place for auditing and oversight to assure compliance with the provision.

4.27. What will be the process to assure that all hospital calculations and EP payment incentives (including tracking EPs' 15% of the

net average allowable costs of certified EHR technology) are made consistent with the Statute and regulation?

Standard: Hospital calculations for Medicare and Medicaid are based, in part, on Medicare or Medicaid inpatient bed-days. An EH for Medicare is deemed eligible for Medicaid but the Medicaid calculation must still be made. EHs are paid on fiscal year and EPs on calendar year. EPs are capped at “net” average allowable cost, that is, average allowable cost minus payments from other sources (other than State or local governments). Pediatricians (Table 8) with a volume of more than 20 but less than 30 percent Medicaid patient volume may qualify for up \$14,167 in the first payment year.

Table 7: Maximum Incentive Payment Amount for Medicaid Professionals

Maximum Incentive Payment Amount for Medicaid Professionals Cap on Net Average Allowable Costs	85 percent Allowed for EPs	85 percent Allowed for EPs
\$25,000 in Year 1 for most professionals	\$21,250	\$63,750
\$10,000 in Years 2-6 for most professionals	\$ 8,500	
\$16,667 in Year 1 for pediatricians with minimum 20 percent patient volume, but less than 30 percent patient volume, Medicaid patients	\$14,167	\$42,500

Methodology: Payment and verification payment for EPs equals 85 percent of “net average allowable costs.” The caps equal \$25,000 in the first year, and \$10,000 for each of 5 subsequent years (there is an exception for pediatricians with under 30 percent Medicaid patient volume, whose caps are two-thirds of these amounts). Thus, the maximum incentive payment an EP could receive from Medicaid equals 85 percent of \$75,000, or \$63,750, over a period of 6 years. Based on CMS guidance, in situations where the EP has been provided with the actual certified EHR technology, as well as training, support services, and other services that would promote the implementation and meaningful use of such technology, the contribution would not necessarily reduce average allowable costs. (Example: If an FQHC or RHC has provided technology to its staff EPs to use, such technology provision would not be considered a “payment” from another source that would reduce average allowable costs.) This will be an individual provider calculation.

Alabama will be responsible for payment and verification payment for Children’s EHs and acute care hospitals (need to meet the 10% volume requirements) based on Medicaid encounters (FFS and MCO) in the inpatient or ER (duals are not included in the numerator) and intends to use some combination of provider’s Medicare cost reports, MMIS claims payment and utilization information and hospital financial statements and accounting records. The specifics are yet to be established. The Medicaid share is the percentage of non-charity care days attributable to Medicaid

(Medicaid inpatient bed days plus Medicaid managed care inpatient bed days divided by inpatient-bed days divided by total charges).

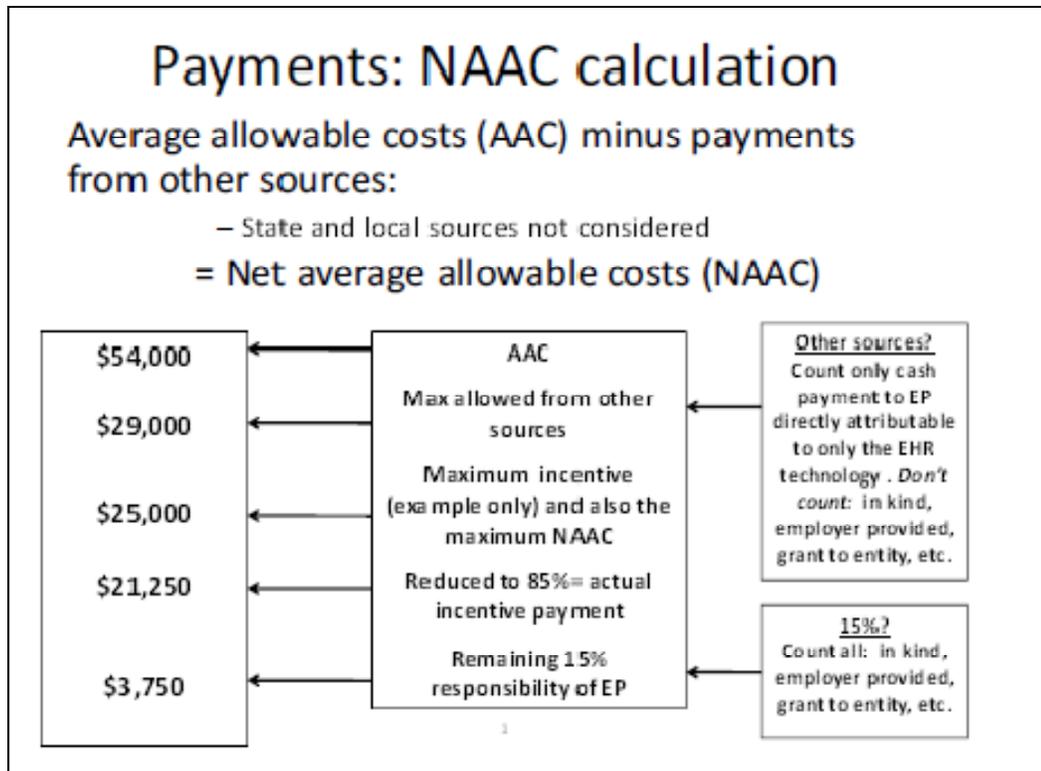
Process: For EHs, Alabama will make no more than 50 percent of the hospital's aggregate incentive payment in one year and over 2-years, no more than 90 percent of the aggregate incentive. The state will determine the aggregate incentive in 2011 and determine prior to that time if payment will be made over 3, 4, 5 or 6 years. For charity care charges, the state has not determined if it will use the revised cost report worksheet S-10 or another auditable data source, but at this time assume it will use the cost report.

