



**STATE MEDICAID HEALTH INFORMATION TECHNOLOGY
PLAN (SMHP) UPDATE TO THE ANNUAL PLAN
FOR A-HIE “ONE HEALTH RECORD®”**

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

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VERSION HISTORY

Version	Approved	Notes
1	2010	Original Submission
2	Nov. 5, 2012	Annual Update
3	February 5, 2013	Annual Update and Updated for MU Stage 1
4	April 1, 2013	Audit Strategy: AIU and MU State 1
5	February 27, 2014	Annual Update and Updated for MU Stage 2
6	May 12, 2014	Response to CMS Questions and Updated for One Health Record® A-HIE

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

1.1 PURPOSE

As former Medicaid Commissioner R. Bob Mullins, Jr., MD, former chair of the Alabama Health Information Exchange (A-HIE) One Health Record®¹ Advisory Commission previously stated, “I made the decision early on that the development of our health-IT system had to be our primary initial goal in order for the agency to meet the demands of the fundamental changes going on in Medicaid and health care.” This principle continues to guide the current Alabama Medicaid leadership.

The A-SMHP was initially submitted in 2010, updated on November 15, 2012, and approved as an update on February 5, 2013. It continues to provide the activities Alabama’s State Medicaid Agency (A-SMA) has engaged in and the proposed actions the state will engage in over in the near and longer term relative to implementing Section 4201 Medicaid provisions of the American Recovery and Reinvestment Act (ARRA). The 2014 annual update of the Alabama State Medicaid Health Information Technology Plan (A-SMHP) includes Stage 2 for Meaningful Use (MU) changes that are to be implemented April 1, 2014, was approved by CMS February 27, 2014.

This update to the currently approve A-SMHP (approved February 27, 2014) specifically addresses One Health Record® updates, which were not addressed in previous update. This update primarily focuses on addressing efforts and actions by the A-SMA that will be implemented July 1, 2014 related to One Health Record®. One of the critical elements of the A-SMHP is to update the “To Be” section to incorporate the transition of Medicaid to the use of Regional Care Organizations (RCOs) and provide the necessary HIT to support the related service delivery and payment reform strategies.

Alabama State Medicaid Agency (A-SMA) agency is currently seeking to positively influence health outcomes of Alabama Medicaid enrollees in several ways, including:

- Transitioning from fee-for-service health care delivery to managed health care delivery through Regional Care Organizations (RCOs) to improve management and coordination.
- Transitioning to paying for performance and value-based purchasing
- Identifying sub-populations with specific needs
- Supporting patient outreach and health education campaigns
- Public reporting to enhance competition

¹ As noted in the initial Alabama State Medicaid HIT Plan (A-SMHP), Alabama has branded its Health Information Exchange as One Health Record®.

One Health Record®, A-HIE, presents new opportunities for A-SMA to improve health outcomes and achieve other program goals by providing the infrastructure to:

- Enhance communication between providers/hospitals and patients through practical, efficient and effective HIT interfaces and tools,
- Enhance community-based care through infrastructure for care coordination and integration,
- Enhance safety net hospitals' efficiency and effectiveness through the use of certified EHRs and connectivity to One Health Record® to reduce hospital-acquired/healthcare-associated infections, hospital-based errors and adverse events, and preventable re-hospitalizations,
- Provide useful data for the RCOs, health officials, and other stakeholders to address the needs of priority populations, reduce disparities, and support payment reform.
- Enhance the ability to use measures of quality and performance.
- Following this A-SMHP update, a HITECH HIT-I-APD will be submitted to support the following: HIT-HIE staff and activities, such as, planning and preparation for One Health Record® expansion statewide over time; creation and implementation of a “proof of concept” shorter-term pilot; on-boarding of EP-types and EHs in specified, focused geographic areas, and responding to requests by EPs and EHs to work with them so they can meet their MU requirements.
- Connecting Alabama Department of Public Health (ADPH) to One Health Record® for purposes of supporting connectivity of EP-types and EHs for EHR Incentive Meaningful Use (MU) payments.
- Continued funding for ongoing EHR Incentive Program staff and contract support, including vendor supported post-payment audit function.
- Continued funding for ongoing administration and operations of Alabama's MU EHR Incentive Payment Program, including post-payment audit functions, and the projected program spending through September 30, 2015.
- Continued funding for the management and oversight of the State Level Registry (SLR) activities including coordination with other States that share the SLR platform and working with the contracted vendor (Xerox Corp.) that maintains the SLR system platform. This is an ongoing activity that requires planning for and managing system enhancements for Stage 2 Meaningful Use. As the program matures and new CMS guidelines/requirements are made known, it is necessary to ensure that SLR system capabilities and functionality meet new program requirements.

1.2 SCOPE

Section 4201 of the ARRA provides 90% FFP HIT Administrative match for three activities to be executed 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 updated SMHP continues to provide the state's plan related to:

- State Level Registry (SLR) management of registration, attestation and submission of quality measures, as well as managing the registration, reporting and payment for eligible professionals (EPs) and eligible hospitals (EHs) for participation in the Medicaid Meaning Use (MU) Incentive Payments Program. This requires that the SLR IT infrastructure support the administration of the incentive payments (100% FFP), including identification and attestation of EPs and EHs for Adopt, Implement or Upgrade (AIU), MU Stage 1, and MU Stage 2 payments.
- Maintenance and upgrade of Alabama's connection to CMS's Registration and Attestation System as needed.
- Automation of the provider appeal functions for EPs and EHs.
- Capacity to address MU measurement reporting.
- Ongoing support for the development and dissemination of educational and engagement communication materials regarding the EHR Incentive Program and/or EHR Adoption/meaningful use.
- Ongoing support for environmental scans, gap analyses, provider needs assessments and multi-state collaborative efforts related to MU.
- Integration of the data from the Registry System into the MMIS provider history.
- Conduction of adequate oversight of the Medicaid MU Incentive Payments Program, which requires IT and human resources (employees and contractors) support (90% FFP for systems and administration) for:
 - Any evaluation of the EHR Incentive Program and costs related to ongoing quality assurance activities, SMHP updates, I-APDs and federally required reporting.
 - Automation of a risk-based auditing approach with a focus on provider eligibility, patient volume, AIU, certified EHR technology and MU audit/oversight activities, including auditing contractor(s), in-house activities, and systems costs for interfaces to verify provider identity/eligibility (e.g., provider enrollment, license verification, sanctions, patient volume).
 - Medicaid's funding of One Health Record® under MU when used to support the Medicaid MU Incentive Payments Program, particularly focusing on the connectivity to the public health meaningful use objectives and technical assistance for Medicaid providers to achieve MU. Others areas include: ongoing management of the Master Patient Index; provider help-line and web site; privacy/security controls; provider needs assessments; provider outreach; Record Locator Service; secure messaging; gateways; health information technology infrastructure; provider directories; development of privacy and governance policies and procedures; interfaces for data (e.g., laboratory) important to successful health information exchange (HIE) for Medicaid providers; electronic reporting of structured laboratory data, clinical summary exchange, and enabling e-Prescribing.

- Creation of an enhanced enterprise data warehouse repository and data analysis capability through One Health Record®, Alabama’s Health Information Exchange (A-HIE) that will be used across state agencies with appropriate cost allocations.
- Pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information (90% FFP for systems and administration).
 - Medicaid’s portion of One Health Record® that impacts an EP or EH’s ability to effectively and efficiently use a certified EHR to promote health care quality and the exchange of health care information, including the ongoing management of activities when used for services that are not MU focus (such as therapies or nursing home care) or when they are used by providers who relate to EPs/EHs receiving EHR Incentive Payments but are not an EP or EH. This would include the Master Patient Index, Record Locator Service, secure messaging, gateways, provider directories, development of privacy and governance policies and procedures, interfaces for data (e.g., home health) important to successful health information exchange for Medicaid providers, clinical summary, electronic reporting of structured laboratory data and enabling e-Prescribing. One Health Record® provides a state query gateway to the eHealth Exchange and provides HISP services in support of DIRECT secure messaging. Alabama One Health Record® will act as the “hub” for the exchange of information intra- and inter-state, allowing providers to meet MU requirements.
 - One Health Record® is under the governance of the Medicaid Agency and costs were allocated between Medicaid and the ONC cooperative agreement grant funding for the development of A-HIE on a fair share basis through February 2014. ONC funding terminated March 2014 and a “fair share” funding methodology has been initiated for the “proof of concept” pilot and planning and preparation for statewide expansion.

Alabama Medicaid will not be the sole funding source, but Alabama Medicaid will be responsible for its fair share “in accordance with benefits received.” Medicaid, Medicare (administered by Blue Cross-Blue Shield of Alabama (BCBSA), CHIP (administered by BCBSA) and BCBSA— the primary payers and managers of care delivered in the state — will receive the benefits. BCBSA is a member of the One Health Record® Advisory Committee, has contributed in-kind contributions since the initiation of the efforts, and is committed to participation long term. The approach provides an integrated, long-term sustainable governance structure and consumers have one web-based “door” to Alabama health care through One Health Record® <http://onehealthrecord.alabama.gov/>.

Figure 1: One Health Record® Website

4/15/2014 State of Alabama - One Health Record



One Health Record
Health information
safe and secure
when and where you need it

Newsroom

The field of health information technology and HIE is rapidly expanding to help patients, physicians and other health care organizations connect to better health care results. For news and information from One Health Record and HIE activities in Alabama, select the link below.

[Click here for news items](#)



One Health Record
Health information
safe and secure
when and where you need it

Meetings

For a calendar of upcoming events regarding the HIE, [click here](#)

Welcome

Welcome to One Health Record. Broad use of health information technology (HIT) has the potential to improve health and health care, by improving quality, preventing medical errors, increasing the efficiency of care and reducing unnecessary health care costs, increasing administrative efficiencies, and improving population health and patient engagement.

One Health Record is Alabama's vision for health information technology. To learn more, select a menu item to the left.



Latest News

The One Health Record web portal is now available to registered providers. To access the portal, [click here](#).

Documents needed by providers to connect to One Health Record are available [here](#).

Independent Evaluation of One Health Record project prepared by the University of Alabama at Birmingham School of Public Health - [Click here](#)

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Have questions or comments about One Health Record? [Click here](#) for information on how you can reach us.

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The end goal is to reform Medicaid through incremental, but critical system wide changes identified within this A-SMHP. Due to Alabama's extensive Medicaid population and expanded provider network, the infrastructure MUST work for Medicaid in order to work for the rest of the payers in the State.

1.3 TIMEFRAME

This updated A-SMHP addresses the activities and responsibilities of the A-SMA related to One Health Record's® relationship to the EHR Incentive MU Program and the meaningful use of health information. In addition, Section E of this A-SMHP has been updated to provide a current picture of the five year roadmap for the State of Alabama. The initial A-SMHP provided the basis for funding for the Medicaid portion of One Health Record® and the initial I-APD provided the State's request for Medicaid funding. However, the CMS approval letter authorized the funding of the registry activities, but did not address One Health Record®. Therefore a latter A-SMHP re-iterated the inclusion of the areas identified above under scope and an updated I-APD was subsequently submitted and approved. Alabama intends to update the A-SMHP at minimum annually.

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. The priorities for the State are enormous, complex and inter-dependent in a time of immense budget constraints and policy transformational activities, both federally mandated and optional. Previous A-SMHP updates identified and addressed the integration of mental health, senior services and public health infrastructure to assure more accurate and appropriate Medicaid payment and Medicaid eligibility, as well as MMIS development needed to manage the growing Medicaid population. All of these changes will have momentous impacts on Medicaid.

1.5 STAKEHOLDER ENGAGEMENT

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 Acting Medicaid Commissioner Stephanie Azar, as the chair of the A-HIE One Health Record® Advisory Commission (along with the State Public Health Director as the Vice-Chair) and the Medicaid Agency as the Executive Sponsor for the A-SMHP, the Medicaid Agency staff the A-HIE One Health Record® Advisory Commission. Used for both the A-HIE S/OP and the A-SMHP, the One Health Record® has been able to engage and retain engagement with Governor appointed leaders for providers, advocates, Regional Extension Center (RECs) and Universities engaged in health-IT education.

The One Health Record® Advisory Commission is also the steering committee for project oversight of the A-SMHP and resulting activities. The A-HIE four (4) work groups, which reflect the five domains prescribed by ONC (Governance and Finance, Technical Architecture/Business and Technical Operations, Legal/Policy) plus the additional Communications/Marketing Committee added by Alabama to focus specifically on engagement of providers, consumers and

stakeholders, provide advice and health-IT oversight for the A-SMHP as well as One Health Record®.

Examples of previous marketing and educational material created to assure a consumer-centric approach were previously provided in Attachments 8.1 and 8.2. A copy of a weekly report on specific outreach activities was previously provided in Attachment 8.3. The web is currently being updated and additional examples are available upon request. Economies of scale have resulted as key personnel overlap between technical assistance (TA) and communication efforts related to MU and One Health Record® support and its relationship to the Medicaid EHR Incentive Program.

Updated information on the current “as is” state for both the AHIES/OP and the A-SMHP, which includes explicit questions related to meaningful use status and plans, is provided in Section A. Multiple surveys, data collection and analysis activities have been undertaken and previously shared with CMS. Examples were previously provided in Attachments 8.3, 8.4, 8.5 and 8.6. 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.

Alabama Medicaid continues to provide leadership on other inter-state issues through the Southeast Regional Collaboration for HIT and HIE (SERCH) and the State Health Policy Consortium on Behavioral Health. Alabama has been engaged in ONC State HIE activities with a team of public and private providers and stakeholders. Alabama is represented on various national workgroups regarding critical issues, including mental health. In addition, Alabama continues to participate in the National Governor Association (NGA), Southern Governor Association, and National Association of Medicaid Directors (NAMD). It further serves in a leadership role in other national activities, including the AHRQ Medicaid Medical Directors Learning Network.

2. SMHP SECTION A: ALABAMA’S “AS IS” HEALTH-IT LANDSCAPE

2.0 INTRODUCTION TO “AS IS” HEALTH-IT LANDSCAPE

Standard:

Alabama sought to use a consistent approach to determine the health-IT landscape, including readiness of providers for meaningful use. The baseline provided in the initial A-SMHP confirmed that Alabama providers had limited experience with electronic health records (EHRs) and no health information exchange capability. The functionality required to exchange information in a meaningful way did not exist.

Methodology:

Copies of some of the actual original environmental scan survey tools and results are provided in Attachments 8.4 and 8.5. The Alabama responses to the earlier American Hospital Association electronic survey were compiled and provided in Attachment 8.3. Although the number of responses to this survey were small, about one half of the hospital respondents indicated a plan to pursue meaningful use but most did not have the capability to meet the thresholds for CPOE,

clinical decision support, provide electronic copies to patients, exchange clinical information and report quality measures.

During the first two quarters of FFY 2014, A-SMA talked directly to providers in the geographic area where the state is pursuing a “proof of concept” pilot to support the Medicaid RCOs. Information from those discussions provided more current information on the “as is” state and barriers to address in moving forward.

- There are over 50+ different EHRs in Alabama EP-type locations.
- Many providers have low technical capabilities.
- There are many different platforms: cloud, client/service, local hosted with leased line clients.
- Many provider have reservations as to the value of adopting MU.
- Hospitals are much further along because they have more financial resources, greater technical staffing and experience and have a better understanding of the value.

Lessons: Moving from design and development to implementation and operations is resource intense.

Process:

- The focus of One Health Record® will be a concentrated effort on the pilot to address feasibility and provide some evidence of the value for primary care physicians.
- A-SMA has embarked on a concentrated effort to do one-on-one discussions with providers in the geographic area of the pilot.
- The state is submitting a Medicaid I-APD-U to CMS to request funding for staff to support the pilot.
- The state has committed to quarterly meetings of the One Health Record® Commission.

State IT Requirements: Although Alabama’s state IT infrastructure requirements for networking services are established through Department of Finance, there was no defined statewide architecture.

One Health Record®:

1a: Implementation Activities

Implementation Activities	Date
\$10 M grant (ARRA)	2011
Contracted with HIE vendor, Truven	2011
Provided web portal with services to include Master Patient Index, Clinical Document Exchange, provider directory, secure messaging	2012
Loaded Medicaid and CHIP claims	2012
Piloted connection to three hospitals and one clinic	2013

1b: SPA Health Home Primary Care

	Alabama State Plan Health Home Primary Care Registered as EPs as of September 30, 2013	Connected to and have used One Health Record® at least once as of September 30, 2013	Have met meaningful use as of September 30, 2013
EPs	3	3	3

Additional One Health Record® connectivity and use to date include:

- 76 organizations are enabled for Direct secure messaging with 502 individual users enabled.
- Six organizations total to date have been enabled for query-based exchange with three individual users enabled.

An ongoing analysis of readiness by geographic area provided the state with possible gateways for phases one and two of One Health Record® implementation, including the technical capability to support DIRECT and CONNECT. One Health Record® provides secure messaging, a provider directory, DIRECT support and patient index (MPI) so providers statewide will be able to participate in the Medicaid incentive program and use health information in a meaningful way.

While many design, development and implementation activities have taken place and public and private support for One Health Record® has been favorable throughout the process, there remain significant implementation and operational realities in the “as is” health-IT environment.

- The rate of adoption and participation by providers and hospitals has been low. There are over fifty different EHRs in Alabama; thus, the requirement to upgrade to a 2014 certified EHR has had a timing and financial impact on individual providers, small clinics, and hospitals throughout the state. It has also affected the timing and prioritization of their connectivity to One Health Record®. The value of connectivity to One Health Record® becomes more evident with Meaningful Use Stage 2; however, MU Stage 2 is very recent and did not align with the timing of One Health Record® activation.
- Medicaid service delivery transformation is underway and creates a sense of urgency for HIT infrastructure and One Health Record®. RCOs and their providers will need to access meaningful, reliable, actionable patient information in order to effectively and efficiently provide care; thus, they need to be “on boarded” to the HIE with sufficient lead time. The focus of One Health Record® is very Medicaid centric, but “fair share” funding from private entities is required in order to access Medicaid funding. The “value” beyond Medicaid has to be validated to the private market. Their commitment is to the “promise” of value, rather than actual current value.

Figure 2: “As Is” Barriers



EHR Adoption/EHR Incentive Program Meaningful Use:

1d: Implementation Activities

Implementation Activities	Date
Registration Implementation	4/14/2011
AIU Attestation Implementation	4/14/2011
Payments Implementation	4/14/2011
Audits Implementation	10/1/2011
MU Attestation	4/1/2012

Based on CMS data, as of 9/30/13 Medicare has issued over \$200 million in total payments to 92 Alabama EHs and 964 EPs. Alabama Medicaid has disbursed over \$116 million to almost 1300 EPs and 92 EHs.

The focus for 2011 was AIU and the focus for 2012 was attesting for MU Stage 1. The process has moved to providers' readiness for use of their certified EHR in a meaningful way as well as connectivity to One Health Record®.

1e: EP Registered Providers

	Alabama Medicaid EP registered Providers who have met MU (9/30/13)	Alabama Medicaid EP registered Providers met meaningful use in 9/30/12 as well as MU in 9/30/13
EP Registered Providers 231	12	0 (none met in 2012)

1f: EP/EH Meaningful Use

	Meaningful Use Alabama EPs/EHs (documented registration with Alabama SLR) as of September 30, 2013	Signed DURSA with One Health Record® and have validated operational connectivity as of September 30, 2013
EPs	231	12
EHs	52	2

Provider Outreach: In 2014, Alabama is moving forward on implementation of a statewide initiative to engaged potential eligible providers to adopt electronic health record adoption and enroll in the Electronic Health Record Incentive payment program.

A-SMA supports a website (<http://onehealthrecord.alabama.gov/>), that links to federal and state sites, and contains information and answers to providers’ questions concerning MU. Stakeholder information regarding certified EHRS and MU requirements are provided by CMS and then forwarded to One Health Record by the State,

- A-SMA is submitting a Medicaid I-APD-U to CMS to request funding for staff to assist in onboarding of providers to the HIE to meet the core MU public health systems requirements, including immunization and cancer registry, syndromic surveillance and public lab reporting.
- The state is in discussions with the Alabama REC regarding continued leveraging of their services.

Structured Lab: The 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, EH, 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.

The certification criteria for EHRs in incorporating clinical-lab test results are as follows: electronically receive clinical-lab test results in a structured format and display such results in human readable format, electronically display all the information for a test report specified at 42 CFR 493.1291(c) (1) through (7). CMS lab test report standards), and electronically attribute, associate, or link a laboratory test result to a laboratory order or patient record.

Alabama began the landscape assessment by identifying each laboratory operating in the state using data collected from the Clinical Laboratory Information Act (CLIA) website, as well as State data. Although there are over 3,700 labs in the state, Medicaid identified 630 laboratories currently providing services to A-SMA. This includes: 385 physician office labs (POLs), 100 public health agencies, 105 hospitals, 29 independent labs, 7 advanced nurse practitioner practices, and 1 dialysis center. As part of the Structured Lab information baseline, Tuskegee University verified, corrected and expanded the Medicaid data and is in the process of completing a survey to provide more accurate baseline data.

1g: Labs

Program Priority	Status as of December 2011	Target for December 2012	Status as of December 2012	Target for December 2013	Status as of December 2013
% of labs sending electronic lab results to providers in a structured format	50%	55%	53.2%	55.5%	53.2%
% of labs sending electronic lab results to providers using LOINC (Documentation of discrete data using controlled vocabulary, creating fixed fields within a record or file, or another method that provides clear structure to information (is not completely free text)).	36%	40%	40.3%	42.5%	40.3%

Patient Summary Report: The MU Incentive Program includes both core and menu measures for patient care summaries:

- The core measure set for Stage 1 meaningful use requires that EPs, EHs and CAHs must perform at least one test of the certified EHR’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.
- The menu set measures for Stage 1 of meaningful use requires that EPs, EHs or CAHs that transition patients to another setting or provider must produce a summary of care record for more than 50% of transitions of care and referrals.

As part of the ONC initial Strategic and Operational Plan process, an environmental scan was conducted to assess current capabilities. A total of 237 providers responded. In order to ascertain additional information for planning, a follow-up telephone survey was conducted on behalf of the Agency by Alabama State University. The survey was targeted to Medicaid-enrolled providers with a paid claim volume of 500 or greater. One thousand and one responses were received.

Table 1h: EPs Use of EHRs in Practice

Provider Type	Responses Received	% Currently Using EHR in Practice
General Practitioners	619	32%
Pediatricians	172	45%
Dentists	140	36%
Nurse Practitioners	70	38%
TOTAL	1,001	35%

Of those providers responding, almost 41% (409/1,001) indicated they have a Medicaid patient volume of 30% or higher. However, when asked whether or not the practice was planning to apply for Meaningful Use Incentive Payments, the blended responses were 13% yes, 64% unsure and 23% no.

Table 1i: Electronic Care Summaries

Program Priority	Status as of December 2011	Target for December 2012	Status as of December 2012	Target for December 2013	Status as of December 2013
% of hospitals sharing electronic care summaries with unaffiliated hospitals and providers	39.2%	44%	41%	44%	44%

E-Prescribing: Alabama used SureScripts data to determine the baseline of physicians which utilize e-Prescribing in the state. According to data compiled by SureScripts, the percent of retail community pharmacies enabled to e-Prescribe and actively e-Prescribing on the SureScripts Network in Alabama grew from 64% in December 2008 to 89.7% in August 2011. In addition, new prescription requests were 625,353 (86.3% of all e-Prescribing requests on the SureScripts Network for the State of Alabama) vs. 40,108,996 (80.8% of all e-Prescribing requests nationwide).

The total number of e-Prescribers grew from just under 1,500 in March 2010 to just fewer than 4,000 in March 2011. According to data compiled by SureScripts, as of August 2011 29.4% of office-based physicians in Alabama sent an electronic prescription on the SureScripts network using an EHR compared to 37.6% nationwide.

Medicaid has sponsored an e-Prescribing initiative to provide connectivity to SureScripts through a Medicaid Agency sponsored web-interface. Using the cross-indexed list of pharmacies, One Health Record® has identified areas in the State that have pharmacies capable of e-Prescribing, and it will work with the REC to educate those physicians about the benefits of e-Prescribing.

Table 1j: e-Prescribing

Program Priority	Status as of December 2011	Target for December 2012	Status as of December 2012	Target for December 2013	Status as of December 2013
% of pharmacies participating in e-prescribing	91.4%	93%	94%	96%	96%

Secure Messaging: As of March 1, 2014, there were 783 patient queries and 1562 Direct messages. Alabama Medicaid has established a tool within One Health Record® for provider-to-provider secure messaging. The Web portal features Direct Secure Messaging (DSM) or DIRECT

exchange and will facilitate the MU Stage II requirement for securely exchanging summary of care documents among Alabama hospital and office-based providers (Provider Priority Area 3) during transitions of care or with referrals from one provider to another.

The DIRECT engagement efforts are currently targeting a pilot site in East Alabama where Care Network of East AL, Inc., a 501(c)(3) organization, operates one of four active community-based networks in the State that support primary medical providers (PMPs) among Alabama Medicaid's Patient First eligibles. Selection of this Pilot site for office-based and other healthcare providers could prove advantageous given the close working relationships established since 2011 between Network physicians, hospitals and the network professional staff such as the medical director, pharmacists, nurses, case managers and behavioral health specialists.

Providers who sign up for DIRECT follow a series of standard registration steps such as reviewing One Health Record® policy and procedure documents, and signing a participant agreement, a business agreement, and a qualified services organization agreement. Once enrolled the State team offers system administrators within practices a training on the web account and DSM as well as a site visit for follow-up to assist with any issues or concerns and to monitor progress using the Web portal. In speaking with hospitals that are approaching a 'live' connection with One Health Record®, one information services officer observed that the hospital's EMR and associated physician practices' EHR systems also offered a secure messaging feature and that instead of using the Exchange to send summaries of care securely to other providers they will use their native application. Thus, for the institutions that have purchased well-integrated EHR or EMR systems, their summaries of care will be generated internally rather than using the Directed exchange option. However, providers in Alabama who do not yet have an EMR/EHR installed within their facility or their system cannot interface with the Health Information Exchange now have the option of querying Alabama's One Health Record® for historical data on their new or existing patients.

In addition, in March 2013, The Florida Health Information Exchange established Direct Secure Messaging service with systems in Georgia and Alabama. Through this national standard connection, providers in each of the three states are able to send encrypted messages across state lines to colleagues who have registered for the service in their respective states. The connectivity is expected to be important for residents who live near state borders who may cross over for health care services.

2.1 WHAT IS THE CURRENT EXTENT OF EHR ADOPTION BY PRACTITIONERS AND BY HOSPITALS?

In addition to the information provided above, all Alabama EPs and EHs were able to begin registering/applying in April 2011 for their first year meaningful use incentive payment by attesting that they adopted, implemented or upgraded - "AIU" – to certified EHR technology via the Alabama State Level Registry (SLR). The project implementation was originally scheduled for 5 months. However, contract approval was delayed from 11/4/2010 to 2/9/2011 but the "go live" date was not delayed and the scheduled time frame from project kickoff to the 'go live' date for the system was compressed to 51 days. That time frame was extended by two weeks from

the originally announced date to 4/17/11. Due to the aggressive time frames for implementation, a number of system components were not fully developed and many of the processes were manual and labor intensive.

Extensive outreach activities were deployed in Alabama to get registered EPs and EHs registered, including efforts by the HIT Coordinator, meetings with associations, weekly webinars to educate providers, instructional information on the SLR for registration, direct phone numbers for Medicaid Staff, and a state website with educational material. Some examples of Alabama Medicaid best practices which produced desired results include website educational material with step-by-step instructions for registration in the SLR (Attachment 8.5) and weekly webinars for the first month of registration. Alabama continues to participate in a state user group for the SLR vendor with weekly meetings to discuss phases of system implementation, share approaches, successes and challenges, and ultimately reach a collaborative approach to development of features. This approach also allows for state-configuration when necessary or desired. Since it was anticipated that the cost of the SLR would be shared amongst participating states, the cost to the state was significantly less than comparable stand-alone systems.

Table 2: Provider Outreach 2013 (1/1/13 – 9/30/13)

Outreach Type	Occurrences- Approximate	Outreach Events
HIT Coordinator & Medicaid Staff	24	Outreach projects in 3 Rural counties to engage providers in adopting Health IT technology
Phone contacts	1500	–Average 50 calls per month per staff person
Site visits	5 by MU Staff;	5 for MU Staff; augment with additional visits by HIT Director and staff
Incoming Phone Calls	1500	Average 50 calls//staff person
Emails	12,000	Average 100 emails/week/ staff person

As of 9/30/13, the metrics for EHR activities in Alabama are as follows:

Figure 1a: Total Registration and Attestation Submissions

Registered (Active)	2396
Registered (Inactive)	810
Submitted Attestation	1994
Not Submitted (Still in process)	312

Figure 2: Submissions by Type

Physicians	1282
Nurse Practitioners	362
Dentists	176
Physicians' Assistants	14
Certified Nurse Midwives	10

Dual Eligible Hospitals	148
Children's Hospital	<u>2</u>
Total	1994

Figure 3: Registration and Attestation Submissions by Location through 9/30/2013

Registration and Attestation Submissions by Location							
ABBEVILLE	1	DOZIER	1	KILLEN	1	RAINBOW CITY	3
ALABASTER	19	EAST GADSDEN	1	LACEYS SPRING	2	RAINSVILLE	1
ALBERTVILLE	23	ELBA	1	LAFAYETTE	2	RAMER	2
ALEXANDER CITY	11	ENTERPRISE	14	LEESBURG	2	RED BAY	1
ALEXANDRIA	1	EUFAULA	11	LINDEN	1	RED LEVEL	1
ALICEVILLE	2	EUTAW	5	LINEVILLE	3	REPTON	1
ANDALUSIA	14	EVERGREEN	6	LIVINGSTON	3	ROANOKE	1
ANNISTON	61	FAIRFIELD	2	LOXLEY	4	RUSSELLVILLE	9
ARAB	3	FAIRHOPE	17	LUVERNE	9	SCOTTSBORO	15
ASHLAND	4	FAYETTE	8	MADISON	17	SECTION	3
ATHENS	13	FLORALA	3	MARION	4	SELMA	29
ATMORE	3	FLORENCE	40	MCINTOSH	1	SEMMES	4
ATTALLA	2	FOLEY	7	MIDFIELD	3	SHEFFIELD	8
AUBURN	15	FORT DEPOSIT	1	MILLRY	1	SIPSEY	2
AUTAUGAVILLE	3	FORT PAYNE	13	MOBILE	251	SLOCOMB	2
BAY MINETTE	1	FRISCO CITY	3	MONROEVILLE	14	SUMITONN	1
BAYOU LA BATRE	1	FT PAYNE	9	MONTGOMERY	73	SYLACAUGA	21
BESSEMER	23	FYFFE	5	MOODY	6	TALLADEGA	10
BIRMINGHAM	331	GADSDEN	37	MORRIS	1	TALLASSEE	3
BLOUNTSVILLE	1	GARDENDALE	9	MOULTON	5	THOMASVILLE	1
BOAZ	7	GENEVA	2	MOUNT VERNON	2	TONEY	2
BREWTON	12	GEORGIANA	4	MOUNTAIN BROOK	2	TROY	11
BUTLER	5	GERALDINE	1	MUSCLE SHOALS	4	TRUSSVILLE	4
CALERA	1	GILBERTOWN	1	NEW HOPE	6	TUSCALOOSA	55
CAMDEN	4	GRAND BAY	5	NEW MARKET	1	TUSCUMBIA	11
CARBON HILL	2	GREENSBORO	6	NORTHPORT	8	TUSKEGEE	7
CARROLLTON	8	GREENVILLE	15	OAKMAN	2	TYLER	2
CENTER POINT	2	GROVE HILL	5	ONEONTA	8	UNION SPRINGS	6
CENTRE	7	GUNTERSVILLE	16	OPELIKA	28	UNIONTOWN	2
CENTREVILLE	8	GURLEY	3	OPP	4	URIAH	2
CHATOM	5	HALEYVILLE	12	OZARK	4	VALLEY	4
CHILDERSBURG	3	HAMILTON	3	PARRISH	4	VALLEY HEAD	1
CLANTON	6	HARTSBORO	1	PELHAM	6	VREDENBURGH	1

Registration and Attestation Submissions by Location							
CLAYTON	3	HARVEST	4	PELL CITY	23	WADLEY	1
COLUMBIANA	3	HEFLIN	4	PHENIX CITY	4	WALNUT GROVE	1
COURTLAND	3	HELENA	1	PHIL CAMPBELL	1	WEDOWEE	5
CROSSVILLE	7	HOOVER	8	PIEDMONT	3	WEST BLOCTON	1
CULLMAN	24	HORTON	1	PINE APPLE	2	WETUMPKA	7
DADEVILLE	10	HUNTSVILLE	73	PINE HILL	1	WINFIELD	4
DAPHNE	2	IRVINGTON	7	PINSON	9	WOODSTOCK	1
DECATUR	32	JACKSON	7	PISGAH	2	YORK	2
DEMOPOLIS	22	JACKSONVILLE	9	PLATEAU	1		
DOTHAN	85	JASPER	21	PRATTVILLE	6		
DOUBLESPRINGS	2	KELLYTON	11	PRICHARD	4		

The state established the deadline for EP registration and attestation for a 2013 payment as 3/13/14. Between January and March 2014, EPs wishing to register and attest for an incentive payment associated with calendar year 2013 were able to do so. While this option is available to EPs during the attestation process within the SLR, it is not automatic and EPs are required to specify that their payment year will be 2013.

EHS may register and attest for incentive payments that are associated with the federal fiscal year (FFY). For FFY 2014, EHS, except for children’s hospitals, must have established their qualifying patient volumes during the period covered by auditable hospital cost report that ended anytime during the federal fiscal year 10/01/12 – 09/30/13. For example, if the hospital’s cost report covered the period January 1, 2009 – December 31, 2009, the EH could use that cost report to apply for a 2014 incentive payment.

For payment year 2013, the definition for Children’s Hospital was revised to include ‘any separately certified hospital, freestanding or hospital within a hospital that predominately treats individuals under 21 without a CMS certification number because they do not serve Medicare beneficiaries’. These hospitals will be issued an alternative number by CMS to enroll in the incentive program. This provision is not applicable to Alabama Children’s Hospital at this time.

As of September, 2013, a total of 1478 (1390 EPs and 88 EHS) were approved for AIU payments for a total amount of \$92,170,427.15 (\$62,916,248.15 EHS and \$29,254,179.00EPs). Another 303 (243 EP and 60 EH) were approved for MU payments of \$26,928,230.89 (\$2,045,672.00EPs and \$24,882,558.89EH). An additional 183 attestations are being processed for payment and 268 attestations are in process by providers.

Table 2a: MU EPS/EHS and DURSA

	Meaningful Use Alabama EPs/EHS (documented registration with Alabama SLR) as of September 30, 2013	Numerator: Signed DURSA with One Health Record® and have validated operational connectivity as of September 30, 2013
EPs	231	12

EHS	52	2
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Table 2b: Connection to One Health Record®

Category	Cumulative Number Connected to One Health Record® 9/30/13	Percentage Number Connected to One Health Record®9/30/13
Eligible EPs 231 (MU does not include AIU)	12	5.2%
Eligible EHS 52 (MU does not include AIU)	2	3.85%

Table 2c: Early Innovators

Early Innovators	All Alabama Medicaid registered and connected Early Innovators as of September 30, 2013	All Alabama Medicaid registered and connected Early Innovators who have met meaningful use as of September 30, 2013
EPs	12	12
EHS	2	2

Table 2d: EPs Met MU 2012 and 2013

	Alabama Medicaid EP registered Providers who have met MU as of September 30, 2013	Alabama Medicaid EP registered Providers met meaningful use in previous year (9/30/12) as well as MU in reporting year (9/30/13)
EP Registered Providers 231	12	0 (none met in 2012)

The plan for advancement is to focus One Health Record® efforts on fulfilling the needs of Medicaid Regional Coordinated Care providers in both meeting their meaningful use reporting requirements and assisting in the care management of Medicaid enrollees. The State is developing a Regional Pilot around East Alabama Medical Center to demonstrate and measure success. East Alabama Medical Center is already connected to One Health Record®, involved in the Medicaid Patient First Program for east Alabama, and receives referrals from Alabama Quality Care (FQHC). Provider's will: (1) send and receive full clinical data through their EHRs to One Health Record®; (2) have the ability to log into the One Health Record® portal and review and/or print patient records; (3) have the capability to receive ADT alerts on patients; (4) send, read and receive referrals, notes, test results, and images to another member of One Health Record®; (5) automate reporting of immunizations, labs, and syndromic data to Public Health; and (6) track patient utilization of services and care coordination.

A-SMA supported the connectivity of a community HIE (Huntsville Regional HIE), to One Health Record® through ONC funding and technical assistance. Huntsville Hospital is currently designing a local HIE to support the operations and care coordination for that region. Huntsville Hospital will be building a Federated Model of HIE. This will provide an opportunity to explore the issues related to connecting to and using data from such a model. Through supporting Huntsville

Hospital's effort, One Health Record® will gain insight into private HIE implementation, and the integration of a local HIE and One Health Record®.

Table 2d: One Health Record® Activities

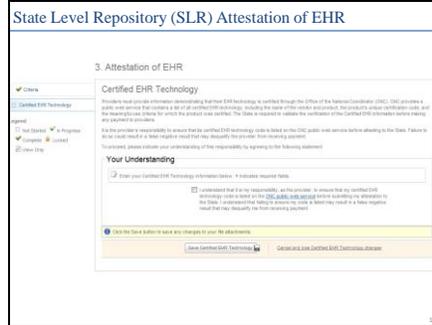
Activity	Actual Date
Alabama One Health Record® Ongoing Operations	Ongoing
East Central Alabama MHC Initial Submission	8/15/2012
East Central Alabama MHC "Go Live"	08/31/2012
One Health Record® e-Health Exchange connectivity Initial Submission	3/3/2012
One Health Record® e-Health Exchange connectivity "Go Live"	8/28/2012
Early Innovator Pilot 1 Initial Submission	3/1//2012
Early Innovator Pilot 1 "Go Live"	2/26/2013
HIE Report Analytics Initial Submissions	1/1/2013
HIE Report Analytics "Go Live"	4/16/2013
Early Innovator Pilot 2 Initial Submission	10/1/2012
Early Innovator Pilot 2 "Go Live"	6/3/2013
East Alabama Care Network Initial Submission	2/1/2013
East Alabama Care Network "Go Live"	3/3/2013
Marketing and enrollment of pilot sites	11/2013-4/2014
Kick-Off with Springhill	4/3/2014
East Alabama Pilot Operational/Evaluation Period	7/2014-10/2014
East Alabama Pilot Expansion to include 3 more Regional Hubs	10/2014 – 4/2015
RCO Regional Expansion	4/2015 – 2/2016
Statewide Implementation	12/31/2018

The state will, also, seek Medicaid funding to expand One Health Record's® HL7 capabilities related to ADT feeds and public health for lab, immunization registry, cancer registry, and syndromic surveillance reporting.

2.1.1 How recent is this data? The AHA survey (Attachments 8.4 and 8.5) was completed in January 2011 and the Alabama MU and Medicare data is current as of 9/30/13. The data related to One Health Record® is current as of April 2014. Tuskegee University completed an analysis specifically related to lab, e-Prescribing and patient summaries, which is provided in Attachment 8.3. The hospital data in Attachment 8.6 was provided by each of the hospitals and provider networks in October 2011 through a web-based, voluntary process for those entities seeking to be One Health Record® gateways in phase one.

2.1.2 Does it provide specificity about the types of EHRs in use by the State’s providers? Through the MU registration process, EPs and EHs provide the certified EHR for AIU. A copy of the attestation of EHR screen shot is provided in Figure 4.

Figure 4: State Level Repository (SLR) Attestation of EHR



In addition, the data provided by entities seeking to be One Health Record® gateways also includes the EHR vendor as well as the vendors for the other systems (Attachment 8.6). The REC has also collected information on the EHR vendors for Alabama providers considered REC “priority” providers.

2.1.3 Is it specific to just Medicaid or an assessment of overall statewide use of EHRs? Some of the data is specific for Medicaid, however other data — such as the initial hospital survey data — is broader than Medicaid. However, the hospital survey questions specifically address Alabama hospitals’ “intent” related to the Medicaid incentive program (Attachment 8.4). Depending on the provider and their focus of interest, the data obtained through the EHR Incentive Program is Medicaid and Medicare specific.

2.1.4 Does the SMA have data or estimates on eligible providers broken out by types of provider? The AIU submission data is categorized according to provider type.

Figure 5: Submissions by Type

Physicians	1282
Nurse Practitioners	362
Dentists	176
Physicians’ Assistants	14
Certified Nurse Midwives	10
Dual Eligible Hospitals	86
<u>Children’s Hospital</u>	<u>2</u>
Total	1932

The information provided by EHs and networks which are seeking to be Phase One or Phase Two One Health Record® gateways is by provider type. Since these are the entities

seeking state approval to connect their EHRs to other providers, entities and the state for MU through One Health Record® as a gateway, they have provided the most detailed information. They also likely have the most capability (Attachment 8.6).

Does the SMA have data on EHR adoption by types of provider (e.g. children’s hospitals, acute care hospitals, pediatricians, nurse practitioners, etc.)? See above. Alabama has 3 critical care hospitals: Red Bay Hospital, Washington County Infirmary and Randolph County Hospital. The State has a Children’s Hospital, which has received its incentive payment for AIU, as well as a Women’s and Children’s Hospital that both qualify as children’s hospitals. The Stage 1 changes effective in 2013 that resulted from the MU Stage 2 Final Rule do not affect Alabama’s Children’s Hospital. Alabama has multiple acute care hospitals (all which responded to the AHA survey providing Alabama specific information).

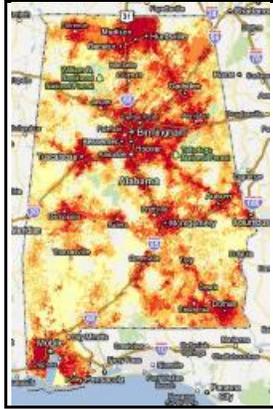
2.2 TO WHAT EXTENT DOES BROADBAND INTERNET ACCESS POSE A CHALLENGE TO HIT/E IN THE STATE’S RURAL AREAS? DID THE STATE RECEIVE ANY BROADBAND GRANTS?

The ConnectingALABAMA multi-year initiative promotes the availability and adoption of broadband Internet access throughout the state of Alabama. ConnectingALABAMA, funded through the Department of Commerce National Telecommunications and Information Administration’s (NTIA’s) State Broadband Data and Development Grant Program, has developed drafts of Broadband Investment Plans of each of 12 Alabama regions. The development by each region affects the potential for the exchange of information statewide. The regions are: Region 1 (Colbert, Franklin, Lauderdale, Marion, Winston), Region 2 (Bibb, Fayette, Greene, Hale, Lamar, Pickens, Tuscaloosa), Region 3 (Blount, Chilton, Jefferson, Saint Clair, Shelby, Walker), Region 4 (Calhoun, Chambers, Cherokee, Cleburne, Clay, Coosa, Etowah, Randolph, Talladega, Tallapoosa), Region 5 (Bullock, Butler, Crenshaw, Lowndes, Macon, Pike), Region 6 (Choctaw, Clarke, Conecuh, Dallas, Marengo, Monroe, Perry, Sumter, Washington, Wilcox), Region 7 (Coffee, Covington, Dale, Henry, Houston, Geneva, Barbour), Region 8 (Baldwin, Escambia, Mobile), Region 9 (Autauga, Elmore, Montgomery), Region 10 (Lee, Russell), Region 11 (Cullman, Lawrence, Morgan) and Region 12 (DeKalb, Jackson, Limestone, Madison, Marshall). 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.

As of June 2011, there was only one broadband provider in the yellow areas, 2 in the light orange, 3 in the medium orange, 4 in the light red and 6 or more in the dark red. The best broadband coverage is in Birmingham, Montgomery, Mobile and Huntsville with significant gaps in the rural areas. This data was taken into consideration when determining where the One Health Record® gateways needed to be located

**Figure 6: Alabama
Broadband Coverage**

**Figure 7: Alabama
Lack of Broadband Coverage**



Note: Broadband density indicated by colored areas.



Note: No broadband coverage in dark 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.

Figure 8:

Alabama FQHCs

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. Because of the location and involvement of the APHCA and their critical role in the state, the state is considering the possibility of APHCA becoming a gateway for One Health Record®.

Through the APHCA leadership, several initiatives that support Alabama’s HIT vision are underway including EHR deployment. FQHCs are high volume 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 One Health Record®.

In June 2010, Whatley Health Services in Tuscaloosa, Alabama also received \$645,875 as part of the announced \$83.9 million in grant funding to help networks of health centers adopt EHRs and other HIT systems. The funds are part of the \$2 billion allotted under ARRA to HRSA 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.

No data is currently being shared with VA, DoD or IHS.

The VA facilities in Alabama are provided in Table 2e.

Table 2e: VA Facilities in Alabama

Veterans Health Administration - VISN 7: VA Southeast Network			
Station ID	Facility	Address	Phone
521GG	Bessemer Clinic	975 9th Avenue, SW-Suite 400, UAB West Medical Center West Bessemer, AL 32055	205-428-3495
521	Birmingham VA Medical Center	700 S. 19th Street Birmingham, AL 35233	(205) 933-8101 (866) 487-4243
0302	Birmingham Vet Center	1201 2nd Avenue So, Birmingham, AL 35233	(205)-212-3122
619A4	Central Alabama Veterans Health Care System East Campus	2400 Hospital Road Tuskegee, AL 36083-5001	(334) 727-0550 (800) 214-8387
619	Central Alabama Veterans Health Care System West Campus	215 Perry Hill Road Montgomery, AL 36109-3798	(334) 272-4670 (800) 214-8387
619GB	Dothan Clinic	2020 Alexander Drive Dothan, AL 36301	334-673-4166
619GB	Dothan Mental Health Center	3753 Ross Clark Cir Ste 4 Dothan, AL 36303	(334) 678-1903
521GC	Florence Shoals Area Clinic	422 DD Cox Blvd. Sheffield, AL 35660	256-381-9055
619	Ft. Rucker (VA Wiregrass) Outpatient Clinic	301 Andrews Avenue Fort Rucker, AL 36362	334-503-7831/7836
521GD	Gadsden Clinic	206 Rescia Ave Gadsden, AL 35906	256-413-7154
521GA	Huntsville Clinic	301 Governor's Drive, S.W. Huntsville, AL 35801	256 535-3100
521GF	Jasper Clinic	3400 Highway 78 East - Suite #215 Jasper, AL 35501	205-221-7384
521GB	Madison/Decatur Clinic	8075 Madison Blvd., Suite 101 Madison, AL 35758	256-772-6220
334	Montgomery Vet Center	215 Perry Hill Road, Bldg. 6, 2nd Floor Montgomery, AL 36109	334-272-4670
521GE	Oxford Clinic	96 Ali Way Creekside South Oxford, AL 36203	256-832-4141
679	Tuscaloosa VA Medical Center	3701 Loop Road, East Tuscaloosa, AL 35404	(205) 554-2000 (888) 269-3045
Veterans Health Administration - VISN 16: South Central VA Health Care Network			
Station ID	Facility	Address	Phone
520-2	Mobile Outpatient Clinic	1504 Springhill Ave , AL 36604 Mobile, AL 36604	251-219-3900

Veterans Health Administration - VISN 7: VA Southeast Network			
Station ID	Facility	Address	Phone
0313	Mobile Vet Center	2577 Government Blvd. Mobile, AL 36606	(251)-478-5906
520GA	VA Gulf Coast Health Care System - Mobile Outpatient Clinic	1504 Springhill Ave. Mobile, AL 36604	251-219-3900
Veterans Benefits Administration - Southern Area Office			
Station ID	Facility	Address	Phone
334	Montgomery Regional Office	345 Perry Hill Rd. Montgomery, AL 36109	1-800-827-1000

The DoD facilities in Alabama are provided in Table 3.

Table 3: Department of Defense Facilities in Alabama

Branch	Location
Army	<u>Fort McClellan</u> <u>Anniston Army Depot</u> <u>Redstone Arsenal</u> <u>Fort Rucker</u>
Air Force	<u>Gunter Annex</u> <u>Maxwell AFB</u>
Coast Guard	<u>Group Mobile</u> <u>Marine Safety Office Mobile</u> <u>Aviation Training Center Mobile</u>

Alabama Medicaid has a long standing working relationship with the Native American Nations in Alabama; however, there are no IHS facilities in Alabama. There is a tribal clinic, the Poarch Bank of Creek Indians at Atmore, Alabama, which is on the roadmap as the state connects with the clinics and hospitals around Mobile (south Alabama). Alabama has a traditional working relationship with the Poarch Band of Creek Indians. This tribe is a historical Medicaid provider enrolled as an FQHC and as a medical home provider. Outreach efforts are planned to keep tribal leaders aware of health-IT activities. Information regarding the tribal clinic is provided in Table 4.

Table 4: Tribal Clinic in Alabama

Tribal Clinic	Address	Phone
Poarch Band of Creek Indians:	5811 Jack Springs Road, Atmore, AL 36502	(251) 368-9136

Future plans to incorporate connectivity to such federal entities require that they must sign an agreement with EHealth Exchange in order to be able to exchange data with federal agencies; therefore One Health Record® has designed the Alabama agreements to align with DURSA. A copy of the Alabama DURSA is provided in Attachment 8.23.

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 throughout the development of the A-HIE S/OP and A-SMHP has been the engagement of a broad set of stakeholders as indicated in the A-HIE S/OP.

- *Presentations:* Throughout the state and nationally by the HIT Coordinator and key staff, including regional presentation to MGMA, HIMSS and medical associations and societies. Some specific examples include the Alabama Primary Healthcare Association Annual Conference, Health Information Management (HIM) HIE Planning Session, Alabama Medical Association Board Meeting and American Academy of Pediatrics and AAFC webinar.
- *Commission and Work Groups:* The Alabama One Health Record® Advisory Commission meets quarterly. The Commission met in October 2011 for an all-day work plan meeting and the various workgroups within the Commission (Communication/Marketing, Governance/Finance, Technical/Technical and Business Operations) hold calls as needed to work through critical areas for implementation, including but not limited to policies and procedures, privacy/security agreements, linkages to support MU reporting, etc. A copy of the One Health Record® Policies and Procedures required for participation in Alabama's HIE is provided in Attachment 8.24. Acting Medicaid Commissioner Stephanie Azar continues as chair of the Commission and Medicaid issues remain at the forefront of all policy and operational discussions. The activities of the Commission are released on the One Health Record® website.
- *Involvement of Educational Institutions:* The state continues to contract with Tuskegee, University of South Alabama (USA), Alabama State University and Auburn University to support efforts. The Medicaid Agency contracted with University of Alabama at Birmingham (UAB) to evaluate the health-IT activities under the ONC grant, including the value of One Health Record® to EPs and EAs in meeting MU. The evaluation is provided in Attachment 8.25.

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: One Health Record® continues to be governed by the One Health Record® Commission under the authority and auspices of the Alabama State Medicaid Agency.

One Health Record® Commission will meet on a quarterly basis to report progress. Alabama Medicaid Agency (AMA) continues to be a voting member of the Statewide One Health Record® (A-HIE) Advisory Commission, which is an advisory commission to A-SMHA, along with its workgroups for the Five Domains plus One, and provides staff support for One Health Record®. During FFQ 2-3 2014, contingent on the success of the pilot, work groups will continue their work regarding the development of long-term governance, finance, and sustainability plans.

In addition to the State HIT Coordinator, John Heitman (25% Medicaid/75% Public Health), the Medicaid team includes state employees Gary Parker, Director Utilization Intervention Development and Meaningful Use Administration (100% Medicaid), and staff support for the EHR Incentive Program, Janice Miles, LaKeshia Powell, and Holly Jarnagin (all 100% Medicaid). EHR Incentive Program auditing and additional support for One Health Record® is handled through Medicaid contracted support.

Finance: As One Health Record® remains a part of A-SMA; Medicaid funding is an integral part of the financing mechanism for One Health Record®, which provides the infrastructure for providers to meet MU. A-SMA submitted an I-APD in early 2012 which was approved to support components of the A-SMHP related to:

- Medicaid portion of contracted support from George Washington University (policy and operational consulting); FourThought Group (policy and procedure consulting, implementation and operational support of the SLR and MU); UAB (evaluation); Tuskegee (education and outreach); USA (HIT Coordinator), ASU (special projects) and Auburn (Commission support). The contracts with FourThought, AUM, ASU, and George Washington University continue.
- The Medicaid portion of One Health Record® technical and human resources. Medicaid contracts have been added to support both HITECH-HIT-MU and HITECH-HIT-HIE.
- Data repository and analytic capabilities

The AHIE S/OP provides detailed information related to the budget and the inter-connectivity but separation of the Medicaid and ONC funding. The A-SMA implemented financial policies, procedures and controls in compliance with generally accepted accounting principles and all relevant OMB circulars.

The state has pursued stakeholder and Medicaid “fair share” funding to implement and manage the Medicaid focused “proof of concept” Regional Pilot with an expected time table of fourth quarter FFY 2014 through FFY 2015. The state is proposing to CMS, for the “proof of concept” period that Public Health contributes \$50,000, Alabama Hospital Association contributes \$40,000, Alabama Blue Cross Blue Shield contributes \$250,000 and Medicaid is responsible for the remaining costs (approximately \$1.5 M of which 90% is federal dollars and 10% is state dollars. Since the focus is Medicaid and the value is yet to be established for the other contributors, the contributions are a good faith effort by the stakeholders to give One Health Record* sufficient time to provide value.

A longer term cost allocation methodology for multiple stakeholders will be developed for funding beyond the initial “proof of concept” to cover the estimated annual \$3 to \$4 million operational costs.

Geographic: A-SMA continues to participate in 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). A-SMA is also a member of the State Health Policy Consortium on Behavioral Health, comprised of 5 states (Alabama, Florida, Kentucky, New Mexico, and Michigan).

Technical Infrastructure: One Health Record®, which is part of the MMIS system of systems, is 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 EHealth Exchange. Direct secure messaging went live January 2012. Query exchange went live April 2012.

The technical infrastructure provides secure messaging, a Master Patient Index, a secure provider web site, privacy/security controls, Record Locator Service, gateways, health information technology infrastructure, provider directory, capacity to enable e-Prescribing, electronic reporting of structured laboratory data and clinical summary exchange, and interfaces for data (e.g., laboratory) important to Medicaid providers to be fully successful in the health information exchange (HIE) environment.

Technical and Business Operations: The focus of the One Health Record® Business and Technical Operations is on implementation of One Health Record®, which is needed to support providers in obtaining and retaining meaningful use incentives and support the state in carrying out its oversight responsibilities. 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). 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 worked with other states, including the SERCH and Xerox User Group members, and conducted 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.

Communications and Marketing: The state’s goal is to utilize One Health Record® to support Medicaid’s service delivery transformation through RCOs. Facilitating Medicaid provider connectivity and meaningful use is the state’s priority. The One Health Record® website, leveraging Alabama’s REC work under their ONC funding, will continue to be important mechanisms for ongoing communication and education.

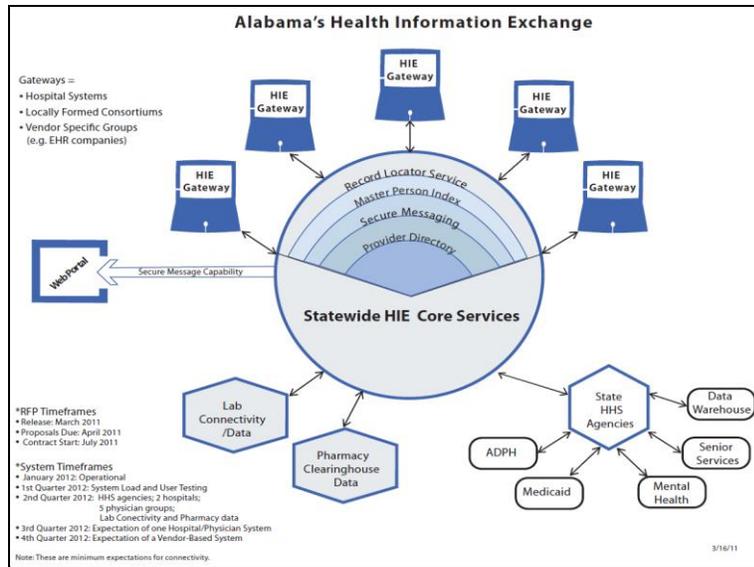
The One Health Record® communications are comprehensive and include MU opportunities and requirements as well as the role of One Health Record® to support the exchange of information in a meaningful ways. The comprehensive Communication and Marketing plan addresses core

messaging audiences that were identified, including but not limited to EHS, EPs, 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 Alabama Medicaid website for One Health Record®, <http://www.onehealthrecord.alabama.gov/>, provides information and links to documents and information specifically relating to meaningful use, <http://onehealthrecord.alabama.gov/providers.aspx>. It also links to the REC site at <http://www.al-rec.org/>, which in turn links back to updates from the Medicaid Agency related to MU and One Health Record®. The goal is a consistent, focused message by all the partners/stakeholders working with providers to reach MU.

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?

Geographic Reach: The only statewide health information exchange that will exist in Alabama will be One Health Record®. There are no other statewide entities. Medicaid, as a key member of the One Health Record® Commission provides a patient-centered hub that connects through gateways to the state agencies, provider systems and small community providers. One Health Record® provides direct connectivity to those providers not part of a health system. Further, One Health Record® will support MU reporting of public health measures.

Figure 9: One Health Record®



As of 9/30/13, 12 of the 231 (5.2%) eligible Medicaid Meaningful Use (MU) EPs and 2 of the 52 (3.85%) EHs (not including AIU), have been successfully connected to the One Health Record®. In addition, 12 of the 231 MU Alabama EPs and 2 of the 52 EHs have signed a DURSA with One Health Record® and have validated operational connectivity. All have met meaningful use.

As of 9/30/13, all of the registered Alabama State Plan Health Home Primary Care EPs (3) were connected to and have used One Health Record® at least once and met meaningful use for the same reporting period. Both of the Alabama Medicaid Community Mental Health Centers who are enrolled as State Plan Health Home providers are connected to and have used One Health Record® at least once.

The establishment of the statewide HIE aligns with the federal IT principles as it:

- Puts “individuals first” by creating immediate access to critical health information for patients, providers, and payers at the point of care;
- Allows the state to be a worthy steward of the country’s money and trust through facilitating administrative efficiencies and clinical effectiveness, including reduction of medical errors, avoidance of duplicative procedures and better coordination of care by linking public and private, physicians, clinics, labs and medical facilities;
- Supports health-IT benefits for all by allowing health care providers to share information about their patients in order to aid clinical decision making;
- Is outcomes focused in that it supports Medicaid/Medicare financial incentives to encourage providers to adopt EHRs and to undertake the meaningful use (MU) of them;
- Builds boldly upon what works through the efforts led by the Alabama REC located at the University of South Alabama, and
- Encourages innovation as providers will need to have their own certified EHR in order to fully utilize the benefits of One Health Record® but will be also be able to use the secure messaging/DIRECT capability.

One Health Record® Governance Structure and A-SMA Involvement:

One Health Record® Leadership	FFY 13 (9/30/13)		
	Name	Medicaid	PH
State HIT Director	John Heitman	25%	75%
Administrative Manager	Megan Youngpeter	100%	
Commission Chair	Stephanie Azar, Acting Medicaid Commissioner	Part of Medicaid Director Duties	
Commission Co-Chair	Dr. Williamson, State Health Officer, Commissioner of Public Health and Chair of the Medicaid Transition Team	Part of PH Director Duties	

The State Designated Entity, A-SMA is the administrator of the ONC Cooperative Agreement and the State HIE, One Health Record®. Under the state structure and budget, staff is Medicaid and a part of the Medicaid Health IT Division; all activities are under the direction of the Alabama (Acting) Medicaid Commissioner, and most contracts are Medicaid contracts, with the exception of a few ONC funded only contracts.

The chair of the One Health Record® Commission is and has been since the beginning the (Acting) Medicaid Commissioner. The organizational structure and staff have been included in the ONC Strategic and Operational Plans (A-S/OPs) since the inception and in the SMHP since the initial submission and has not changed.

As indicated in the 11/30/12 A-SMHP and all updates, “As Medicaid Commissioner R. Bob Mullins, Jr., MD, chair of the Alabama Health Information Exchange (A-HIE) One Health Record® Advisory Commission has said, “I made the decision early on that the development of our health-IT system had to be our primary initial goal in order for the agency to meet the demands of the fundamental changes going on in Medicaid and health care.”

Discussions with Tom Romano, CMS, on June 18, 2013, and negotiations with Jessica Kahn and staff, including Carrie Feher and others, in June 2012 resulted in the July 24, 2012 approval letter from CMS. Alabama, since the inception of the program, has had Medicaid staff and contractors working on One Health Record® as One Health Record® was designed for and is needed for state Medicaid EPs/EHs to meet meaningful use. Based on the direction of CMS, the state did pursue funding for infrastructure, except for the Truven contract which was later removed and funded solely through ONC funding, until a signed agreement could be reached with BCBS of Alabama for their fair share of the cost of operations. Only ONC funds were used for the DDI of the health-information technology infrastructure for One Health Record®. CMS agreed that funding for the staff and contractors at a 50% share (ONC funding 50%) was appropriate and included in the approved HIT-I-APDU (July 25, 2012).

Medicaid has approximately 950,000 enrollees. BCBS appears to have about 60% of the population, other state agencies about .2%, and other private carriers about 6.8%. A-SMA is in discussion with BCBS and expects to reach an agreement with BCBS prior to the end of this federal fiscal year. Upon completion of the agreement, an HIT-I-APDU will be submitted for the Medicaid “fair share” for the operation of the One Health Record®.

A-SMA staff are, under the HITECH Medicaid MU, “conducting adequate oversight of the Medicaid MU Incentive Payments Program, which requires IT and human resources (employees and contractors) support (90% FFP for systems and administration) for: Medicaid’s “fair share” of One Health Record® when used for oversight of the Medicaid MU Incentive Payments Programs, including the following: ongoing management of the Master Patient Index; provider help-line and web site; privacy/security controls; provider needs assessments; provider outreach; Record Locator Service; secure messaging; gateways; health information technology infrastructure; provider directories; development of privacy and governance policies and procedures; interfaces for data (e.g., laboratory) important to Medicaid providers to be fully successful in health information exchange (HIE) environment; procurement of technical assistance for Medicaid providers to achieve MU; electronic reporting of structured laboratory data, clinical summary exchange, and enabling e-Prescribing. A-SMA staff are providing planning and preparation support under Meaningful Use for the future of One Health Record®.

Finance: As One Health Record® remains a part of A-SMA; Medicaid funding is an integral part of the financing mechanism for One Health Record®, which provides the infrastructure for providers to meet MU. Medicaid staff and contractors working on MU have had joint training sessions with REC staff and co-ordinate on activities almost daily. Due to the Medicaid volume and impact on providers, Medicaid is a core factor in all of them. Medicaid is the starting place for all policy decisions with appropriate cost allocations for funding.

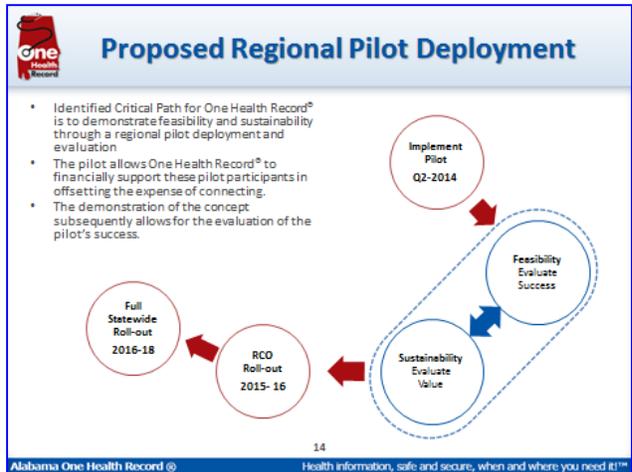
The A-SMA has implemented financial policies, procedures and controls to maintain compliance with generally accepted accounting principles and all relevant OMB circulars.

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 is transforming the way the state purchases and oversees Medicaid. It is simultaneously addressing both the evolution of health and the innovations within health care delivery. The relationship between the activities through MMIS-MITA and Alabama’s State Medicaid’s HIT Plan (A-SMHP) as the means to provide the technical infrastructure for the transformation is evident in timing, as well as impact. A-SMA has made it a priority to align the work so the needs of the Alabama Medicaid RCO efforts can be met through the infrastructure of one (HIE) as well as for timely and appropriately operation of the EHR Incentive Program Meaningful Use.

One of the major initiatives in Alabama is the transition of Medicaid from fee-for-service to managed care through Regional Care Organizations (RCOs). Starting in 2013, a major focus of One Health Record® efforts has been to provide critical health information technology infrastructure to support the developing RCOs and the Medicaid providers who will be a part of the RCO networks. A Critical Path identified for One Health Record® is to demonstrate usefulness to the Medicaid Program and the Medicaid RCO networks through a regional deployment and evaluation “proof of concept” pilot. Therefore, the One Health Record® Commission approved on December 19, 2013 a geographic “proof of concept” pilot using One Health Record®

capabilities in eastern Alabama. The regional “proof of concept” pilot, designed around East Alabama Medical Center (an early adopter), will seek to demonstrate feasibility, access the benefits and functions, and measure success. The “proof of concept” pilot project will involve the installation of an interface for each electronic record system to connect with and use One Health Record® for data exchange during the next four to six months. After installation, state officials will focus on the impact of information exchange on physician and hospital workflow and also on physician-hospital communications.



The state is also coordinating the effort for e-Clinical Quality Measures (e-CQMs). The infrastructure for the One Health Record® will be leveraged to the extent possible for quality reporting and care management efforts of EP-like and EH Medicaid providers and state staff. The MITA-MMIS infrastructure is also being considered for non-MU eligible providers with the goal of a uniform way of improving care management and fully utilizing the e-CQMs for quality oversight and payment reform.

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?

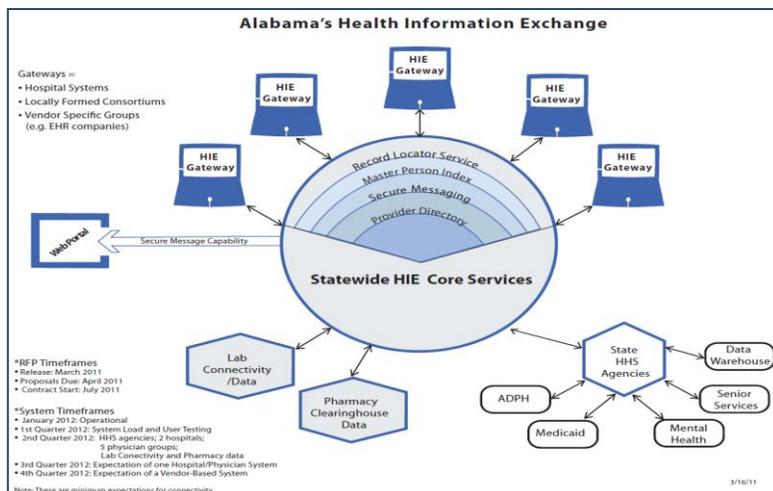
Alabama One Health Record® has complete Phase 1, which included connections to the Medicaid MMIS and CHIP claims and eligibility systems. The core One Health Record® technical infrastructure, which includes DIRECT secure messaging and robust query exchange, is up and operational. Alabama One Health Record® has initiated Phase 2 with connection to the first Early Innovators completed. Phase 2 including onboarding of the substantial Medicaid MU providers statewide to One Health Record®, which requires administrative support for coordination and administration to accomplish those tasks.

In addition, Alabama’s complete SMHP and A-S/OPs have provided and continue to provide detail on how One Health Record® is the only HIE in the state, it is statewide and the means for eligible providers (EPs) and eligible hospitals (EHs) to meet meaningful use stage two. Copies of both documents can be resubmitted to you, although both documents are on file at CMS.

As stated above, A-SMA is using the HIE functionality and the MU program to demonstrate and support PHI exchange. One Health Record® will help Alabama’s EP’s and EH’s meet various MU

measure(Core Measures 12-15) because One Health Record® is MU2 certified and a production participant on the eHealth Exchange (NwHIN). Therefore, A-SMA is leveraging both programs to support and increase participation in both. This increases sustainability of the HIE as well.

One Health Record® is the infrastructure that will support connectivity to public health for the public health objective; it has both secure messaging (DIRECT) and query capacity to allow EPs/EHs/ to transport CCAs; it is a certified by MU system; it has a DURSA agreement that complies with all federal and state privacy and security requirements, and it is a node on Healthway (the first state to do so). In addition, the state is leading the effort to



address behavioral health data and is exchanging information with Florida and other states, assuring inter-state, as well as intra-state exchange of data in a meaningful way. There is no other option in the state of Alabama for Medicaid EPs/EHs to meet meaningful use and receive their incentive payments. The “go live” for the latest round of providers was this spring and was designed to meet the needs of EPs/EHs to meet Stage 2 meaningful use.

As indicated in every updated to the A-SMHP, the state is pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information (90% FFP for systems and administration). Alabama Medicaid will not be the sole funding source as indicated in response to Section 2.6. Alabama Medicaid will be responsible for its fair share “in accordance with benefits received.” The benefits received will be to Medicaid, Medicare (administered by Blue Cross-Blue Shield of Alabama (BCBSA)), CHIP (administered by BCBSA) and eventually BCBSA, who are the payers in the state and manage almost all of the care delivered in the state. The “proof of concept” focus is Medicaid and the immediate benefit will be received by A-SMA. BCBSA is a member of the One Health Record® Advisory Committee, has contributed in-kind contributions since the initiation of the efforts, and is committed to participation long term.

One Health Record® impacts an EP or EH’s ability to effectively and efficiently use a certified EHR to promote health care quality and the exchange of health care information, including the ongoing management of the following activities when they are used for services that are not a MU focus (such as therapies or nursing home care) or when they are used by providers who relate to EPs/EHs receiving EHR Incentive Payments but are not an EP or EH. This includes the Master Patient Index, Record Locator Service, secure messaging, gateways, provider directories, development of privacy and governance policies and procedures, interfaces for data (e.g., home health) important to Medicaid providers to be fully successful in HIE environment, clinical summary, electronic reporting of structured laboratory data and enabling e-Prescribing. One

Health Record® is under the governance of the Medicaid Agency and costs are allocated between Medicaid and the other stakeholders for the development of A-HIE is on a “fair share” basis going forward; however, the original design, development and implementation were totally funded through ONC grant funding.

Alabama continues to operate with the Alabama Health Information Exchange Strategic/Operational Plan (AHIE S/OP), which was updated June 2012, and the A-SMHP as 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 along with the A-SMHP continue to be dependent upon and provide opportunities for each other. One Health Record® will provide a state CONNECT gateway to the eHealth Exchange and provide HISP services in support of DIRECT secure messaging. Alabama One Health Record® acts as the “hub” for the exchange of information intra- and inter-state, allowing providers to meet MU requirements. Until One Health Record® went “live” in April 2012; the means for secure messaging and provider directories between EPs, EHs and other entities in the health care system did not exist. A-HIE conducted a follow-up telephone survey of Medicaid-enrolled providers which produced 1,001 responses. Of those providers responding to that survey, 35% (354/1,001¹) indicated current use of electronic health records and thus have the potential to take advantage of secure messaging with other providers through the One Health Record®.

One Health Record®, which is part of the MMIS system of systems, is 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 EHealth Exchange.

Alabama 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. Alabama has developed and is using both an HIE Readiness Assessment and Interoperability Services Guided to gauge provider health-IT maturity levels and determine the next steps required to connect and exchange information using One Health Record®.

In addition to the activities identified previously, the Medicaid Agency completed the following actions:

- Tuskegee University, on behalf of the Alabama Medicaid Agency (A-SMA), developed a tactical plan for a MU Outreach program that details the resources, activities and timelines necessary in order to provide outreach services for the rural and underserved Black Belt counties which are the geographic priority areas for this strategy. The Black Belt counties are indicated in the darker color on the map. The tactical plan created for the Black Belt will be used as the basis for each of the additional quadrants of

Figure 10: Black Belt Counties



the state as defined in the Meaningful Use Outreach Plan (Attachment 8.3). Two focus areas of the outreach are lab exchange and e-Prescribing.

- Meaningful Use Outreach pilot project that provides both a learning experience and a valid test of the Meaningful Use Outreach Plan that is to be implemented statewide. The pilot program incorporated as many aspects of the outreach plan as can be reasonably executed. The pilot program was based in Macon County. Macon County was selected for the pilot program based on its proximity to Tuskegee University and its demographics. The following excerpt from the Meaningful Use Outreach Plan is an overview of the demographics for Macon County:
 - Macon County- located in South Alabama. The county seat is Tuskegee, Alabama. The total population as of 2010 was 21,452. The cities within the county include: Franklin, Notasulga, Shorter, and Tuskegee. The racial makeup of the county includes: White 15.5%, African American 82.6%, 1.1% Latinos, 1% Native American, 4% Asian. The median household income is \$26,328, with 38.6% of the population living below poverty line. Healthcare facilities in the county are located in the cities of Tuskegee and limited coverage in Notasulga.
- Gather, parse and present information regarding the current and projected levels of utilization of Structured Lab Data Exchange for in-state physician labs.
- Create additional materials that will be used to support Structured Lab Data Exchange as part of the outreach activities. The materials to be created will include brochures, post cards, presentations and other communication materials to address adoption of Structured Lab Data Exchange in support of Meaningful Use compliance.
- Implementation of the Medicaid e-Prescribing capability through Alabama MMIS to streamline and secure the prescription process while lowering overhead costs. As of November 2011 providers can access their patients' full medical histories and send electronic prescriptions directly to pharmacies.

Multiple marketing and communication materials are provided in Attachments 8.1 and 8.2.

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.

State HIT Coordinator: Continued coordination with Medicaid and ONC's various grant and cooperative agreements has been a core principal of Alabama's efforts. Coordination between the REC, One Health Record® and the rest of Medicaid has been an ongoing process.

The HIT Coordinator in Alabama, who reports to the Medicaid Commissioner, is John Heitman. Mr. Heitman, who oversees One Health Record* , coordinates with the Medicaid Utilization Intervention Development and Meaningful Use Administration manager and staff to provide the tools and capability for EPs and EHRs to obtain EHR Incentive payments. For example, the HIT

Coordinator coordinates with the EHR Incentive Program to provide verification that EPs or EHS have complied with PH reporting.

REC: Dr. Dan Roach, former HIT Coordinator, is now the Alabama REC Director. In addition the Alabama REC has participated in the following activities to support the administration of the EHR Incentive Program:

- The REC is under contract with A-SMA to recruit and encourage EPs to participate in One Health Record* and qualify for incentive payments.
- As speakers and panelists at the MASA Technical Symposium in Montgomery, AL, MASA Governmental Affairs Washington Meeting in Washington, DC, Rural Quality Network in Prattville, AL and ONC Regional Meeting in Atlanta, GA
- As exhibitors at MASA Annual Conference, Alabama Academy of Family Physicians Annual Meeting, American Academy of Pediatrics - Alabama Chapter Spring, Annual & Fall Meetings, MGMA Alabama Chapter - Summer Meeting
- Through workshops, including Train the Trainer Workshop, ALREC staff and account representatives received training on Meaningful Use, Quality Measures & Reporting, Attestation & Registration, Implementation, Privacy & Security and Workforce Development, and hosting a 2 Day Risk Analysis Workshop
- At the annual ONC Conference: ALREC staff attended the ONC Annual Conference in Washington, DC

The REC has been working directly with their priority providers towards specific milestones.

2.11 WHAT OTHER ACTIVITIES DOES THE SMA CURRENTLY HAS UNDERWAY THAT WILL LIKELY INFLUENCE THE DIRECTION OF THE EHR INCENTIVE PROGRAM OVER THE NEXT FIVE YEARS?

Alabama, like most states, is simultaneously managing multiple initiatives to reduce costs and transform health care. Each initiative is dependent on health-IT to support the changes enrollees and providers will encounter. The success of the EHR Incentive Program will create the potential for success in the delivery system and payment reforms. The coverage and payment changes create a demand for the meaningful use of health information from new and existing data sources, including EHRs and One Health Record®. Three significant areas follow:

One Health Record® Technical Infrastructure: The One Health Record® infrastructure is being enhanced specifically with MU requirements in mind, such as connectivity to Alabama Department of Public Health (ADPH) for purposes of reporting the EHR Incentive Program lab, immunization and cancer registry, and bio-surveillance. The core technical components to assure trusted information sharing include a Master Patient Index (MPI), provider directory, XDS Registry/Repository, XCA/XCPD, auditing and logging, continuity of care viewer and DIRECT/CONNECT 3.0 capabilities.

Health Home for Individuals Chronic Conditions SPA Initiative: Patient 1st, Medicaid's current Primary Care Case Management under a 1915(b) waiver was amended and a health home for individuals with chronic conditions State Plan Amendment (SPA) has been approved by CMS.

Medicaid staffs are working across initiatives to align MU measurement and health-IT infrastructure. The Patient 1st Networks and Primary Medicaid Providers (PMPs) are priority for implementation and considerations for their relationship to the Phase One gateways is currently under discussion. The requirement that health home initiatives utilize health-IT makes the engagement of providers in One Health Record[®] and MU critical.

The Networks will provide population health management by furnishing preventive services and information; systematic data analysis to target enrollees 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. All of these components are dependent on adequate health-IT.

Networks will provide disease management to high risk, high acuity enrollees to ensure that they receive appropriate evidence based care. Population management, disease management and medical coordination of treatment and prevention will be provided to enrollees enrolled with a Network and Network PMP. Networks and PMPs will receive increases in the pm/pm so that enhanced care management services can be provided. In addition to the services stated above, enhanced services include but are not limited to a 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.

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.

Regional Care Organizations (RCOs): As previously address in Section 1.1, 20.0 and 2.8, RCOS are a critical component of the health care delivery transformation on Alabama's Medicaid Program and the RCOs are dependent on the One Health Record[®] system to provide the infrastructure to support the needed exchange of information and payment reform strategies. A-SMA is y seeking to positively influence health outcomes of Alabama Medicaid enrollees through transitioning from fee-for-service health care delivery to managed health care delivery through Regional Care Organizations (RCOs) to improve management and coordination.

RCOs and their providers will need to access meaningful, reliable, actionable patient information in order to effectively and efficiently provide care; thus, they need to be "on boarded" to the HIE with sufficient lead time. The focus of One Health Record[®] is very Medicaid centric, but "fair share" funding from private entities is required in order to access Medicaid funding. The "value" beyond Medicaid has to been validated to the private market. Their commitment is to the "promise" of value, rather than actual current value.

Evaluation of One Health Record® and MU: The “Evaluation of One Health Record® March 4, 2014, required for the ONC HIE Cooperative Agreement has been completed and submitted to ONC. It is available to CMS upon your request.

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.

Alabama has an approved State Plan Amendment to expand the definition of a physician under the Medicaid Program in order to allow optometrists to participate in the EHR Incentive Payment program. The goal was to remove the definitional barrier to optometrists becoming EPs. Alabama received approval for the State Plan Amendment and Optometrists were added to Alabama’s list of Eligible Professionals effective October, 2011.

The One Health Record® Legal and Policy workgroup is also focused on policies and procedures for the operation of One Health Record®, which went “live” in April 2012. Since authority already exists for MU and One Health Record®, there is no need for state legislative action at this time. The focus for the 2012 legislative session was on the Exchange so there were no changes related to the implementation of the EHR Incentive Program.

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.