For EPs, Alabama will have a process in place and methodology for verifying that payment incentives are not paid at amounts higher than 85 percent of the net average allowable cost and a process in place and a methodology for verifying that professionals pay 15 percent of the net average allowable cost of the certified EHR technology. Alabama will provide on the State Level System a laundry list for the EP to attest to additional costs to make the 15% responsibility, including but not limited to annual fee, access fee, TA, REC Fee and maintenance . Alabama proposes to allow EPs to attest to the accuracy of the forms, which will be developed and provided to the potential EPs by the state and audit after the fact a sample of providers and any EPs identified as "risk" by program integrity. EPs will be required to attest to having received no other sources of funding from other than State and local governments as payment that is directly attributable to the cost of the technology or identifying the source, purpose and amount. In-kind contributions such as EHR technology or free software provided by vendors are not cash payments and therefore are also not costs that must be subtracted. Further, in the case of grants like the HRSA Capital Improvement Program grants that are used to finance many projects within an organization; for example, research projects, infrastructure, construction or repair and renovation of health centers, health care services, etc., will not be considered as directly attributable as payments for the certified technology but rather are payments for several projects of the organization.

Alabama's approach assumes that a vast majority of EPs will spend, or receive funding from other sources in the amount of 15 percent of the maximum net average allowable cost (or \$3,750 in the first year and \$1,500 in subsequent years). For AIU, Alabama will take into consideration providers' verifiable contributions up through the date of attestation. (Example, if a provider adopted EHR technology for \$100 in January 2010 and then paid for the upgrade to the newly certified version for an additional \$100 in December of 2010, the sum of both investments; that is, \$200, should be applicable to their 15 percent of the net average allowable cost.) However, Alabama will have processed in place to validate a sample of the attestations that providers were responsible for 15 percent of the net average allowable costs of the certified EHR

technology using the chart below provided by CMS in the regulation responses (Figure 15).

Figure 15: National Average Allowable Cost Calculation



4.28. What will be the role of existing SMA contractors in implementing the EHR Incentive Program – such as MMIS, PBM, fiscal agent, managed care contractors, etc.?

As indicated previously, the Alabama FA for MMIS and FA activities (HP), Medicaid Transformation Grant contractor (Xerox- formerly ACS) for interoperability of QTool, and yet to be named AHIE contractor will be engaged in the implementation of the EHR Incentive Program as they all involved in critical components for which success is dependent. Since the MMIS will be enhanced and expanded to accommodate all the HIT needs to support MU, an I-HIT-APD will be forthcoming.

4.29. States should explicitly describe what their assumptions are, and where the path and timing of their plans have dependencies based upon:

- **The role of CMS (e.g. the development and support of the National Level Repository; provider outreach/help desk support)**

- **The status/availability of certified EHR technology**
- **The role, approved plans and status of the Regional Extension Centers**
- **The role, approved plans and status of the HIE cooperative agreements**
- **State-specific readiness factors**

While there are multiple dependencies throughout A-SMHP, the most critical is time dependency and funding dependency. The state has limited time to received approval of the A-SMHP, I-APD, implement the technical infrastructure for the MU internal and connectivity to NLR, train and communicate with providers and do so with very constrained state financial and human resources. Leveraging is critical.

CMS central office has been extremely responsive and the dependency of the state on the continuation on ONC and CMS continued responsiveness cannot be understated. If there is a delay in the response on the AHIE S/OP from ONC or an issue with the plan and/or if there is a delay in approval of the A-SHMP and following I-APD, the timelines and stimulus incentive payments become at risk. The state will do everything it can to mitigate that risk and depends on the federal government to do the same.

5. SMHP SECTION D: ALABAMA'S AUDIT STRATEGY

5. What will be the SMA's methods to be used to avoid making improper payments? (Timing, selection of which audit elements to examine pre or post-payment, use of proxy data, sampling, how the SMA will decide to focus audit efforts etc)

Standard: ASMA will comply with all traditional Medicaid audit, control and oversight requirements. Specifically related to MU, the state has added the processes and actions identified previously in Table 2.

- **Controls/Edits:** ASMA will complete upfront registration of EHs and EPs and then check for compliance with AIU (payment year 1) and MU (90 days for payment year 1 of MU and full year for MU payment year 2).
- **Audit:** The state will implement an automated process to randomly select for audit purposes and as needed for ongoing operations providers to determine continued eligibility as an EP or EH MU provider

Methodology:

- **Controls/Edits:** ASMA and will download information from the NLR into the MMIS system, which will be IT infrastructure for MU. Since registration and payment will be expansions on the current system rather than a system outside the current claims system, many of the current front loaded controls are already in place or will be amended to address MU specific issues. ASMA will check for sanctions and exclusions, including deceased; hospital-based status; eligibility to participate (provider type, percentage of required enrollees, practice predominance in non-hospital, EP predominance in FQHC.RHC); eligibility for AIU (acquisition, implementation or upgrade of a certified EHR), and length of time (90 days initial MU and full year after initial year).
- **Audits:** For the initial year (2011), ASME will sample Medicaid only EHs and EPs for initial eligibility as providers (population, AIU, certified EHR, practice predominance in non-hospital, EP predominance in FQHC.RHC). The IT infrastructure is designed to not let a provider register and/or attest if the data within the MMIS system does not match the data he/she is attesting to for starters. A priority for pre-review design has been out-of-state providers as there is less knowledge of their denominator than providers within the state due to the engagement of the RECs and the multiple associations in the process.

In 2012 and going forward, the state intends to do strategic sampling to re-verify provider types who have been brought to the attention of Medicare or Medicaid. For example, if other states are experiencing problems with dentists, the State may choose to strategically sample registered dentists. The sample size of any provider population will be determined by the total number of registered providers. In some cases it might make more sense to sample 100% of records and in other situations it makes sense to sample a subset. Edits will continue within the provider applicant system and claims system to recheck for areas of vulnerability related to patient volume requirements (yearly attestation, predominance of EP practices in a non-hospital setting and/or in a FQHC/RHC (different methodologies come into play depending on the answer, but the need to know the status is the first step of the process); use of certified EHR (which will move from is the system certified as a whole/not just the modules) to use in a meaningful way for at least 90 days. Another edit will be in place for selection of Medicare and/or Medicaid, but this will be in the federal system so should only require cross checking and linkages to internal system to a selection of Medicare or Medicaid from another state automatically creates an error of the provider's access to the incentive system as well as initiate notice of appeal rights.

There is only ONE wholly functioning Children's Hospital. This hospital will be subject to the same auditing processes and parameters as other acute care hospitals participating in the incentive program. 4.3 has been amended to state: Since Medicare will not be auditing the Medicaid only hospitals (children's hospitals), and there is only one wholly functioning Children's Hospital,, the hospital will be subject to the same auditing processes and parameters as other acute care hospitals participating in the incentive program.