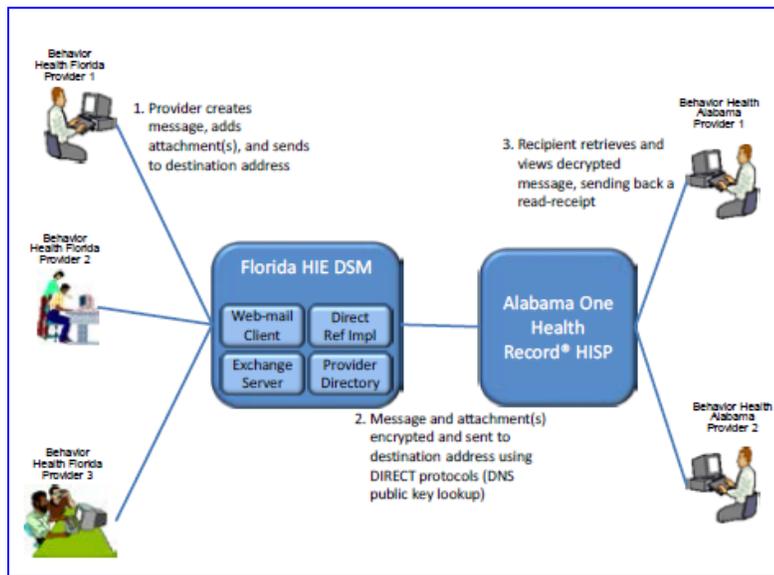
The A-SMA continues to coordinate with Border States to address the matter of Medicaid recipients crossing State lines to access health care services

- *One Health Record® Interstate- e-Health Exchange:* Alabama became a full participant on the eHealth Exchange, formerly known as the Nationwide Health Information Network (NWHIN), in September 2012. Alabama was one of only five State HIEs to become a certified NWHIN participant at the time.
- *HITECH Conference:* A-SMA staff and contractors.
- *Community of Practice Calls:* A-SMA staff and contractors participate in the Meaningful Use, Audits, Performance Measures, Financial, I-APD/SMHP and Eligible Hospital as well as the CQM Workshop.
- *ONC Annual Conference in DC:* Alabama HIT Coordinator, along with staff and contractor attended the ONC conference in January 2014
- *SERCH:* A-SMA has participated in and led SERCH calls related to Supporting Stage 1 MU, HIE Comparisons (UNC Study), provider directories, specialists and MU, evaluation, sustainability and 90/10 funds, EMRs, HIEs and Local Health Departments, RTI Disaster Preparedness Team Update, validation of patient encounters and HIE program, patient volumes, DIRECT and State HIE Plans. The state has also participated in SERCH discussions threads on AIU payments, group volume and hospital cost reports. Participants include

HIT Coordinators, REC project managers, Medicaid staff and other state representatives including Governor Office representatives.

- *SHPC on Behavioral Health: A-SMA* is a charter member of this 5-state consortium that is developing a standardize set of policies and procedures for the interstate exchange of sensitive behavioral health information. Alabama partnered with the State of Florida as a member of a 5-state consortium that developed a standardized set of policies and procedures for the interstate exchange of sensitive behavioral health information, including substance abuse treatment records. Alabama’s HISP has a trust relationship with West Virginia’s HISP and Georgia’s HISP.

Figure 10a: Inter-State Exchange



- *HITECH All States Calls: A-SMA* continues to participate in the calls where the state has gained insights and guidance on matters related to the continued administration of the MU program, including Monitoring EHR Incentive Programs, Program Changes through implementation of each Stage, Auditing, HIT I-APD, CMS-37, and CMS-64 and HITECH Funding Used for HIE Development. Staff has participated in webinars on Micro-strategy Reports and GUI Training. The All States calls have provided opportunities for the state to better understand Medicaid Directors Letters, and learn best practices and tools, including research on provider readiness for the EHR Incentive Programs and the EHR Certification Number.
- *AHRQ Medicaid Medical Directors Learning Network: Alabama’s Medicaid Medical Directors, Dr. Robert Moon, a One Health Record® workgroup member, is a member of the national Medicaid Medical Directors Learning Network which provides a forum for clinical leaders of the State Medicaid programs to discuss their most pressing needs as policymakers. Two of those focus areas are MU, current and going forward, and health homes for individuals with chronic conditions. These are also priorities for A-SMA.*

2.14 WHAT IS THE CURRENT INTEROPERABILITY STATUS OF THE STATE IMMUNIZATION REGISTRY AND PUBLIC HEALTH SURVEILLANCE REPORTING DATABASE(S)?

Alabama Department of Public Health (ADPH) is a key participant in One Health Record®. ADPH's State Health Officer is co-chair of the One Health Record® Advisory Commission and ADPH was represented at the earlier all day work plan meeting of the Commission.

ADPH's CHIP data and EPSDT screening data were included in Phase 1 of the One Health Record®. ADPH is working with the One Health Record® vendor, Truven, to will allow Alabama providers to access and report public health (PH) immunization registry data and report lab, cancer and bio-surveillance data for purposes of MU through One Health Record®.

ADPH 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). ADPH believes One Health Record® capabilities will greatly improve its disease surveillance capacity. In addition, the Department is well on its way to having a modern laboratory information system through A-SMHP efforts. The state envisions this will become a part of One Health Record®, which will greatly assist epidemiological studies.

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.

A description was provided in the initial A-SMHP regarding the Alabama Medicaid Transformation Grant (MTG), which provided the process and structure for the current One Health Record® design, development and implementation. Q-Tool, which was developed as a part of the MTG, was terminated as of 9/30/11. It is no longer needed with advent of the One Health Record®.

The state has built on, and benefited from, the many years state and stakeholders worked under the 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.

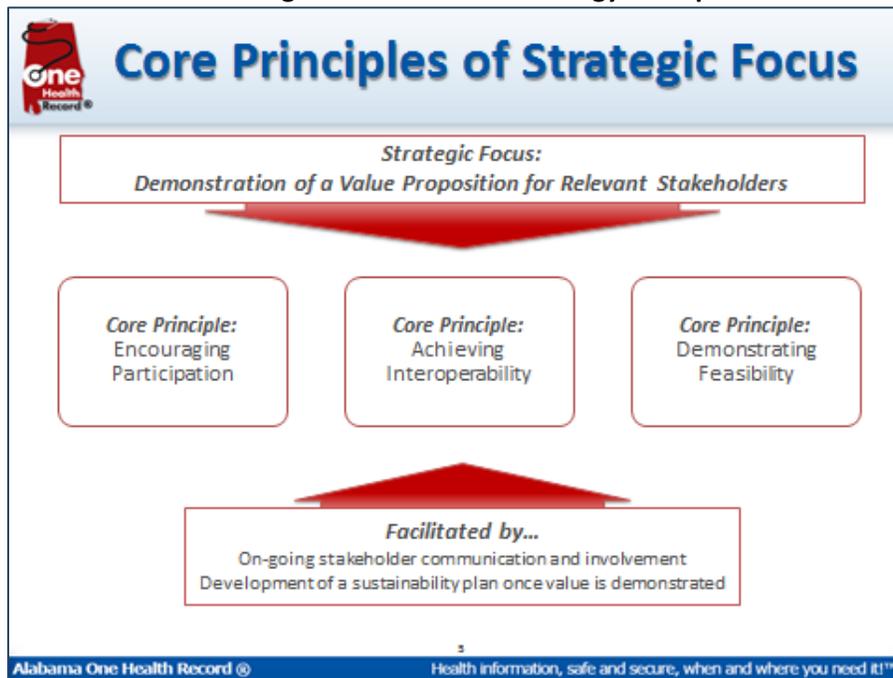
3. SMHP SECTION B: ALABAMA’S “TO BE” LANDSCAPE

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 Exchange of Health Information and health-IT: The state’s approach is to provide an “individuals first”, health-IT infrastructure that provides “benefits for all”, is “outcomes focused”, “builds boldly on what works” and “encourages innovation”. The goal is to align with federal health care objectives (better health, better care, lower costs) and federal health-IT principles through a transparent multi-stakeholder process. The goal is to assure trusted information sharing that is based on national standards and provides the technical components to meet the gaps in HIE capabilities for MU, including but not limited to provider directories, identify management, secure messaging, and consumer access to their information.

The core principles for the current Medicaid statewide HIT strategy are depicted in the following Figure 10b.

Figure 10b: Core HIT Strategy Principles



There are several components of the statewide strategy. Due to the Medicaid volume and impact on providers, Medicaid is a core factor in all of them. Medicaid is the starting place for all policy decisions with appropriate cost allocations for funding. The other key purchasers are Medicare

through Alabama Blue Cross Blue Shield (A-BCBS), CHIP through A-BCBS and Alabama State Employees through A-BCBS.

“To Be” Meaningful Use:

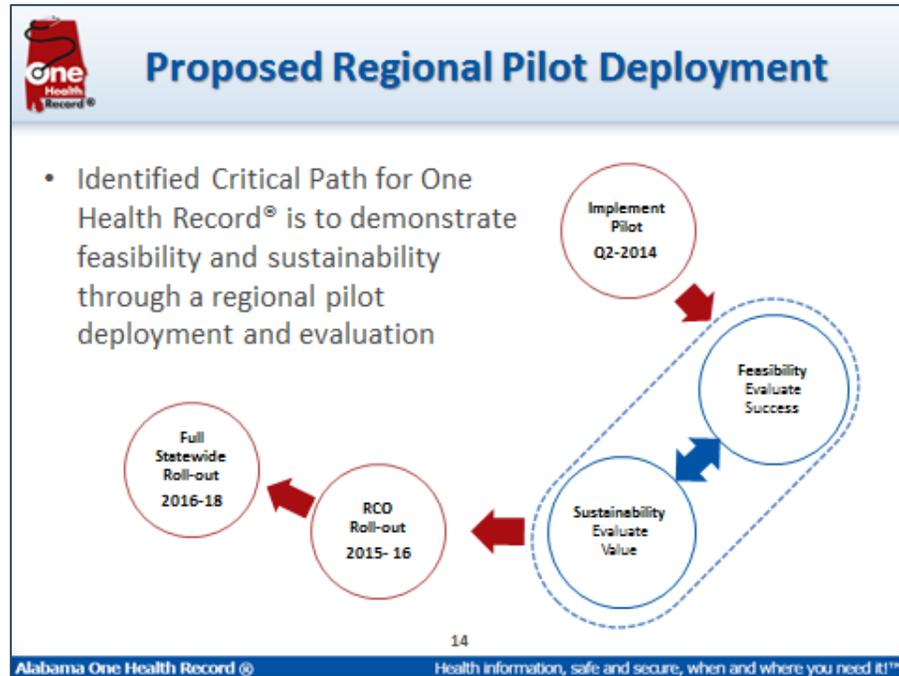
- *Internal Medicaid Agency:*
 - *Standard:* One clear internal state government goal is to effectively and efficiently purchase and manage the Medicaid Program. There are two specific objectives to support the goal. One is to integrate the activities of the EHR Incentive Program organizationally into the broader Medicaid Agency. For example, the Program Integrity (PI) Division will manage the audit functions in coordination with the A-SMA and the MITA staff will include MU in the updated MITA Self-Assessment.

The other goal is to provide actionable, near-real time information to providers, state staff, the federal government, consumers and stakeholders. The supporting objective is to have an enhanced data repository/warehouse with analytic capabilities that can access and accommodate new and currently available data sources.
 - *Methodology and Process:* A-SMA has updated its strategy to include two specific initiatives in 2014 and 2015 to support Medicaid RCOs and provide a “proof of concept” of value to other purchasers
 - Expansion of HL7 capabilities of One Health Record® to supplement the standard Continuity of Care Document Architecture, including ADT, notes, labs, immunizations and orders.
 - Development of a Regional Pilot around East Alabama Medical Center (Centralized Model) to demonstrate and measure success.

The proposed “proof of concept” regional pilot deployment is illustrated in Figure 10c. This geographic “proof of concept” area was selected because it met the following criteria:

- The presence of an existing network of Care Coordinators through the Primary Care Network (PCN)
- A Regional anchor hospital and a rural referring hospital, a core set of referring clinics that cover pediatrics, ortho, ENT, etc., a wide selection of family practitioners, urgent care clinics and private clinics, and FQHC involvement.
- Engagement of pilot participants who were interested and willing to be open to the process; committed to using One Health Record®; allowed access to staff for interviews related to work flow impact and feedback, and allowed the use of the pilot results to be published.

Figure 10c: Proposed Regional Pilot Deployment



- Meaningful Use (MU):**
 - Standard:** The overarching goal for A-SMA is to assure that any potentially eligible EP and/or EH in Alabama is aware of, has access to and receives appropriate EHR incentive payments. As of September 2013, a total of 1478 (1390 EPs and 88 EHS) were approved for AIU payments for a total amount of \$92,170,427.15 (\$62,916,248.15 EHs and \$29,254,179.00 EPs). Another 303 (243 EP and 60 EH) were approved for MU payments of \$26,928,230.89 (\$2,045,672.00 EPs and \$24,882,558.89 EH). An additional 183 MU attestations are being processed for payment and 268 attestations are in process by providers.
 - Methodology:** Alabama intends to continue this positive trend, but recognizes the potential for a drop off as the focus shifts from AIU to attesting for MU. The process moves to providers' readiness for use of their certified EHR in a meaningful way and connectivity to One Health Record®. Therefore, the state has directed its metrics to process measures related to assuring providers are aware of the opportunities and requirements and proper oversight and accountability is in place. The following information was required by ONC to be reported on a yearly basis by Medicaid as a result of its HIE Cooperative Agreement.

Table 5: MU of Health Information Metrics and Goals

Program Priority	Report in first SOP Update		Report January 2013		Report January 2014
	Status as of December 2011	Target for December 2012	Status as of December 2012	Target for December 2013	Status as of December 2013
% of labs sending electronic lab results to providers in a structured format	50%	55%	53.2%	55.5%	53.2%
% of labs sending electronic lab results to providers using LOINC ²	36%	40%	40.3%	42.5%	40.3%
Public Health agencies receiving ELR data produced by EHRs or other electronic sources. Data are received using HL7 2.5.1 LOINC or SNOMED Yes/No or %	Yes	Yes	Yes	Yes=100%	Yes
Immunization registries receiving electronic immunization data produced by EHRs. Data are received in HL7 2.3.1 or 2.5.1 formats using CVX code Yes/No or %	Yes	Yes	Yes	Yes=100%	Yes
Public health agencies receiving electronic syndromic surveillance hospital data produced by EHRs in HL7 2.3.1 or 2.5.1 formats (using CDC reference guide)Yes/No or %	No	Yes	No	Yes=100%	No
Public Health agencies receiving electronic syndromic surveillance ambulatory data produced by EHRs in HL7 2.3.1 or 2.5.1 Yes/No or %	No	Yes	No	Yes=100%	No

- *Process:* The current goal is to retain a significant portion of the AIU EPs and EHs. Alabama is trending slightly ahead of the rest of the states for EP retention in the MU program and has accomplished 68% retention for EHs.
- *One Health Record®:*
 - *Standard:* The breakthrough goal for the state of Alabama for Medicaid and for its ONC grant is that “all Alabama Medicaid providers use One Health Record® for “meaningful use” of health information. An ongoing analysis of readiness by geographic area has provided the state with possible gateways for One Health Record® implementation, including the technical capability to support DIRECT and query. One Health Record® provides secure messaging, provider directory, DIRECT support and a patient index (MPI) so providers statewide will be able to participate

² **Structured format:** Documentation of discrete data using controlled vocabulary, creating fixed fields within a record or file, or another method that provides clear structure to information (is not completely free text).

in the Medicaid incentive program and use health information in a meaningful way. One Health Record® provides the statewide infrastructure needed for the actual exchange of information in order for providers to meet meaningful use requirements and deliver care more efficiently and effectively. A screenshot of the One Health Record® login follows in Figure 10d.

Figure 10d: One Health Record® Login Screenshot



- Methodology:** The goal metrics for 5 years is 80% of all Alabama Medicaid eligible providers (those who meet the provider and population requirements) are meeting meaningful use through One Health Record®. (Denominator: All Alabama Medicaid Providers who meet the provider type and population requirements X 0.80 Numerator: Of denominator, those who have met meaningful use in previous year). The progress measure for 2 years is that “early innovators” who sign up are meeting meaningful use through One Health Record®. (Denominator: All Alabama Medicaid Early Innovators Numerator: Of denominator, those who have met meaningful use in that year.) The progress measure for one year is that One Health Record® implementation and connectivity to “early innovators” is complete. The system is “live”. (Measurement: Data exchanged through One Health Record® with two non-associated providers and public health)
- Process:** ONC funding terminated 2/7/2014. An HIT-I-APD will be submitted in 2014 to address specific activities to support MU Stage 2 and move toward MU Stage 2:

- Funding for costs associated with the Medicaid specific staffing, contracted personnel support, systems, and activities supporting One Health Record® planning and preparation, including the Medicaid “proof of concept” activity. One Health Record® has connections to the Medicaid MMIS and CHIP claims and eligibility systems. The core One Health Record® technical infrastructure, which includes DIRECT secure messaging and robust query exchange, is up and operational. The emphasis is on use. Onboarding of the substantial Medicaid MU providers in geographic areas to One Health Record® is important. A “fair share” methodology specific to the pilot will be addressed in the cost allocation section.
- Funding for Public Health (PH) to interface with One Health Record® for bio-surveillance, immunization and cancer registries, and lab to support EHR Incentive Payment program MU submissions. The interface requirements are those of the federal implementation guidelines and require no additional functionality for the EPs or EHS.

Funding for onboarding of EP-types and EHS to One Health Record® for purposes of reporting to PU for MU is also included. The proposed requirements for One Health Record® connection to ADPH and for One Health Record® connection to EP-types and EHS for purposes of Medicaid MU reporting include the following:

- EHS and EPs can onboard for one or multiple PH connections and can onboard for PH prior to completing a full onboarding of all One Health Record® services unless this requires a change in the core services already operational.
- A web site that ADPH and One Health Record® can view and download project status for each provider who has contacted the vendor regarding on boarding connectivity to ADPH through One Health Record®.
- Analytic reporting on status of each provider project maintained through the life cycle of the provider testing and operation, including verification of One Health Record® receipt from provider and transmission to either Biosense or ADPH, depending on effort.
- Outreach and communication plan to include onboarding guide and outreach/communication material updated to inform EHS that the Biosurveillance reporting (ADT) is triggered at admit and discharge.
- National transport and content standards with an automatic upgrade to national standard upgrades.
- One Health Record® administration shall determine when and if the four PH categories of records shall be stored in One Health Record® for more than a time limited period.

- Provide an electronic means for EP's and EH's or their vendors to submit completed facility guides that include required information for each site(s)/location(s), including the EPs names, NPI and State Medical License numbers for each facility. Provide access to ADPH on these data elements in an electronic format that can be consumed by A-DPH.
 - Obtain from One Health Record® administration verification of signed appropriate legal documentation regarding access, data security and visibility prior to activation of link. One Health Record® administration is responsible for collection and retention of legal documents from providers, vendor, ADPH and BioSense as appropriate.
 - Support connectivity for EP's and EH's connectivity to both ADPH SOAP WSDL's; test and production. Maintain a testing and a production environment.
 - Support the capability to receive and retain an ADPH acknowledgement of receipt and acceptance or rejection of the messages sent to ADPH. Additionally, support the capability to send that acknowledgement back to EPs and EHs.
 - Trouble shoots ability during test and production phases, including if file/records are missing.
 - Create and maintain technical capacity for DIRECT secure messaging for ADPH for purposes of reporting immunizations, labs, bio-surveillance and cancer registry information.
- *Eligibility:*
 - *Standard:* The goal is for the Alabama Medicaid eligibility system to be operational, effective, and federally compliant, and consumer centric effective 2014.
 - *Methodology and Process:* The update of A-SMA's eligibility determination system is an enhancement of the Children's Health Insurance program (CHIP) system to support Modified Adjusted Gross Income (MAGI) determination according to the requirements of the Affordable Care Act (ACA) and the Medicaid final policy rule. Alabama acquired information technology services in-house to support the State as it works to build an eligibility system for the State's Medicaid and CHIP programs, while exploring the possibility of expanding to other HHS programs in the State of Alabama such as TANF, SNAP at a later phase in the project. CMS has approved enhanced Federal funding for the services through the period ending on December 30, 2015.

The project is being implemented in four (4) phases. The first three phases have been completed. The first phase is the application intake functionality for Medicaid for Low Income Families (MLIF), Plan First and CHIP. (October 2012 -October 2013). The second phase is the fully functional E&E system for MLIF, Plan First, and CHIP.

(October 2012 - December 2013). The third phase is stabilization and enhancements such as on line reporting tools, federal and other management reports, and performance tuning. (November 2013 - Jun 2014). The fourth phase, E & E for Elderly and Disabled, is anticipated to be completed by December 2015.

3.2 WHAT WILL A-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?

Alabama's One Health Record® Figure 11 looks basically the same in 2015 with adaptations to accommodate health-IT, health care and health care delivery changes. The difference is that the "vision" is "reality". Building off the eHealth Exchange model, One Health Record® 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 eHealth Exchange supporting DIRECT and query.

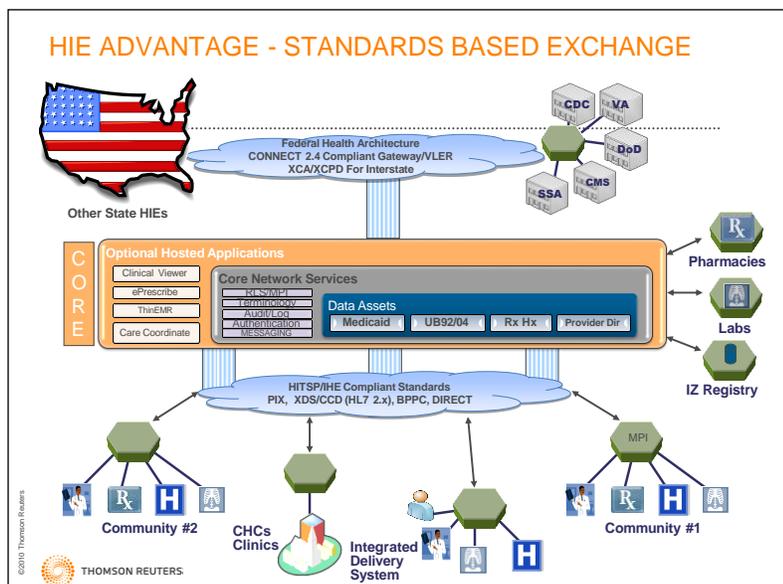


Figure 11: One Health Record®

"To Be" Future State Functionality and Systems Architecture:

- *"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 contracted with an outside vendor for the Medicaid EHR Incentive Program at the state level. The web-based approach provides a system to capture and track provider applications, 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 interfaces with the CMS Registration and Attestation System. The state intends to submit an I-APD to address funding for the audit structure and to capture and document appeal decisions.

The following chart identifies the IT functionality required by year for MU. The IT systems are all part of the MMIS, although some are a part of the claims processing system and other functions and architecture are not.

Table 6: MU IT Functionality by Year

Feature	Detail
Year 1 MU Functionality (2012)	
Account Creation <ul style="list-style-type: none"> • State-specific EULA • Forgot User ID (Identify Yourself /Challenge Question / Email solution) • Forgot Password (Challenge Question / Email solution) 	Incorporates the Registration and Attestation functionality found in SLR version 1.0. Includes full capabilities around account creation, user ID lookup and password information as currently exists in the SLR today.
Validation of Identifying Information	Includes same validations currently in place for the SLR to confirm the provider’s identifying information. Incorporates functionality to let states have more control over configuration items.
About You	Includes the same functionality and validations currently in place for the SLR to validate the provider registration data. Incorporates functionality to let states have more control over configuration items.
Confirm Medicaid Eligibility	Includes the same functionality and validations currently in place for the SLR to validate Medicaid eligibility. Incorporates functionality to let states have more control over configuration items.
Attestation of EHR <ul style="list-style-type: none"> • Certified EHR Technology 	Includes the same functionality for capturing and validating the EHR Certification ID currently in place for the SLR. Incorporates functionality to let states have more control over configuration items.
Review, Sign, and Submit Attestation	Includes same functionality for the Attestation Agreement and submission currently in place for the SLR. Incorporates functionality to let states have more control over configuration items.
Payment Calculation	Includes the same functionality for calculating payments as currently exists in the SLR.
My Account	Includes same functionality for account creation as currently exists in the SLR
Change Requests	At a minimum, includes all change requests related to the above items to ensure the MU build is consistent with the most current version of the SLR.

Feature	Detail
Year 2 MU Functionality (January 1, 2013 to accommodate Stage 1 changes as a result of Final MU Regulation)	
Incorporate Stage 1 Meaningful Use functionality (EP and EH) <ul style="list-style-type: none"> • Meaningful Use (MU) Questionnaires • Clinical Quality Measures (CQM) Questionnaires • Support dually-eligible hospital requirements • Support changes as a result of Stage 1 changes because of the Final MU Stage 2 Regulation (see following Table 6a.) 	<p>Questionnaires are based on the CMS screens for the Medicare program and work essentially the same way. All objectives are data driven and set up in a way that provides flexibility for states to revise objectives if approved by CMS, indicate required objectives, and accommodates the future stages of MU without significant recoding.</p> <p>The MU workflow takes the provider through the process and instantly displays if the provider is meeting objectives. The navigation tree is dynamically updated as the provider selects the menu set objectives and CQM alternate core measures are automatically enabled if and EP has at least one core CQM measure with a denominator of zero.</p>
Implement workflow with summary level statuses <ul style="list-style-type: none"> • Change Control (if steps 2 or 3 are changed, then Attestation Agreement must be redone) 	This duplicates the new approved workflow for the steps in the SLR to ensure that if provider data is updated, the attestation agreement must be reprinted reflecting the new information, signed and updated.
Implement CQM data upload function	This feature meets the requirements of allowing providers to electronically submit clinical quality data in 2012. Suggested format is to use the existing PQRI data format for reporting so providers can use the same files used for PQRI reporting.
Incorporate Year-Over-Year functionality	This includes all functions required to set the SLR up for the second year of the program, including: <ul style="list-style-type: none"> • Proposed 3 month grace period • Automatic redirection of provider to MU if Year 1 attestation was successfully completed • View only data for Year 1 information • Allowing groups to convert providers from previous year and remove providers no longer in the group. • PMF data updates for year 2 to ensure provider records are updated appropriately
Implement Client-State “meta data driven” features	This feature involves setting up the configurable items to be meta data driven instead of hard coded to allow for greater flexibility in updating configuration items.
Implement Group Practice/ Representative functions and features	This incorporates the group functionality currently under development in the SLR.
Include ability to upload “mass practice data” for numerous providers (3/1/12)	Intent is to allow group administrator to upload numerators, denominators and exclusions for multiple providers via spreadsheets or file imports

Feature	Detail
Implement reports for end users (like the Registration and Attestation Summary Report)	Includes the Registration and Attestation Summary report and other provider reports to be defined, if needed.
Year 3 MU Functionality (October 1, 2013 to accommodate Stage 2 changes as a result of Final MU Regulation)	
Program Year 2014 Stage 2 Meaningful Use Measures (EP and EH)	Incorporates the data set of Core and Menu objectives and expanded CQMs for Stage 2 as defined in the Final Rule into the SLR attestation process (EP and EH).
SLR Data Management	
Functionality and features for States to maintain their specific business rules and meta data	This feature is the administration function that gives each state control over configurable items so that changing configuration items, such as adding a new subject to a document drop down list can be made more quickly and at the discretion of the state.
Manage which items require validation, as well as soft and hard stops (including instruction text)	This feature allows management of the validation items, how they should be handled, and any specific configurable text.
Change management, reporting, audit, appeals, payment adjustment and recoupment capabilities.	Meaningful Use Administration staff will monitor the approved audit process utilizing audit reports submitted at the conclusion of the provider post payment audits. Monthly QA reviews are conducted by the Director to review auditor recommendations regarding process and follow-up activity on providers. Medicaid utilizes the current processes already established for appeals, payment adjustments and recoupments. When required, A-SMA will report the changes to CMS through the standardized D18 mechanism.
Help Desk Dashboard	
Provider Support	This includes functionality to allow the help desk user to view the provider's information to provide assistance as needed.
Help Desk Reports	Monthly reports of SLAs for Help Desk activity are available to management for review.
User Management <ul style="list-style-type: none"> Incorporate features for Help Desk to reset passwords and unlock user accounts (for Providers and State users) 	Allows for easier unlocking of user accounts and resetting passwords so that such requests can be completed in a timely manner without requiring assistance from the development team.
Provider Master File Improvements	
Rework database to improve data normalization <ul style="list-style-type: none"> ETL area and SLR DB 	This involves looking at issues currently encountered with the PMF and the way the data is loaded to the PMF table and to the SLR tables to ensure data issues don't impact development.

**Table 6a: Alabama's Implementation of the Final Rule
Stage 1 Medicaid EHR Incentive Program Changes Effective in 2013**

Stage 1 Provision	Policy Decisions	Implementation Actions Prior to 1/1/13	System Changes Prior to 1/1/13
Revised definition of “Children’s Hospitals”	<p>Children’s Hospital definition revised to include ‘any separately certified hospital, freestanding or hospital within a hospital that predominately treats individuals under 21 without a CMS certification number because they do not serve Medicare beneficiaries’.</p> <p>This provision is not applicable to Alabama Children’s Hospital at this time.</p>	<p>CMS:</p> <ul style="list-style-type: none"> Alabama’s Children’s Hospital has been issued a number by CMS and has enrolled in the incentive program. . <p>A-SMA:</p> <ul style="list-style-type: none"> In the event a new Children’s Hospital is created, Alabama will take appropriate action 	<p>NLR Interface: Changes to CMS NLR interface to accept new number.</p> <p>SLR:</p> <ul style="list-style-type: none"> New codes for Children’s Hospitals Update coding so system recognizes new codes & applies the correct business rules.
Certified EHR technology at one clinical location revision	Require for EP patient volumes that at least one of the clinical locations used has certified EHR technology during the payment year for which the EP is attesting.	<p>A-SMA:</p> <ul style="list-style-type: none"> Alabama validates that at least one location used to establish EP’s patient volume has certified EHR technology during the payment year. 	SLR: functionality exists to accept multiple locations and allow providers to attest that 50% of encounters are at locations with certified EHR technology.
Expanded definition of encounters for the patient volume calculation for EPS to include individuals enrolled in a Medicaid Program regardless of payment liability, including Medicaid expansion patients and	<p>The expanded definition of encounters will be implemented to attestations submitted for program year 2013 forward; existing regulations and guidelines will continue to apply to attestations through the 2012 grace period, which is 3/31/13.</p> <p>Encounters includes services rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability, including zero-pay claims and encounters with patients in Title 21-funded Medicaid</p>	<p>A-SMA:</p> <ul style="list-style-type: none"> Alabama currently requires each provider to submit a workbook detailing how Medicaid encounters are determined and to provide reports from an auditable source (such as a Practice Management System) to support the data submitted. Information on the State website, the SLR, and the workbook have been revised to incorporate the expanded definition. Provider Outreach includes: (1) e-Mail, webinars and website updates; (2) 	SLR: The revised workbook is an attachment that is available within the SLR.

Stage 1 Provision	Policy Decisions	Implementation Actions Prior to 1/1/13	System Changes Prior to 1/1/13
those with zero-paid claims.	<p>expansions, but not separate CHIPs. Since Alabama’s CHIP program is a stand-alone, those patients will not be counted.</p> <p>Zero-pay claims include claims: (1) denied because the Medicaid enrollee has maxed out the service limit, (2) denied because the service wasn’t covered under the State’s Medicaid program, (3) paid at \$0 because another payer’s payment exceeded the Medicaid payment, and (4) denied because claim wasn’t submitted timely.</p>	<p>dissemination of information to provider associations); and (3) for those providers who were not eligible for 2011 Program Year, Medicaid staff continued to work with each provider to exhaust every effort to establish eligibility for the incentive program.</p> <ul style="list-style-type: none"> • Changes to the audit protocol accommodated this change. 	
90-day Representative Period Option	<p>Alabama has the option to allow EPs and EHs to calculate total Medicaid encounters for Medicaid patient volume for “90-day Representative Period” across last 12 months prior to the EPs/ EHs attestation rather than CY for EPs and FY for EHs. The State option also exists for “needy population” for FQHC calculation.</p> <p>Alabama has made the policy decision to take this option. The state will retain the current option to also include within the most recent CY for EPs and recent FY for EHs.</p>	<p>A-SMA:</p> <ul style="list-style-type: none"> • Alabama currently requires each provider to submit a workbook detailing how Medicaid encounters are determined and provide reports from an auditable source (such as a Practice Management System) to support the data submitted. • Information on the State website, the SLR, and the workbook were revised to incorporate the expanded definition. • Provider Outreach includes: (1) e-Mail, webinars and website updates; (2) dissemination of information to provider associations); and (3) for those providers who were not eligible for 2011 Program Year, Medicaid staff worked with each provider to exhaust every effort to 	<p>SLR:</p> <ul style="list-style-type: none"> • A new reporting period alternative created in the SLR (12 months immediately preceding attestation) • Validations enabled.

Stage 1 Provision	Policy Decisions	Implementation Actions Prior to 1/1/13	System Changes Prior to 1/1/13
		establish eligibility for the incentive program. <ul style="list-style-type: none"> Changes to the audit protocol accommodated this change. 	
Panel Member Encounters for Patient Volume	For “panel member” methodology, Alabama has the option to look-back for at least one Medicaid encounter in the last 24 months rather than 12 months prior to the 90-day representative period. Patient panel methodology requires at least one Medicaid encounter taking place in the 24 months prior to 90-day period. This is a voluntary option for the state and Alabama has made the policy decision to take this option.	A-SMA: Alabama currently does not have true ‘managed care,’ it has a voluntary, stand alone, PCCM program in which providers may participate. If providers have difficulty in meeting Medicaid Patient Volume, Alabama developed a query to capture panel member encounters for the ‘look-back’ period to identify additional Medicaid encounters associated with panel members, providers are instructed to contact Medicaid directly for assistance with capturing these additional encounters.	SLR: There were no system changes required for this change
“Practices Predominantly” Definition	The Alabama application will define "Practices Predominantly" to include the following: <ul style="list-style-type: none"> within the most recent calendar year, or within the 12-month period preceding attestation 	A-SMA: <ul style="list-style-type: none"> Alabama requires each provider to submit a workbook detailing how Medicaid encounters determined and provide reports from an auditable source (such as a Practice Management System) to support the data submitted. Alabama modified the application and the audit. Information on the State website, the SLR, and the workbook were revised to incorporate the expanded definition. Provider Outreach includes: (1) e-Mail, webinars and website updates; (2) dissemination of information to provider associations; and 	SLR: SLR help text revised to redefine “practices predominantly”

Stage 1 Provision	Policy Decisions	Implementation Actions Prior to 1/1/13	System Changes Prior to 1/1/13
		(3) for those providers who were not eligible for 2011 Program Year, Medicaid staff continued to work with each provider to exhaust every effort to establish eligibility for the incentive program.	
Hospitals Switching States	In the event that a hospital changes participation in another state's Medicaid EHR incentive program to participate in Alabama's program, Alabama will not pay the hospital more than the aggregate incentive amount calculated by the previous state. Alabama will consult with CMS as directed should this situation occur.	A-SMA reviews the data from the previous state and make the payment calculation based on the methodology required for hospitals switching states. As required, Alabama will consult with CMS as directed should this situation occur	The SLR will incorporate the capability to (1) capture historical information from another state, (2) capture data used to calculate the hospital incentive payment from the previous state to ensure the calculated amount remains correct, and (3) indicate the hospital doesn't receive the year 1 payment, but gets the appropriate subsequent year payment.
EH Incentive Calculation use of Information from the Most Recent Continuous 12 Month Period	Hospitals that begin participating in FFY 2013 or later the base year to the use discharge-related amount from most recent continuous 12-month period selected by the State but ending before the FFY that serve as the first payment year, while hospitals that began participating before FFY 2013 shall use discharge data from the hospital fiscal year that ends during the FFY prior to hospital fiscal year that serves	A-SMA: <ul style="list-style-type: none"> • Alabama adjusted the policy to ensure alignment with the change in the MU regulation. • A-SMA has selected as the most current continuous 12-month period for hospitals attesting for the first time in 2013 the following time period: the 12 months prior to the FFY prior to the hospital payment year. Currently A-SMA allows EHs to submit hospital cost reports for any time period 	SLR: No changes to the SLR as the system already accepts the most recent continuous 12-month period ending before the FFY that serves as the first payment year. However, the SLR vendor will incorporate functionality for hospitals with fewer than 4 years

Stage 1 Provision	Policy Decisions	Implementation Actions Prior to 1/1/13	System Changes Prior to 1/1/13
	<p>as the first payment year. All hospitals that initiate participation beginning in 2013 must adhere to the change.</p> <p>The policy applies to hospitals attesting for the first time in 2013 only. 82 of Alabama's 106 hospitals have submitted attestations using cost reports. According to the Alabama Hospital Association, those hospitals that have not attested have not done so due to reasons other than eligibility.</p>	<p>that ends during the FFY prior to the payment year; therefore, the change in regulation will have no impact on EHS in Alabama.</p> <ul style="list-style-type: none"> • Provider Outreach includes e-mail, webinars, website updates, and dissemination of information to the hospital associations. 	<p>of data prior to the most recent continuous 12-month period ending before the FFY that serves as the first payment year.</p>
Hospital-Based EPS	<p>EPs can be excluded from the definition of hospital based if the EP can demonstrate that the EP funds the acquisition, implementation and maintenance of the Certified EHR technology, including supporting hardware and any interfaces necessary to meet MU without reimbursement from an EH or CAH, and uses such Certified EHR Technology in the inpatient or emergency department of a hospital. EPs that can show they fund the acquisition, implementation and maintenance of the CEHRT can be determined to be non-hospital based.</p> <p>If an applicant is determined to be hospital based but wishes to be determined non-hospital based due to their funding of the acquisition, implementation and</p>	<p>A-SMA:</p> <ul style="list-style-type: none"> • Alabama made the appropriate changes. • Provider Outreach includes e-mail, webinars, website updates, and dissemination of information to the hospital associations. • As appropriate, Alabama modified the application and the audit. • As appropriate, information on the State website, the SLR, and the workbook were be revised to incorporate the change. 	No change required.

Stage 1 Provision	Policy Decisions	Implementation Actions Prior to 1/1/13	System Changes Prior to 1/1/13
	<p>maintenance of CEHRT, Alabama will utilize an administrative process to review the request based on the requirements and make a determination.</p>		
<p>CMS Proposed MU Auditing/ Appeals for Dual Eligible Hospitals</p>	<p>This is a voluntary option for the state and Alabama has made the policy decision to take this option to have CMS perform audits and handle any subsequent appeals of whether a EH is a “meaningful user” on behalf of the state. Alabama will sign the required agreement that:</p> <ul style="list-style-type: none"> • Designates CMS to conduct all audits and any resulting appeals of eligible hospitals' meaningful use attestations; • Is bound by the audit and appeal findings; • Will perform any necessary recoupments arising from the audits; • Will be liable for any FFP granted the state to pay EHs that, upon audit (and any subsequent appeal) are determined not to have been meaningful EHR users; and • Acknowledges that the results of any adverse CMS audits would be subject to the CMS administrative appeals process and not the Alabama appeals process. 	<p>A-SMA:</p> <ul style="list-style-type: none"> • Alabama has notified CMS as a part of the A-SMHP and included it in the cover letter to the A-SMHP submission. 	<p>SLR and Interface with CMS: , appropriate system changes related to providing data to the CMS/Medicare auditors and to accommodate possible recoupments has been addressed</p>

Stage 1 Provision	Policy Decisions	Implementation Actions Prior to 1/1/13	System Changes Prior to 1/1/13
	<p>The state understands that CMS will only be auditing meaningful use and, the other eligibility criteria, as well as AIU are still the responsibility of the state of Alabama.</p>		
<p>Additional Alternate Measure for CPOE Objective</p>	<p>A-SMA will accommodate the additional optional measure for 2013 for the CPOE objective: More than 30% of the medication orders created by the EP or authorized providers of the EH's or CAH's inpatient or ER (POS 21 or 23) during the EHR reporting are recorded using CPOE.</p> <p>The current measure option will be retained: 30% of unique patients with at least one medication in their medication order entered using CPOE.</p>	<p>A-SMA:</p> <ul style="list-style-type: none"> Information on the State website and SLR have been revised to incorporate the change to the objective. Provider Outreach includes (1) e-mail, webinars, website updates, and dissemination of information to provider groups (provider and hospital associations), and (2) coordination of AL-REC to engage CAHs to achieve MU. 	<p>SLR: The SLR was revised to allow this objective as optional as of January 1, 2013, for 2013 onward.</p>
<p>Additional e-Prescribing Exclusion</p>	<p>Alabama will accommodate the required addition of an additional e-prescribing exclusion that may be claimed by any EP who does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period.</p>	<p>A-SMA: Required for 2013 forward for EPs attesting to Stage 1 of MU.</p> <p>Information on the State website and SLR have been revised to incorporate the change.</p> <p>Provider Outreach includes e-mail, webinars, website updates, and dissemination of information to provider associations,</p>	<p>SLR: The SLR was revised to support this requirement for EPs attesting to Stage 1 of MU.</p>
<p>Vital Signs Addition of Alternative Age Limitations</p>	<p>A-SMA will accommodate this optional measure for 2013 and make it mandatory 2014 that affect the age limitations on growth charts and blood pressure. More than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient</p>	<p>The definition for a second denominator was added with the ability for the user to indicate which denominator they are using for reporting.</p> <ul style="list-style-type: none"> Information on the State website and SLR have been 	<p>SLR: The SLR has been revised to support this option for 2013 only for EPs attesting to Stage 1 of MU.</p>

Stage 1 Provision	Policy Decisions	Implementation Actions Prior to 1/1/13	System Changes Prior to 1/1/13
	<p>or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data.</p>	<p>revised to incorporate the change.</p> <ul style="list-style-type: none"> • Provider Outreach includes e-mail, webinars, website updates, and dissemination of information to provider groups (provider and hospital associations). • Coordination of AL-REC to engage CAHs to achieve MU. 	
Vital Signs Exclusions Change	<p>A-SMA will accommodate the following optional modifications to the exclusions for 2013 and make them mandatory 2014:</p> <ul style="list-style-type: none"> • Any EP who sees no patients 3 years or older is excluded from recording blood pressure • Any EP who believes that all three vital signs of height, weight and blood pressure have no relevance to his/her scope of practice is excluded from recording them • Any EP who believes that height and weight are relevant to his/her scope of practice, but blood pressure is not is excluded from recording blood pressure • Any EP, who believes that blood pressure is relevant to his /her scope of practice, but height and weight are, not, is excluded from recording height and weight. 	<p>A-SMA:</p> <ul style="list-style-type: none"> • Information on the State website, SLR, and workbook has been revised to incorporate the change. • Provider Outreach includes e-mail, webinars, website updates, and dissemination of information to provider associations, 	<p>SLR: The SLR was revised to support this as optional for 2013 only for EPs attesting to Stage 1 of MU and makes it required for 2014.</p>
Removal of Electronic Transmission	<p>A-SMA will remove the objective that required the capability to exchange key</p>	<p>A-SMA:</p> <ul style="list-style-type: none"> • Information on the State website and SLR were 	<p>SLR: The SLR was revised to remove this objective</p>

Stage 1 Provision	Policy Decisions	Implementation Actions Prior to 1/1/13	System Changes Prior to 1/1/13
of Key Clinical Information Objective	<p>clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically for Program Year 2013:</p> <ul style="list-style-type: none"> • CY for EPs • FY for EHs 	<p>revised to remove the objective for EPs CY 2013 and EHs FY 2013.</p> <ul style="list-style-type: none"> • Provider Outreach includes e-mail, webinars, website updates, and dissemination of information to provider associations, 	<p>effective Program Year 2013 (CY for EPs and FY for EHs) and going forward.</p>
Eliminate Reporting Ambulatory or Hospital Clinical Quality Measures to CMS or the States	<p>A-SMA will remove the separate objective and all validations effective Program Year 2013; however, EPs, EHs and CAHs are still required to report on clinical quality measures in order to achieve MU as this objective has been directly incorporated into the definition of a MU user and eliminated as a separate objective.</p>	<ul style="list-style-type: none"> • A-SMA: Information on the State website and SLR were revised to remove this objective for Program Year 2013 as a separate objective but assure providers are aware they are still required to report on clinical quality measures in order to achieve MU. • Provider Outreach includes e-mail, webinars, website updates, and dissemination of information to provider associations. 	<p>SLR: The SLR was revised to remove this objective and all validations effective Program Year 2013 and going forward.</p> <p>A-SMA removed the separate attestation for the stand-alone objective but retained the reporting capability of the measures.</p>
Public Health Objective:	<p>A-SMA will add “except where prohibited” to the public health objective and accommodate reporting of “test” reporting beginning reporting year 2013. This accommodates the change to all of the Stage 1 public health objectives (submitting data to an immunization registry, submitting data to a syndromic surveillance database, or submitting reportable data to the public health agency) to require that providers perform at least one test of their Certified</p>	<p>A-SMA:</p> <ul style="list-style-type: none"> • Information on the State website and SLR were revised add “except where prohibited” to all public health objective measures effective Program Year 2013 • Provide information that all of the Stage 1 public health objectives (submitting data to an immunization registry, submitting data to a syndromic surveillance database, or submitting reportable data to the public health agency) will require that providers perform at 	<p>SLR: The was revised to add “except where prohibited” to all objectives effective Program Year 2013 and going forward and accommodate the reporting of the testing of data submission.</p>

Stage 1 Provision	Policy Decisions	Implementation Actions Prior to 1/1/13	System Changes Prior to 1/1/13
	Technology's capability to send data to public health agencies, "except where prohibited," even when they are not required by State/local law. If the test of submission is successful, the provider should institute regular reporting with the entity with whom the successful test was conducted.	least one test of their Certified Technology's capability to send data to public health agencies, "except where prohibited," even when they are not required by State/local law.	

The changes to the Core and Menu Measures and CQMS that became effective 10/1/13 for EHS and 1/1/2-14 for EPs are incorporated into Screen Shots that have been submitted to and approved by CMS. An updated set of screen shots are included in Attachment 8.19 that incorporates corrected CQM descriptions issued by CMS on 9/26/2013.

- “To Be” Future State of One Health Record® to Support the Exchange of Information for Meaningful Use:* The overarching goal of Alabama’s One Health Record® is the development and facilitation of technology that will enable providers to exchange health information. To this end, Alabama started at its simplest level, secure messaging. While Alabama providers are able to exchange information with an aligned hospital, the State does not have local, regional or statewide health information capacity at present. It is recognized that providers will need a pathway and a process to exchange information with other qualified organizations, state and national agencies, and/or providers, interstate and intrastate health information organizations, and other information sources to be determined.

One Health Record® is envisioned as t **Figure 12: HIE Advantage**
the state to connect with other state HIEs and Medicaid agencies, federal agencies, and the eHealth Exchange. To achieve that goal, Alabama will use a staged implementation that allows for each phase to be fully implemented and integrated with the prior phase. The purpose of a staged implementation is to allow for a period of time of response and flexibility and most importantly, provider engagement and education. Funded through

the ONC State HIE Cooperative Agreement, the initial phase included secure messaging to enable the exchange of clinical information from provider to provider, the technical functionality of a secure website that creates a web service for providers to log in or to interface through their EHR and a robust provider directory that enables secure, authenticated messaging. The provider directory, populated with information from Medicaid, Blue Cross/Blue Shield (BCBS) and CHIP, updates per provider “hit” with the most current e-mail from the initiator who has logged in through his/her account.

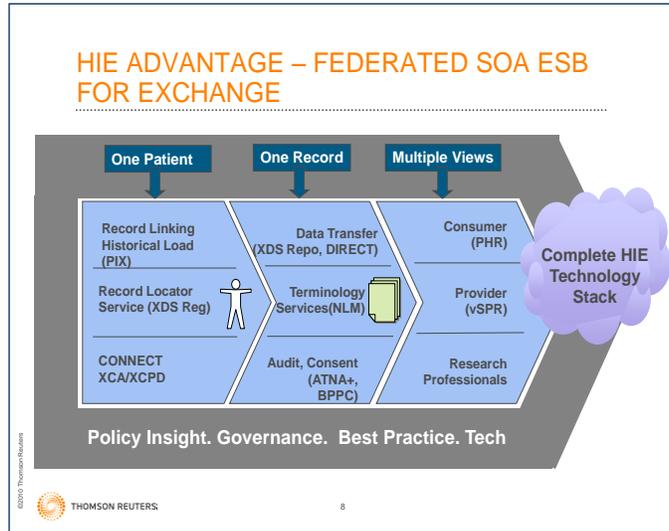
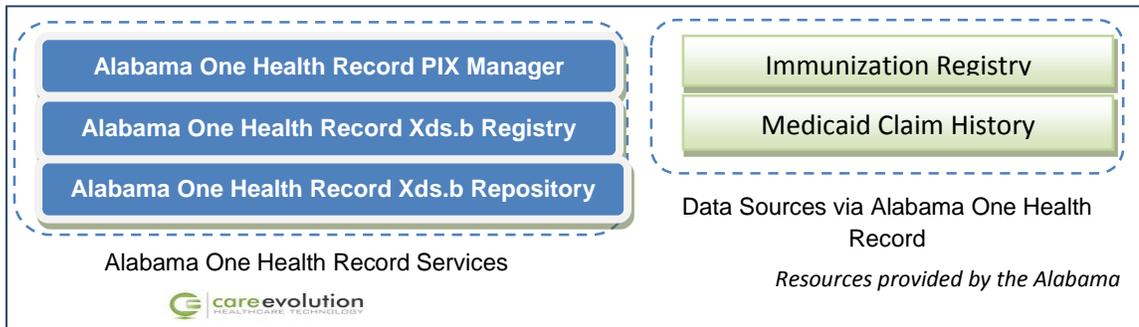


Figure 13: One Health Record® Services and Data Sources



The administrative functionality includes and supports the establishment and management of the provider “account”, communication and coordination with the 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 includes 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, CHIP and BCBS], and agreement to comply with the privacy and security rules of engagement through an agreement that aligns with the national DURSA agreement.

The state has looked at the technical design with an eye on the capability to push information into a secure repository and then out to providers for integration into their EHRs. The state seeks to construct its exchange using enterprise service bus technologies and service oriented architecture (SOA) principles and components. The network is composed of gateways that communicate using a messaging platform and other market accepted health information exchange protocols as they become available. One Health

Record® serves as the nexus of these gateways, capable of routing messages among all providers, and orchestrating messages according to business rules needed to deliver meaningful use functions.

By consolidating access, the state is able to share and minimize operational costs, increase user acceptance and participation, and maximize benefits to all stakeholders. The goal of One Health Record® is to allow providers to access clinical data via their native EHR interface with a secure Web browser in order to meet meaningful use requirements.

One Health Record® complies with all national standards as defined in the HITECH Act, and the final Standards and Certification Criteria established by ONC to support the Final Rule on Meaningful Use, including all specified content, vocabulary and privacy and security standards. One Health Record® also utilizes standardized code sets and nomenclature such as: ICD-9/ICD-10 for indicated conditions, SNOMED-CT for clinical terminology, CPT-4 for procedures and anatomic pathology, LOINC for clinical pathology results, RxNorm for medications, and CVX for immunizations. Encryption is a core privacy and security process and utilizes current standards. Other encryption is layered on as and when needed (e.g. encryption of data at rest). As additional encryption standards are defined and specified by standards bodies, Alabama will analyze, decide and make appropriate IT infrastructure updates to support new algorithms or security processes. These standards include any Federal Information Processing Standards (FIPS) that are announced by the National Institute of Standards and Technology (NIST).

It will be necessary to evaluate the capabilities and risks associated with various encryption approaches including the ability of the private sector to implement the proposed algorithms. For example, the TLS protocol using the SHA-1 algorithm should be avoided and replaced with the SHA-2 family for digital signatures as described in NIST’s Policy on Hash Functions. It is expected that encryption and security standards will continue to evolve and that an ongoing function of the HIE will be to stay abreast of evolving privacy and security risks, standards, and approaches.

Transactions in the secure website will be recorded when electronic health information is routed (source, destination, message ID, date and time) created, modified, accessed, and deleted to include which actions were completed, by whom (ID or username), when (date and time), and from where (host address/name) for auditing purposes. For data integrity, The Secure Hash Algorithm (SHA-1), as specified by NIST, will be used to verify that electronic health information has not been altered in transit.

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:

Table 7: One Health Record® Technical Functionality

Core Services
<i>Provider Registry/Directory:</i> The design includes a centralized provider registry that allows providers to register into an account, update, and interface with other providers through a secure web-interface. The

Core Services

provider directory capability includes information from one or more sources that will have the ability to identify providers (individuals or organizations). The directory includes specific levels of security, including authentication and access controls and necessary firewalls. The provider directory and secure web-based service includes both technical functionality and administrative functionality. The provider directory creates a web service for providers to log in or to interface with through their EHR through this web service, which will be based on EHealth Exchange standards and protocols. Each provider has an account interfaced with a robust provider directory that enables secure, authenticated messaging. This service allows providers to exchange basic health information through direct messaging or email attachments. The provider directory was populated with information from Medicaid, Blue Cross and CHIP and will update per provider "hit" with the most current e-mail from the initiator who has logged in through his/her account.

The administrative functionality includes and supports 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 of the mechanism needed to receive the appropriate incentives. The web service includes 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 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 are provided.

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

Privacy: The system supports 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 supports 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 EHealth Exchange / 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 the 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.

Core Services

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

Patient Registry: Centralized patient registry with functionality that 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 eHealth Exchange model. These consent policies provide a consistent source of a consumer’s preferences, thereby enabling patient engagement and provider access to clinical information.

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 eHealth Exchange messaging platform. The intersection of user roles as defined by the user directory and trust models in the proposed solution provided.

Terminology Management (HITSP C83 / C80 Support): This is required to enable uniform transport of the CCDs.

Integration and Message Transformation: Integrated Healthcare Enterprise (IHE) Profile Support (PIX) Manager, XDS Registry, XDS Repository, etc.): Support for the eHealth Exchange 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.

- “To Be” Future State of Other Health Information Technology to Support the Meaningful Use of Health Information:* The state is undergoing major health care transformations and simultaneously developing health-IT to support those changes, which encompass payment reform, changes in service delivery for individuals with chronic illnesses and eligibility expansions. Some of the technical infrastructure that is a part of the Alabama health-IT structure going forward includes the One Health Record[®], including enhancements for public health reporting of immunizations, labs, cancer and bio-surveillance, state enterprise wide data warehouse/repository with analytical capabilities, and an enhanced Medicaid eligibility system. Many of the technologies developed and implemented for One Health Record[®] can and will be leveraged.

The following table provides some of the health-IT enhancements that the state is looking across Medicaid initiatives to reuse or develop.

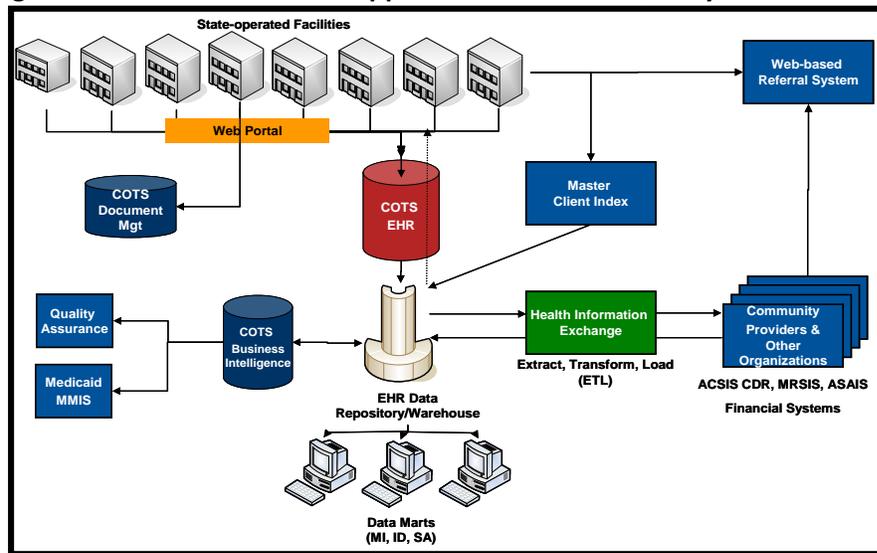
Table 8: Cross Medicaid Initiative Health IT Enhancements

Health IT Enhancement
One Health Record [®] is the single-entry interface that allows constituents to access disparate programs/activities related to health care, including public health reporting

Health IT Enhancement
Health IT infrastructure for cross-agency transfers and referrals relating to responsibility for regulating, enforcement and implementation.
State enterprise wide repository/warehouse with analytic capability.
Standardized authorization and physical and technical security framework.
Identify management as a common service.
Shared common business intelligence, rules engines and reporting functionality.
Service-Oriented Architecture (SOA), where interactions are standardized through messaging protocols and Enterprise Service Bus (ESB) technologies.

The schematic for the data warehouse system architecture to support Medicaid MU Quality Measurement, current and future follows in Figure 14.

Figure 14: Architecture to Support Medicaid MU Quality Measurement



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.)?

The state has contracted with HP (fiscal agent) for its claims and provider management MMIS system. It has contracted with XEROX for its SLR. HP transfers required information regarding Medicaid provider status, etc. to XEROX. The appropriate interfaces between the two vendors are required by Alabama as a part of their vendor contracts.

For the EHR Incentive Program registration and reporting of MU data, the provider interfaces directly with XEROX. Screenshots of the SLR Registration and attestation are provided in Attachment 8.8. The website for the SLR is <http://al.arraincentive.com/>. The One Health Record® website also plays a role as the site provides information regarding MU, a link to the SLR, a checklist for submitting a provider's SLR application, a Workbook for EPs, Workbook for EHs, and information that will help EPs/EHs, in determining their patient volume for eligible professionals and groups. An example of information provided to potential EPs/EHs in the checklist in Figure 16.

Figure 15: SLR Screenshot



Figure 16: MU Checklist



Getting Ready To Submit Your State Level Registration?

Congratulations! You are ready to submit your registrations and attestations for your practice or hospital. Before hitting "Send", here is a checklist to ensure your application is processed as rapidly as possible.

The documents listed below are vital to your attestation – so, leaving any of these off your registration will delay the process and payment until we receive them. Listed below are the documents and the "Step" in the SLR where you upload the documents.

SLR Step	Documents To Be Uploaded
Step 2 Confirm Alabama Medicaid Eligibility	1. Completed Workbook 2. Practice Management System Documentation <ul style="list-style-type: none"> For EPs, this is the source information for the numbers you are reporting to compute your patient volume percentage, and especially for your denominator. For EHs, this includes documentation supporting data that is not included or discernible from your cost report. Such a source may be your General Ledger. ("Note: From the drop-down menu within the "Attach Files" function, you will be able to select either "Eligibility Workbook", or "Practice Management Report" as the appropriate category for your document. You may enter multiple documents.")
Step 3 Attestation of EHR	In Part 1, you are asked to upload documentation that shows proof of your Adopt, Implement or Upgrade (AIU). This must include documents, whether a single document or combination of documents, that prove you have the EHR technology you described for AIU or has obligated you to its acquisition, e.g a signed contract, invoice and payment receipt, etc. In Part 2, you are asked to upload documentation that adequately describes the certified EHR you are claiming. This must adequately describe the EHR product including the name, version, Vendor, and CMS certification number. Again, one or multiple documents may be uploaded for this purpose. An example is a letter from the EHR vendor, on the vendor's letterhead, that adequately describes the product and that it is being provided/sold to you.
Step 4 Review and Sign Agreement	At this step, you will first print out your Attestation Agreement (AA), sign and date it. You must then scan and upload the signed AA back into the SLR.
(Optional Step 3)	Before a payment can be made, we must have a W-9 for the Payee. Providers may assign their payments to a party other than themselves and this "Payee" must be identified at the time of registration at both the NLR and SLR. We will need a W-9 for that payee. A W-9 may be uploaded in Part 2 or Step 3. From the drop-down menu, select "Other" for this purpose.

Any Questions?
Request assistance by:

Telephone: (334) 353-3301 Email: info@onehealthrecord.alabama.gov

Rev: 11/10/11

"To Be" Future State: A-SMA has completed changes that provide for a more automated payment system and integration with the EHR Incentive payment history into the provider's payment history. Payment information is produced in the SLR and transmitted to the FA; however, the actual payments are issued by the MMIS and are thereby captured in the provider's payment history.

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 ORGANIZATION THAT 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.

The development and governance of the A-HIE (One Health Record®) and MU have always been under the auspices of A-SMA. As with many new initiatives, the Medicaid Agency designated a small team to focus on MU and on the initial design, development and implementation of the state HIE technical, technical and business operations, governance, finance and legal/policy areas.

There are two Medicaid areas that address HIT activities. The Utilization Intervention Development and Meaningful Use Administration manages the MU activities and HIT staff that manage One Health Record® activities. Table 9 provides the key staff and consultants along with their roles.

Table 9: Key Staff/Consultants and Roles

Staff/Contract Support	Roles
HIT Coordinator: John Heitman (25% Medicaid and 75% PH)	Provides leadership, direction, management and coordination for One Health Record®.
Director, Utilization Intervention Development and Meaningful Use Administration: Gary Parker	Responsible for MU under the Medicaid Program.
Meaningful Use Project Manager: Janice Miles	Coordinates the efforts set forth by CMS for the implementation and adoption of MU criteria by EPs/EHs in the Medicaid system
Reporting/ Accounting Analyst: vacant	Coordinates the multiple reporting and accounting requirements that must be met through the various funding sources.
HIT Analyst: LaKeshia Powell	Assists other HIT staff in day to day operations of MU.
HIT Analyst: Holly Jarnagin	Assists other HIT staff in day to day operations of MU.
FourThought Group	MU SLR System Development, Operations and Program Implementation Consulting
George Washington University	Subject Matter Expert and Consulting on MU, HIE, and Medicaid IT
Auburn University Montgomery	HIE Project Support
GDH Government Services	Operations, program management, and marketing support.
UAB	Evaluation of health-IT activities under the ONC grant, including the value of One Health Record® to EPs and EHs in meeting MU

Since initial funding for One Health Record® came from the ONC Cooperative Agreement, the process to cost allocate back to Medicaid came later. The initial A-SMHP and I-APD included discussion and a request for Medicaid cost allocation funding. The funding approval from CMS

addressed the state's request for funding relative to the SLR, but did not include the Medicaid share for human and technical resources for One Health Record® beyond staffing. The state re-submitted the cost allocation request as a part of an I-APD that was submitted in early 2012. The I-APD has been approved. All relevant contracts have been submitted to CMS for review and approval with the HIE project support contracts submitted simultaneous to the submission on this A-SMHP.

"To Be" Future State of the Alabama Utilization Intervention Development and Meaningful Use Administration Division: A-SMA has undergone some organizational changes, including a name change to Utilization Intervention Development and Meaningful Use Administration Division. The HIE activities are within A-SMA but transitioned to another component of A-SMA.

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 A-SMA will continue the multiple and diverse activities it has taken in the past to encourage provider/hospital adoption of certified EHR technology, including presentations within the state and focused efforts in cooperation with the REC. For those providers who were not eligible for a particular Program Year, Medicaid staff will have already worked with each provider to exhaust every effort to establish eligibility for the incentive program. As an active participant in this process, once it was clear that the provider could not meet the Medicaid encounter threshold to establish eligibility for the program year, each provider was already aware of their status. Therefore, every provider who is deemed ineligible for an incentive payment is aware before formal notification. New and expanded efforts include site visits to potential "early innovator" gateways, a targeted geographic "proof of concept" pilot, targeted strategies with Patient 1st providers and networks, and a focused outreach initiative through Tuskegee University in the Black Belt counties that can be taken statewide. The Tuskegee University Outreach Plan and an example of a weekly status report are included in Attachment 8.3. As the end of the program year approaches the status of all EH accounts are reviewed and an individual communication is sent to any EH that has not submitted an attestation for the year detailing the current status of successful attestations and the requirements for attestation for the next program year. A sample of the communication is shown in Attachment 8.22.

The A-SMA, as a part of the One Health Record®, has a detailed communications plan for engagement of providers, the state legislature and other stakeholders. The communications/marketing plan was included in the initial A-SMHP. The Communications and Marketing One Health Record® Workgroup has moved from planning to implementation. An example of a communication tool (post card) that has been developed to engage providers in one of the priority areas for MU, e-Prescribing, follows. Figure 17 provides an illustration of the e-prescribing fact sheets and brochures that can be found in detail in Attachments 8.1 and 8.2.

Figure 17: e-Prescribing Tools Examples



In addition and specifically related to the changes effective January 2014 related to Stage 2 MU, A-SMA will provide outreach to providers via e-mail, website updates, webinars, and dissemination of information to provider and hospital associations. A-SMA is providing training to the AL-REC staff on the changes to the MU requirements and coordinating with AL-REC to engage Critical Access Hospitals to achieve Meaningful Use. The One Health Record® website has also been updated and enhanced.

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?

As indicated in Section 2, 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. Because of the location and involvement of the APHCA and their critical role in the state, the state is considering the possibility of APHCA becoming a gateway for One Health Record®.

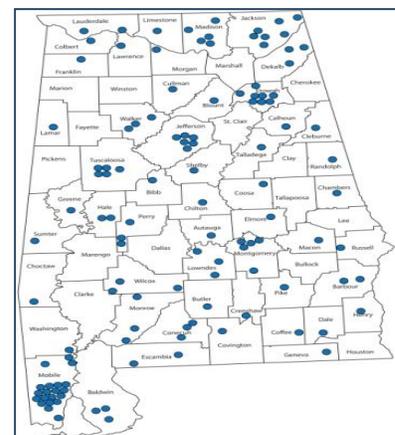


Figure 8: Alabama FQHCs

Through the APHCA leadership, several initiatives that support Alabama’s HIT vision are underway including EHR deployment. FQHCs are high volume 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 One Health Record®.

3.7 HOW WILL THE SMA ASSESS AND/OR PROVIDE TECHNICAL ASSISTANCE TO MEDICAID PROVIDERS AROUND ADOPTION AND MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY?

A-SMA has numerous explicit strategies for continuing to assess (significant assessment has already been completed) Medicaid providers’ adoption and meaningful use of certified EHR technology. For those providers who were not eligible for a particular Program Year, Medicaid staff work with each provider to exhaust every effort to establish eligibility for the incentive

program. As an active participant in this process, once it is clear that the provider cannot meet the Medicaid encounter threshold to establish eligibility for the program year, each provider is already aware of their status. Therefore, every provider who is deemed ineligible for an incentive payment is aware before formal notification.

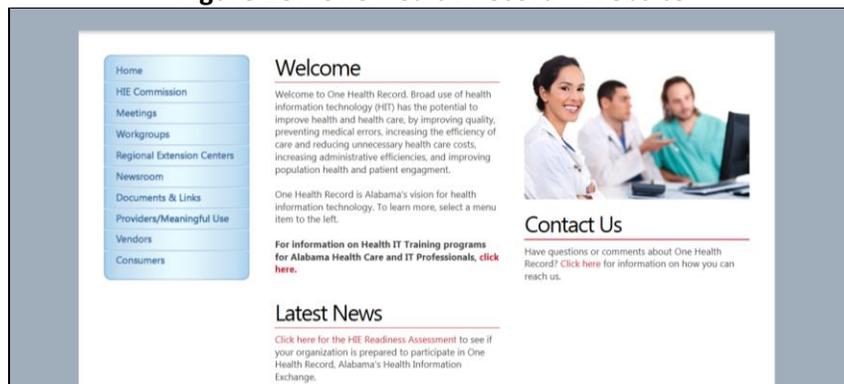
In addition and specifically related to the changes effective January 2014 related to Stage 2 MU, A-SMA will provide outreach to providers via e-mail, website updates, webinars, and dissemination of information to provider and hospital associations. A-SMA is coordinating with AL-REC to engage Critical Access Hospitals to achieve Meaningful Use.

The state also has initiated and has plans for many technical assistance (TA) strategies through the EHR Incentive Payment and One Health Record® implementation processes, REC, and state staff/contractor initiatives. The state has engaged with the Department of Defense regarding connectivity and the state plans to initiate discussions with Medicare in the future implementation of One Health Record®.

Alabama has employed a number of methods for providing technical assistance to and engaging the provider community as part of the launch of its meaningful use program. They include:

- Participation in numerous presentations to provider groups and associations, conferences and workshops throughout the state.
- The One Health Record® website (www.OneHealthRecord.alabama.gov) publishes information on a regular basis to educate providers about meaningful use of electronic health records and eligibility for the incentive payment program. The website has been updated and enhanced.

Figure 18: One Health Record® Website



- Specific information is provided about all aspects of the Meaningful Use program, including an e-mail address and direct telephone contact number.

Figure 19: Meaningful Use

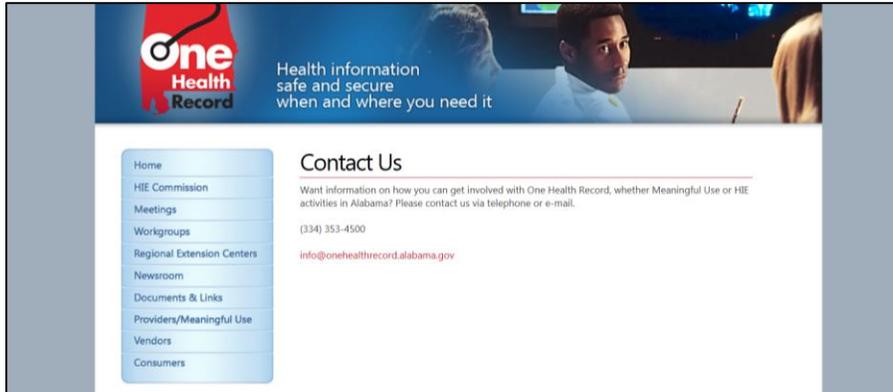


Figure 20: Overview of MU Program

Alabama's Meaningful Use Incentive Payment Program Eligible Professionals

Medicare or Medicaid—Which is Right for Me?		Patient Volume Requirements
<p>Medicare</p> <ul style="list-style-type: none"> • Pays up to \$44,000 over 5 years* • Program spans 2009—2015 • Must meet criteria every year • Must participate consecutive years • Payment adjustment beginning 2015 • Must meet meaningful use measures day one 	<p>Medicaid</p> <ul style="list-style-type: none"> • Pays up to \$63,750 over 5 years • Program spans 2009—2015 • Does not have to be consecutive years • Must begin program by 2016 • No payment adjustment • Provides for a period to Adopt, Implement or Upgrade 	<p>There are Three Patient Volume Thresholds—</p> <ol style="list-style-type: none"> 1. Minimum of 50% Medicaid patients (as a ratio of total patient volume) 2. Pediatricians ONLY can have a minimum of 20% Medicaid Patient Volume (once achieved payment of 25% of the total incentive) 3. EPs practicing in FQHCs or RHCs 50% of the time can use newly individuals in meeting patient volume requirements.
<p>Medicaid Eligible Professional Requirements</p> <p>Medicaid Eligible Professionals Include:</p> <ul style="list-style-type: none"> ⇒ Physicians (all types) ⇒ Nurse Practitioners ⇒ Certified Nurse Midwives ⇒ Dentists ⇒ Physician Assistants (PAs) working in either a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) that is led by a PA. (PAs working in a physician led clinic are NOT eligible) 		<p>Defining Patient Volume</p> <p>Encounters (also: Claims)</p> <ul style="list-style-type: none"> • Services provided to a Single Person on a Single Day • All papers must be considered in determining the encounter denominator <p>Managed Care Providers</p> <p>PMPs may include additional panel members if:</p> <ul style="list-style-type: none"> • Patient not Member • Medicare Advantage Members • Maternity Care Patients • Not seen in the reporting period, then there is a 12 month look behind period • Look behind is based on panel members at the end of the reporting period • Patient not Panel Group assignments may be averaged among EPs
<p>Medicaid's Focus—The First Year</p> <p>Adopt, Implement or Upgrade (AIU)</p> <ul style="list-style-type: none"> • No time period required for use of EHR technology • Eligible Providers must meet criteria (definition of EP and Medicaid Patient Volume) <p>Adopt—EP has acquired, purchased or secured access to certified Electronic Health Record (EHR) technology.</p> <p>Implement—EP has commenced using certified EHR technology (e.g., staff training, data entry of patient demographics, data use agreements)</p> <p>Upgrade—EP has upgraded an existing EHR system to certified technology (e.g., added new or expanded functionality)</p>		<p>Medicaid Encounter</p> <p>If costs are paid or partially paid by Medicaid, then the provider may include these in their numerator:</p> <ul style="list-style-type: none"> • Claims paid amount must be greater than zero • Includes premiums, co-pays, or other cost sharing <p>Newly Individuals</p> <ul style="list-style-type: none"> • All or part of the service paid by Medicaid and/or the Alabama CHIP Program • An individual that paid on a sliding scale • Uncompensated Care <p>Group Volume/Multiple Practice Sites</p> <p>Groups may elect to use a group calculation if:</p> <ul style="list-style-type: none"> • ALL providers practice at the same level • Volume applies to all eligible EPs within the group
<p>EHR System Certification</p> <p>Providers must register the EHR system using the "Chapel" website: http://onc-chplatform.com/ehrcert (CHPL—Certified HIT Product List)</p> <ul style="list-style-type: none"> • Upon verification of Accreditation, a code is issued • The code must be entered into the State Level System • The state validates this code against the National Listing 		<p>http://onehealthrecord.alabama.gov http://al.com/news/one</p> <p>Health information, safe and secure, when and where you need it.</p>

3/9/2011

- Alabama's State Level Registry (Figure 21) also includes a Provider Outreach Page that contains comprehensive and detailed information to assist with applying for the Incentive Payment Program, but links to related information at CMS and other HealthCare IT news.

Figure 21: Provider Outreach Page on Alabama's SLR



- As part of the launch of the Incentive Payment program, Alabama conducted weekly webinars twice daily for eligible providers and hospitals throughout the state and provided an opportunity for providers to ask questions directly of HIT staff. The State Level Registry was demonstrated during the webinars, staff direct phone numbers were shared and providers were encouraged to contact staff directly to assist with establishing incentive program eligibility and submitting attestations.
- Regular distribution of HIT related information on the state’s listserv.
- Alabama routinely reviews the database of providers that have started the attestation process and, after an extended period of time has elapsed, have not completed submission. The providers are contacted to determine the reason for the incomplete submission and technical assistance is offered to complete the attestation.
- Similar assistance is provided for those providers whose applications are pended during the review process. Providers are contacted via e-mail or directly by telephone to assist with the completion of the attestation.
- For those providers who are not eligible for a particular Program Year, Medicaid staff work with each provider to exhaust every effort to establish eligibility for the incentive program. As an active participant in this process, once it is clear that the provider cannot meet the Medicaid encounter threshold to establish eligibility for the program year, each provider is already aware of their status. Therefore, every provider who is deemed ineligible for an incentive payment is aware before formal notification.

“To Be” Future State for Assessing Adoption and Meaningful Use & TA Strategies: The State has initiated a targeted geographic approach to align with the Medicaid RCO development and implementation. The state has prioritized groups of safety net and small providers to assure “no

one is left behind”, including Patient 1st Primary Medicaid Providers (PMPs) and Networks, RCO potential providers, FQHCs through APHCA, and providers serving the underserved in the Black Belt counties. A-SMA through the ONC Cooperative Agreement has also prioritized strategies and assessments focused on 3 priority areas for MU: e-Prescribing, Lab Exchange and Care Summary Exchange. Information on the results of those efforts were presented in in Section 2.0.

The A-SMA is entering into a contract with the REC for TA and has included performance metrics and deliverables that are focused on assessing adoption and meaningful use by EP-types and EHS, particularly rural hospitals and providers. In addition, A-SMA has established performance metrics for the MU auditors to assure that as EPs and EHS move from AIU to Stage 1 and Stage 2 that the meaningful use requirements are met.

3.8 HOW WILL THE SMA ASSURE THAT POPULATIONS WITH UNIQUE NEEDS, SUCH AS CHILDREN, ARE APPROPRIATELY ADDRESSED BY THE EHR INCENTIVE PROGRAM?

The underserved geographic areas and individuals with chronic conditions have been addressed previously in this document. Please see Sections 2.11, 4.13 and 6 for further information regarding individuals with chronic conditions. Section 2.9 explicitly addresses underserved geographic areas.

Children, who make up the largest portion of the Alabama Medicaid Program, are another population focus for One Health Record[®]. Alabama has a stand-alone CHIP program through the ADPH and administered by A-BCBS, both members of One Health Record[®] Advisory Commission. Pediatricians and family physicians, whose practices are extensively Medicaid, are represented on the One Health Record[®] Advisory Commission by Linda Lee, Executive Director, Alabama Chapter American Academy of Pediatrics, and Jeff Arrington, Executive Vice President, Alabama Academy of Family Practice Physicians.

“To Be” Future State for Children: One of the critical delivery systems for children is the Children’s Hospital in Birmingham, which is being considered as an “early innovator” gateway. The children’s hospital has received its first EHR Incentive Payment for AIU. The state is also considering Patient 1st PMPs and Networks in their implementation strategy to support their strategies related to health home for individuals with chronic conditions, including children.

As indicated in the initial A-SMHP, Alabama has represented the CHIP program on the IOM Pediatric Quality Measures effort and the AHRQ quality measurement process under the CHIPRA legislation. Additionally, Alabama 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 A-SMA Deputy Commissioner and Medical Director, Dr. Moon, provides a leadership role on the One Health Record[®] Advisory Commission, is a part of the leadership team for Patient 1st, and has overall management responsibility for the MU. Dr. Moon is chair of the AHRQ funded Medical Directors Learning Network, where he has led targeted efforts to leverage the reporting of MU measures for more than the EHR Incentive Payment Program.

While the focus for 2014 moves from AIU to MU Stage 1 and Stage 2, including changes that have resulted from the final MU Stage 2 rule, A-SMA 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. The state has created a table of all the MU measures, including the proposed for Stage 2 and Stage 3, proposed CHIPRA Children, Medicaid adult, ACO and Hospital Value Based Purchasing measures (a copy can be provided to CMS upon CMS's request). The evolving document has provided a tool to assure quality measurement for all populations, including children and other underserved populations, is coordinated.

3.9 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.?

“To Be” Future State Leveraging across Initiatives: The state has a commitment to utilize human and IT resources, policies and procedures, and technical and business operation processes across initiatives to enhance the benefits and reduce costs. Using the MITA framework, A-SMA seeks to approach issues functionally rather than by initiative, such as member, provider, contractor, operations, program and program integrity management. Examples of leveraging across initiatives were reported in previous sections.

- Section 1.2, which spoke to the use of Medicaid staff and contractors to support MU and One Health Record®, fully utilizing the ONC Cooperative Agreement funding and the knowledge gained through the design, development and implementation process.
- Sections 1.5 and 2.5, which discussed the common One Health Record® A-SMA Advisory Commission and work groups established for the ONC Cooperative Agreement and used for stakeholder input into the initial and updated A-SMHP. Section 1.5 also addressed the involvement of Alabama with other states, ONC and CMS regarding MU and HIE issues and opportunities to learn and share.
- Section 2.10, which identified how the REC has supported the Medicaid Agency's effort to promote and engage targeted EPs in using certified electronic health records.
- Section 3.2, which addressed the proposed leveraging of health-IT infrastructure across the ONC State Cooperative Grant, the EHR Incentive Program and the Medicaid eligibility system.
- Section 3.8, which addressed the use of MU quality measurement across health home, CHIP and Medicaid quality initiative. (Figure 22).

Figure 22: Measures Document Table of Contents

**Meaningful Use Measures - CHIPRA Children Measures - Medicaid Adult Measures -ACO
Measures -Hospital Value-Based Purchasing Measures
October 27, 2011**

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3.10 DOES THE SMA ANTICIPATE THE NEED FOR NEW OR STATE LEGISLATION OR CHANGE 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.

The state may or may not seek state legislation in the upcoming legislative session. The A-SMA, through a State Plan Amendment, expanded the definition of a physician to allow optometrists to be eligible as an EP and receive, upon meeting all the requirements, an EHR incentive payment.

Privacy and security issues are being addressed through the One Health Record® Participation and Data Use and Reciprocal Support Agreement (DURSA) and a Business Associate Agreement between One Health Record® and participants, both which are in final draft and available to CMS upon request. Based on clarifications from SAMSHA, the state has also created a Qualified Service Organization Agreement (QSOA).

If an unanticipated issue arises that requires legislative action, the A-SMA will address the need at that time.

Figure 23: State QSOA
AHIE
 Qualified Service Organization Agreement (QSOA)
 (for Participants with Substance Abuse Records)



As of the Effective Date, OneHealthRecord ("AHIE") and the undersigned Participant hereby enter into a qualified services organization agreement ("QSOA"), whereby the AHIE agrees to provide the Participant with services outlined in the Participation Agreement/DURSA. By virtue of this Participation Agreement/DURSA, substance abuse information may be electronically shared, and this QSOA is established in order to adequately meet the terms of the Participation Agreement/DURSA.

Furthermore, the Parties:

1. acknowledge that in receiving, transmitting, transporting, storing, processing, or otherwise dealing with any information from the Participant's substance abuse program about patients in the substance abuse program ("protected information"), they are fully bound by the provisions of the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2; and the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R., Parts 142, 160, 162 and 164, and may not use or disclose the information except as permitted or required by this QSOA or by law;
2. agree to resist any efforts in judicial proceedings to obtain access to the protected information except as expressly provided for in the regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2.
3. agree to use appropriate safeguards to prevent the unauthorized use or disclosure of the protected information.