Process: ASMA is in discussion, along with other states using the same fiscal agent, with HP regarding IT support for the Medicaid Incentive Payments and proper oversight of payments and eligibility. As indicated in response to questions in Section C, the system will have "hard stops" for some risk components and reports with "suspend" status for others depending on the appropriateness and timeliness of the next action by the provider, the state or the NLR.

The goal is to have more pre-payment edit structure limitations and exclusion than pre-payment manual activities or post-payment recovery; however, never approach will totally be avoided. NPRE interface stops for state audits *Systems Edits/Audits:*

- EOs (Medicaid only, Medicare and Medicaid,)EOs (Medicaid, Medicare – not eligible for Medicaid)
- Patient volume requirements continue to be met

- EP practice predominantly in non-hospital
- Practice predominantly FQHC/RHC
- Provider met “MU”
- Provider using certified EHR
- Provider submitted quality measures (year 2 and year 3)
- Numerator/Denominator
- Provider Type (compare to MMIS)
- Alabama to check NLR for incentive payments already made to provider

ASMA actions for denials:

- Determine denial or closure based on basis of ineligibility (not an eligible provider), not able to demonstrate IAU or MU, has not reported quality measures, etc.
- Send notice of denial to provider
- Send provider appeal rights.
- Implement appeal process.
- Post-appeal decisions incorporated into ASMA system and notification back to CMS.

ASMA makes payment.

- EP Limits Payment Yr 1 = \$21,250
- Payment Yr 2-5 = \$8,500
- Start date of incentive payment for provider specific stop date

ASMA calculates payment for each provider.

- Hospitals: formula described in reg. EPs:
- AAC/NAAC process described in regulation
- System edits against sanctions/death files before payment
- MMIS disburses payment to TIN – states validates TIN
- MMIS creates report to notify NLR that a payment was made to EH or EP and amount. Alabama’s understanding is that ASMA will provide the following to the NLR: provider eligibility daily; payment determination batch – weekly; after payment monthly.
- MMIS creates reports for internal management
- Reports to Finance for Drawdown (37/64)MMIS creates Payment History By Provider

ASMA Initiates tracking of provider:

- Continued eligibility as a provider annually

- Start date of incentive payment for provider specific stop date
- ASMA receive and utilize data

ASMA. Federal and state fiscal reporting: 37 and 64 – obtain initial and ongoing state budget match for FFP

ASMA Other Activities:

- Oversight of e-prescribing
- involvement in structured lab and clinical exchange
- Quality Report: Design and Implementation of reporting measures, oversight and feedback to providers based on the electronic specifications provided by CMS
- Inform the NLR of incentive payments made to Medicaid Hospitals and EPs.
- determine if any MCO implications and if so implement adjustments

5.1 Describe the methods the SMA will employ to identify suspected fraud and abuse, including noting if contractors will be used. Please identify what audit elements will be addressed through pre-payment controls or other methods and which audit elements will be addressed post-payment.

Standard: It is too early in the process to determine if state staff will need to be augmented via contract in the initial and or outgoing years and via contract in future years depending on the work load. With the risk variables heavily weighted toward the initial year, when there is a difficult timeline, lack of clarity in all the rules/processes, development and communication demands. Yet the number of providers and the scope of the initial review lend a potential for a wide variance in potential needs. State staff will be augmented with contractual support.

Methodology: ASMA also intends to fully utilize its fiscal agent contract for design, development and implementation of the system as well as the business practices as the risk for fraud and abuse will go down with an increase in clarity regarding the rules of engagement and the edits/audits in the system at the get go. It is the intent of the state to avoid inappropriate payments being made and limiting recoveries to those items that cannot be efficiently and effectively addressed pre-payment.

Process:

- Control/Edits: ASMA will amend the FA contract to include in the MMIS system the capability to automate initial and review of EHs using the FY and EPs using calendar year (CY). The state will make a determination and code the EHs appropriately (Medicaid only EHs, Medicare and Medicaid EHs) based on the

download from the NLR and EPs appropriately (Medicaid EPs or Medicare EPs and thus not eligible for Medicaid) using the same data source. For EPs coded Medicare, the system will exclude them from approval as a Medicaid EPs, but retain the ability for the state through the data exchange with the NLR to accept a change one time in status. For EPs coded Medicaid, the system will track them as an Alabama designated EP with the ability to change status to another status up to an actual payment being made but not after a payment is made. The system will retain coding for Alabama EP (eligible for payment) and a code for “other” state EP (not eligible for payment); however, the “other” state designation will only be activated when an approved Alabama EP changes to another state.

- **Post-payment Audit:** As indicated previously, for the initial year (2011), ASME will sample Medicaid only EHs and EPs for initial eligibility as providers (population, AIU, certified EHR, practice predominance in non-hospital, EP predominance in FQHC.RHC). The IT infrastructure is designed to not let a provider register and/or attest if the data within the MMIS system does not match the data he/she is attesting to for starters. A priority for pre-review design has been out-of-state providers as there is less knowledge of their denominator than providers within the state due to the engagement of the RECs and the multiple associations in the process.

In 2012 and going forward, the state intends to do strategic sampling to re-verify provider types who have been brought to the attention of Medicare or Medicaid. For example, if other states are experiencing problems with dentists, the State may chose to strategically sample registered dentists. The sample size of any provider population will be determined by the total number of registered providers. In some cases it might make more sense to sample 100% of records and in other situations it makes sense to sample a subset.

Since Medicare will not be auditing the Medicaid only hospitals (children’s hospitals), and there is only one wholly functioning Children’s Hospital, the hospital will be subject to the same auditing processes and parameters as other acute care hospitals participating in the incentive program.

The Alabama Program Integrity Unit is establishing a work plan to incorporate oversight of EPs and EHs for meaningful use into the ongoing processes of the unit and will implement that work plan effective January 1, 2011, to assure the state fully utilizes its current processes in overseeing a new component of the Medicaid program. The state currently has key strategies for oversight of Medicaid providers and intends to integrate the post-payment audit functions for EPs and EHs into those strategies.

The system will initiate a notification to NLR and provider that the provider is excluded or eligible. ASMA will initiate an ongoing process to inform the NLR of the final eligibility of EPs and Hospitals that selected Medicaid.