Executed this ____ day of _____, 20____, which is the Effective Date.

<u>AHIE</u>	<u>PARTICIPANT</u>
By: _____	By: _____
Printed Name	Printed Name
Signature	Signature
Title	Title

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

Standard: One of the stated priorities of the One Health Record® A-HIE Strategic and Operational Plans (S/Ops) is 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 S/OPs with the A-SMHP”. This remains a top priority as the state continues to move from concept to implementation for One Health Record®, from AIU to MU Stage 1 and from MU Stage 1 to MU Stage 2.

Methodology: Alabama has put the patient in the center, built upon existing resources to create a bold vision that’s incrementally implemented to support both EP’s and EH’s health-IT needs so that they might qualify and receive MU incentive payments and foster innovation.

Process: A-SMA complies with all federal requirements and CMS guidance and is transitioning its focus from AIU and the more manual efforts required for implementation into MU and increased automation. It is evolving from an office that handled all components of the efforts for One Health Record® and MU into integrating some of the activities in their appropriate division within Medicaid, for example, incentive payments will be issued through the MMIS and captured in the provider payment history.

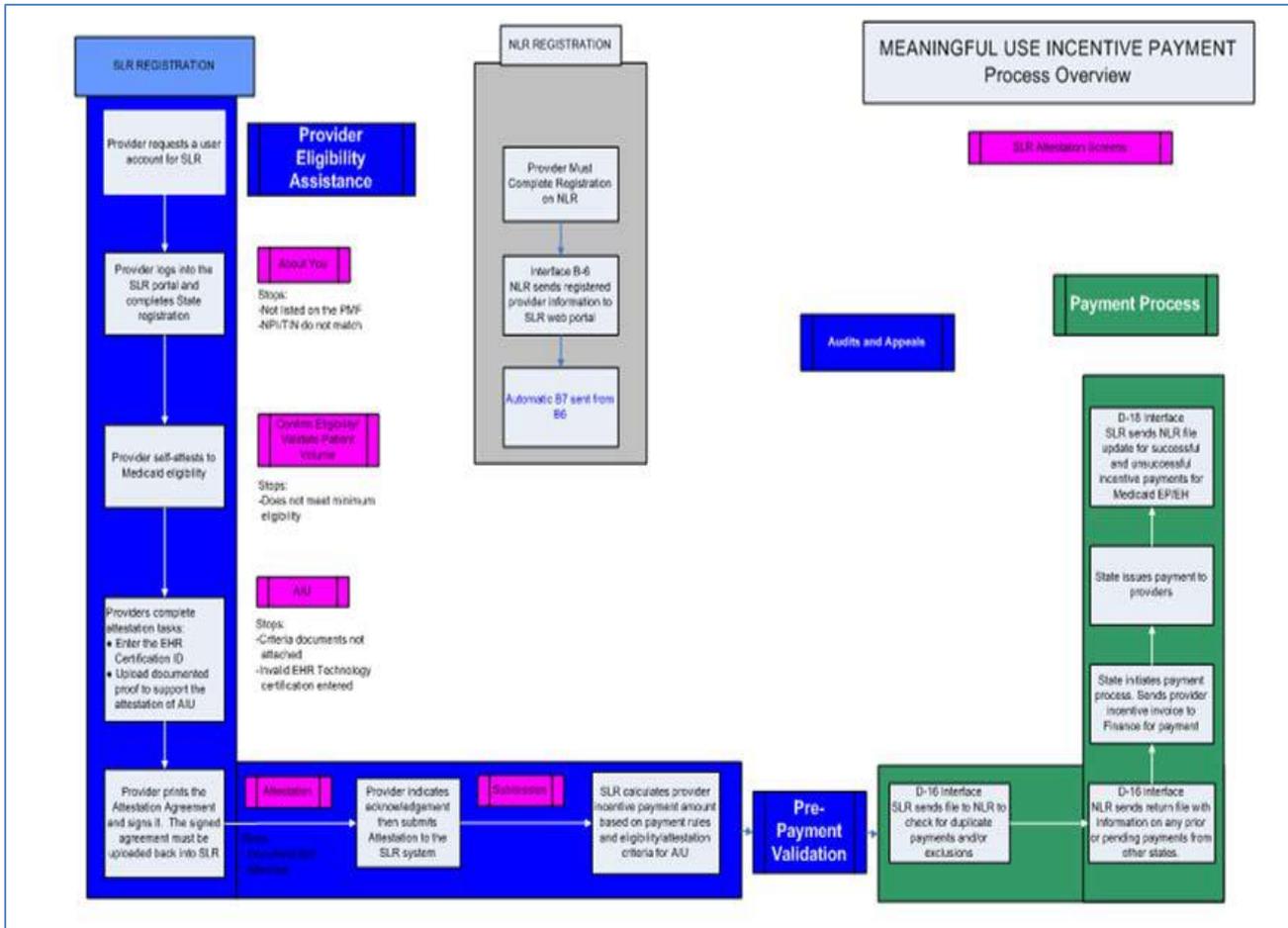
There are four (4) components of the overall strategy to administer and oversee the EHR Incentive Payment Program:

- Pre-payment Processes, including provider eligibility assistance, registration and attestation;
- Payment Processes;
- Post-payment Processes, including processes for review and validation of meaningful use payments; and
- Statewide Infrastructure Assurance that the technical architecture is available to providers and consumers for private and secure messaging and exchange of information through DIRECT and/or CONNECT to other providers, public health and Medicaid for purposes of reporting on MU measures.

MU registration and attestation tools to help providers determine their potential eligibility are provided in Attachment 8.7. Screenshots for the SLR registration and attestation pre-payment process are provided in Attachment 8.8. The processes for review and validation of the MU Incentive Payments are available in Attachment 8.9. Examples of screenshots for the SLR update effective January 1, 2013 are provided in Attachment 8.13, and the screenshots for Stage 2 changes effective Program Year 2014 are provided at the end of this document in Attachments 8.17 and 8.18. Both sets of screenshots are approved by CMS; however the Stage 2 screenshots incorporate corrections to the CQM screens issued by CMS on 9/26/2013. The Stage 2 screenshots were submitted to CMS by Alaska on behalf of the states in the Xerox User Group consortium and were approved as submitted. The state has created and separated the

confidential Meaningful Use Incentive Payment Program Audit Requirements and Procedures for AIU and previously provided it to CMS as a separate, stand-alone document. The State’s approved Audit Strategy to address MU is provided in Section 5.

Figure 24: SLR Registration



The state and its vendor, XEROX, have developed multiple tools to enable eligible providers and hospitals to establish that they have satisfied the minimum requirements. For example, one of the tools from Attachment 8.7 that was updated to address the Stage 1 MU changes effective 1/1/13 and is updated as needed in response to provider input is the EP Patient Volume Worksheet included in Attachment 8.20.. The updated patient volume worksheet for EPs is provided in Figure 25 and Attachment 8. 20

**Figure 25: EP Patient Volume Worksheet
Updated 11/1/13**

Eligible Professional (EP) Workbook to determine Eligibility for the Alabama Medicaid EHR Incentive Program

Overview: This workbook is required for EACH year of attestation and is designed to help you collect information needed to complete the Eligibility components of the SLR. In particular, this workbook will assist you in determining your Alabama eligibility by guiding you in the computation of your Alabama Medicaid patient volumes. Please use this workbook in conjunction with the EP Tipsheet located at <http://onehealthrecord.alabama.gov/providers>.

General notes/instructions for completing this workbook:

1. Each EP must complete the Tab named "Patient Volume REQUIRED" of this Workbook. The "Additional Encounters", "FOHC or RHC Needy Individuals" and "Group Member List" Tabs are all conditional. **All SLR Attestation documents** must be retained for your records for a period of 6 years and serve as an auditable source of your attestation information.
2. A. If you perform 90% or more of your Medicaid services in an Inpatient hospital (POS 21) or emergency room (POS 23) OR B. If you Practice Primarily in a Tribal Health Program Clinic or a Federal Clinic without an Alabama license OR C. If you are a Physician Assistant (PA) and DO NOT practice predominately in a PA led FOHC or RHC: **You are NOT eligible to participate in the Alabama Medicaid EHR Incentive Payment Program.**
3. An EP must achieve at least 30% Alabama Medicaid patient volumes, though Pediatricians who achieve a 20-29% volume may qualify to receive a reduced incentive payment amount. However, Pediatricians who practice predominately in a FOHC/RHC must achieve at least 30% volume.
4. Your completed EP workbook must be uploaded into the State Level Registry (SLR). In Step 2 of the attestation process, there will be an "Add Files" button and from the drop-down menu, select "Eligibility Workbook" as the subject and then add the file.
5. Documentation to support the Encounter information you enter in this workbook and the SLR is also required to be uploaded in Step 2 of the SLR. The total patient encounters (all payers) and the total Medicaid encounters must be clearly documented. Total Encounters will be your denominator and total Medicaid encounters will be your numerator in calculating your patient volume percentage. This time, in Step 2, add files, you will select attachment subject of "Practice Management Report", which can represent any system or source of documentation you relied upon to capture the data being reported. Rather than a large file, you may upload only a summary report, title page, or a representative sample that describes the system or source of the information being reported. If the Practice Management Report does not provide enough identifying information such as EP Name, EP Individual NPI, 90-day Representative Period, Group Name (if applicable), Group NPI (if applicable), then you may hand write it on the report. Please include as much detail/clarification as possible.
This is the NUMBER ONE reason applications are PENDED!
6. If you are a CRNP working under Physician Supervision, with no claims under your NPI, you will be asked to provide an employment statement to verify your employment during the representative period in which you are attesting.
7. If you are an OB/GYN and use encounters not billed to Medicaid because they are included in the Medicaid global payment policy, please include supporting documentation of that as well in addition to your Practice Management Report.
8. This workbook is designed for Eligible Professionals only. A different workbook is used for Eligible Hospitals.

Confirm Alabama Medicaid Eligibility (Step 2 of the SLR)

Additional Encounters Worksheet

Please contact the State Level Registry Helpdesk @ 866-879-0109 for assistance with this Tab. **This Tab should only be used if you did not meet the required Patient Volume percentage. (Denominator and Numerator on the Patient Volume Tab).**

Additional Encounters (1)	
Those Alabama Medicaid Managed Care Panel (Patient 1st) Members Seen in the Look-Behind Period (Medicaid Agency can assist)	0

Additional Encounters (2)	
(A) Medicaid Dual Eligibles in a Medicare Advantage Panel Counted in Total Encounters but NOT Total Medicaid Encounters on the Patient Volume Tab.	0
(B) Those Seen In Look Behind Period	0

Additional Encounters (5)	
Patients for Whom Medicaid Paid Medicare Part B Premium and were counted in your Total Encounters (Patient Volume Tab) and NOT counted in your Total Medicaid Encounters (Patient Volume Tab)	0

Additional Encounters (3)	
(A) Medicaid Maternity Care Program -OB Patients NOT already captured in Total Medicaid Encounters but were counted in Total Encounters on the Patient Volume Tab	0
(B) Currently enrolled Medicaid Maternity Care OB Patients not counted in (3A) nor on the Patient Volume Tab but were seen ONLY during the look-behind period.	0

Additional Encounters (4)	
Those NON-Medicaid Managed Care Panel Members Not already counted in Total Encounters in the Patient Volume Tab but Seen ONLY in the Look-Behind Period.	0
If you count any Medicaid patients in the Look-Behind period, then you MUST complete "Additional Encounters (4) if not already included in Additional Encounters (1), (2B), and (3B).	

Additional Encounters (6)	
Individuals enrolled in a Medicaid Program but who encounters are NOT paid by Medicaid	0

	Numerator	Denominator	Patient Volume
Total Encounters	0	0	
Total Medicaid Encounters	0		#DIV/0!
Additional Encounters (1)	0	0	#DIV/0!
Additional Encounters (2A)	0		#DIV/0!
Additional Encounters (2B)	0	0	#DIV/0!
Additional Encounters (3A)	0		#DIV/0!
Additional Encounters (3B)	0	0	#DIV/0!
Additional Encounters (4)		0	#DIV/0!
Additional Encounters (5)	0		#DIV/0!
Additional Encounters (6)	0		#DIV/0!
Total	0	0	#DIV/0!

All Information below is required for "Additional Encounters" Tab Only

Assistance Provided by:	
Date Completed:	
Person Completing this workbook	
Contact Person Name	
Contact Person Phone #	
Contact Person Email	

updates for those MU Stage 2 changes effective with Program Year 2014 in Attachment 8.17 and 8.18.

Figure 26: SLR Provider Incentive Payment Screenshots

EHR Certification

Providers must provide information demonstrating that their EHR technology is certified through the Office of the National Coordinator (ONC). The ONC Certified HIT Product List (CHPL) contains the list of all certified EHR technology products and is used by the providers to generate the unique EHR Certification ID that represents the system or combination of modules that is capable of meeting Meaningful Use. The State is required to validate the verification of the Certified EHR information before making any payment to providers.

It is the provider's responsibility to generate an EHR Certification ID that accurately reflects the complete EHR or combination of modules representing a complete EHR used by the provider before attesting to the State. Failure to do so could result in a false negative result that may disqualify the provider from receiving payment.

To proceed, please indicate your understanding of this responsibility by agreeing to the following statement: [more info...](#)

I understand that it is my responsibility, as the provider, to ensure that my certified EHR technology code is listed on the [ONC public web service](#) before submitting my attestation to the State. I understand that failing to ensure my code is listed may result in a false negative result that may disqualify me from receiving payment. ✓

Your EHR Certification Information

EHR Certification Number ✓

- 1) Go to the ONC website: <http://onc-chpl.force.com/ehrcert>
- 2) Search for your product(s) and add each to the shopping cart by clicking "Add to Cart"
- 3) When you have added all product(s) to your shopping cart, click the "View Cart" link
- 4) Click "Get CMS EHR Certification ID"
- 5) Your CMS EHR Certification ID will be displayed on the screen. This is the number you will need to enter above as a part of your attestation.

NOTE: ONC does not allow you to mix inpatient products and Ambulatory products together to represent a complete EHR solution. Additionally, if the product(s) you add to your shopping cart do not represent a complete EHR solution capable of achieving meaningful use criteria, you will not be able to click "Get CMS EHR Certification ID" in step 4.

Attach Documentation

At least one of the following are required: ✓

- Contract
- Action plan
- Invoice
- Invoice
- Vendor Letter
- Receipts for Software EHR Vendor
- Sales Contract
- Service Performance Agreement
- Screenshot of the Sign-on
- Copy of the Agreement for Upgrade
- Cost Report
- Other

File Name	Subject	Remove
No records to display.		

- Upon receipt of a completed, submitted attestation, the state reviews the application to validate information provided and makes a decision to either reject or approve the provider's application for an incentive payment.

The SLR system performs the following validation process and during the provider's application process, any step that is not validated prevents the provider from continuing the attestation process until that step is performed satisfactorily.

The SLR has six (6) distinct steps in the state registration and attestation process:

- Account Creation
 - Step 1: Identification and Eligibility
 - Step 2: Medicaid Eligibility
 - Step 3: AIU – Adopt, Implement or Upgrade
- MU – Meaningful Use of CEHRT
 - Step 4: Attestation Agreement to All Provisions
 - Step 5: Submission of Attestation

Table 14: SLR System Validation Process

Attestation Component	System Validation	State Action	Provider Action
Provider’s Credentials: Submit TIN and NPI	Confirms matching TIN/SSN and NPI are registered in the CMS Registration and Attestation System and are valid in Medicaid’s Provider Master File	None	Correct erroneous information and re-enter data to the CMS Registration and Attestation System. Provider may contact Medicaid’s Provider Enrollment Section for assistance.
Provider is not a hospital based physician.	<p>Provider must attest through “checkmark” that he/she does not provide 90% or more of services in an inpatient hospital (21) or emergency room setting (23). Defined as services are provided in POS 21 or 23.</p> <p>Changes to the Stage 1 requirements effective January 1, 2013 related to the definition of hospital based physician have been addressed.</p>	Provider is compared to the POS report maintained by the State and if POS 21 or 23 is greater than 75% and less than 90%, of <i>Medicaid</i> encounters, flag for post payment audit.	None
Professional License Number and Provider Status	<p>SLR will validate the provider’s License Number on the Provider Master File & current status including:</p> <ul style="list-style-type: none"> • The PMF shows an active status • Does not show a “sanctioned” status • Does not show status of deceased 	None	If the provider receives an error message they must contact either the SLR Help Desk or the Medicaid Provider Enrollment section at the number provided on the screen.

Attestation Component	System Validation	State Action	Provider Action
<p>Medicaid Eligibility: Provider must meet patient volume of at least 20% Medicaid encounters for pediatricians and 30% for all other designated providers</p>	<p>Numerator and denominator information entered by provider must be at least 20% of pediatrician patient volume and 30% of all other providers' total encounters.</p> <p>For patient volume, encounters are defined to include all services rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability, including zero-pay claims and encounters with patients in Title 21-funded Medicaid expansions, but not separate CHIPs. Since Alabama's CHIP program is a stand-alone, those patients will not be counted</p> <p>The expanded definition of encounters from previous 12 months to previous 24 months will be implemented to attestations submitted for program year 2013 forward; existing regulations and guidelines will continue to apply to attestations through the 2012 grace period.</p> <p>Alabama currently requires each provider to submit a workbook detailing how Medicaid encounters were determined and reports from an auditable source (such as a Practice Management System) to support the data submitted. Information on the State website, and the SLR was revised to incorporate the expanded definition.</p>	<p>All Medicaid encounters for the numerator will be validated by the agency. If the Medicaid claims reported by the provider are 15% higher than the Medicaid claims of record, the file will be flagged for post payment audit.</p> <p>If panel information is included and the information was not obtained from the Agency, AHIE will run reports from the following systems to confirm panel information: Patient First, Medicare Advantage, and Medicare dual eligible patients. If additional information causes the Medicaid patient volume to drop below 30% (20% for pediatricians), the provider is not eligible.</p>	<p>If provider does not meet minimum patient volumes percentage with Medicaid encounters, provider may obtain assistance from Medicaid and apply patient encounters from panel members in the following programs: Patient 1st, Medicare Advantage, Maternity program, or Medicare dual eligible patients. Providers will not be able to continue through the SLR until volume requirements are met.</p>
<p>Total Encounters</p>	<p>Medicaid Patient Volume/Total Patient Volume > or = 30%, 20% for pediatricians</p>	<p>The summary report from the provider's practice management</p>	<p>SLR System will not allow provider to proceed if</p>

Attestation Component	System Validation	State Action	Provider Action
		<p>system is reviewed to substantiate the total patient volume. Medicaid will select a statistically valid sample of provider denominator reports for further review and potential audit. (Also see Numerator data that is flagged for audit.)</p>	<p>volumes do not meet criteria.</p> <p>Alabama currently requires each provider to submit a workbook detailing how Medicaid encounters were determined and reports from an auditable source (such as a Practice Management System) to support the data submitted. Information on the State website and the SLR is being revised to incorporate the expanded definition</p>
Additional Medicaid Encounters	None	Same as State Actions under “Medicaid encounters” above	
Provider practices in an FQHC/RHC	None	The agency will verify provider’s employment in an FQHC/RHC against information provided by APHCA. If provider is not on the provided list, the agency will contact the FQHC for additional information.	None
Medically Needy Patient Volumes	<p>Only applicable to providers attesting to practicing in an FQHC or RHC.</p> <p>Changes as a result of the MU Final Regulation have been incorporated effective 1/1/13.</p>	Medically Needy patient volumes submitted must match volumes included in the APHCA report for FQHC. If no match, contact the provider for clarification. If there is a discrepancy of over 10%, flag completed attestation for post payment audit. For Medicaid volume percentages below 30% (20% for pediatrician),	Contact APHCA to revalidate volumes.

Attestation Component	System Validation	State Action	Provider Action
		STOP, provider is ineligible.	
Alabama Medicaid Volume Hospital Demographics Information	<p>The SLR system validates that the percentage of Medicaid patients is 10% or above.</p> <p>Changes as a result of the MU Final Regulation have been incorporated effective 1/1/13</p>	All information to establish eligibility for the program is based on the hospital's annual cost report submitted to Medicare and to the Medicaid Agency. Staff compares the data submitted in the SLR to the hospital cost reports. If the data submitted does not match the data on the cost reports, staff will contact the hospital representative for clarification.	Correct attestation data and resubmit.
Provider's attestation of Adoption, Implementation or Upgrade of EHR.	Method of compliance is selected and documentation of adoption, implementation, or upgrade of an EHR is present.	<p>Validate the appropriate documents are submitted for attestation of AIU against the following list:</p> <ul style="list-style-type: none"> • Receipts for Software EHR Vendor • Sales Contract or Agreement • Copy of the Agreement for Upgrade • Vendor Letter containing EHR description, version, and ONC certification number • Work Plan (EH) • Invoice • Other 	Upload acceptable attestation document
The provider must attest to the meaningful use of CEHRT	Based upon the previously submitted attestation, the system calculates the appropriate MU Stage, Payment Year, Attestation	None	None

Attestation Component	System Validation	State Action	Provider Action
for the appropriate Stage.	Period (90 days or 1 Year), to which the provider may attest.		
The provider must submit certification number of provider's ONC certified EHR Technology	The system validates the certification number against the ONC Certified HIT Product List database.	Verify that the certification number submitted matches the EHR technology to which the provider attested. If the certification number does not match, contact the EP/EH representative for clarification and pend the application.	Submit correct certification number.
Provider must sign and attach the Attestation Agreement.	A document is present	Review and confirm that: <ul style="list-style-type: none"> • Attestation Agreement is present. • Entries 7-10 match information submitted by provider. • Signature of EP of record or EH representative of record and current date is present. If any of the above conditions are not met, contact provider for a properly executed document. Pend the attestation pending receipt of the correct document.	Upload Attestation Agreement with correct signature and current date

For the EP validation process, the reviewer will review the following documents, which have been updated to accommodate changes as a result of the MU final regulation effective payment year 2013.

Table 15: EP SLR System Validation Process

Provider Place of Service (POS) Report
 APHCA List of FQHC Provider Information
 Program Integrity Review/Investigations List
 Patient Volume Worksheet or Excel List Created by State Staff
 EP Workbook
 Practice Management Summary Report Supporting Provider's Denominator
 AIU Certification Document(s) from Provider
 Attestation Agreement
 Other Documents that may be Submitted by Provider

For the EH validation process, the following documents, which have been updated to accommodate changes as a result of the MU final regulation effective payment year 2013, will be reviewed by the reviewer.

Table 16: EH SLR System Validation Process

Cost Report Data submitted to Medicaid Internal Audits Section
 EH Workbook
 AIU Certification Document (s) from Provider
 Attestation Agreement
 Other Documents that May Be Submitted by Provider:

- Approval: Using a checklist, the reviewer reviews provider's submission and related documentation to validate provider's attestation to all eligibility requirements.
- Pend: In reviewing the aforementioned checklist or if the information submitted is inadequate or unclear, the application will be 'pending,' meaning the account will be re-opened so the provider can resubmit the application with corrected or additional supporting data.
- Rejection: In reviewing the aforementioned checklist, a staff member finds the provider does not meet eligibility requirements set by the state. The provider is rejected.
- The state has the responsibility to audit providers who have received payment. Alabama has taken the option for CMS to audit the eligible hospitals based on the specifications and agreement presented earlier.
- Those providers whose application was rejected may appeal the decision.

It is Alabama's intent to validate as much information as reasonable prior to issuance of a payment to minimize the need to recoup payments issued to ineligibles. This review is balanced with the intent to minimize the burden on providers and to issue payments within 60 days of a successful submission of an application to the state and payment issued within 30 days of approval. A-SMA's conversion of the payment from manual invoices to issuance through the MMIS payment requires that payments are issued on the MMIS payment cycle, twice monthly. Preparation of the approved attestations for entry to the MMIS payment system has added time

to the review cycle and, once submitted to the MMIS vendor, there is a minimum 10 day processing cycle for issuance of Electronic Fund Payments to providers.

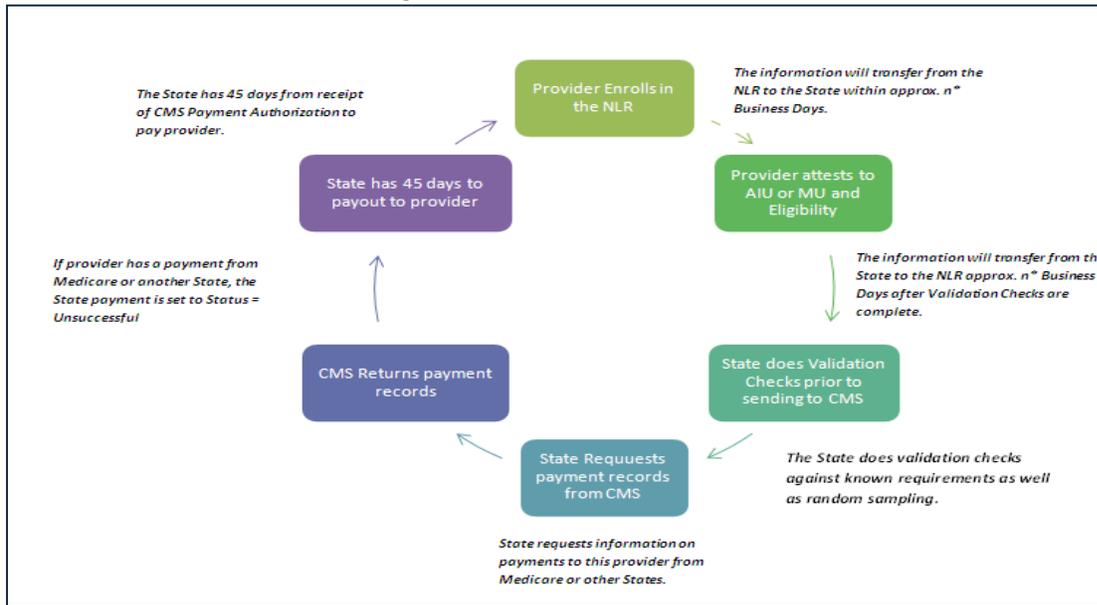
In February, 2013, A-SMA amended the SLR contract to supplement A-SMA resources with operations staff to support review of EP attestations. Xerox support staff assists Medicaid in support of the SLR activities and verifications and are also required to complete timely and accurate incentive payments to Alabama providers. Xerox provides an Alabama-specific SLR Provider Support Lead and two Provider Support Specialists to process providers up to approval and payment and provide the appropriate reporting to the State. A-SMA retains responsibility for approval for payment. In addition, complex, ambiguous or questionable attestations are referred to A-SMA for further review. The Pre-Payment Validation Guidelines developed for this purpose are included in Attachment 8.19. The guidelines are updated as program requirements change. Xerox does not review EH attestations due to the complexity and high dollar value of the EH incentive payments.

Alabama has made the policy decision to take the voluntary option to have CMS perform audits and handle any subsequent appeals of whether a EH is a “meaningful user” on behalf of the state. A-SMA hereby agrees that Alabama:

- Designates CMS to conduct all audits and any resulting appeals of eligible hospitals' meaningful use attestations;
- Is bound by the audit and appeal findings;
- Will perform any necessary recoupments arising from the audits;
- Will be liable for any FFP granted the state to pay EHs that, upon audit (and any subsequent appeal) are determined not to have been meaningful EHR users; and
- Acknowledges that the results of any adverse CMS audits would be subject to the CMS administrative appeals process and not the Alabama appeals process.

The following diagram is a high-level overview of the process for a provider’s Year 1 AIU phase of the meaningful use incentive program. This document has been updated to accommodate the processes for attesting to and demonstrating Stages I and 2 Meaningful Use of EHR technologies. Figure 27 is the Process Overview.

Figure 27: Process Overview



Incomplete Registrations: There are two categories of incomplete registrations. There are registrations with exceptions due to stops and registrations/attestations that have been completed up to a certain point. The state monitors incomplete registrations and, if a registration remains incomplete, the state contacts the provider to inquire the reason and offer assistance. The outcome of the call is documented in the SLR dashboard.

Payment Processes: Once determined eligible, the payment process (Attachment 8.9) was initiated by the A-SMA using spreadsheets and manual processes until the SLR Administrative Dashboard was fully functional in October 2011. At that time, it was the intent of the state to integrate the payment processes into the MMIS claims payment and financial systems through an amendment to its FA contract (HP). However, after discussions with the FA liaison on the plan to move forward, it was determined that the process was not cost beneficial to A-SMA. Instead, the state was able to continue processing the payment data through the SLR, producing an invoice for the State’s Fiscal Office to produce paper checks. The State has completed the process of transitioning the payment processes to a web-based administrative interface within the SLR and is pursuing issuing payments through the FA’s electronic funds transfer (EFT) process. The State has received concurrence from CMS on this approach. The state has initiated an interim process with its FA of generating payment data from the SLR, sending the data to the FA; the FA enters the payment data to the MMIS and EFTs are generated on the FA’s biweekly schedule with other Medicaid payments. This allows the incentive payments to be included in the provider claims history.

Post-Payment Processes: The high level steps of post-payment process, including processes for review and validation of meaningful use payments, (Attachment 8.12 and 8.15) are provided in Table 17:

Table 17: Post-Payment Process

Focus	Provider Selection	Method of Review
<p><i>The focus of the post payment audit are those areas that the agency is unable to validate during the pre-payment validation, including:</i></p> <ul style="list-style-type: none"> • <i>Place of Service for Non-Medicaid Encounters</i> • <i>FQHC/RHC providers that are not vetted by APHCA as >50% time base</i> • <i>Total Encounters by all payers</i> • <i>Certified EHR System is as reported</i> 	<p><i>The providers or hospitals selected for audit will be based upon the following categories:</i></p> <ul style="list-style-type: none"> • <i>A statistically valid sample or minimum of 15% Random Sample of all providers and all hospitals electing to receive incentive payments for AIU</i> • <i>All submissions identified as “flag for post payment audit</i> 	<p>The method of review/audit will include on-site visits by contracted staff.</p> <p>Alabama has taken the option for CMS to complete the audits and handle any subsequent appeals of whether a EH is a “meaningful user” on behalf of the state</p>

Statewide Infrastructure Assurance: In order to adequately oversee and efficiently manage the EHR Incentive Program as it moves to MU Stage 2 the IT infrastructure needs to be available to state, providers and consumers for private and secure messaging and exchange of information. Through DIRECT secure messaging, query, and the One Health Record® provider directory, providers and the state can transfer clinical data, including information required for reporting and reviewing on MU quality measures, to other providers, Public Health and Medicaid.

The state is reviewing options for maximizing the technical infrastructure and technical and business operations for the required clinical quality measures for Meaningful Use Stage 2, ongoing operations of the Patient 1st Program, and implementation of Medicaid Regional Care Organizations where MU measures will be used for quality improvement, state program integrity activities and state oversight responsibilities yet to be determined. A potential consideration requiring further analysis is the option to use the infrastructure as a doorway to provide information to and receive information from consumers relative to the EHR Incentive Program.

Alabama will continue to accept attestations from 2013 that fall into the tail period with the Stage 1 requirements and continue to register and accept attestations for AIU for new registrations. Alabama’s strategy for implementing the changes for MU effective in 2014 follows:

Target Date	Description
1/1/2014	<ul style="list-style-type: none"> • EH Stage 1 MU changes that were identified in the SMHP approved on February 5, 2013. • NEW: Implement new functionality to identify any EH that has attested to MU in 2011, 2012 or 2013 and implement a hard stop message that prevents them from submitting a 2014 attestation. Any EH that does not have a prior attestation for MU will be allowed to submit attestation.
4/1/2014	<ul style="list-style-type: none"> • EP Stage 1 MU changes effective 2014

Target Date	Description
	<ul style="list-style-type: none"> • EP Stage 2 MU changes
TBD but before 10/1/2014	<ul style="list-style-type: none"> • EH Stage 2 MU changes • New: Implement new functionality for handling 2 C5 files for one EH and preventing payment from being issued until the second C5 has been received

Alabama, as a part of the multi-state initiative with Xerox, has accommodated in its system design the Stage 1 and the Stage 2 requirements during the three month window at the start of the 2014 participation year for Eligible Hospitals (EH) and Eligible Providers (EP).

The specific provisions addressed in this A-SMHP include implementation of those provisions of the Stage 2 Final Rule that become effective 10/1/13 for EHs and 1/1/14 for EPs, specifically changes to core and menu measures and CQM reporting. The specific changes will be discussed in Section 4 and listed in Attachment 8.16, Program Year 2014 Changes to MU and depicted in Attachments 8.17 (EP Attestation Screenshots – Program Year 2014 Changes to MU) and 8.18 (EH Attestation Screenshots – Program Year 2014 Changes to MU).

In order to assure all possible EHs and EPs understand and have easy access to register and attest for meaningful use, multiple on-line tools were created and provided. (Attachment 8.7) Screenshots of the actual material is provided in Attachment 8.10. Much of this effort was done in cooperation with other states using the same vendor for develop and support their State Level Registry. The state has taken pre-payment (Attachment 8.9) and post-payment auditing processes (Attachment 8.11) very seriously. Attachment 8.9 has been substantially updated and is replaced with Attachments 8.19 (Pre-payment Validation Guidelines). Additional detailed audit requirements and procedures document is provided in Attachment 8.12, which will be updated as a part of the annual SMHP update. Examples of the updated screenshots directly related to the changes in Meaningful Use Stage 1 that have been reviewed by CMS are provided in Attachment 8.13. Updated mock-ups of screen shots depicting changes for Program Year 2014 and Stage 2 are shown in Attachment 8.18; they were previously provided to and approved by CMS but have been updated to accommodate corrections issued by CMS to CQM language.

Updated EP and EH workbooks are provided in Attachment 8.20. AMA has developed a separate EH workbook for Year 2 and 3 submissions to specifically capture only continuing Medicaid eligibility information. Updated information on the Alabama Audit Strategy is provided in Attachment 8.15. Attachments 8.13, 8.14 and 8.15, which are new, are provided at the end of this document. Attachments 8.16, 8.17, 8.18, 8.19 and 8.20, are new. They are being submitted as part of this A-SMHP update and are included in a separate file.

4.1 HOW WILL THE SMA VERIFY THAT PROVIDERS ARE NOT SANCTIONED, ARE PROPERLY LICENSED/QUALIFIED PROVIDERS?

Standard: A-SMA 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. A-SMA 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.

Methodology: Alabama Medicaid provider eligibility status will be determined as a first step in the program registration process. Providers must be currently enrolled and eligible Alabama Medicaid providers in order to be eligible for MU through A-SMA. The SLR system currently provides files from the MMIS provider subsystem that enables the SLR system to verify the current provider status related to required ownership, control, relationship and criminal conviction information. While the CMS Registration and Attestation System audits against the national data bases, the Alabama system audits against the current Medicaid provider system to assure eligibility. If a provider is not eligible for “Active Medicaid Provider” status, has been suspended or denied for any reason, the SLR system will not allow the provider to create a user account. Alabama tracks against the exclusion information to the state from the CMS Registration and Attestation System. 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.

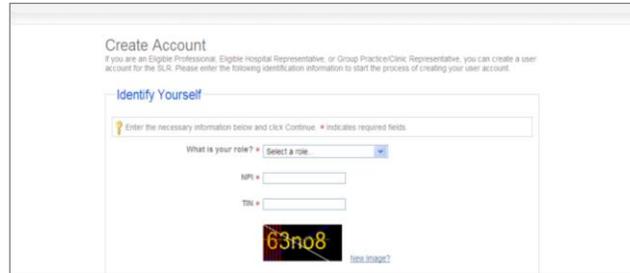
Initially, once the state reviewer completed the checklist, but prior to approval, A-SMA checked the provider against the list maintained by Program Integrity to determine whether the provider is under investigation, is under a recoupment status or has an action against him or pending. . The automatic system validations for eligibility that are conducted throughout the attestation and review precluded the need for this manual process and it was eliminated. Any change to the eligibility status to the provider is routinely and, on a real-time basis, updated in the Provider Master File.

Process: The process for approving issuance of Meaningful Use incentive payments has been provided earlier in Section 4. Alabama has partnered with XEROX, a Xerox company, to implement the SLR through which eligible professionals and hospitals will establish their eligibility for incentive payments for meaningful use of electronic health record (EHR) technology and systems. The first phase of the EHR Incentive Program is a process that spans establishing eligibility to participate in the program with CMS at the national level, establishing eligibility to participate at the state level, attesting to the adoption, implementation or upgrade of a system certified by the CMS Office of the National Coordinator (ONC), meaningful use of the CEHRT for

the period as required by the Provider’s MU Stage, and the state’s validation of that information for the purpose of authorizing issuance of the incentive payment.

The SLR account page establishes the provider’s identity. The information entered by the provider, National Provider Identifier (NPI) and Tax Identification Number (TIN), is compared to that entered into the CMS Registration and Attestation System. If the information is not found or does not match, an error message is returned and the provider must identify the source of the error and correct the problem at the CMS Registration and Attestation System.

Figure 28: SLR Account Page



The pre-payment review and validation process the state performs to exercise due diligence regarding licensure and sanctioning prior to issuing a payment to any provider or hospital (unless noted otherwise, the term provider will refer to an eligible professional or hospital) requires as a part of attestation that the provider confirm licensure and that no sanctions against the applicant are pending. The professional license number and provider status on the provider master file (PMF) will be validated by the SLR. The SLR confirms the provider’s NPI is registered in the CMS Registration and Attestation System and is valid in Medicaid’s Provider Master File. Validation includes: PMF active status does not show a “sanctioned” status and does not show a status of deceased. If the provider receives an error message they must contact either the SLR Help Desk or the Medicaid Provider Enrollment section at the number provided on the screen. If there is a match, the following information is returned from the CMS Registration and Attestation System Record for an EP and EH:

Figure 29: EP

If an applicant is determined to be hospital based but wishes to be determined non-hospital based due to their funding of the acquisition, implementation and maintenance of CEHRT, Alabama will utilize an administrative process to review the request based on the requirements and make a determination.

Process: The provider attests through “checkmark” that he/she does not provide 90% or more of services in an inpatient hospital (21) or emergency room setting (23). Provider is compared to the POS report maintained by the State and if POS 21 or 23 is greater than 75% and less than 90%, of *Medicaid* encounters, flag for post payment audit. The SLR system performs the validation process to confirm the provider’s credentials and status. The Agency will review Medicaid MMIS claims data reporting the number of Medicaid claims made during the representative period for which the physician is applying. If the percentage of claims showing POS 21 or 23 is above 75% and below 90%, the file is flagged for audit.

The state has created a Place of Service (POS) report generated from MMIS claims data. The report identifies the total number of POS 21 and 23 services thereby enabling the state to compare the number of hospital based services to total services. While this report is based on Medicaid claims data, it cannot be viewed determinative of the provider’s total patient services. Thus, the POS report is used as an indicator of the provider’s practice. If the POS report shows less than 75% of the provider’s service are hospital based, then the provider is likely to satisfy the requirement. If the POS report shows that the percentage is between 75 and 90, then the provider may be approved but is also flagged for a post-payment audit to confirm that the total services are actually less than 90%. If the report shows 90% or more, the provider’s total is likely to exceed 90% and the provider will be contacted to supply supporting documentation to prove eligibility. If the additional documentation cannot overcome the state’s conclusions, then the application will be denied and the provider advised of the appeal procedure.

If an applicant is determined to be hospital based but wishes to be determined non-hospital based due to their funding of the acquisition, implementation and maintenance of CEHRT, Alabama will first require the provider to submit appropriate supporting documentation and will consult with CMS prior to making a final determination.

4.3 HOW WILL THE SMA VERIFY THE OVERALL CONTENT OF PROVIDER ATTESTATIONS?

Standard: Alabama has implemented a thorough pre-payment validation of provider attestations to prevent improper Medicaid EHR Incentive payments and limit what must be done post-payment to address potential fraud, waste, and abuse.

Methodology: The overall process has been provided earlier in Section 4 with additional details related to licensure and location in Sections 4.1 and 4.2. A-SMA has also addressed the following in its pre-payment validation process either through SLR system edits and audits or review of documentation submitted by the EP or EH: practicing predominately in FQHC/RHC, EP/EH type, patient volume, certification of EHR and AIU. The focuses for the SLR system’s capability is to support a user-friendly application process and verification and completion of all required provider attestation data.

EP Process:

- *Provider Type:* Provider confirms HITECH provider type (pediatrician-20% threshold).
- *Patient Volume:* Medicaid Patient Volume/Total Patient Volume > or = 30%, 20% for pediatricians. The numerator and denominator Medicaid information entered by provider must be at least 20% of pediatrician patient volume and 30% of all other providers' total encounters. For purposes of determining patient volume effective payment year 2013, encounters includes services rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability, including zero-pay claims and encounters with patients in Title 21-funded Medicaid expansions, but not separate CHIPs. Since Alabama's CHIP program is a stand-alone, those patients will not be counted.

The definition of encounters has also expanded from previous 12 months to previous 24 months will be implemented to attestations submitted for program year 2013 forward; previous regulations and guidelines continued to apply to attestations through the 2012 grace period. A-SMA reviews the summary report from the provider's practice management system to substantiate the total patient volume. All Medicaid encounters for the numerator will be validated by the agency. A-SMA can generate a report from MMIS claims data that includes encounters, claims, services and number of recipients for every Medicaid provider by NPI for the 90-day period identified by the EP.

A-SMA continues to use a representative period of 3 calendar months, beginning on the first (1st) of the month, rather than the exact 90 day period. This decision was based on administrative efficiency in ensuring consistency, accuracy or information, minimal confusion and easier manipulation and access of information from the MMIS. . The report data is compared to the info submitted by the provider to determine the number of Medicaid encounters during the representative period.

Effective January 1, 2013, providers have the option to elect to use either a 90 day period in the previous calendar year, or in the 12 months immediately preceding the attestation. Alabama currently requires each provider to submit a workbook detailing how Medicaid encounters were determined and reports from an auditable source (such as a Practice Management System) to support the data submitted. Information on the State website, the SLR, and the workbook incorporate the expanded definition.

Attestations submitted for program year 2013 forward are allowed to include services rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability, including zero-pay claims and encounters with patients in Title 21-funded Medicaid expansions, but not separate CHIPs. Since Alabama's CHIP program is a stand-alone, those patients will not be counted. Zero-pay claims include claims: (1) denied because the Medicaid enrollee has maxed out the service limit, (2) denied because the service wasn't covered under the State's Medicaid program, (3) paid at \$0 because another payer's payment exceeded the Medicaid payment, and (4) denied because claim wasn't submitted timely.

An additional change that will be accommodated effective payment year 2013 is the requirement for EP patient volumes that at least one of the clinical locations used has

certified EHR technology during the payment year for which the EP is attesting. Alabama will validate that at least one location used to establish EP’s patient volume has certified EHR technology during the payment year.

If a provider submits managed care panel information that was not obtained from the Agency, A-SMA will obtain reports from the Patient 1st Program, in order to confirm panel information. If this additional information does not increase Medicaid patient volume to at least 30% (20% for pediatricians), the system creates a “STOP” and the provider is not able to complete the application. The provider may then contact A-SMA staff for assistance. SLR System will not allow provider to proceed if volumes do not meet criteria. If the provider must use patient encounters from the Maternity Program, or Medicare Advantage program, the provider must submit documentation substantiating the patient volume.

- **FQHC/RHC:** If a provider is attesting that he/she practices in an FQHC/RHC, A-SMA verifies the provider’s employment in an FQHC/RHC against information provided by APHCA. If the applicant is not on the provided list, the agency will contact the FQHC for additional information. Medically Needy patient volumes submitted must match volumes included in the APHCA report for that FQHC. If there is no match, the provider is contacted for clarification. If there is a discrepancy of over 15% and the volume change would cause the Medicaid Percentage to drop below 30% (20% for pediatrician), the provider is ineligible.

A copy of the standardized format that is provided by A-SMA to APHCA for completion and the basis for validation follows:

Table 19: FQHC Provider Participation

<p>Alabama Federally Qualified Health Center XXX XXXXX Avenue XXXXXX Alabama XXXXX NPI: XXXXXXXX 90 Day Period: 01/01/2010 - 03/31/2010 Total Encounters: 2828 Total Alabama Medicaid Encounters: 603 Total Panel Members Assigned: N/A Total Alabama Medicaid Panel Members Encounters: N/A Total Medically Needy Patient Encounters: 1157 Eligibility: 62.23 % of Time in FQHC: 50% or more</p>						
Last Name	First Name	NPI Number	License Number	Provider Type, SPC	Street Address	City

- **Certified EHR Technology:** The provider must submit the certification number of the provider’s ONC certified EHR Technology. The system validates the certification number against the ONC Certified HIT Product List database and verifies that the certification

number submitted matches the EHR technology to which the provider attested. If the certification number does not match, A-SMA contacts the EP or EH representative for clarification. The provider can submit the correct certification number. In 2014, all Certified EHR Technology must meet 2014 ONC certification requirements.

- **AIU:** The provider selects his/her method of compliance and provides documentation of EHR AIU. A-SMA validates the submitted appropriate documents against: receipts for software EHR vendor, sales contract, EHR Support or Training, agreement, screen shot of the sign on, copy of the agreement for upgrade, vendor letter that includes product name, version and certification number, work plan (EH only), invoice or other appropriate document. If documentation is missing, is not one of the documents above, or does not match the EHR system described, A-SMA staff will contact the provider to request that the provider submit the correct documents. Pursuant to clarifying direction from CMS, A-SMA is informing providers and insuring that documentation clearly establishes that the certified EHR technology has been installed or a legal obligation has been incurred.
- **MU:** Effective payment year 2013, the SLR will accommodate the change in requirements that for EP patient volumes at least one of the clinical locations has certified EHR technology during the payment year for which the EP is attesting.

EH Process:

The SLR system validates that the percentage of Medicaid patients is 10% or above. All information to establish eligibility for the program is based on the hospital’s annual cost report submitted to Medicare and to the Medicaid Agency. Staff compares the data submitted in the SLR to the hospital cost reports. If the data submitted does not match the data on the cost reports, staff will contact the hospital representative for clarification.

As a final check, the attestation agreement is reviewed to confirm that the entries (7-10) match the information submitted in the SLR by the provider and is signed. If any of the above conditions are not met, A-SMA contacts the provider for a properly executed document and pends the attestation until receipt of the correct document.

The following is a copy of A-SMA’s Pre-Payment Validation Checklist, which is used by staff.

Figure 31: Pre-Payment Validation Checklist
EP Pre-Payment Validation Checklist



Alabama Incentive Payment Pre-Payment Validation
Eligible Provider Checklist

Provider Information:

Provider Name		NPI	
Group Name		NPI	
Contact Phone		Name	
E-mail:			

Action Taken:

Recommendation:	Approve		Reject	
Pend		Date	RAP Re-submittal Date	
Reason for Pend:				
Reason for Rejection:				
By:			Date	

Documents Submitted:

	Yes	No		Yes	No
EP Workbook			W-9		
Practice Management Summary Report			Other		
AIU Certification Document(s)			Other		
Attestation Agreement			Other		

Attestation Component Review Criteria	Meets Initial Criteria?	Additional Review – If...	Post Payment Audit	Notes
Place of Service 21 or 23 Less than 75% of Medicaid encounters on Medicaid POS Report.	Yes <input type="checkbox"/> No <input type="checkbox"/>	POS 21 and 23 equals < 90% and > 75% of Medicaid encounters, flag for audit		
FQHC/RHC Status Provider is on the APHCA Report List indicating 50% of practice is at FQHC or RHC.	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	The Provider is not on APHCA list, contact FQHC or RHC to validate provider's time base. If time base fewer than 50%, flag for audit.		
Medically Needy patient volumes Medically Needy patient volumes submitted must match volumes included APHCA report for FQHC or RHC.	Yes <input type="checkbox"/> No <input type="checkbox"/>	If Medically Needy volumes do not match APHCA report, contact FQHC for clarification.		
Medicaid Encounters (Numerator) EP Workbook submitted and numerator matches data provided by Medicaid.	Yes <input type="checkbox"/> No <input type="checkbox"/>	EP Workbook not submitted but Medicaid encounters submitted		

Attestation Component Review Criteria	Meets Initial Criteria?	Additional Review – If...	Post Payment Audit	Notes
All members of a group must report the same Medicaid patient volume. Numerator data from MMIS is within 15% of volume submitted by provider.		<ul style="list-style-type: none"> • do not match quantities previously provided by Medicaid, or • all members of a group do not use the same patient volume, or • reported Medicaid encounters vary by 15% or more for same period from volume obtained from MMIS database. 		
Total Encounters All members of a group must report the same Total patient volume. Validate quantity submitted against quantity on Practice Management Summary Report.	Yes <input type="checkbox"/> No <input type="checkbox"/>	<ul style="list-style-type: none"> • Discrepancy between quantity entered and quantity on Practice Management Summary Report. • All members of a group do not use the same patient volume, or If the discrepancy is greater than 15% flag for post payment audit.		
Additional Medicaid Encounters Validate Medicaid staff name on worksheet and volume same as on record with AMA internal Patient Volume worksheet.	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Worksheet submitted does not include Medicaid staff name, no worksheet submitted, or discrepancy between quantity entered and quantity provided by Medicaid, mark for audit.		
AIU Attestation Document (Attachment) Information on document submitted matches certified EHR system reported.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Document does not match certified EHR system reported, contact provider for clarification/correction.		
Attestation Agreement (Attachment) Correct document is attached and signed by provider of record.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Signature is missing or not the signature of the provider of record, contact provider to submit new agreement with correct signature.		
Program Integrity Review/ Investigations List Provider is not on list	Yes <input type="checkbox"/> No <input type="checkbox"/>	Provider is on review list, flag for post payment audit.		

Attestation Component Review Criteria	Meets Initial Criteria?	Additional Review – If...	Post Payment Audit	Notes
		Provider is on investigation list; obtain clearance from Program Integrity Management to issue payment. Pend application if PIM cannot respond by end of current review cycle.		

The deployment of the administrative Dashboard in the SLR allows the State significantly more flexibility in reviewing, validating and approving attestations for payment. The State has the ability to process individual provider accounts and has real-time capabilities for certain functions. As a result, the state implemented a work flow process that permits provider attestations to be reviewed and approved and invoices submitted for payment on a weekly basis, thereby reducing the delays required for the previous batch processing. For those providers that submit complete and acceptable documentation, payments can be processed in as little as three weeks (or 12-15 days) from submission. For those providers whose submissions are incomplete, the account can be pended and re-opened immediately allowing the provider to resubmit documentation. These SLR system enhancements have significantly improved the time frame for payment processing.

The following functionality is currently available:

- *Manage Providers*: allows the user to search for, view, and review the progress of providers' EHR Incentive submissions.
- *Manage Attestations*: allows the user to take action on or record information about a provider's attestation. Users can approve or reject attestations, view attachments, audit a completed attestation, take action on validation exceptions generated during an attestation, etc.
- *Verify Attestations*: allows the user to verify each provider's attestation application.
- *Approve Reject, or Pend Attestations*: allows the user to approve attestations for payment, reject them, or pend them to unlock them and help the Provider resolve any issues.
- *Select Providers for Transmission*: allows the user to select providers that have no exceptions to be included in B7 or D16 data exchanges.
- *Audit Providers*: allows the user to perform Eligibility, Financial, and either Adopt, Implement, or Upgrade (AIU) or Meaningful Use audits on attestations. These audits are performed post-payment.
- *Adjust Financial Information*: allows the user to view and recoup or adjust payment information for providers.

- *Adjustments and Recoupments*: document these changes in the amounts paid to providers in SLR, including sending updates to CMS.
- *Appeals*: document and manage Appeals and communicate changes and results to CMS.
- *View Eligibility Queries*: allows the user to identify providers that are eligible, not eligible, or whether any providers had soft or hard stops on any of the attestation pages. For example, if required criteria documents were not attached, the attestation application would be ineligible.
- *Audit Queries*: queries are available that will display audited providers.
- *Run Reports*: allows the user to generate several reports to help to management of the project, such as NLR Applications Waiting on SLR, Providers with Volumes from Multiple States, Active Registrations Not Meeting Eligibility Threshold, etc.

The steps in the verification process have been incorporated into the SLR Administrative Dashboard and the reviewer updates the status in the SLR whether each provider meets each criterion. This verification is acceptance by the user that the appropriate update has been completed. This “Passed by User” is a literal value captured after the EP or representative of EH has verified that the information is correct. It is considered an accountability measure on the provider. Below are sample screens from the Administrative Dashboard for the Verification process. The full SLR State Dashboard User Manual detailing the functionality is Attachment 8.21.

Figure 31a: Example SLR Administrative Dashboard Verification Screen

Item	Required	Description	Status	Exceptions
1	Yes	Place of Service	Passed by User	None
<small>Last Updated: MNewboldAL 7/10/2013 1:51:57 PM</small>				
2	Yes	FQHC/RHC Status	Passed by User	None
<small>Last Updated: MNewboldAL 7/10/2013 1:52:22 PM</small>				
3	Yes	Needy Individual Patient Volumes	Passed by User	None
<small>Last Updated: MNewboldAL 7/10/2013 1:52:55 PM</small>				
4	Yes	Medicaid Encounters (Numerator)	Unverified	None
<small>Last Updated: acsopsAL 7/5/2013 1:22:12 PM</small>				
5	Yes	Additional Medicaid Encounters (Numerator)	Unverified	None
<small>Last Updated: MNewboldAL 7/10/2013 2:01:29 PM</small>				
6	Yes	Total Encounters (Denominator)	Passed by User	None
<small>Last Updated: acsopsAL 7/15/2013 7:03:07 AM</small>				
7	Yes	AIU Attestation Documents	Passed by User	None
<small>Last Updated: acsopsAL 7/15/2013 7:06:13 AM</small>				
8	Yes	Attestation Agreement	Passed by User	None
<small>Last Updated: acsopsAL 7/15/2013 7:08:55 AM</small>				
9	Yes	Program Integrity List Review	Passed by User	None
<small>Last Updated: acsopsAL 7/15/2013 7:09:26 AM</small>				

Approve Reject Pend Mark for Audit

Figure 31b: SLR Administrative Dashboard Verification Item

Verification Detail

ITEM # 1 of 9	CURRENT STATUS Passed by User
VERIFICATION DESCRIPTION Place of Service	
VERIFICATION INSTRUCTIONS Less than 75% of Medicaid encounters report POS as 21 or 23. If POS 21/23 equals <90% and > 75%, flag for audit.	

Notes Attachments Verification History

[+ Add Notes](#)

Date/Time	User	Note
7/10/2013 1:51:51 PM	MNewboldAL	POS 21 & 23 – 12.11%; EP meets requirement.

[Return to Verification List](#)

The detailed description for each step is described and allows the reviewer to add notes, attachments as necessary and
 If the provider does not meet the criterion, that element is failed.

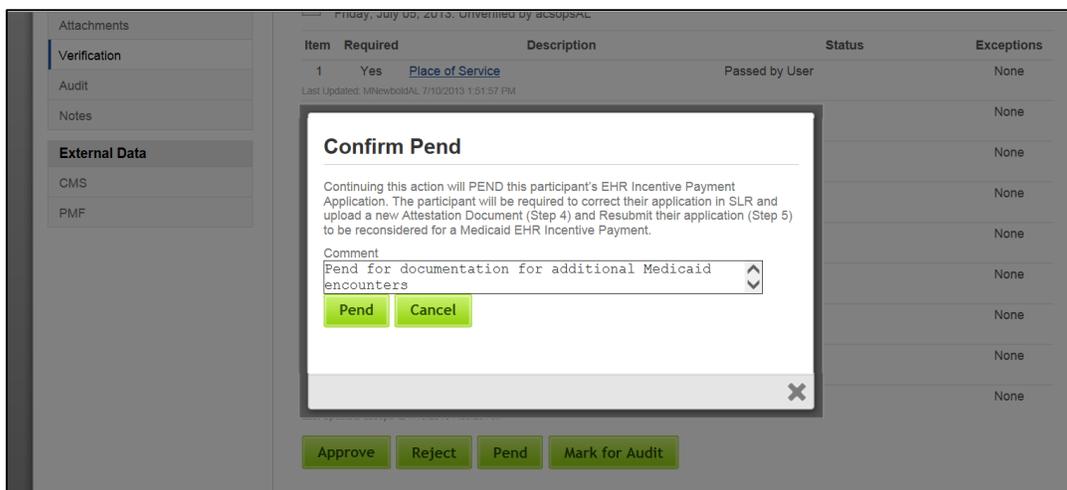
Figure 31c: SLR Administrative Dashboard Verification Screen

Verification History [+ Add Verification](#)
 Friday, July 05, 2013: Unverified by acsopsAL

Item	Required	Description	Status	Exceptions
1	Yes	Place of Service	Passed by User	None
<small>Last Updated: MNewboldAL 7/10/2013 1:51:57 PM</small>				
2	Yes	FQHC/RHC Status	Passed by User	None
<small>Last Updated: MNewboldAL 7/10/2013 1:52:22 PM</small>				
3	Yes	Needy Individual Patient Volumes	Passed by User	None
<small>Last Updated: MNewboldAL 7/10/2013 1:52:55 PM</small>				
4	Yes	Medicaid Encounters (Numerator)	Unverified	None
<small>Last Updated: acsopsAL 7/5/2013 1:22:12 PM</small>				
5	Yes	Additional Medicaid Encounters (Numerator)	Failed by User	None
<small>Last Updated: Ibarber1 11/14/2013 11:33:56 PM</small>				
6	Yes	Total Encounters (Denominator)	Passed by User	None
<small>Last Updated: acsopsAL 7/15/2013 7:03:07 AM</small>				
7	Yes	AIU Attestation Documents	Passed by User	None
<small>Last Updated: acsopsAL 7/15/2013 7:06:13 AM</small>				
8	Yes	Attestation Agreement	Passed by User	None

If the state elects to contact any provider for additional information; the reviewer may “Pend” the application until the provider submits acceptable data.

Figure 31d: SLR Administrative Dashboard Verification Screen - Pend



Once all elements are passed, the provider may be approved by the state.

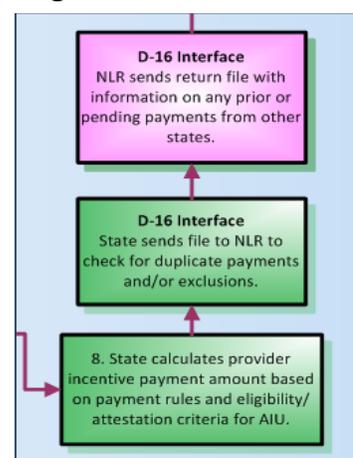
4.4 HOW WILL THE SMA COMMUNICATE TO ITS PROVIDERS REGARDING THEIR ELIGIBILITY, PAYMENTS, ETC.?

Standard: In addition to the attestation process communications indicated in 4.3, the state has established an additional notification for hospitals that are participating in both the Medicaid and Medicare Programs. EHs, unlike EPs, may participate in and receive EHR incentive payments under both Medicare and Medicaid EHR incentive programs during the same federal fiscal year. When applying under both programs during the first year of participation, it is important that the EH understands the differences in the two programs before deciding which program to apply to first. Under Medicaid, an EH may choose to receive its first payment based on the AIU option. AIU is not available to an EH under the Medicare program. A-SMA has created a communication tool to notify potential EHs prior to their selection of which program to apply to first.

A-SMA's strategy for communicating the changes that have resulted from the final regulation for MU Stage 2 include providing information on the State website, the SLR and the workbook that are a part of the attestation process. In addition, provider outreach efforts include targeted e-mails, webinars and website updates; dissemination of information to provider associations; and for those providers who were not eligible for the previous program year, at the request of the providers Medicaid staff will continue to work with each provider to exhaust every effort to establish eligibility for the incentive program. In addition, Alabama's REC (ALREC) has received funding to provide outreach to Alabama's smaller rural hospitals to assist with meeting meaningful use.

In order to help educate providers, A-SMA also makes available a workbook on the SLR portal that contains all the steps for completing the incentive payment

Figure 32: SLR interface



registration and attestation process. Prior to entering data into the actual SLR, eligible providers and hospitals must complete the workbook to assemble the information that will establish eligibility. The Agency requires that the workbook is loaded into the SLR with all other attestation documents. The EP workbook has been updated with the changes that resulted from the Stage 2 regulation that affected Stage 1 requirements.

A separate workbook is available for EPs and EHs. To improve the quality and accuracy of the information submitted and reduce the risk of potential errors, every EP and EH must submit the workbook as part of the attestation process. If the document is not uploaded, the provider is contacted with a request to submit the document. The attestation will then be pended so the workbook and any other additional documents can be submitted. . A separate workbook has been developed for EHs submitting attestations for Program Years 2 and 3.

Providers are also informed they must submit a W-9 prior to payment. Providers may submit the W-9 by uploading it to the SLR portal.

Methodology: A-SMA has created a communication tool for potential EHs that include the following chart for hospitals participating in both the Medicare and Medicaid Programs. Once a provider incentive payment amount has been calculated based on CMS payment rules, A-SMA communicates the payment to the EP/EH.

Table 20: Hospitals Participating In Both Medicare and Medicaid

Payment Year	Medicaid Incentive Program Only	Medicaid 1 st , then Medicare in same FY	Medicare 1 st then Medicaid in same FY / Medicare 1 st , then Medicaid in a later FY
1 st payment yr.	AIU	AIU (Medicaid); MU, 90 day reporting period (Medicare)	MU, 90 day reporting period
2 nd payment yr.	Stage 1 MU, 90 day reporting period	Stage 1 MU, 12 month reporting period	Stage 1 MU, 12 month reporting period
3 rd payment yr.	Stage 1 MU, 12 month reporting period	Stage 1 MU, 12 month reporting period	Stage 1 or Stage 2 MU, 12 month reporting period depending upon program year.

*If the usual 12 month reporting period occurs in 2014, the reporting period is 90 days.

Process: All EHs are encouraged to carefully consider the requirements and limitations under both programs before making a decision on whether they will apply first to Medicare or Medicaid. An EH may apply under the Medicaid incentive program first in order to take advantage of the AIU option. After approval and payment under the Medicaid AIU option, the EH may then attest under Medicare wherein it will still have to meet Medicare’s meaningful use requirements for the first year payment. This includes attesting to a 90-day reporting period for Stage 1 Meaningful Use (MU). Since the Medicare incentive program does not have an AIU component for EH, an EH that chooses to participate in the Medicare EHR incentive program first, will have to be a meaningful user. This means the EH will have attested to a 90-day reporting period for Stage 1 MU. If during the same federal fiscal year the EH chooses to subsequently

apply for a payment under the Medicaid program that EH will be “deemed” a meaningful user for the Medicaid program and the AIU option will not be available to that EH. Under this deeming scenario, the 90-day reporting period and MU data reported for Medicare will be carried over to Medicaid. The 4th column of the above table describes the effect of attesting under Medicare before applying to Medicaid.

A communication has been developed to notify EHs that if an attestation is made to Medicare first and there is no subsequent attestation to Medicaid until the following year that first Medicaid attestation will have to be based on a full year reporting period.

The A-SMA has also worked closely with the Alabama Hospital Association to educate eligible hospitals. To date, 94 of Alabama’s 106 EH hospitals have attested and only one has elected to attest to Medicare prior to attesting to Medicaid. In its effort to communicate to dual eligible EHs the significance of the proper sequence of attestation between Medicare and Medicaid, for the 2014 Program Year, Alabama has prepared the document below containing the current status of attestations for each EH and guidance for next steps to avoid issues with the proper sequence for attestations.

4.5 WHAT METHODOLOGY WILL THE SMA USE TO CALCULATE PATIENT VOLUME?

Standard:

- *EP Patient Volume:* 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, representative 90-day period within the most recent calendar year prior to reporting through payment year 2012. The denominator is all patient encounters for the same EP over the same 90-day period. Although Medicaid MCO use is not significant in Alabama, the Patient 1st Medical Home Program is a managed care model for purposes of calculating patient volume as authorized in the regulation: $\{[Total (Medicaid) patients assigned to the provider but not seen in any representative continuous 90-day period in the preceding calendar year, with at least one encounter taking place during the calendar year preceding the start of the 90-day period] + [Unduplicated (Medicaid) encounters in the same 90-day period] / [Total patients assigned to the provider but not seen in that same 90-day period, with at least one encounter taking place during the calendar year preceding the start of the 90-day period] + [All unduplicated encounters in that same 90-day period]\} * 100$

Effective payment year 2013, EPs have the option to elect to use either a 90 day period in the previous calendar year or 12 months immediately preceding the attestation. In addition an expanded definition of encounters will be implemented to attestations submitted for program year 2013 forward; existing regulations and guidelines continue to apply to attestations submitted through the 2012 grace period. Encounters includes services rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability, including zero-pay claims and encounters with patients in Title 21-

funded Medicaid expansions, but not separate CHIPs. Since Alabama's CHIP program is a stand-alone, those patients will not be counted.

Zero-pay claims include claims: (1) denied because the Medicaid enrollee has maxed out the service limit, (2) denied because the service wasn't covered under the State's Medicaid program, (3) paid at \$0 because another payer's payment exceeded the Medicaid payment, and (4) denied because claim wasn't submitted timely.

- *FQHC/RHC Patient Volume:* EP practicing 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. An EP meeting this definition would be allowed to count enrollees who are Medically Needy, including CHIP and uninsured as well as Medicaid in their patient volume thresholds.

The same changes that were implemented 1/1/13 for Medicaid patient volume are accommodated for "needy individuals" for purposes of FQHCs/RHCs patient volume. For example, Alabama took the option to allow EPs and EHs to calculate total Medicaid encounters for Medicaid patient volume for "90-day Representative Period" across last 12 months prior to the EPs or EHs attestation. The State took the same option for the "needy population" for the FQHC calculation.

- *EH Patient Volume:* The requirement is for 10% Medicaid hospital patient volume. Alabama has also taken the option effective payment year 2013 to allow EHs to calculate total Medicaid encounters for Medicaid patient volume for "90-day Representative Period" across last 12 months prior to the EHs.

Methodology: Alabama is using the CMS specified definitions provided in the regulation. However, for the 90 day representative period, the A-SMA utilizes a 3 consecutive calendar month period through payment year 2012. This significantly increases the efficiency and ease of accessing MMIS data, the accuracy and consistency of the data. Effective payment year 2013, Providers will have the option to elect to use either a 3 consecutive calendar month period in the previous calendar year or 12 months immediately preceding the attestation. Alabama currently requires each provider to submit a workbook detailing how Medicaid encounters were determined and reports from an auditable source (such as a Practice Management System) to support the data submitted. The EP Workbook has been updated and information on the State website and the SLR will be revised to incorporate the expanded definition.

- *EH Patient Volume:* For purposes of calculating the 10% Medicaid hospital patient volume, Medicaid Patient Volume is determined by dividing the Total Medicaid Inpatient Discharges by the Total Hospital Inpatient Discharges; however, hospitals may also include Emergency Room/Department (ER) encounters in these numbers in order to achieve the minimum patient volume requirement. If ER encounters are used, the EH must designate the location in the Cost Report or the source documents for the hospital where these numbers can be found. Alabama includes general short-term hospitals, cancer hospitals, and critical access hospitals that meet the Medicaid patient volume criteria. Figure 33 represents the online EH workbook that captures the necessary data from the EH's cost report that must be submitted in the SLR. This online workbook also

automatically calculates the EH incentive payment. The completed workbook must be saved and a copy uploaded to the SLR as an attachment as part of the EH's application.

Figure 33: EH Patient Volume Worksheet

Eligible Hospital (EH) worksheet for Eligibility for the Alabama Medicaid EHR Incentive Program

Overview: This workbook is designed to help you collect information needed to complete the Eligibility components of the SLR. It is designed to gather detailed information regarding your hospital and create summarized data for entry into the SLR. You can also use this workbook to estimate your Alabama Medicaid eligibility based on your patient volumes.

General instructions for completing this workbook:

1. Each eligible hospital must complete all worksheets and retain a copy for the hospital records for a period of 6 years.
2. The information entered on the About You worksheet is entered on the About You page in the SLR. The information entered on the Discharges and Demographics worksheets are entered on the Confirm Medicaid Eligibility page in the SLR.
3. This workbook is designed for the eligible hospital only. Different worksheets are used for Eligible Professionals and Groups.
4. When you have completed using this workbook to enter your information into the State Level Registry (SLR), you must upload this completed workbook to the SLR. Do this at Step Two in the SLR. Note: If you use data from your General Ledger or other reports or business records for Charity and Uncompensated Care, or Emergency Room encounters, you must also upload the pages that identify the report and contain this information.

Update data from this worksheet in the About You Page of the SLR.

About You

The information you provide to the Alabama SLR is in addition to the information you provided when you registered with the NLR. This additional information is used by the State of Alabama to determine your eligibility to participate in Alabama's Medicaid Meaningful Use Incentive Payment Program.

Contact Person

Contact Person Phone Number

Contact Person E-mail Address:

Please provide the information below about the person completing the Worksheet

Name:

Phone:

Email:

NAME OF HOSPITAL:

Enter the data from this worksheet in the Confirm Eligibility Page of the SLR

Determining 10% Patient Volume

In order to be eligible for the Meaningful Use Incentive Payment Program, EHs must meet a minimum 10% Medicaid patient volume during a specified representative period.

You must specify a "**Representative Period**" from which you will obtain the necessary data to establish Medicaid eligibility. The designated Representative Period is the one year period covered by the hospital's most recently audited or filed cost report for the period ending anytime during the preceding federal fiscal year (FFY), or any continuous 90-day period (Alabama requires using 3 calendar months for this option) that begins on the first day of a month and also ends wholly within the preceding FFY. Alabama requires use of the cost report unless using the 90-day period is the only way to meet the minimum 10% Medicaid patient volume requirement.

Effective January 1, 2013, EH's may also choose any continuous 90-day period, which is 3 calendar months for Alabama, during the 12 month period immediately preceding the date of application.

Medicaid Patient Volume is determined by dividing the Total Medicaid Inpatient Discharges by the Total Hospital Inpatient Discharges; however, nursery/newborn days and swing beds must not be included in these totals. Hospitals may also include Emergency Room/Department (ER) encounters in these numbers in order to achieve the minimum patient volume requirement. If ER encounters are used, designate in the space provided below the location in the Cost Report or the hospital source documents where these numbers can be found. All data reported via the SLR or relied upon for that purpose must come from auditable sources. Alabama has designated the hospital's audited (or filed) cost report as the primary acceptable source document. See the workbook tab "Cost Report References" for identifying the appropriate cost report data.

Whenever other hospital Business Records are used, or any other documentation other than the cost report, to support or supplement documentation for data not included or readily identifiable in the cost report, the report or documentation must clearly show the name of the hospital and period from which the data is obtained. If not a report that automatically prints the identifying information on the report, that information may be hand-written on the report along with the name of the person preparing the report.

It is important to note that the supporting documentation for the reported data must be attached to the application in addition to this EH Workbook. When using cost report data, the appropriate pages from the cost report, with the specific numbers pointed out, must be attached. If the EH elects to use a 90-day representative period (3-calendar months) instead of the cost report period, it is imperative to identify and attach the source documentation for the reported data with the reported numbers specifically pointed out. If this documentation is not attached, the application will not be approved.

Start Date Of Representative Period	
End Date of Representative Period	
<input type="checkbox"/> Using hospital cost report data and/or <input type="checkbox"/> Using other hospital business records	

Total Medicaid Inpatient Discharges <small>(S-3, Column 14, Line 12)</small>		+	Total Medicaid ER Encounters <small>(Designate CR location or data source below)</small>		=	Total Medicaid (Encounters)	0
Total Inpatient Discharges <small>S-3, Column 15, Line 12)</small>	0	+	Total ER Encounters <small>(Designate CR location or data source below)</small>		=	Total Patients (Encounters)	0
						Medicaid Patient Volume	#DIV/0!
Source of ER Encounter Data							

Average Length of Stay	=	Total Inpatient Bed Days	0	/	Total Discharges	0	=	#DIV/0!	Days
<p>(This number will be calculated based on entries in other fields.)</p> <p style="text-align: center;">Note: Nursery or newborn days, and swing beds, must NOT be included in the totals for inpatient bed days or discharges.</p>									

Incentive Payments	Percentage of Total Incentive
First Incentive Payment	50%
Second Incentive Payment	30%
Third Incentive Payment	20%
Total Incentive Payments	100%

- EP Patient Volume:* Pediatricians, who achieve a 20% volume, may qualify to receive a reduced payment amount. Encounter counts are based on the rendering (aka performing) provider, a supervising physician may add the encounters of a nurse-practitioner as part of the physician’s volume calculation. If an Eligible Provider practices at multiple sites, one or all sites can be used to compute patient volume. Through payment year 2012, an Eligible Provider must have at least 50% of all patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with the certified EHR technology. Effective payment year 2013, an EP must have the certified EHR technology at one of the locations during the EHR reporting period.

Related to “PA led,” Alabama follows 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, the state 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 allows clinics and group practices to use the practice or clinic Medicaid patient volume (or needy individual patient volume, insofar as it applies) and applies 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 “panel member” methodology effective payment year 2013, Alabama has taken the option to look-back for at least one Medicaid encounter in the last 24 months rather than 12 months prior to the 90-day representative period. Patient panel methodology requires at least one Medicaid encounter taking place in the 24 months prior to 90-day period.

An EP 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. At least one of the clinical locations used for EP patient volumes is required to have certified EHR technology during the payment year for which the EP is attesting. Alabama will validate the attestation that one location used to establish EP’s patient volume has certified EHR technology during the payment year as a part of the post-payment audit.

The SLR requires the EP to identify the location of the EHR to which the attestation for the incentive payment is submitted. Effective payment year 2013, SLR functionality exists to accept multiple locations and allow providers to attest that 50% of encounters are at locations with certified EHR technology.

The patient volume methodology that is used by the state is provided by the state to potential EPs so they can determine their individual patient volume. The steps of the A-SMA methodology are provided in the following patient volume worksheet. Changes have been made to the worksheet for 2013 that address the changes to patient volume definition, look-back period, etc.

Figure 34: EP Patient Volume Worksheet Updated for Stage 1 MU Changes

Confirm Alabama Medicaid Eligibility (Step 2 of the SLR)					
Additional Encounters Worksheet					
Please contact the State Level Registry Helpdesk @ 866-879-0109 for assistance with this Tab. This Tab should only be used if you did not meet the required Patient Volume percentage. (Denominator and Numerator on the Patient Volume Tab).					
Additional Encounters (1)		Additional Encounters (2)		Additional Encounters (5)	
Those Alabama Medicaid Managed Care Panel (Patient 1st) Members Seen in the Look-Behind Period (Medicaid Agency can assist)		(A) Medicaid Dual Eligibles in a Medicare Advantage Panel Counted in Total Encounters but NOT Total Medicaid Encounters on the Patient Volume Tab.		Patients for Whom Medicaid Paid Medicare Part B Premium and were counted in your Total Encounters (Patient Volume Tab) and NOT counted in your Total Medicaid Encounters (Patient Volume Tab).	
0		0		0	
		(B) Those Seen in Look-Behind Period			
		0			
Additional Encounters (3)		Additional Encounters (4)		Additional Encounters (6)	
(A) Medicaid Maternity Care Program -OB Patients NOT already captured in Total Medicaid Encounters but were counted in Total Encounters on the Patient Volume Tab		Those NON-Medicaid Managed Care Panel Members Not already counted in Total Encounters in the Patient Volume Tab but Seen ONLY in the Look-Behind Period.		(B) Currently enrolled Medicaid Maternity Care OB Patients not counted in (3A) nor on the Patient Volume Tab but were seen ONLY during the look-behind period.	
0		0		0	
(B) Currently enrolled Medicaid Maternity Care OB Patients not counted in (3A) nor on the Patient Volume Tab but were seen ONLY during the look-behind period.		If you count any Medicaid patients in the Look-Behind period, then you MUST complete *Additional Encounters (4) if not already included in Additional Encounters (1), (2B), and (3B).			
0					

Process:

- *EH Patient Volume:* Since there is no Medicaid patient volume for Children’s Hospitals, A-SMA made sure no unnecessary barriers were established that could delay participation by the children’s hospital. The definition of a Children’s Hospital has been revised to include ‘any separately certified hospital, freestanding or hospital within a hospital that

predominately treats individuals under 21 without a CMS certification number because they do not serve Medicare beneficiaries'. These hospitals will be issued an alternative number by CMS to enroll in the incentive program (Payment has already been received by Alabama's two children's hospital).

- *EP Patient Volume:* An example of a screen shot illustrating one of the reporting elements for determining the Medicaid patient population for EPs as updated for the January 1, 2013 changes is provided in Figure 35. Attachment 8.13 includes additional screenshots.

Figure 35: EP 90 Day Period

The screenshot displays a web-based form titled "2. Confirm Alabama Medicaid Eligibility". The form is part of a "State Level Registry" system. It includes a sidebar on the left with navigation links such as "Home", "Add New Encounter", "View Encounters", "Reports", and "Settings". The main content area contains several input fields and sections:

- Practice Eligibility Details:** A section with a checkbox to "Enter your eligibility information below" and a note that "Red asterisk indicates a required field".
- Total Representative Period:** A dropdown menu currently set to "12 months preceding the attestation".
- Total Alabama Medicaid Encounters:** An input field for the number of encounters.
- Total Patient Members Assigned:** An input field for the number of members.
- Total Additional Encounters for Alabama:** An input field for additional encounters.
- Eligibility Formula:** A section with radio buttons for "FQHC", "RHC", and "None", and a text input for "Eligibility Formula 1 99.99%".

4.6 WHAT DATA SOURCES WILL THE SMA USE TO VERIFY PATIENT VOLUME FOR EPs AND ACUTE CARE HOSPITALS?

Standard: The data for the total patient volume (denominator) is not available within the Medicaid data base (MMIS). Total Patient Volume for EPs must be drawn from the provider's practice management system. Total Patient Volume for an EH is derived from the EH's cost report. For an FQHC/RHC EP, Medically Need patient totals are obtained from the APHCA or the facility's practice management system.

Methodology:

- *EH Patient Volume:* All data reported or relied upon for these purposes must come from auditable sources. Alabama has designated the hospital's auditable cost report as the primary acceptable source document. Other hospital Business Records may be utilized to supplement documentation for data not included or readily identifiable in the cost report. The designated Representative Period is the one year period covered by the hospital's most recently auditable cost report, or any continuous 90-day period that begins on the first day of a month and also ends within the one year period covered by the most recent auditable cost report through payment year 2012. Effective payment year 2013, Providers will have the option to elect to use either a 90 day period in the previous calendar year or 12 months immediately preceding the attestation. Alabama currently requires each provider to submit a workbook detailing how Medicaid encounters were determined and reports

from an auditable source (such as a Practice Management System) to support the data submitted. Information on the State website, the SLR, and the workbook will be revised to incorporate the expanded definition.

The hospital may choose whichever period allows it to meet the minimum 10% Medicaid patient volume requirement. In either case, the one year period covered by the cost report must have ended at some time within the 12-month period preceding the start of the current federal fiscal year.

Medicaid Patient Volume is determined by dividing the Total Medicaid Inpatient Discharges by the Total Hospital Inpatient Discharges; however, hospitals may also include Emergency Room/Department (ER) encounters in these numbers in order to achieve the minimum patient volume requirement. If ER encounters are used, the EH must designate in the space provided below the location in the Cost Report or the source documents for each hospital where these numbers can be found.

- *EP Patient Volume:* All data entered in the SLR must be derived from an auditable data source and is subject to State verification and audit. Medicaid encounters will be verified by the State from its Medicaid Management Information System (MMIS) paid claims data. Non-Medicaid encounters must be drawn from Providers' practice management systems or other auditable data sources and will be subject to State audits.

"Encounter" is re-defined effective January 1, 2013, but the process remains the same; thus, providers must be sure of how they evaluate the data from their practice management systems and ensure that they are counting encounters only. The data source for patients within the Medicaid Maternity Care Program in which Providers are paid a global fee that covers all prenatal, delivery and post-partum services is the EP's practice management system. For patients for whom Medicaid paid Medicare Part B, the EP's practice management system is also the data source. Many times a Medicaid claim may not be submitted to the State's MMIS claims system for these patients so the EP must run a list of Medicare patients who were also Medicaid recipients during the representative period from his/her practice management system. The list must contain the patient's Medicare number and dates of service. The EP must submit this list to A-SMA to be run against Medicaid's buy-in file to determine if Medicaid paid the Part-B premium for that patient for that month. If the Part-B premium was paid and the encounter was not counted as a Medicaid encounter then each unduplicated date of service will count as one encounter and added in the numerator only. If no premium was paid, the patient cannot be counted.

Individual Eligible Providers who find that they do not meet the patient volume requirement on their own and are members of a group practice may be able to use the encounters of the entire group to meet the requirement. The encounters for each member of the group must be counted and added together for a group total. Encounters billed only under the group's NPI, and not to a rendering provider, may be added to the total (and must be counted in the same manner as for EPs described above).