ASMA will send the NLR the eligibility of new Medicaid providers that have requested registration into HITECH.

5.2 How will the SMA track the total dollar amount of overpayments identified by the State as a result of oversight activities conducted during the FFY?

Standard: ASMA will track the total dollar amount of overpayments identified by the State as a result of oversight activities using the same methodology and process as is used today for other Medicaid overpayment collections and will report those overpayments through the same federal reporting mechanisms. Overpayments are defined as either duplicate payment or a payment that was later found to be made in error. For example, the provider falsified their attestation and did not meet criteria. Overpayments will be identified through post-payment review, post payment validation of data (though many upfront checks are being implemented and coordinating with state and federal resources).

Methodology: ASMA will report to CMS on the appropriate federal reporting documents, all overpayments by category (Medicaid Incentive Payments). ASMA assumes CMS will provide additional guidance on how the current reports shall be amended and/or enhanced to assure the information is provided to CMS in the format meets CMS' needs. ASMA will abide by the same timeline requirements as are in place for all Medicaid overpayment recoveries.

Process: If an ASMA program integrity staff makes a determination that a provider was overpaid, a demand letter shall be sent to the provider, at his last known mailing address as established on the provider data base in the MMIS system. If a provider designated a payee, the demand letter may be mailed to a provider's last known mailing address. If a provider disputes the amount of overpayment, a provider may initiate the administrative appeals process. A timely filed request of administrative appeal process shall state the recoupment activities by ASMA pertaining to the issues on appeal until the administrative appeal process is final. If ASMA determines that no adjustments are required, the initial determination shall stand. If the department determines that the amount of overpayment demand should be reduced, a refund due to the provider shall be refunded to him within thirty (30) calendar days from the date of the action. If the administrative appeal process results in a new or modified determination letter, new appeal rights shall be provided in accordance with this administrative regulation.

However, if the state is upheld, thirty (30) calendar days after the issuance of the final order, ASMA will initiate collection activities, and take all lawful actions to collect the debt; and enact program terminations, sanctions or other actions.

5.3 Describe the actions the SMA will take when fraud and abuse is detected.

Standard: ASMA will use the same policy and procedures that the state uses for any other program integrity action, including fraud and abuse including the use of MFUCU and SURS.

Methodology: The state is anticipating an increase in activity during the initial two years, but is not anticipating an overload that will distract staff from other areas of the Medicaid Program or not allow them to adequately do their work in this area. The state currently requires the fiscal agent to identify suspected fraud and the FA will be required to do that for this area of activity as well. The audit elements and areas of potential risk have been identified in previous tables and questions. When a pre-payment or post-payment control indicates the need for human interaction, the state has specific policies and procedures that will be followed.

Process: The state intends to fully utilize the activities of the federal agency in their oversight of the Medicare program. In addition, the ASMA Program Integrity unit, following established policies and procedures, will manage a sampling process as well as cases where a pre-payment or post-payment control has identified an area of concern. Using a sampling process that is focused the first year on verification of provider eligibility and AIU, followed the second year with actual meaningful use, the staff will verify content of provider attestations. The state intends to pursue a relationship with the REC to the degree potential conflicts of interest are addressed. Provider attestation verifications are anticipated to be completed approximately 90 days after the NLR are done. As further clarifications are provided by CMS regarding the availability and processes that will be used for Medicare, ASMA may make additional adaptations to the state policies and procedures.

5.4 Is the SMA planning to leverage existing data sources to verify meaningful use (e.g. HIEs, pharmacy hubs, immunization registries, public health surveillance databases, etc.)? Please describe.

Standard: For the initial year for verification of provider eligibility and attestations, the core sources of data will be the current MMIS, which will be leveraged highly, the CMS NLR, which will also be leveraged extensively, and other data sources as they are

identified. For year two and going forward, when quality measurement requirements will be activated for MU, the state will use all available data resources.

Methodology: The state is reviewing data source options. The state fully intends to leverage the AHIE to the degree possible for verification of meaning use quality measures. The state will also be collecting quality measures for the CHIP program and will utilize data and results through applicable reporting options.

Process: The Dept. of Public Health is working with Medicaid to be one of the gateways of the AHIE as part of the AHIE and to enhance the immunization registry system to make it a more viable source for provider reporting and state oversight of MU measures related to children. Immunization registry is only one of the data sources and responsibilities of public health in relationship to MU. Public Health will be involved also in lab results, reportable diseases, family planning, care management, well child exams and home health. The viability of the AHIE as a data source for structured lab will be considered, but at a minimum it will be the core source for verification of clinical exchange. The MMIS system and the AHIE may provide some support for e-prescribing verification, but until additional focus can be put towards analysis of the quality measures, the appropriateness of various sources is unclear. Additional data sources and systems that may play a role in MU that will move from being an isolated system to part of the AHIE include the trauma registry, HIV/AIDS surveillance, newborn, vital statistics, disease surveillance, family planning, EPSDT, lab and care management. All state data systems will be considered as well as any data source that the state has appropriate access to.

In the “To Be” vision, the state has incorporate a data warehouse infrastructure to support the MU quality measures related to mental health as it is expected that quality measures will be required in this area going forward; therefore the state must begin now to assure providers can report the data at the necessary time.

5.5 Will the state be using sampling as part of audit strategy? If yes, what sampling methodology will be performed?* (i.e. probe sampling; random sampling)

Standard: Yes, the state intends to do sampling as part of the audit strategy and the sampling strategy will be a mixed approach and will potentially change over time.

Methodology: The state has not historically used the probe sampling method, but it has relevance to this new program. The state will consider taking representative samples from various provider types within EPs in order to gain some knowledge on the granularity of the issues as well as send a message that the state is looking. If the granularity identifies a risk all, like provider types may be reviewed.

Process: Due to the limitations of time and competing work, the state will default to Medicare on appropriate providers/hospitals, but will also communicate with Medicare to learn if there is a provider type that a more focused sampling should be pursued. The process will evolve as the state and process moves from AIU to MU and from structural review of hardware/software to quality measurement.

There is only ONE wholly functioning Children's Hospital. This hospital will be subject to the same auditing processes and parameters as other acute care hospitals participating in the incentive program. 4.3 has been amended to state: Since Medicare will not be auditing the Medicaid only hospitals (children's hospitals), and there is only one wholly functioning Children's Hospital,, the hospital will be subject to the same auditing processes and parameters as other acute care hospitals participating in the incentive program.