- **FQHC Patient Volume:** Medically Needy patient volumes submitted must match volumes included in the APHCA report for FQHC. If the provider’s FQHC/RHC is not a member of APHCA, a cost report must be submitted to support the Medically Needy volumes. Changes as a result of the Stage 2 regulation for Stage 1 related to medically needy patient volumes has been incorporated into the A-SMA policy, SLR and business processes.

Process: All screenshots were submitted by Alaska as part of the group effort and approved by CMS. A-SMA understands that the inclusion of the screenshots in the submission of the A-SMHP does not constitute submission of the screen shots.

- **EH:** The screens shots illustrating the reporting process and data source for deterring the 10% Medicaid patient population for EHs follows:

Figure 36: Medicaid Patient Population Data Source

Figure 37: Medicaid Patient Population Documentation

- **EP:** The screen shots and guidance provided to EPs regarding the reporting process and data source for determining the Medicaid patient population for EPs and the Medically Needy for FQHCs follows:

Figure 38: EP Population Data Source

The screenshot shows a web-based form for confirming Alabama Medicaid eligibility. The main heading is 'State Level Repository (SLR) Confirm AL Medicaid Eligibility'. Below this, there is a section titled '2. Confirm Alabama Medicaid Eligibility'. The form includes a 'Practice Eligibility Details' section with several input fields and checkboxes. A large blue arrow points to the 'Eligibility Form 2' section, which contains a 'Submit' button and a 'Use This Formula' link. The form also includes a 'Notes' section at the bottom with a checkbox for 'Your State Alabama Medicaid Eligibility Requirements'.

Figure 39: EP /EH Documentation

Documents To Be Uploaded

1. Completed Workbook
2. Practice Management System Documentation
 - For EPs, this is the source information for the numbers you are reporting to compute your patient volume percentage, and especially for your denominator.
 - For EHs, this includes documentation supporting data that is not included or discernible from your cost report. Such a source may be your General Ledger.

(*Note: From the drop-down menu within the "Attach Files" function, you will be able to select either "Eligibility Workbook", or "Practice Management Report" as the appropriate category for your document. You may enter multiple documents.)

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 through payment year 2012. Effective January 1, 2013, Alabama application will define "Practices Predominantly" to include within the most recent calendar year or within the 12-month period preceding attestation.

Methodology:

- 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 the FQHC/RHC, standard is met. If not, it is not. 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.

Process: EPs must attest to their denominator and in attesting to the denominator of their total book of business, A-SMA requires that the EP state locations of practice, including FQHCs/RHCs

and total population by location. APHCA collects data on behalf of the Medicaid Agency on the Alabama FQHCs/RHCs, reviews federal reports substantiating the information and provides a report to Medicaid validating the information. The agency validates the provider’s employment in an FQHC/RHC against information provided by APHCA. Where the EP states he/she is full-time at the FQHC/RHC and the APHCA information confirms, the standard is met. (For auditing purposes, A-SMA 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, A-SMA will make a determination of “predominantly at an FQHC”. If the EP is less than full time but the EP can reach the 30% standard using Medicaid enrollees only from non-FQHC/RHC locations, 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. If provider is not on the APHCA provided list, the agency will contact the FQHC for additional information to make this determination. Medically Needy patient volumes submitted must match volumes included in the APHCA report for FQHC. If there is no match, the provider will be contacted for clarification. If there is a discrepancy of over a designated percent and volumes cause the Medicaid percentage to drop below 30% (20% for pediatrician), the provider is ineligible. Discrepancy cases will be flagged for post payment audit.

4.8 HOW WILL THE SMA VERIFY ADOPT, IMPLEMENT OR UPGRADE (AIU) OF CERTIFIED ELECTRONIC HEALTH RECORD TECHNOLOGY BY PROVIDERS?

Standard for 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. 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 CMS Registration and Attestation System and select Alabama as the payment state. Since EPs/EHs can switch prior to payment, review of the CMS Registration and Attestation System prior to payment is completed through the state submitting a file to the CMS Registration and Attestation System for verification.

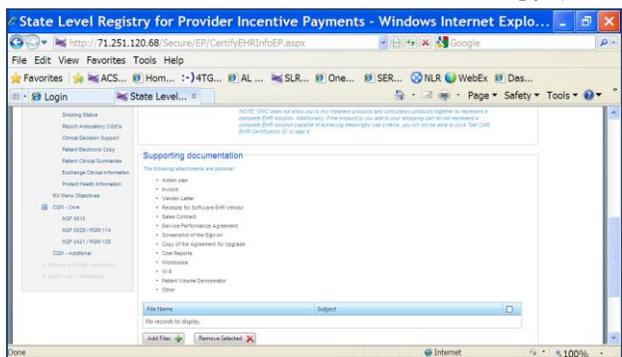


Figure 40: Documentation Options

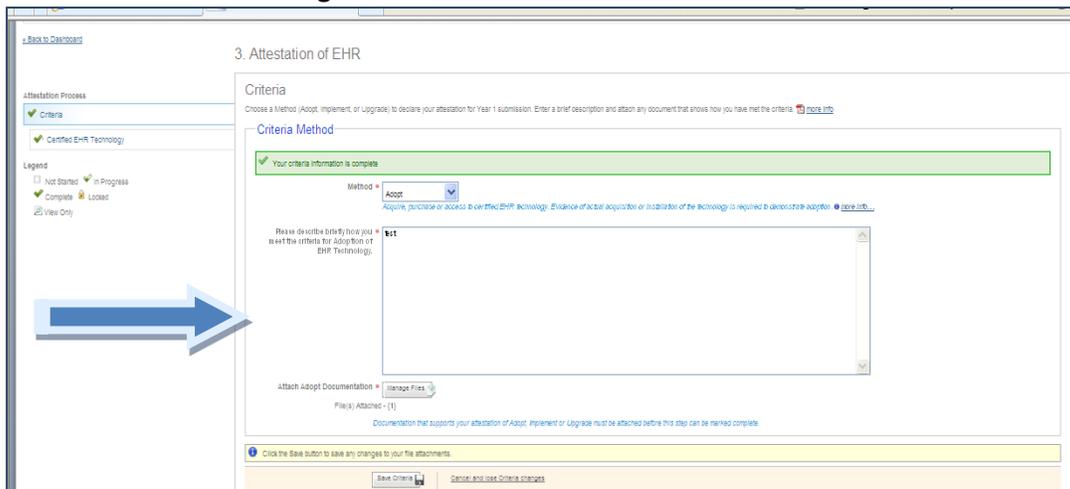
Methodology: EPs and EHs must attest to AIU and provide evidence that demonstrates actual purchase/acquisition and or installation. The EP or EH must submit the certification number of the provider’s ONC certified EHR Technology as a part of the registration and attestation process. The EP and EH must sign and attach the Attestation Agreement.

Process: The state validates that the appropriate documents are submitted for attestation against the following list: receipts for software EHR vendor, sales contract, agreement, and screenshot of the sign on the EHR, a copy of the agreement for upgrade, vendor letter, containing vendor name, version and certification number, and work plan (EH), cost report, invoice, or other reasonable documents. If there is no document or it is not one of the documents listed above, the state contacts the provider to request correct documents. If the document provided does not match the EHR system described, the state will contact the provider. In any of these situations, the state will pend the application for submission of appropriate documents.

The SLR system validates the certification number against the ONC Certified HIT Product List database. The system verifies that the certification number submitted matches the EHR technology to which the provider attested. If the certification number does not match, the provider is unable to proceed with the application. The state then contacts the EP or EH for clarification. The application pends in the meantime. Pended applications are reviewed periodically and the provider is sent follow-up e-mails and, if no response, telephone calls.

If the attestation agreement is present, entries 7-10 match information submitted by the provider and the signature of EP of record or EH representative is present, the EP/EH is eligible for payment for AIU. The screen shot for submitting the attestation of a certified EHR follows in Figure 41.

Figure 41: Attestation of Certified EHR



4.9 HOW WILL THE SMA VERIFY MEANINGFUL USE OF CERTIFIED ELECTRONIC HEALTH RECORD TECHNOLOGY FOR PROVIDERS' SECOND PARTICIPATION YEAR?

Standards: In order to receive Medicaid incentive payments, providers will be required to demonstrate - and A-SMA will track and validate - meaningful use of CEHRT 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 One Health Record® AHIE S/OPs has made e-Prescribing, structured lab results and clinical exchanges core functionalities. One Health Record® went "live" April 2012.

In response to the regulatory changes for Stage 1 MU, A-SMA will implement January 1, 2013, the mandatory and optional changes into Alabama’s policy, SLR and business processes. This includes changes to the A-SMA audit protocol. The audit strategy is provided in detailed in Attachment 8.15.

Methodology: Starting in 2012, meaningful use objectives and clinical quality measure results were reported to the state by EPs and EHs to demonstrate that they have used EHR technology in a meaningful way.

The changes effective payment year 2013 related to the reporting of measures are provided in the following Table 20a.

Table 20a: Payment Year 2013 Changes to Reporting Measures for Objectives

Attestation Component	System Validation	State Action	Provider Action
Additional Alternate Measure for CPOE Objective	<p>A-SMA accommodated the additional optional measure for 2013 for the CPOE objective: More than 30% of the medication orders created by the EP or authorized providers of the EH’s or CAH’s inpatient or ER (POS 21 or 23) during the EHR reporting are recorded using CPOE.</p> <p>The current measure option will be retained: 30% of unique patients with at least one medication in their medication order entered using CPOE.</p>	<p>A-SMA:</p> <ul style="list-style-type: none"> • Information on the State website and SLR has been revised to incorporate the change to the objective. • Provider Outreach includes (1) e-mail, webinars, website updates, and dissemination of information to provider groups (provider and hospital associations), and (2) coordination of AL-REC to engage CAHs to achieve MU. 	<p>SLR: The SLR was revised to allow this objective as optional as of January 1, 2013, for 2013 onward.</p>
Additional e-Prescribing Exclusion	<p>Alabama has accommodated the required addition of an additional e-prescribing exclusion that may be claimed by any EP who does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP’s practice location at the start of his/her EHR reporting period.</p>	<p>A-SMA: Required for 2013 forward for EPs attesting to Stage 1 of MU.</p> <p>Information on the State website and SLR have been revised to incorporate the change.</p> <p>Provider Outreach includes e-mail, webinars, website updates, and dissemination of information to provider associations,</p>	<p>SLR: The SLR has been revised to support this requirement for EPs attesting to Stage 1 of MU.</p>
Vital Signs Addition of Alternative	<p>A-SMA has accommodated this optional measure for 2013 and made it mandatory 2014 that</p>	<p>The definition for a second denominator has been added with the ability for the user to</p>	<p>SLR: The SLR has been revised to support this</p>

Attestation Component	System Validation	State Action	Provider Action
Age Limitations	<p>affect the age limitations on growth charts and blood pressure. More than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data.</p>	<p>indicate which denominator they are using for reporting.</p> <ul style="list-style-type: none"> • Information on the State website and SLR were revised to incorporate the change. • Provider Outreach includes e-mail, webinars, website updates, and dissemination of information to provider groups (provider and hospital associations). • Coordination of AL-REC to engage CAHs to achieve MU. 	<p>option for 2013 only for EPs attesting to Stage 1 of MU.</p>
Vital Signs Exclusions Change	<p>A-SMA has accommodate the following optional modifications to the exclusions for 2013 and make them mandatory 2014:</p> <ul style="list-style-type: none"> • Any EP who sees no patients 3 years or older is excluded from recording blood pressure • Any EP who believes that all three vital signs of height, weight and blood pressure have no relevance to his/her scope of practice is excluded from recording them • Any EP who believes that height and weight are relevant to his/her scope of practice, but blood pressure is not is excluded from recording blood pressure • Any EP, who believes that blood pressure is relevant to his /her scope of practice, but height and weight are, not, is excluded from recording height and weight. 	<p>A-SMA:</p> <ul style="list-style-type: none"> • Information on the State website and SLR has been revised to incorporate the change. • Provider Outreach includes e-mail, webinars, website updates, and dissemination of information to provider associations, 	<p>SLR: The SLR has been revised to support this as optional for 2013 only for EPs attesting to Stage 1 of MU and makes it required for 2014.</p>

The changes to the Core and Menu measures and CQMs identified in the Final Rule that are effective in Program Year 2014 are under development for inclusion in the SLR. The screen shots have been submitted to and approved by CMS and are included in Appendices 8.17 and 8.18 and include those corrections to CQMs issued by CM on 9/26/2013.

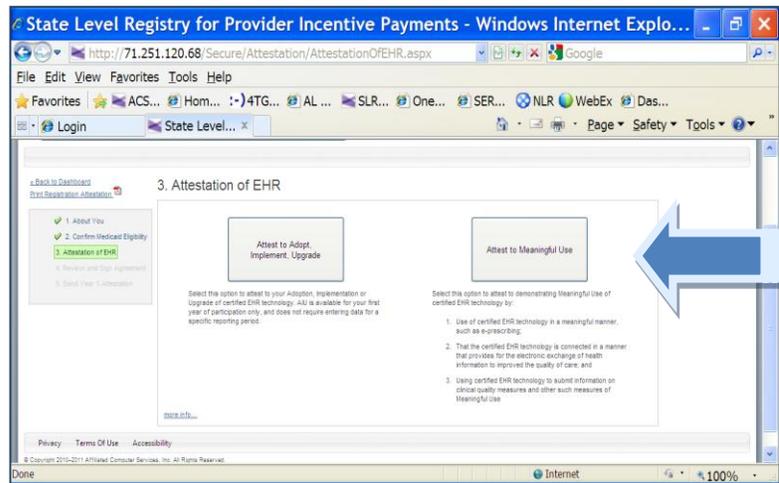
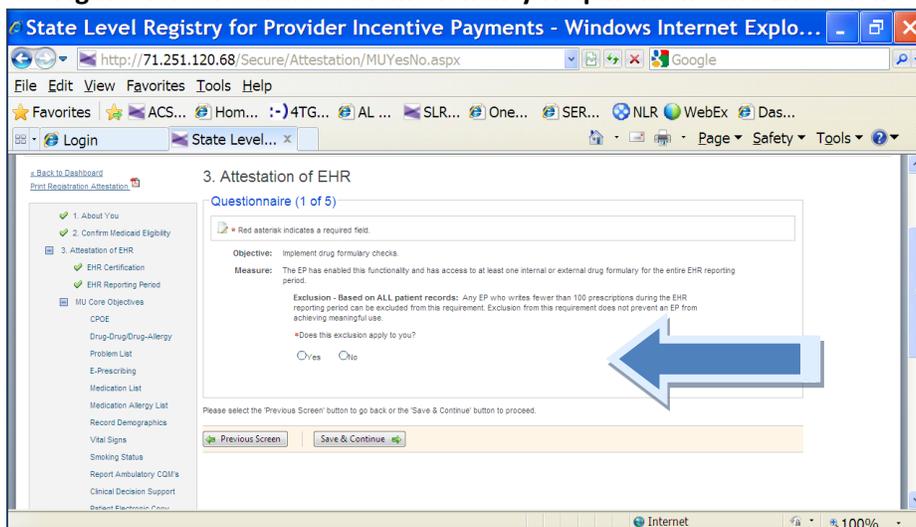


Figure 42: Screenshot to Attest to MU

Process: CQMs are reported during the attestation process along with the meaningful use core and menu objectives. Providers enter the denominator, numerator and any applicable exclusion results directly into the attestation system. A-SMA will continue many of the steps of Payment Year 1 (for AIU) into the MU processes, but has added appropriate additional technical functionality and business processes to address the new parameters, including the EHR certification period and MU core objectives. A-SMA’s vendor (XEROX) went “live” with the MU phase in April 2012.

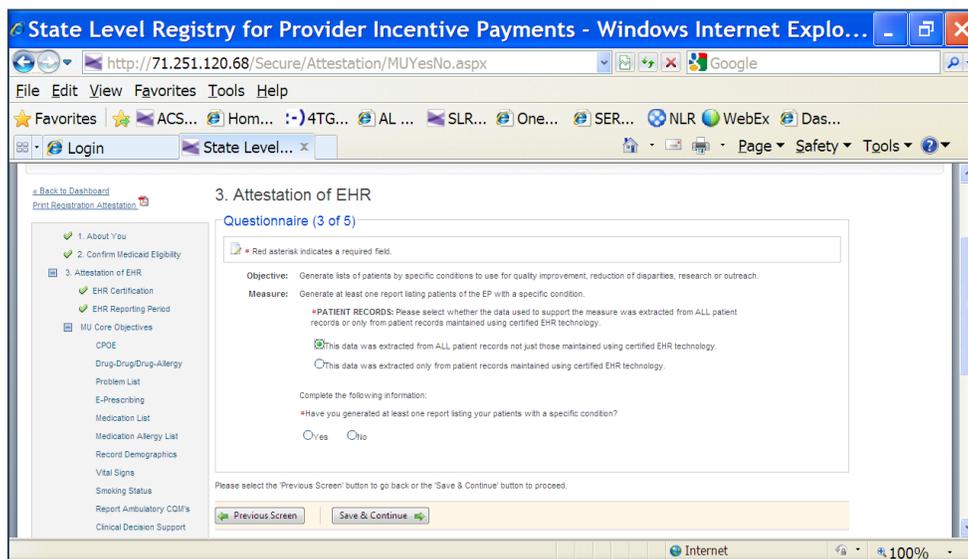
Alabama EPs and EHs will follow the same basic process for attesting for MU as was followed for AIU. However, EPs and EHs will be attesting to use of their certified EHR in a meaningful way. To allow providers to attest to core objectives, the SLR provides a screen that identifies the objective, provides exclusion criteria, and allows providers to exclude themselves from a measure when appropriate. All core objectives are provided on the left side of the screen with the particular objective for attestation with measurement specification on the right side of the screen. Some objectives deal with functionality and others with use.

Figure 43: Screenshot of Functionality Requirement and Exclusion



When an objective requires data from a patient record, the provider must attest to as to whether the data was extracted from all patient records or only from patient records maintained using certified EHR technology. An example of a relevant screen shot is included in Figure 44.

Figure 44: Patient Record Data



Other objectives require connectivity to public health, such as reporting of immunizations and syndromic surveillance. An updated screen shot of the attestation for reporting information to a public health immunization registry that accommodates the Stage 1 MU changes January 1, 2013, follows, and the screenshots for syndromic surveillance is provided in Attachment 8.13, which is included at the end of this document.

Figure 45: Attestation for Reporting Immunizations

EP CORE 16 IMMUNIZATION REGISTRY

Questionnaire (16 of 17)

Red asterisk indicates a required field.

Objective: Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice.

Measure: Successful ongoing submission or electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period.

Exclusion: Any EP that meets one or more of the following criteria may be excluded from this objective:

- 1) the EP does not administer any of the immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period;
- 2) the EP operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required for CEHRT at the start of their EHR reporting period; ***Note: if an entity designated by the immunization registry or immunization information system can receive electronic data submissions, a provider may not claim this exclusion.**
- 3) the EP operates in a jurisdiction where no immunization registry or immunization information system provides information timely on capability to receive immunization data, or
- 4) the EP operates in a jurisdiction for which no immunization registry or immunization information system that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional EP's.

* Does this exclusion apply to you?

Yes No

Complete the following information:

* Do you have successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period?

Yes No

Immunization Registry or Information System

Select

Date of Registration of Intent

Have you received Acknowledgement from the Immunization Registry? Yes No

[← Back to Dashboard](#)
Print Registration Information

3. Attestation of EHR

Questionnaire (9 of 10)

Red asterisk indicates a required field.

Objective: Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and actual submission in accordance with applicable law and practice.

Measure: Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically).

Exclusion 1 - Based on ALL patient records: An EP who does not perform immunizations during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

*Does this exclusion apply to you?

Yes No

If a letter was issued from the Immunization Registry stating it was not possible to test during the Reporting Period, or that a test failed, please attach it using the Attach Files component on this page.

Attach Files

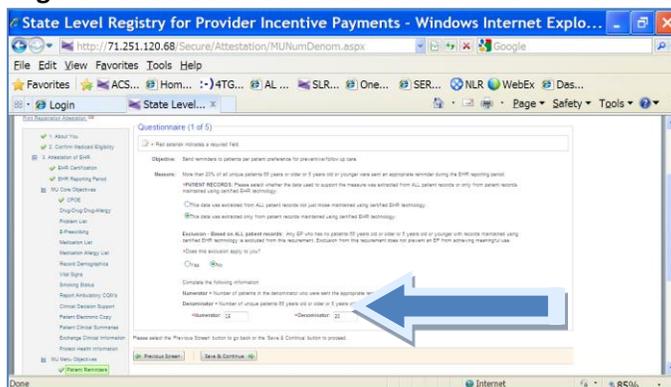
The following attachments are optional:

- Other Attachment

File Name	Subject	Remove
No records to display.		

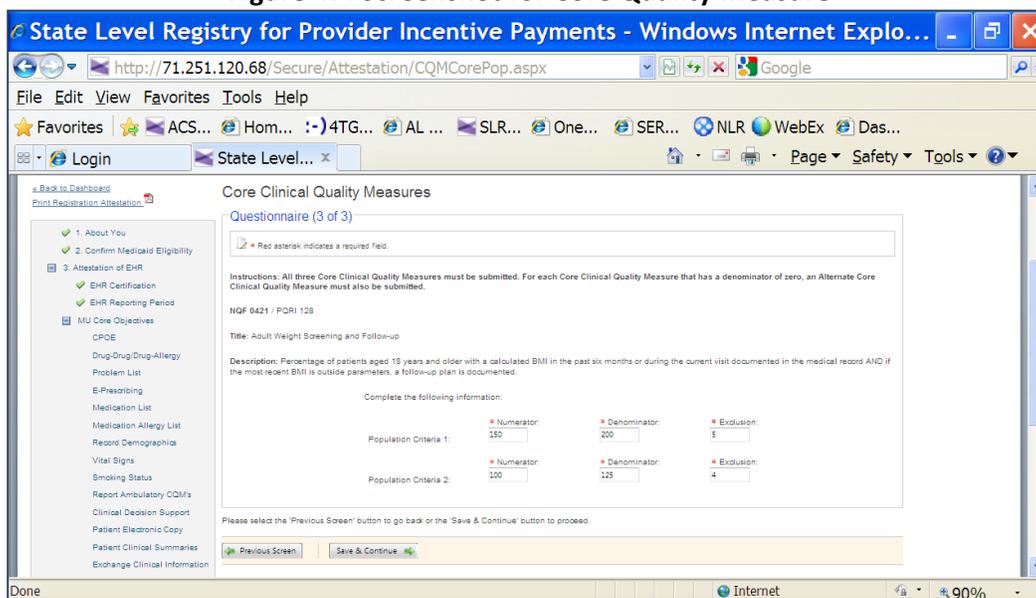
The menu objectives require reporting numerator and denominator using federally established specifications. The measure, specification, definitions and exclusions are provided by A-SMA and the provider can attest to exclusion or the actual numerator and denominator for each. A screen shot illustrating one of the menu measures follows.

Figure 46: Screenshot Attestation of Menu Measure



Lastly, providers must report on EHR technology to report clinical quality measures. The state provides screens for the provider to attest to the selection of the 3 core or alternative and 3 additional objectives and related measures, data source, exclusions, population criteria, numerator and denominator. An example of a screenshot for a core measure follows:

Figure 47: Screenshot for Core Quality Measure



For EHs for both the Medicare and Medicaid EHR incentive programs, CMS will collect the meaningful use measures; therefore the Alabama SLR has the capacity to collect from CMS, retain, analyze and use the information for Medicaid purposes. A-SMA is able to access the MU data from the C5 file transmitted from CMS by hospitals eligible for both Medicare and Medicaid EHR incentive payments in order for the State to integrate the data into SLR data fields for EH

MU Core and Measure and CQMs. A-SMA is thus able to use the data during the state’s oversight processes. A-SMA accepts the C5 file as evidence of Medicare attestation approval all dual eligible EHs and uses that approval as acceptance of the EH’s Meaningful Use of CEHRT.

All screenshots were submitted by Alaska as the lead representative of the SLR collaborative states that use the Xerox COTS platform. These were approved by CMS. A-SMA understands that the inclusion of the screenshots in the submission of the A-SMHP does not constitute submission of the screen shots.

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.

A-SMA is not proposing any changes to the MU definitions at this time.

4.11 HOW WILL THE SMA VERIFY PROVIDERS’ USE OF CERTIFIED ELECTRONIC 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. A-SMA will verify compliance with all three components for MU.

Methodology:

- *Pre-Payment:* A-SMA will validate the appropriate documents are submitted for attestation. Validate documents include receipts from the software EHR vendor, a sales contract or agreement, a copy of the agreement for upgrade, vendor letter that confirms acquisition or a legal obligation or invoice. After the AIU stage, acceptable documentation for MU will eliminate work plans and action plans.
- *Post-Payment:* The focus of the post payment audit is the areas that the agency is unable to validate during the pre-payment validation, including the certified EHR System is as reported and is used, the EHR is the data source for measurement, and the EP/EH is accurately reporting the measurements and results. The updated audit strategy is provided in Attachment 8.15.

Process: If documentation is not one of the documents identified above, or does not match the EHR system described by the EP/EH, the state will contact provider to request the submission of the correct documents and pend the application for submission of appropriate documentation.

The provider must also submit the certification number of the provider's ONC certified EHR Technology. The SLR system validates the certification number against the ONC Certified HIT Product List database. Where an issue has been identified, the provider is flagged for post payment audit.

EPs and EHs will be selected on a 10-15% random sample. In addition, EPs or EHs whose submissions have been identified as "flag for post payment audit" will be automatically selected for audit.

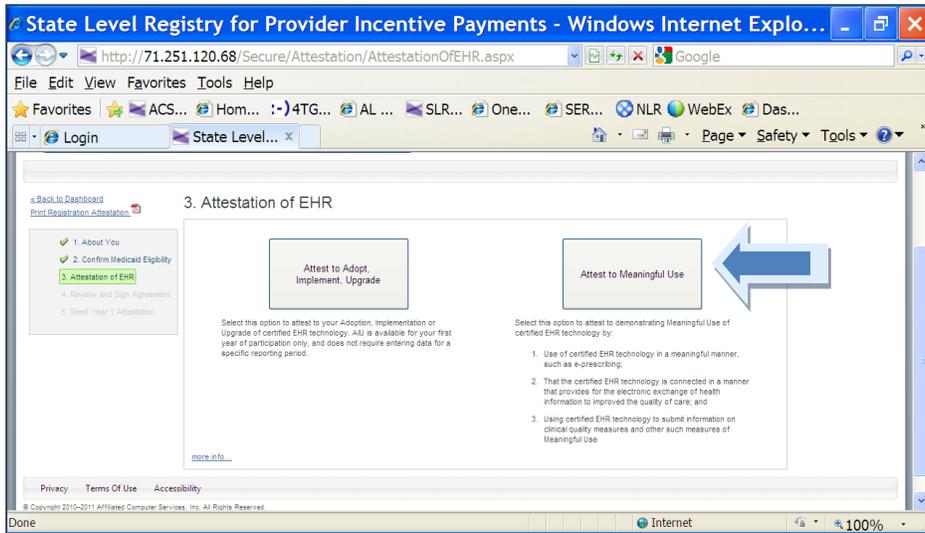
4.12 HOW WILL THE SMA COLLECT PROVIDERS' MEANINGFUL USE DATA, INCLUDING THE REPORTING OF CLINICAL QUALITY MEASUREMENTS? DOES THE STATE ENVISION DIFFERENT APPROACHES FOR THE SHORT-TERM AND A DIFFERENT APPROACH FOR THE LONGER-TERM?

Standard: The initial reporting period for collection of meaningful use data is 90 days. During this period the provider must demonstrate meaningful use of certified EHR technology and the state is required to validate to CMS that providers meet all of the eligibility criteria to qualify for Medicaid incentive payments for the meaningful use of information, including the applicable patient volume thresholds, hospital-based requirements, and all other requirements. CQMs are reported during the attestation process along with the meaningful use core and menu objectives.

Methodology: As explained in great detail in Section 4.9, starting in January 2012, meaningful use objectives and clinical quality measure results will be reported to the state by EPs and EHs to demonstrate that they have used EHR technology in a meaningful way using the same attestation process and SLR as they used for AIU. Providers will enter the denominator, numerator and any applicable exclusion results directly into the attestation system to demonstrate meaningful use. For demonstration that they are meaningful users of Electronic Health Records (EHRs), EPs should use the EHR reporting period associated with that payment year. For the first payment year that an EP is demonstrating meaningful use, the reporting period is a continuous 90-day period within the calendar year through 2012. Effective payment year 2013, Providers will have the option to elect to use either a 90 day period in the previous calendar year or 12 months immediately preceding the attestation. Alabama currently requires each provider to submit a workbook detailing how Medicaid encounters were determined and reports from an auditable source (such as a Practice Management System) to support the data submitted. The workbook has been updated and information on the State website and the SLR will be revised to incorporate the expanded definition. For subsequent years, with the exception of Program Year 2014, the period is the full calendar year. In 2014, the reporting period is 90 days.

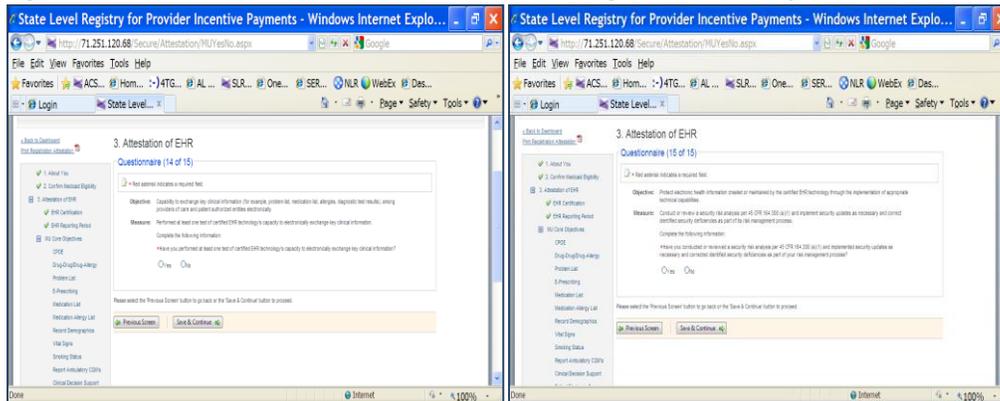
Process: The process is fully explained in 4.9. The requirement changes from AIU to MU resulted in a change in the attestation screen which states what the EPs and EHs must attest to for MU. Each provider must provide reports from his/her practice management system (PMS) validating the denominator and numerator.

Figure 48: MU Attestation Screenshot



Copies of all the original screen shots are provided in Attachment 8.10. Updated screenshots for Stage 1 are provided in Attachment 8.13. There are 15 components of the Attestation Questionnaire for MU, including as shown below attestation of capability to exchange information and complete a security risk assessment.

Figure 49: Screen Shots for Information Exchange and Security Risk Assessment



Screenshots for updated measures effective for the 2014 Program Year are provided in Attachments 8.17 and .8.18.

4.13 * HOW WILL THIS DATA COLLECTION AND ANALYSIS PROCESS ALIGN WITH THE COLLECTION OF OTHER CLINICAL QUALITY MEASURES DATA, SUCH AS CHIPRA?

Standards: A chart of all the quality measures by program, including MU, is provided in Attachment 8.17 and 8.18.

Methodology: The attestation process for MU requires the reporting of the actual numerator and denominator. Some measures have denominators of unique patients regardless of whether the patient’s records are maintained using certified EHR Technology or not and other measures

include in the denominator of only patients whose records are maintained using a certified EHR. Other measures require only a yes/no attestation.

The state has identified measures specifically for their Patient 1st Program and the approved A-SMA's State Plan Amendment (SPA) for health homes for individuals with chronic illness measures align with MU in measure specifications. For example, Patient 1st measures for care coordination include the "reconciled medication list" and "timely transmission of transition care record".

Process: Alabama is moving to more electronic information sharing so information can be available, accessible and integrated in the care team's work flow as well as available at the point of care. The intent is to allow the Medicaid Regional Care Organization (RCO) care team members and patients to communicate clearly, consistently and accurately about a patient's health status and service delivery needs through the use of tools and resources which facilitate data exchange. It is the longer term goal of A-SMA through its RCOs to provide timely and complete clinical information to health care providers at the point of care, including PMPs, and Network team members; specialty physicians; emergency physicians; hospitalists and other providers within acute care facilities; health care providers at skilled nursing facilities and rehabilitation centers. Through the use of One Health Record[®] capacity, RCOs and their network providers will be able to access imaging, laboratory and pathology and medications.

Alabama intends to leverage the EHR Incentive Program clinical quality measures for both the adult Medicaid measures (A-SMA is a grant awardee for the adult Medicaid measures) and the RCOs, which includes children and adults, including pregnant women and individuals with chronic conditions. A-SMA's focus is currently on transitioning from claims based measurement to clinical measures based on data from the certified EHRs. In addition, A-SMA is moving to a Regional Care Organization (RCO) Medicaid delivery system and incorporating the efforts of Patient 1st into the planning and preparation for the RCOs. The A-SMA is currently in the planning and preparation stage related to e-CQMs. One Health Record[®] is expected to be the transport mechanism for the meaningful use e-CQM measures.

Although Alabama has a separate CHIP program, the state views standardization of data collection and measurement as a core principle for infrastructure development. In addition to gaining dual benefit from the reporting of these measures, the approach decreases provider burden. A-SMA intends to use the four clinical quality measures that overlap MU and CHIPRA proposed measures for children: Weight Assessment Counseling for Children and Adolescents, Chlamydia Screening for Women, Childhood Immunization Status and appropriate testing for children with pharyngitis. 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?

Standards: The initial SMHP addressed the various IT, fiscal and communication systems used to implement the Alabama EHR Incentive Program as the SLR became operational in 2011. The expanded MMIS, using the MITA framework 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, includes a separate contract for the SLR (XEROX as vendor), interfaces with the MMIS claims and provider systems (HP fiscal agent as vendor), and as of 2012 interfaces with One Health Record® (TR as vendor).

Methodology: To meet initial timelines, some processes were manual for the initial year. As of June 2013 all meaningful use payments are processed through the A-SMA MMIS system and such are handled through the electronic fund transfer capabilities used for claims. There are still two scenarios that require incentive payments to be processed manually through the new state finance system. These two scenarios deal with two state medical school entities.

Process: A-SMA is now reviewing various approaches to collect clinical quality measures from meaningful use providers that incorporate an enterprise approach to data analytics. At this time a combination of the One Health Record® and the MMIS decision support system is being contemplated. A-SMA is also considering the viability of using the SLR to capture QRDA 1 measures. (Maturity Level 3-4).

4.15 WHAT IT SYSTEMS CHANGES ARE NEEDED BY THE SMA TO IMPLEMENT THE EHR INCENTIVE PROGRAM?

Standards: The initial A-SMHP provided the high level overview of the year one IT system changes needed to implement the EHR incentive program for AIU. In addition to the systems currently in place for registration and attestation for AIU through the SLR, systems support is provided for the payment process. Changes to the SLR, will accommodate MU attestation, reporting and payment.

The system's structure, as indicated in the initial I-APD is to support provider eligibility, payment and allow the state to adequately provider financial and quality oversight. The changes to the SLR and the interface with the NLR required to address the changes to Stage 1 as a result of the final MU Stage 2 regulation were provided earlier in Table 2a and Table 6a. All system changes for January 1, 2013 have been implemented. System changes for those provisions of the regulations that will become effective in Program Year 2014 are listed in Attachment 8.16. Screenshots for this functionality have been approved by CMS and are listed in Attachments 8.17 and 8.18.

Methodology: Screen shots for the attestation and reporting provided in previous sections indicate some of the IT changes required to support MU. Reporting requirements for ARRA and ongoing Medicaid are through the current financial reporting systems. The original I-APD for MU included funding for all components related to the MU system and the current vendor contract provisions include system updates for all anticipated program changes.

The ASM SLR interfaces with the CMS Registration and Attestation System in order to determine compliance with all of provider eligibility requirements, including:

- Appropriate provider type,
- Choice of Medicare vs. Medicaid for EPs,
- Choice of Alabama as the state of payment (information which will be provided through the CMS Registration and Attestation System),
- Use of certified EHR system (list of certified systems to be provided by CMS and cross-checked)
- Meets either the AIU or MU requirements.

The A-SMA SLR is able to retain documentation required by the state to validate the acquisition and installation or upgrade to a certified system in the initial implementation and activation.

Additional SLR functionality that is included and already operational:

- Web portal that allows EPs and EHs to complete the application process, view their information and track payment information. The web portal system pre-populates information from the CMS Registration and Attestation System, as well as receives and stores current Alabama MMIS provider enrollment. The system also addresses all requisite steps of the provider application process, including provider applicant eligibility determination, attestation, and payee determination; application submittal confirmation; Medicaid payment determination (including CMS Registration and Attestation System confirmation) and payment generation.
- Repository of all registration and attestation data and document upload.
- Capacity for certain authorized users (e.g. state staff) to enter notes at various stages of the process. (Secure email functionality directly from the system has not yet been enabled.)
- Print and download capability in an unalterable format.
- Application progress tracking and payment.

Process: The SLR (XEROX) provides capacity to accommodate connectivity to the CMS Registration and Attestation System for registration, support the SLR registration, attestation and reporting, is able to validate and track EPs and EHs, and has the capacity to create invoices, make, track, report and audit payments and ongoing eligibility.

Additional activities, such as payment, require a combination of system and manual activities. For example, attestations approved for payment are extracted from the SLR system. The system then creates a payment listing for transmittal to the FA for payment through the MMIS. Upon completion of the payment, A-SMA retrieves the payment data from the MMIS, and the SLR is updated. A D-18 is sent to CMS.

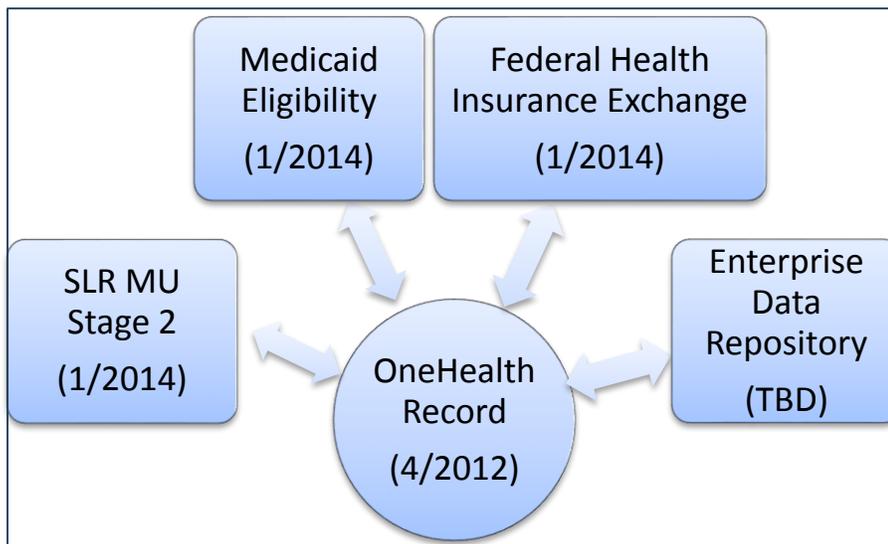
Enhancements to the SLR were completed to go from AIU to MU. Additional enhancements are under consideration to more fully automate the overall process, including areas such as electronic signatures. An enterprise state data repository is also required to support the MU measurement oversight process. Finally, One Health Record® (A-HIE) is needed to support EHs and EPs in the exchange of clinical information and connectivity to public health for reporting immunizations and syndromic surveillance. An I-APD was submitted and approved that includes

necessary changes to the SLR and funding for the Medicaid share of One Health Record® staff and appropriate system linkages to SLR.

4.16 WHAT IS THE SMA'S IT TIMEFRAME FOR SYSTEMS MODIFICATIONS?

The state will make system modifications as needed. The changes to the SLR for MU that are required for changes to Stage 1 as a result of the Stage 2 MU regulation were implemented prior to January 1, 2013. Those changes to the SLR that are effective for the 2014 Program Year are on target to be implemented by January 1, 2014 for EH and April 1, 2014 for EP. Those changes to the SLR that are effective for the 2014 Program Year are on target to be implemented by January 1, 2014 for EH and April 1, 2014 for EP. Those changes to the SLR that are effective for the 2014 Program Year are on target to be implemented by January 1, 2014 for EH and April 1, 2014 for EP. One Health Record® went “live” in April 2012. Alabama Medicaid eligibility system will also “go live” prior to January 2014. The enterprise data repository does not have a specified date. Appropriate I-APDs will be submitted in the near future.