5.6 **What methods will the SMA use to reduce provider burden and maintain integrity and efficacy of oversight process (e.g. above examples about leveraging existing data sources, piggy-backing on existing audit mechanisms/activities, etc)?

Standard: As indicated throughout, ASMA fully intends to leverage cross-state activities.

Methodology: The state intends to reduce provider burden through standardized formats and requirements (Alabama has not deviated from the rules as published), build on the current MMIS using the MITA framework and limiting duplication of effort through existing audit mechanisms/activities.

Process: Through SERCH, the multi-state southeast region collaborative, Alabama, GA, Texas, VA, Kentucky and, Mississippi are working through each week, topic by topic, standardized approaches building off the work related to disaster preparedness. The current area of focus is CCHIT, including how to educate providers/consumes/public consistently across states. The one-hour weekly conversation, hosted by Tennessee, has dealt with sustainability, consent and other policy and operational topics. Alabama, through NGA, RTI, AHRQ and Medicaid Transformation Grant sponsored efforts, is also working with NC (DURSA), Florida (various operational issues) and other states who are contracting with the same FA.

Going forward the principle that has been established for the state is standardization with federal agencies and other states, which should limit duplication, create more validated information, reduce human and fiscal resources, and reduce the burden on providers.

In addition, the State Level System will have the capability for providers to upload documents to support data provided. This will alleviate the need for significant post payment review.

5.7 Where are program integrity operations located within the State Medicaid Agency, and how will responsibility for EHR incentive payment oversight be allocated?

Standard: In the broadest sense, program integrity is the responsibility of everyone in the ASMA. The policy staff is responsible for writing the policies and procedures and implementation of the rules aligning with the requirements of the federal law and regulations. The MMIS staff is responsible for the oversight of the MMIS, implementation of edits/audits and operation of the MMIS to avoid overpayments. The SURS and Program Integrity staff will have direct responsibility for the oversight of the EHR Incentive Program under the leadership of the new MU Manager in the HIT Office. As MU will require some clinical expertise, ASMA's Medical Directors will also be involved.

Process: ASMA will utilize existing financial audit staff (hospital and nursing home) cost report people and staff in each of the areas identified above as appropriate under the leadership of the HIT Office MU Manager. Since the area of dental in relationship to MU is less clear at this date, the state is taking a closer look at the role of the dental school, the activities of FQHC dentists and alternative or enhanced mechanisms for the state to consider in this area.

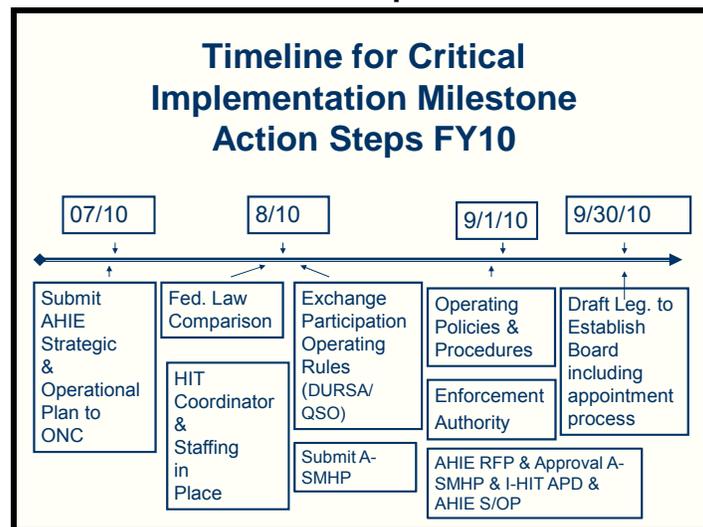
6 SMHP SECTION E: ALABAMA'S "ROADMAP"

6.1 Provide CMS with a graphical as well as narrative pathway that clearly shows where the SMA is starting from (As-Is) today, where it expects to be five years from now (To-Be), and how it plans to get there

The inter-relationship of the State Strategic/Operational Plan and the State Medicaid HIT Plan (SMHP) is evident in timing as well as impact, creating simultaneous demands of time and efforts. The Commission and the State Medicaid Agency have made it a priority to align the work so the needs of both efforts can be met and the dependencies of infrastructure of one (HIE) for success in the other (MU) can be addressed timely and appropriately.

For the immediate future (the remainder of FFY 2010), the priorities are approval of the A-SMHP, I-HIT-APD and implementation of the provider registry, connectivity to the NLR, the business and technical operations to support the Medicaid EHR incentives, approval of the AHIE S/OP, issuance of the RFP for the AHIE, staffing of the HIT Office (including the MU Manager), and implementation of the A-SMHP and AHIE S/OP (governance, technical infrastructure, technical and business operations, finance, legal/policy and marketing and communications). Core to success is communication, communication and more communication – with CMS, other states, within state government, all the AHIE stakeholders and a special focus on EPs and EHs for meaningful use engagement.

Figure 16: Timeline for Critical Implementation Milestones FY10



It is very clear, very quickly that that risk facing the state and providers is the abundance of work that needs to be completely efficiently, accurately and in a transparent way in a very quick time frame. The following tables address the immediate time frame for both the AHIE S/OP and the SMHP, as the work in either is very demanding, but combined requires detailed work plans, time lines and staff commitment. There are two applicable tables. One addresses the timeline for the AHIE S/OP and the A-SMHP, while the other addresses the time line for the related infrastructure development.

Table 8: Timelines for Plans			
Strategic/Operational Plan		SMHP Plan & MU	
May 2010	Environmental Scan (completed)	May 2010	Environmental Scan (completed)
May 2010	Advisory Commission Approval of Strategic Plan (completed)	July-August 2010	Advisory Commission Review SMHP Plan (completed)
May-June 2010	Work Group Development & Approval of Operational Plan (completed)	September 2010	SMHP Plan for Submission to CMS (completed)
May 2010	RFI Released (completed)	January 2011	Eligible Hospitals
July 2010	Final Strategic/Operational Plan Approval by Advisory Commission (completed)	January 2011	Eligible Providers
August 2010	Submission of Strategic/Operational Plan to ONC (completed)	October 2011	Eligible Hospitals (Quality Measures – 7/1/11)
September 2010	RFP Released for Vendor/Functionality	January 2012	Eligible Providers (Quality Measures – 10/1/11)

NOTE: Timeline based on hospitals being able to meet meaningful use quality reporting criteria July 1, 2011; system needs to be operational 90 days prior

Table 9: Timelines for Infrastructure Development					
AHIE Infrastructure		Meaningful Use Infrastructure		Current Medicaid Responsibilities Infrastructure	
June 2010	HIE System Features/Design Finalized (completed)	Fall 2010	Provider Registration System I-APD	January 2012 for 5010 October 2013 for ICD-10	Implement 5010 Implement ICD-10
September 2010	HIE ITB/RFP Released	Fall 2010	Connection to CMS NRL Group 1 Testing	2011 – 2014	Eligibility System & Claims Processing, Changes required for CHIPRA, ARRA & HC Reform
November 2010	HIE Bids Due	Fall 2010	CSR to Current MMIS Contractor	2011-2014	Mental Health & Public Health HIT
January – February 2011	HIE Contract Begins	Spring 2011	State Medicaid Attestation System	2010-2014	Health Insurance Exchange System Implementation

Consistent with the ONC “Five Domains Plus One” approach of Alabama for the AHIE S/OP, the state has approach its critical three (3) to five (5) year “Roadmap” through the same sub-components: technical architecture, technical and business operations, governance, finance, legal/policy and marketing and communications. The following table provides not only the critical activities for each domain, but the state’s proposed approaches to each of the identified activities.

Table 10: Alabama Activities and Approaches Roadmap		
Activity	Year	Approach
Technical Architecture Activities and Approaches to Activities		
Become consistent with HHS adopted interoperability standards	2010	AHIE & SMHP will monitor and apply HHS interoperability standards as they are developed. Technical infrastructure will deploy standard interface for connectivity to the statewide network. AHIE will adhere to the HHS standards when exchanging

Table 10: Alabama Activities and Approaches Roadmap

Activity	Year	Approach
		records with another entity on the NHIN
Design, develop and implement the state MU Infrastructure as expanded MMIS	2010-2011	MMIS architecture built to interoperability, privacy and other Stage 1 standards to allow interface with NLR, provide the support required for provider identification, payment and oversight. Initial HIT focus on payment for AIU, including testing with CMS 10/10 to 12/10 for full implementation prior to 4/11. Immediately following, technical support for MU quality measurement reporting, oversight and payment prior to end of FY2011.
Become consistent with MU EHR-certification requirements as expanded MMIS	2010	AHIE architecture built to HHS certification standards for exchange of health records AHIE will require all EHRs connecting to AHIE to be HHS Certified and will work with RECs to implement certified EHRs.
Design, develop and implement other state MU Infrastructure as expanded MMIS	2010-2013	Expanded MMIS architecture built to interoperability, privacy and other Stage 1 standards with capability to evolve to meet Stage 2 standards and support other state MU related activities, such as PH, MH, eligibility, etc. MH I-APD anticipated to be submitted Fall 2010 for a time line starting 1/1/11 for the RFP, 4/11 for the contract and roll-out beginning 5/12. (Additional information will be provided in a future I-APD)
Business and Technical Operations Activities/Approaches		
AHIE RFI	May 2010	An RFI was issued by the state to help define the core functionality and additional functionality as will be required through the state procurement process was identified earlier in Table 2. There were 21 responses to the AHIE RFI, which provided validation to the Technical Infrastructure's workgroup proposed approach.
AHIE S/OP	July 2010	Alabama Strategic/Operational Plan submitted to ONC
AHIE RFP	September 2010	AHIE RFP to be released by the end of September 2010.

Table 10: Alabama Activities and Approaches Roadmap

Activity	Year	Approach
SMHP	September 2010	SMHP developed and submitted to CMS with Phase 1 focus on Stage 1, Year 1 AIU but design and develop for MU for Stage 1, Year 2 for expanded MMIS
I-HIT-APD	September 2010	I-HIT-APD submitted to CMS for first activities. (First of multiple APDs)
Amend Contract with MMIS Vendor	Fall 2010	DDI and ongoing operations of MU IT Support
Group 3 Testing CMS NLR	First Quarter Calendar Year 2011	Alabama has been authorized to be a Group 1 testing cohort for the CMS National Level Repository with the goal of the state able to launce their EHR Incentive Program by January 1, 2011. Testing will occur this fall and may overlap with the beta testing for the AHIE. When and where that occurs, efforts will be initiated to bring together the efforts and limit unnecessary intrusion and demands on the providers seeking to comply with MU timelines and requirements.
MU	Fall Winter 2011	Development and implementation of technical and business operations to support MU aligned with federal and other states.
State MU: Phase 2 expanded MMIS	2011-2013	I-HIT-APDs for expanded MMIS architecture built to interoperability, privacy and other Stage 1 standards with capability to evolve to meet Stage 2 standards and support other state MU related activities, such as PH, MH, eligibility, etc.
Governance Activities/Approaches		
AHIE Operating Commission Charter, By-Laws and Policies/Procedures	2010-2011	Revised and adopt using examples from other states and private organizations
AHIE Operating Commission Members Roles & Responsibilities	2010-2011	Revised and adopt using examples from other states and private organizations
HIT Office	2010-2011	HIT Office established within the Medicaid Agency, including the addition of MU manager

Table 10: Alabama Activities and Approaches Roadmap

Activity	Year	Approach
Enforcement Agency	2010-2011	Identify agency that will enforce HIE/HIO regulations
Trigger to Initiate Operating Commission	2011-2013	Conversion to Operating Commission will occur when specified thresholds are met
Trigger Thresholds	2011-2013	Establish threshold events including participation, financial; budget sustainability, functional and political events
HIT Oversight	2011	Adopt regulations for HIO oversight by HIT Office
Finance Activities/Approaches		
Long-Term Sustainability for AHIE	2011	Commission will advise legislature after research is conducted.
Cost Benefit Analysis of statewide HIE	2010	Blue Cross/Blue Shield of Alabama will conduct the analysis
Business for Participation in AHIE	2010	Alabama State University will conduct this analysis.
Federal Reporting for MU and other ARRA activities (ONC funding)	2010 - 2015	ASMA to create standardized approach to federal reporting through the Medicaid Agency and state HIT Office.
Federal funding through MU authority, Affordability Act authority, CHIPRA authority and ongoing MMIS authority	2010 - 2015	ASMA identify and fully utilize federal funding through MU authority, Affordability Act authority, CHIPRA authority and ongoing MMIS authority. ASMA submit additional I-HIT-APDs and I-MMIS-APDs to support public and mental health activities.
Policy and Legal Activities and Approaches to Activities		
Legislative Requirements		
Establish a statewide policy framework that allows for incremental and continuous development of AHIE policies.	2010	Determine the need for state law that is necessary draft such that changes to federal law automatically trigger a mirror change in state law. Changes to state law should occur within 90 days.

Table 10: Alabama Activities and Approaches Roadmap

Activity	Year	Approach
<p>Establish Requirements for how AHIE & MU Infrastructure will comply with all applicable federal and state legal and policy requirements with a continuing alignment to federal Medicare and Medicaid requirements. Federal regulations will be the floor and Alabama regulations will only be written if they deviate.</p>	<p>2010</p>	<p>Research and identify federal regulations to compare to Alabama state legislation for conflicts, potential updates, or missing legislation.</p> <p>Compare the NHIN business agreement and DURSA and identify potential areas of concern/follow-up for comparison with Alabama state law.</p> <p>Develop and Alabama specific DURSA and Business Agreement.</p> <p>Review Current Law & Regulations/laws to determine from “as is” to “to be” for both federal and state authority:</p> <ul style="list-style-type: none"> • missing and needs to be added • exists and no longer appropriate • exists and needs to continue • exists and needs to change but outside authority of state to change (federal law) <p>Areas of Focus:</p> <ul style="list-style-type: none"> • Privacy and Security: • Federal Law Compliance: HIPAA, FERPA, MH, Adolescent, Substance Treatment, HIV/AIDs, Other • Authorization & authentication • Insurance and “entity” status • Tax Law • Relationship to HISPC and to MITA efforts • Other
<p>Establish recommended priority policies</p>	<p>2010</p>	<p>Legal and Policy Workgroup to provide to Commission</p>
<p>Identify policy issues and establish recommended policy</p>	<p>2010</p>	<p>Medicaid Agency to develop with assistance from Legal and Policy Workgroup...</p>
<p>Privacy and Security</p>		
<p>Examine the federal privacy and security requirements for data security and integrity related to the exchange of health information. (</p>	<p>2010</p>	<p>Research and identify federal regulations to compare to Alabama state legislation for conflicts, potential updates, or missing legislation.</p> <p>ARRA, HIPAA Privacy Rule, HIPAA Security Rule, Confidentiality of Alcohol and Drug Abuse Patient Record Regulation)</p>

Table 10: Alabama Activities and Approaches Roadmap

Activity	Year	Approach
Examine the privacy and security requirements related to health information technology in the state of Alabama and related secondary issues, such as the ability of providers and patients to opt-out of information sharing.	2010	Research and identify privacy and security requirements.
Establish how levels of consumer access to information in the AHIE will be defined and sensitive health information will be protected.	2010	<p>Consumers will be given choice regarding decisions about the collection, use and disclosure of their PHI.</p> <p>Policies will be developed that will ensure that consumers have a timely means to dispute the accuracy of HIE information.</p>
Review the work the Health Information Security and Privacy Collaboration (HISPC) have done in the area relating to privacy and security	2010	<ul style="list-style-type: none"> • There is no HISPC for Alabama. • Alabama Medicaid will investigate local policies.
Development of Exchanges with Other States		
<p>Perform research to gain an understanding of other state policies regarding HIE to determine where common ground exists and to identify where Alabama policy changes may need to be pursued.</p> <p>Conduct a survey of states to determine which states have the most compatible technologies and policies in place.</p> <p>Examine pilot exchanges between states to</p>	2011 – 2012	<p>Alabama Medicaid to begin discussion of this issue with the south eastern states.</p> <p>Alabama Medicaid will look at Florida and Connecticut State Strategic Plans for best practices regarding legal/policy, including transfer of liability issues, consent, by payer requirements.</p> <p>Contractor will contact the state of Indiana to see if they will share policies and procedures for operation of HIE and P&P for day to day operations.</p> <p>Once potential collaborators are discovered, perform a review of the various approaches that could be used to overcome barriers caused by the wide variability in privacy and security requirements.</p> <p>Once solutions for technical and policy incompatibilities</p>

Table 10: Alabama Activities and Approaches Roadmap

Activity	Year	Approach
determine the parameters for its operation and governing regulations.		are agreed to, establish one or more pilot programs. Alabama will target larger communities bordering the state such as Pensacola, FL, Columbus, GA or Chattanooga, TN, where a strong need for coordination of health information across state lines already exists.
Policy and Procedure Development		
Policies and Procedures		
Identify recommended legal policies and procedures related to a statewide policy development process	2010	Legal and Policy Workgroup to identify.
Determine AHIE operational policies and procedures in relationship to University Education: medical education & informatics (U of Southern Alabama contract with ONC)	2010-2011	Legal and Policy Workgroup in conjunction with Governance will identify and develop outline of issues.
Determine policy/procedures in relationship to Workman's Comp. processes if applicable	2011	Legal and Policy Workgroup will identify and develop outline of issues.
Determine operational policies and procedures to in relationship to REC	2010	Legal and Policy Workgroup will identify and develop outline of issues.
Incorporate recommended legal policies and procedures	2010 – 2011	Alabama Medicaid Agency to receive issues from LRT and Legal and Policy Workgroup
Establish recommended priority policies	2010-2011	Alabama Medicaid Agency to develop implementation framework

Table 10: Alabama Activities and Approaches Roadmap

Activity	Year	Approach
Review of, and recommendation of new/existing policy issues	2011	Office of HIT Coordinator to assume responsibility for ongoing maintenance
Oversight and Risk Mitigation		
Establish risk mitigation policies	2010	Legal and Policy Workgroup will identify and develop outline of issues.
Establish oversight and enforcement mechanisms to ensure compliance with HHS adopted standards and all applicable laws and policies for interoperability, privacy and security.	2010.	Will not require legislative change to accomplish.
Incorporate risk mitigation legal policies and procedures	2010-2011	Alabama Medicaid Agency to receive issues from LRT and Legal and Policy Workgroup
Establish risk mitigation priority policies	2010	Office of HIT Coordinator to develop implementation framework in conjunction with Governance Workgroup.
Review of, and recommendation of new/existing policy issues	2010 – 2013	Office of HIT Coordinator to assume responsibility for ongoing maintenance.
Communication and Marketing		
<p>By audience: Providers, (Hospitals, Physician, Laboratory, X-ray, Pharmacy, Ancillary Services, Rural and Safety Net and Other); Healthcare Payers, Purchaser, State Agencies</p> <ul style="list-style-type: none"> • Progress reports and details on AHIE system issued via 	2010 - 2014	<p>By audience: Providers, (Hospitals, Physician, Laboratory, X-ray, Pharmacy, Ancillary Services, Rural and Safety Net and Other); Healthcare Payers, Purchaser, State Agencies</p> <ul style="list-style-type: none"> • Branding/Logo Development – Year 1 • Web site first available – Year 1 • Established feedback/reporting mechanism – Year 1 • Dissemination of news articles for hospital publications for patients, physicians, community – Years 1-4 • Progress reports and details on AL HIE system

Table 10: Alabama Activities and Approaches Roadmap

Activity	Year	Approach
<p>association publications, HIE Web site;</p> <ul style="list-style-type: none"> • Establish and publicize mechanism for regular progress updates and feedback via Web site • Creation of provider-specific “tool kit” for CEO/CIO use with hospital CEOs/boards/medical staff (e.g. fact sheets, FAQs, white paper, slide presentation, sample articles, emails, brochures); available via Web site • Scheduled presentations to providers at their location, society and other state and regional meetings • Physician outreach and education activities in coordination with REC • Development of CME-based educational activities for physicians 		<p>issued via hospital association publications, HIE Web site; Years 1-4</p> <ul style="list-style-type: none"> • Development of White Paper – Year 1; update Years 2-4 • Presentations to physicians at hospital, society and other state and regional meetings – Years 1-4 • Creation of provider-specific “tool kit” for CEO/CIO use with provider CEOs, boards, medical staff (e.g. fact sheets, FAQs, white paper, slide presentation, sample articles, emails, brochures); available Web site. - Year 2 • Update toolkit – Years 3-4 • Development CME Activity for physicians – Year 2 (Physicians) • Dissemination of news articles for patient publications – Years 2-4

6.2 What are the SMA’s expectations re provider EHR technology adoption over time? Annual benchmarks by provider type?

ASMA and the AHIE, including the HIT Manager, have made certified EHR adoption a priority for the state. It is the goal of the state to have all providers using certified EHRs in a meaningful way; however the goal is overtime and not in the near term.

ASMA has not established annual benchmarks by provider type at this time as additional information and analysis is required as 2010 was the baseline year. In addition, there are significant limitations to the information obtained in the Environmental Scan that created the baseline. For instance, none of the EHRs at the

time of the survey were certified under the new regulation so the transferability of the baseline information into a benchmark structure is unknown.

It is true in any transition that increases will vary by year and provider type and that is very evident in this area. Influencing factors are the initial focus on providers eligible for Medicaid EHR incentives and the evolving marketplace and standards. For instance a consistent data source for benchmarking will be the meaningful use data, yet in year one the provider will track AIU, but in year two for the provider, the tracking will be by meaningful use. In addition, some of the provider data will not be reported annually as some providers will skip a year. While the AHA survey will be an annual survey, it is hospital based.

The state intends to track take-up rates, but will be working with the REC, which will be documenting the same information for ONC as a part of their reporting requirements. The process and methodology has yet to be established. In the meantime, the state will be tracking and benchmarking communication and outreach activities and completion of milestones (technological and business processes).

6.3 Describe the annual benchmarks for each of the SMA's goals that will serve as clearly measurable indicators of progress along this scenario.

An overarching principle has been that the inclusion or exclusion of an outcome and/or performance measure should be based on its usefulness for both day-to-day operations and evaluation at the individual, population, initiative and statewide level from the perspective of consumers, providers, purchasers/payers and providers. Examples of key performance measures that are under consideration include proportion of healthcare providers in the state that are able to receive electronic health information using the AHIE technical infrastructure and extent technical assistance is available to those developing health information (business and technical operations). Validation of the involvement will be part of the evaluation process required under the AHIE S/OP and will also be addressed in the 2011 required ONC annual report, leveraging the evaluation component of the ONC grant. Metrics currently under consideration include improvement on response rate to environmental scans of physicians and hospitals, and a measure related to providers seeking to achieve meaningful use meeting their goal.

6.4 Discuss annual benchmarks for audit and oversight activities.

ASMA expects that CMS will provide guidance on the Medicare methodology for audit and oversight activities and that the state will align with that methodology, which will affect the focus of annual benchmarks for audit and oversight activities. In general, just like any risk mitigation strategy, Alabama will annually establish program integrity

efforts and priorities for the year and track to those efforts. Factors that will influence the benchmarks will be ability of the state to leverage CMS/Medicare activities; results from sampling, especially probe sampling, and resource capacity related to the priority activity each year. To the degree the state can use data sources to complete validation and oversight activities, it will do so. Where the efforts require more on- review, the resources will require limitations so as not to spend more in oversight than in operating the incentive program. In the first year the benchmarks will target eligibility of providers (populations, predominance in hospital and/or FQHC, use of certified EHR), while benchmarks in year two of stage one will include the above, but will have an expanded responsibility related to the attestations related to quality measurement. The goal is NOT to have expanded recoveries, but to have more pre-payment actions that avoid inappropriate payments and/or fraud.

7 ACKNOWLEDGEMENTS

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ⁱ SureScripts. "State Progress Report on Electronic Prescribing." Data as of December 2009.
<http://SureScripts.com/about-e-prescribing/progress-reports/state.aspx?state=al&x=22&y=11>

ⁱⁱ SureScripts. "State Progress Report on Electronic Prescribing." Data as of December 2009.
<http://SureScripts.com/about-e-prescribing/progress-reports/state.aspx?state=al&x=22&y=11>

ⁱⁱⁱ Refer to Appendix C, Survey Results, Question 1 – 354 "Yes" responses.