Figure 50: Health-IT System Development and Modifications



4.17 WHEN DOES THE SMA ANTICIPATE BEING READY TO TEST AN INTERFACE WITH THE CMS REGISTRATION AND ATTESTATION SYSTEM?

This was addressed in the initial A-SMHP. The interface was completed prior to implementation of the SLR for AIU. Alabama’s SLR effectively transfers data to and from the CMS Registration and Attestation System on an ongoing basis.

4.18 WHAT IS THE SMA'S PLAN FOR ACCEPTING THE REGISTRATION DATA FOR ITS MEDICAID PROVIDERS FROM THE CMS REGISTRATION AND ATTESTATION SYSTEM (E.G., MAINFRAME TO MAINFRAME INTERFACE OR ANOTHER MEANS)?

Standard: The interface between the CMS Registration and Attestation System and Alabama SLR is a mainframe to mainframe interface as indicated in the initial A-SMHP. There has been no change. All data elements from the CMS Registration and Attestation System are 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, eligible professional or institution type and EH MU Measure data.

Methodology: The CMS Registration and Attestation System will provide information about providers who have applied for the incentive program. After passing high level editing during the CMS Registration and Attestation System 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 is a valid Medicaid provider type, he/she may access the state system.

The system home page has a status bar displaying the status of the provider applicant's record. The system uses the NPI associated with the logon ID to search for a match. If a match is found, the provider has been verified and may proceed to the next step. If no match is found, then the provider is given an error message indicating that there is no match for the record from the NLF. The provider is instructed to contact the CMS Registration and Attestation System.

The Provider enters the SLR and is able to view the CMS Registration and Attestation System 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 EP/EH is directed to the CMS Registration and Attestation System to fix the information. 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.

The Medicaid EHR Incentive Program registration provides 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. The Medicaid EHR Incentive Program attestation section will provide data originally submitted by calendar year. Other SLR information includes payment information (payment summary Information, program year payment issue date, payment method, payment address, payment amount, withheld reason and EHR Incentive Program Status) and 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).

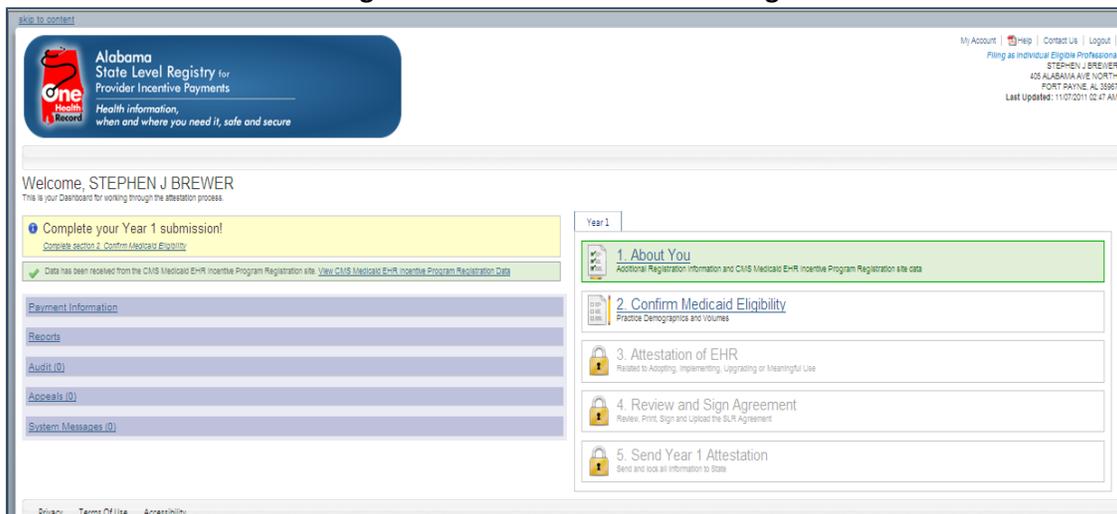
4.19 WHAT KIND OF WEBSITE WILL THE SMA HOST FOR MEDICAID PROVIDERS FOR ENROLLMENT, PROGRAM INFORMATION, ETC?

Standard: As indicated earlier in this document and in the initial A-SMHP, the Web portal allows EPs and EHRs to complete the application process, view their information and track payment information. The website has been operational since April 2011 for AIU and is HIPAA compliant. It has been and will continue to be enhanced, to allow for MU.

Methodology: The web portal system pre-populates information from the CMS Registration and Attestation System, receives and stores current Alabama MMIS provider enrollment, addresses all requisite steps of the provider application process, including provider applicant eligibility determination, attestation, and payee determination; application submittal confirmation; Medicaid payment determination (including CMS Registration and Attestation System confirmation) and payment generation. The web portal has a login requirement and other appropriate privacy and security safeguards addressing access, authorization and authentication.

Process: Copies of the screenshots are provided in Attachment 8.10 and throughout the A-SMHP document in response to appropriate questions. The home page screenshot follows:

Figure 52: SLR Web Site Home Page



The One Health Record® home page provides a link to this site. A link also exists from the A-SMA home page assuring providers can find the site. The SLR portal also provides a link to the CMS Registration and Attestation System to ease provider’s access. (See Figure 53.)

Figure 53: One Health Record® Website

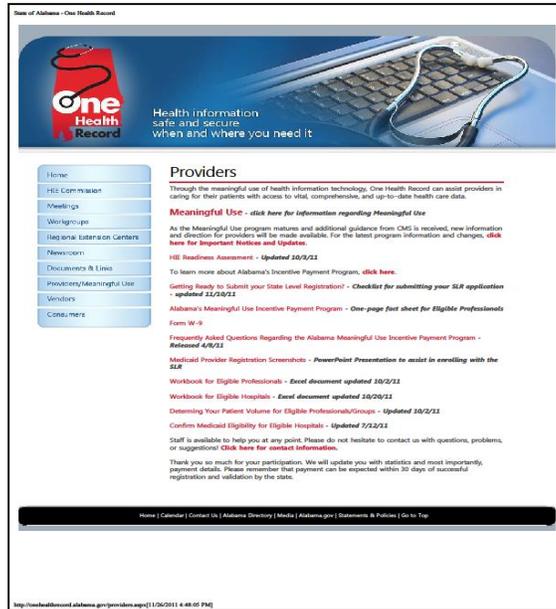


Figure 54: Medicaid

Agency Home Page



4.20 DOES THE SMA ANTICIPATE MODIFICATIONS TO THE MMIS AND IF SO, WHEN DOES THE SMA ANTICIPATE THE MMIS-I-APD?

Standards: As addressed in Section 4.16, Alabama anticipates “modifications” to the “expanded” MMIS system as expansions to the MMIS system of systems to include One Health Record. The state has already received funding and approval for the updated Alabama Medicaid eligibility system.

Methodology: Current interfaces between the SLR and MMIS claims and provider management systems continue. Over time and to the degree possible, manual operations will be replaced by more automated processes but the current priority to inclusion of necessary functionality, ease

and consistency for providers and standardization of activities to assure effective, efficient and timely operation.

Process: As indicated earlier in this updated A-SMHP, an I-APD has been submitted to fund changes related to the EHR Incentive Program, including Medicaid's fair share of One Health Record® and the enterprise state data repository with analytical capabilities. A separate I-APD has already addressed the Medicaid eligibility system.

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: From the beginning of the process, Stakeholder education and engagement have been core principals of the One Health Record® 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. A-SMA's approach to addressing EP and EH questions regarding the incentive program has been multifaceted, including presentations at various stakeholder and provider regional and statewide meetings (AMGA, HIMSS, Academy of Pediatrics, etc.), educational information on the One Health Record® and A-SMA home pages with links to the SLR, information on the SLR website and linkage to the CMS "FAQ" website.

Methodology: A-SMA's A-SMA is responsible for the MU Incentive Activities as indicated in an earlier section. Full time staff is dedicated to the EHR Incentive Program and their contact information (e-mail and phone) is available on the websites. A-SMA's vendor, XEROX, provides a help desk staffed by a call center for providers.

Process: The first point of contact is the A-SMA for questions and information about the EHR Incentive Payment Program. A-SMA staff is available daily to address questions and assist providers in the process. Providers can and do call A-SMA staff daily regarding the program requirements, processes and individual issues and/or clarifications. A-SMA has taken a concrete approach of individually handling any issue identified to them by a provider to reduce any barriers to registration and payment. In addition, XEROX has established a call center with contact information posted on each page (telephone number and e-mail). There are escalation processes in place for systems issues and, if the inquiries are program related, they are sent to the A-SMA either via e-mail or phone.

A-SMA has sought to utilize current methods of communication to assure information is provided readily and consistently. For instance, One Health Record® has established an ongoing "newsletter", which the state has also used for communicating information related to the EHR Incentive Program. When CMS has issued an alert of new FAQs, the state has forwarded the information on to interested parties.

A-SMA also works directly with the REC, which provides direct technical assistance and training for priority REC providers, many of whom are Medicaid providers seeking to become EHs and/or EPs and obtaining and maintaining MU status. Consistent communication material has been

created by Tuskegee University that is available to the REC and A-SMA for provider education. Materials created and disseminated are provided in Attachment 8.1.

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: Providers whose application for AIU or MU is rejected may appeal the decision (Attachment 8.9). EPs and EHs can protest a negative decision by the state related to participation eligibility, attestation decision and calculation of EHR Incentive Payment.

Alabama has taken the option to have CMS perform audits and handle any subsequent appeals of whether a EH is a “meaningful user” on behalf of the state. Via this updated A-SMHP, A-SMA hereby agrees that Alabama:

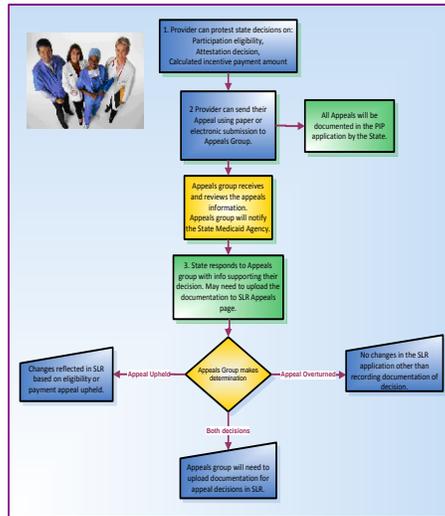
- Designates CMS to conduct all audits and any resulting appeals of eligible hospitals' meaningful use attestations;
- Is bound by the audit and appeal findings;
- Will perform any necessary recoupments arising from the audits;
- Will be liable for any FFP granted the state to pay EHs that, upon audit (and any subsequent appeal) are determined not to have been meaningful EHR users; and
- Acknowledges that the results of any adverse CMS audits would be subject to the CMS administrative appeals process and not the Alabama appeals process.

Methodology: EHR Incentive Payment appeals are treated like other appeals. If a provider disagrees with a Medicaid determination with regard to an appealable issue, the provider may request a dispute resolution meeting. The request can be submitted via paper or electronic. They are submitted to the Alabama Appeals Group and the appeal is documented in the PIP application by the state.

A provider's request for a resolution meeting shall clearly identify each specific issue and dispute, state the basis on which A-SMA'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.

Process: When an appeals group receives an appeal, the group reviews the appeals information and notifies A-SMA. A-SMA then responds to the Appeals Group with the information supporting their decision and will upload documentation to the SLR Appeals page as appropriate. The Appeals Group makes a determination. If the appeal is upheld the appropriate changes are reflected in the SLR. If the appeal is overturned, there would be no changes in the SLR application other than recording documentation of the decision. In either case, the Appeals Group will upload the documentation for the appeal decision into the SLR. The workflow is illustrated in Figure 55.

Figure 55: Provider Appeal Process



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 ADMINISTRATION MATCH, ARE ACCOUNTED FOR SEPARATELY FOR THE HITECH PROVISIONS AND NOT REPORTED IN A COMMINGLED MANNER WITH THE ENHANCED MMIS FFP?

Standard: As indicated in the initial A-SMHP, 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. There have been no changes.

Methodology: As CMS created a new line item on the 64/37, Alabama did the same for state budgetary reporting. In addition, all provider incentive payments are coded to match the federal specifications so only EPs and EHs are paid and the appropriate payment amount is reported to CMS for quarterly federal financial reporting. Alabama has assigned separate fund codes for tracking and accounting purposes (THE: health exchange TMU: meaningful use).

Process: A-SMA has appropriately billed for the 100 percent funding for EHR Incentive Payments issued to date. A-SMA has also appropriated drawn down funding for direct A-SMA staff working on the EHR Payment Program. A-SMA has not made full use of Medicaid funding that is available for the Medicaid share of One Health Record® and contract support. A-SMA will update the SMHP to address changes to the One Health Record® to accommodate efforts to onboard eligible EP types and rural EHs and accommodate quality measurement and reporting needs related to the transition of the state to Medicaid Regional Care Organizations (RCOs) in a follow-up SMHP submission.

Upon submission and approval of the all SMHP updates and related I-APDs, A-SMA will report on the appropriate lines of the CMS 37 and CMS 64 ARRA HITECH HIT-MU expenditures, ARRA HITECH HIT-HIE expenditures and the applicable MMIS. A-SMA will continue to submit relevant

contracts to CMS for review and approval prior to requesting funding for them in the federal reporting.

4.24 WHAT IS THE SMA’S ANTICIPATED FREQUENCY FOR MAKING THE EHR INCENTIVE PAYMENTS (E.G. MONTHLY, SEMI-MONTHLY, ETC.)?

Standard: A-SMA has paid EPs and EHs as their applications have been approved within a payment cycle.

Methodology: The state has established a timeline for EHR Incentive Payments and is communicating the timeline to providers to avoid end of year issues. The Meaningful Use Incentive Payment Program began on April 1, 2011 and will end on December 31, 2021. EPs may receive incentive payments for up to six years for a maximum amount of \$63,750. An EP must submit the first application no later than 2016.

Process: The tables below provide the deadlines and reporting periods for EP Incentive Payment Applications as federal regulations prevent issuance of more than one incentive payment for any payment year. Providers will have the option to elect to use either a 90 day period in the previous calendar year or 12 months immediately preceding the attestation. Alabama currently requires each provider to submit a workbook detailing how Medicaid encounters were determined and reports from an auditable source (such as a Practice Management System) to support the data submitted. The EP workbook has been updated and information on the State website and the SLR will be revised to incorporate the expanded definition. The Alabama has created a new reporting period alternative in the SLR (12 months immediately preceding attestation) and enabled the validations. Within this framework, if an EP or EH completes the requirements and is eligible for an EHR Incentive Payment, the payment will be made at the next Medicaid payment cycle.

Incentive payments are currently issued through the FA MMIS via electronic funds transfer process biweekly unless special handling is required.

Table 21: EHR Incentive Payment Framework

Incentive Payment Basis	Program Year	First Date Provider May Apply	Last Date Provider May Apply	Meaningful Use Reporting Period
Adopt, Implement, or Upgrade and EHR Systems (AIU)	2011	4/18/2011	3/31/2012	There is no required reporting period
	2012	1/1/2012	3/31/2013	
	2013	1/1/2013	3/31/2014	
	2014	1/1/2014	3/31/2015	
	2015	1/1/2015	3/31/2016	
	2016	1/1/2016	3/31/2017	
	2012	4/1/2012	3/31/2013	Any 90 day period within the program year that begins on the first of the month.
	2013	4/1/2013	3/31/2014	

Incentive Payment Basis	Program Year	First Date Provider May Apply	Last Date Provider May Apply	Meaningful Use Reporting Period
Stage 1 90-Day MU Attestation	2014	4/1/2014	3/31/2015	The last date in the year for the reporting period to begin is October 1st of the year.
	2015	4/1/2015	3/31/2016	
	2016	4/1/2016	3/31/2017	
	2017	4/1/2017	3/31/2018	
	2018	4/1/2018	3/31/2019	
	2019	4/1/2019	3/31/2020	
	2020	4/1/2020	3/31/2021	
	2021	4/1/2021	3/31/2022	
Stage 1 365 Day MU Attestation	2014	4/1/2014	3/31/2015	Any 90 day period within the program year that begins on the first of the month
	2015	1/1/2016	3/31/2016	Full program year (January 1 to December 31)
	2016	1/1/2017	3/31/2017	Full program year (January 1 to December 31)
	2017	1/1/2018	3/31/2018	Full program year (January 1 to December 31)
	2018	1/1/2019	3/31/2019	Full program year (January 1 to December 31)
	2019	1/1/2020	3/31/2020	Full program year (January 1 to December 31)
	2020	1/1/2021	3/31/2021	Full program year (January 1 to December 31)
	2021	1/1/2022	3/31/2022	Full program year (January 1 to December 31)
Stage 2-1 Year MU Attestation	2014	4/1/2014	3/31/2015	Any 90 day period within the program year that begins on the first of the month
	2015	1/1/2016	3/31/2016	Full program year (January 1 to December 31)
	2016	1/1/2017	3/31/2017	Full program year (January 1 to December 31)
	2017	1/1/2018	3/31/2018	Full program year (January 1 to December 31)
	2018	1/1/2019	3/31/2019	Full program year (January 1 to December 31)
	2019	1/1/2020	3/31/2020	Full program year (January 1 to December 31)
	2020	1/1/2021	3/31/2021	Full program year (January 1 to December 31)

Incentive Payment Basis	Program Year	First Date Provider May Apply	Last Date Provider May Apply	Meaningful Use Reporting Period
	2020	1/1/2021	3/31/2021	Full program year (January 1 to December 31)
	2021	1/1/2022	3/31/2022	Full program year (January 1 to December 31)

4.24(b) 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: The A-SMA does not take a reduction or rebate on EHR Incentive Payments.

Methodology: These payments are not considered claims based payments. Within the MMIS system, A-SMA set up new transaction codes so these payments are listed as separate line items on the provider’s respective remittance advice.

Process: A-SMA submits a provider payment form to the MMIS that is generated from the SLR. Once the payments are process, A-SMA receives a separate activity report which indicates to whom the payments were paid. The transactional codes used are exclusively designed for EHR Incentive Payments only. Any recoupments outside those specifically related to the EHR Incentive Payments exclude these transactional codes.

4.25 WHAT WILL BE THE PROCESS TO ASSURE THAT MEDICAID PROVIDER 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% OF SUCH PAYMENTS IS RETAINED FOR COSTS UNRELATED TO THE EHR TECHNOLOGY ADOPTION?

Standard: As required in regulation and indicated in the initial A-SMHP, 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. No change has occurred in this area.

Methodology: The provider file provides the person/facility to which the provider wishes payment to be issued and the payment process will issue the payment. The A-SMA provider TIN/NPI would be cross-referenced with the EHR number and/or the bill of sale, to verify the 5%.

Process: A-SMA has not had any requests related to this provision. If and when such does occur, the process will be done manually. The Medicaid provider would need to request in writing the designation of another entity TIN to receive the payment and that information would be included in the attestation signed by the provider. The attestation would state that designation is voluntary on part of the provider, the entity name, address (including e-mail address), and the amount. A-SMA 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.

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 and A-SMA has no Medicaid MCO contracts to date.

Methodology: If and when Alabama enters into any Medicaid MCO risk based contract, the state will put into place a business process which will be manual in nature to assure that the total of the incentive payments through a MCO will not exceed 105 percent of the capitation rate.

Process: There has been no change in Section 4.26 since the initial A-SMHP was submitted to CMS. Alabama commits to assuring that the state will address the requirement when and if the state enters into Medicaid MCO risk contracts.

4.27 WHAT WILL BE THE PROCESS TO ASSURE THAT ALL HOSPITAL CALCULATIONS AND EP PAYMENT INCENTIVES (INCLUDING TRACKING EP'S 15% OF THE NET AVERAGE ALLOWABLE COSTS OF CERTIFIED EHR TECHNOLOGY) ARE MADE CONSISTENT WITH THE STATUTE AND REGULATION?

This question is obsolete based on changes made by CMS to the process that no longer requires a separate state calculation and tracking is required related to the 14% of net average allowable costs of certified EHR technology.

4.28 WHAT WILL BE THE ROLE OF EXISTING SMA CONTRACTORS IN IMPLEMENTING THE EHR INCENTIVE PROGRAM – SUCH AS MMIS, PBM, FA, MANAGED CARE CONTRACTORS, ETC.?

Standard: As indicated in the initial A-SMHP and earlier in this document, the Alabama FA for MMIS and FA activities (HP), the former Medicaid Transformation Grant contractor who is now the contractor for the SLR (Xerox- formerly ACS), and the One Health Record® contractor (Truven) will be engaged in the implementation of the EHR Incentive Program as they all involved in critical components for which success is dependent. Other contractors that remain involved and their

roles have been identified previously and include George Washington University (SME), The FourThought Group (MU operations), and various Alabama Universities.

Methodology: The FA manages the MMIS interfaces with SLR. The SLR contractor manages the SLR technical and technical and business operations. The One Health Record® contract will manage the interface with the SLR through the state “gateway”. Since the MMIS will be enhanced and expanded to accommodate all the HIT needs to support MU, an I-HIT-APD will be forthcoming.

Process: A-SMA has explicitly required coordination between contractors in their contracts with each of the vendors and consultants and specifies roles and responsibilities.

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 CMS REGISTRATION AND ATTESTATION SYSTEM PROVIDER OUTREACH/HELP DESK SUPPORT); THE STATUS/AVAILABILITY OF CERTIFIED EHR TECHNOLOGY; THE ROLE, APPROVED PLANS AND STATUS OF THE RECs; THE ROLE APPROVED PLANS AND STATUS OF THE HIE COOPERATIVE AGREEMENTS; STATE-SPECIFIC READINESS FACTORS.

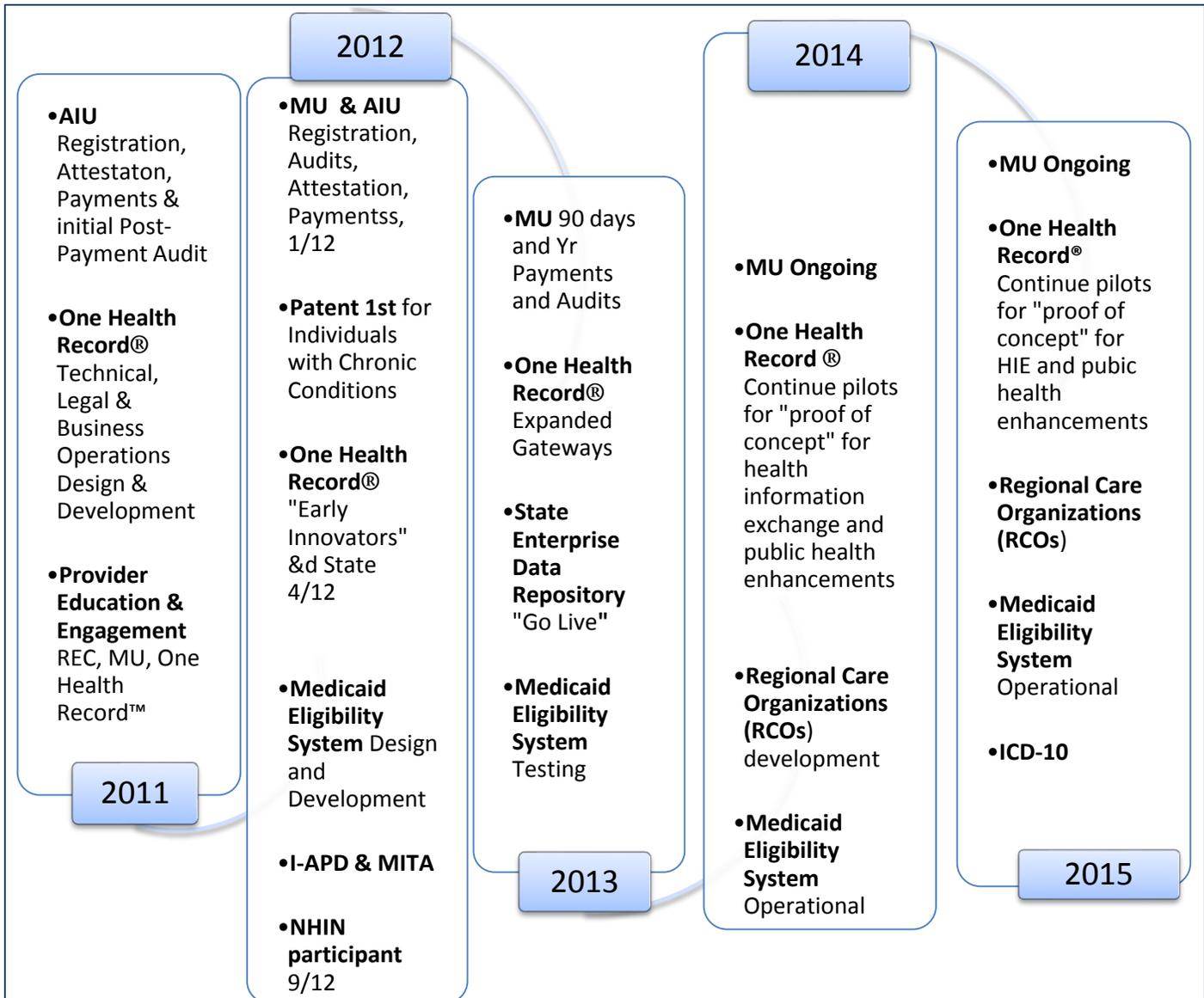
As indicated in the initial A-SMHP, there are multiple dependencies throughout A-SMHP. Time resources (human and financial) remain tight with numerous moving parts, several competing agendas (One Health Record®, Medicaid Eligibility System upgrade ICD-10, etc.) and significant cross-dependencies. (Eligibility information needed for population validation, connectivity between providers and with public health through One Health Record® for MU, etc.) The state has committed to leveraging across programs and initiatives and has initiated business processes and personnel to assure that happens..

CMS central office continues to be extremely responsive and the dependency of the state on the continuation of ONC and CMS continued responsiveness cannot be understated. A quick approval of this updated A-SMHP is needed along with approval of the I-APD, which will be submitted immediately following the submission of this A-SMHP. The state will do everything it can to mitigate that risk and depends on the federal government to do the same.

6. SMHP SECTION E: ALABAMA'S "ROADMAP"

PROVIDE CMS WITH A GRAPHICAL AS WELL AS NARRATIVE PATHWAY THAT CLEARLY SHOWS WHERE THE SMA IS STARTING FROM (AS-IS) TODAY, WHERE IT EXPECTED TO BE IN FIVE YEARS FROM NOW (TO-BE) AND HOW IT PLANS TO GET THERE.

Figure 58: Medicaid Health-IT Roadmap



Alabama is transforming the way the state purchases and oversees publicly funded health care, including Medicaid. It is simultaneously addressing both the evolution of health and the innovations within health care delivery. The relationship between the activities through the ONC State HIE Cooperative Agreement, including Alabama's State Strategic/Operational Plan (A-S/OP), and Alabama's State Medicaid's HIT Plan (A-SMHP) as the means to provide the technical infrastructure for the transformation is was evident in timing, as well as impact, over the last few years.

The One Health Record® Commission and the A-SMA have made it a priority to align the work so the needs of both efforts have been met and the dependencies of infrastructure of one (HIE) for success in the other (MU) can be addressed timely and appropriately.

As the figure above indicates, the "target" is 2015 for the assurance of meaningful exchange of health information to be in place as more providers and enrollees engage in the health care system.

- **2011:** The submission of the A-SMHP was the first step toward moving from concept to implementation and operation of critical health-IT functionality for which Medicaid is a core funder and major benefiter, but not sole participant. The state has been a leader in registering EPs and EHs, completing pre-payment reviews and making significant payments for AIU in 2011. The state updated its environmental scan and identified areas of focus. The state and its vendor completed preparation for registration and attestation for MU starting 2012.

Simultaneously, using ONC State Cooperative Agreement funding, A-SMA staff have supported One Health Record® design and development of governance structure, legal/policy parameters, financing framework, technical and technical/business operations, and communication strategies to create the statewide infrastructure for the exchange of clinical information in a meaningful way. In working with the REC, the One Health Record® Commission workgroups, contracted support and A-SMA direct staff, the state has engaged and informed the multiple stakeholders which are impacted and have impact upon these proposals.

- **2012:** An I-APD was submitted in January 2012 to assure prior federal approval in order to move forward. An updated MITA assessment was also completed. The state updated its environmental scan and identified opportunities and potential risks to mitigate. CMS review of relevant contracts continued.

As indicated earlier in the document, the business processes and technical infrastructure were in place to move from AIU to MU, handle any potential appeals if they arose, integrate MU payment history into the MMIS provider history, and evolve from pre-payment reviews to pre and post-payment reviews and audits.

The state began development for a Medicaid eligibility system to accommodate the changes set forth in the Patient Protection and Accountable Care Act (ACA). One Health Record® statewide Health Information Exchange also went "live" in 2012. Five hospitals and a minimum number of FQHCs were targeted for One Health Record® early adoption in the second calendar quarter of 2012 to meet the needs of providers for meaningful use. One

Health Record® supports both DIRECT and query, provides secure messaging, provider directories and identity management, and also the health information exchange technical infrastructure to support the exchange of information.

A-MSA targeted outreach in coordination with the REC and Tuskegee University. The Alabama REC provided “boots on the ground” outreach to the small practices and has signed up over 80% of their membership, which equates to approximately 700 physicians. A-SMA also became a participant in NHIN in 9/12.

One of the significant health care delivery efforts for Medicaid enrollees with chronic conditions went “live” in 2012. Alabama pursued the State Plan option to provide care management to individuals with chronic conditions to improve health, improve care and decrease costs. The new initiative, which is dependent upon and requires health-IT for the exchange of clinical information between the Patient 1st Primary Medicaid Providers (PMPs) and Networks and for quality reporting, positively impacts high cost and high utilizers of health care.

- **2013:** Using ONC State Cooperative Agreement funding, One Health Record®:
 - Continued to address legal/policy parameters.
 - Established an initial financing framework for the “proof of concept” pilot.
 - Continued to provide technical capacity to support Direct secure messaging and query intrastate and interstate through a contract vendor. This includes a Master Patient Index, provider directory, XDS Registry/Repository, XCA/XCPD, auditing and logging, continuity of care viewer, and DIRECT/Query 3.0 capabilities.
 - Advanced technical/business operations through the connection of One Health Record® to three hospitals (Jackson, East Alabama Medical Center and the University of Alabama at Birmingham, Alabama) and one clinic (Jackson Clinic). Nine Clinical Care Documents have been placed in the HIE database and a few hundred Direct secure messages have been exchanged.
 - Implemented communication strategies to create the statewide infrastructure for the exchange of clinical information in a meaningful way. In working with the REC, the One Health Record® Commission and Commission workgroups contracted support and Medicaid Agency direct staff. The State has engaged and informed the multiple stakeholders which are affected and have impact upon these initiatives.
 - One of the major initiatives in Alabama is the transition of Medicaid from fee-for-service to managed care through Regional Care Organizations (RCOs). Starting in 2013, a major focus of One Health Record® efforts has been to provide critical health information technology infrastructure to support the developing RCOs and the Medicaid providers who will be a part of the RCO networks.
- **2014:** Eligibility using MAGI is active, MU is an ongoing operation, One Health Record® continues to support all of the efforts and ICD-10 has been postponed for a year. The state continues to update its environmental scan and MITA Self-Assessment to identify opportunities and potential risks to mitigate.

States and providers are facing considerable potential risks in light of the great abundance of work that needs to be completed efficiently, accurately, transparently and quickly. However, the potential for health and health care improvement is significant. The state is well positioned to meet the challenges and take full advantage of the opportunities.

- 2015: As the figure indicates, the “target” is 2015 for the assurance of critical health-IT functionality to be in place for the meaningful exchange of health information for which Medicaid is a core funder and major benefiter, but not sole participant.

Operationally, One Health Record® is still at the “proof of concept” stage; however the core principles for Alabama’s One Health Record’s® strategic focus have been and continue to be:

- Encouraging provider participation, including continuing to leverage the REC activities.
- Achieving interoperability, which has been a struggle due to the current state of certified EHR adoption.
- Demonstrating feasibility through the initiation of a pilot.
- On-going stakeholder communication and involvement.
- Development of a longer term sustainability plan once value is demonstrated

One of the major initiatives in Alabama is the continuation from concept to implementation of Medicaid Regional Care Organizations (RCOs). A major focus of One Health Record® efforts has been to continue provide planning and preparation for critical health information technology infrastructure to support the developing RCOs and the Medicaid providers who will be a part of the RCO networks.

Enhancements have been made to One Health Record® website to be more user friendly and create more usable information. The following screenshots are representative of the enhancements.

Figure 59: Screenshots



One Health Record® Patient Lists Screenshots

Select My Patient Lists from the Application Dashboard to view patient records.

From the Census screen you can search for a patient using two or more criteria; you must include Social Security Number, Medical Record Number, Last Name, or Date of Birth as one of the criteria.

After performing the search as above, click anywhere on the row with the patient's name to access the Patient Home Screen or right-click and choose from the menu.

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One Health Record® Summary Tab Screenshots

Summary is the default tab. It provides a longitudinal view of patient's problems, providers, procedures, and medications across clinical encounters.

25

One Health Record® Medications Screenshots

Medications are organized by Date, with most recent prescribed at the top.

Inpatient and outpatient meds are available.

Place your cursor over the meds icon to view detailed information.

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Table 23: Updated A-SMHP Initial Table of Alabama Activities and Approaches Roadmap

Activity	Year	Approach
Technical Architecture		
Become consistent with HHS adopted interoperability standards	Initial Completed - Ongoing	One Health Record® and A-SMHP will monitor and apply HHS interoperability standards as they are developed. Technical infrastructure will deploy standard interface for connectivity to the statewide network. One Health Record® will adhere to the HHS standards when exchanging records with another entity on the eHealth Exchange.
Design, develop and implement the state MU Infrastructure as expanded MMIS	AIU Completed MU SLR Completed Ongoing	MMIS architecture built to interoperability, privacy and other Stage 1 standards to allow interface with CMS Registration and Attestation System, provide the support required for provider identification, payment and oversight. Initial health-IT focus on payment for AIU. Immediately following, technical support for MU quality measurement reporting, oversight and payment completed.
Business and Technical Operations Activities/Approaches		
One Health Record® RFI	Completed	There were 21 responses to the RFI, which provided validation to the Technical Infrastructure’s workgroup proposed approach.
Initial One Health Record® S/OP, A-SMHP and I-HIT- APD	Completed	Alabama Strategic/Operational Plan submitted to ONC
MU	Completed	Development and implementation of technical and business operations to support MU aligned with federal and other states.
Governance Activities/Approaches		
One Health Record® Operating Commission Charter, By-Laws and Policies/Procedures	Completed	Revised and adopt using examples from other states and private organizations
A-SMA Established	Completed	A-SMA established within the Medicaid Agency
Trigger Thresholds	On Hold	Establish threshold events including participation, financial; budget sustainability, functional and political events
HIT Oversight	On Hold	Adopt regulations for HIO oversight by A-SMA
Finance Activities/Approaches		
Long-Term Sustainability for One Health Record® A-HIE	Postponed to 2015 legislative session	Commission will advise legislature after research is conducted.
Cost Benefit Analysis of statewide HIE	Completed	Blue Cross/Blue Shield of Alabama conducted the analysis
Business Case for Participation in One Health Record®	Completed	Alabama State University conducted this analysis.

Activity	Year	Approach
Federal Reporting for MU and other ARRA activities (ONC funding)	Ongoing	A-SMA created a standardized approach to federal reporting through the Medicaid Agency and state A-SMA.
Federal funding	Ongoing	<p>A-SMA identify and fully utilize federal funding through MU authority, Affordability Act authority, CHIPRA authority and ongoing MMIS authority.</p> <p>A-SMA submit additional I-HIT-APDs and I-MMIS-APDs to support public and mental health activities.</p>
Policy and Legal Activities and Approaches to Activities		
Legislative Requirements		
Establish a statewide policy framework that allows for incremental and continuous development of One Health Record®.	Ongoing	Determine the need for state law that is necessary. Draft such that changes to federal law that automatically trigger a mirror change in state law.
Establish Requirements for how One Health Record® & 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.	Completed	<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. Develop an 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
Identify policy issues and establish recommended policy	Ongoing	Medicaid Agency to develop with assistance from Legal and Policy Workgroup.

Activity	Year	Approach
Privacy and Security		
Examine the federal privacy and security requirements for data security and integrity related to the exchange of health information	Completed	Research and identify federal regulations to compare to Alabama state legislation for conflicts, potential updates, or missing legislation. (ARRA, HIPAA Privacy Rule, HIPAA Security Rule, Confidentiality of Alcohol and Drug Abuse Patient Record Regulation)
Establish how levels of consumer access to information in the AHIE will be defined and how sensitive health information will be protected.	Ongoing	Consumers given choice regarding decisions about the collection, use and disclosure of their PHI. Policies developed that will ensure that consumers have a timely means to dispute the accuracy of HIE information.
Review Health Information Security and Privacy Collaboration (HISPC) work in the area relating to privacy and security	Completed	<ul style="list-style-type: none"> • There is no HISPC for Alabama. • Alabama Medicaid will investigate local policies.
Development of Exchanges with Other States		
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. Conduct a survey of states to determine which states have the most compatible technologies and policies in place. Examine pilot exchanges between states to determine the parameters for its operation and governing regulations.	Ongoing	Alabama Medicaid coordinates with the south eastern state (SERCH). Alabama Medicaid has worked with Florida, West Virginia, South Carolina and Georgia to initiate interstate exchange. Alabama is a participant of eHealth Exchange and will expand connections as other states become participants in the e-Health Exchange. This is true for DIRECT as well.
Policy and Procedure Development		
Identify recommended legal policies and procedures related to a statewide policy development process	Completed	Legal and Policy Workgroup to identify.
Determine One Health Record [®] operational policies and procedures in relationship to University Education: medical education & informatics (U of Southern Alabama contract with ONC) & REC	Ongoing	Legal and Policy Workgroup in conjunction with Governance will identify and develop outline of issues.

Activity	Year	Approach
Incorporate recommended legal policies and procedures	Ongoing	Alabama Medicaid Agency to receive issues from LRT and Legal and Policy Workgroup
Establish recommended priority policies	Completed-Annual Work plan	Alabama Medicaid Agency to develop implementation framework
Oversight and Risk Mitigation		
Establish risk mitigation policies	Completed	Legal and Policy Workgroup will identify and develop outline of issues.
Establish oversight and enforcement mechanisms	Ongoing	Will not require legislative change to accomplish.
Incorporate risk mitigation legal policies and procedures	Ongoing	Alabama Medicaid Agency to receive issues from LRT and Legal and Policy Workgroup
Communication and Marketing		
<p>Progress reports and details on AHIE system issued via association publications, HIE Web site;</p> <p>Establish and publicize mechanism for regular progress updates and feedback via Web site</p> <p>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</p> <p>Scheduled presentations to providers at their location, society and other state and regional meetings</p> <p>Physician outreach and education activities in coordination with REC</p> <p>Development of CME-based educational activities for physicians</p>	<p>2010 – 2015</p> <p>Ongoing</p>	<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 1-5 • Progress reports and details on AL HIE system issued via hospital association publications, HIE Web site; Years 1-5 • Development of White Paper – Year 1; update Years 2-5 • Presentations to physicians at hospital, society and other state and regional meetings – Years 1-5 • 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 2-5

6.1 WHAT ARE THE SMA’S EXPECTATIONS RE PROVIDER EHR TECHNOLOGY ADOPTION OVER TIME? ANNUAL BENCHMARKS BY PROVIDER.

The state has not established specific targets for the number of Medicaid potentially eligible EHs and EPs to meet MU, but has made projections for purposes of budgeting. They are as follows:

Table 24: 2012 MU Incentive Payment Projections

	Volume	Average Payment	Budgeted Amount	Assumptions
First Quarter 2012: September included in First Quarter of 2011				
Submitted EH Attestations	16	\$ 1,000,000.00	\$ 16,000,000.00	Payments invoiced in Oct 2011
Eligible EH Attestations	8	\$ 1,000,000.00	\$ 8,000,000.00	Finance end of year. Submissions confirmed in State
Submitted EP Attestations	110	\$ 21,250.00	\$ 2,337,500.00	Level Registry
September Total			\$ 26,337,500.00	
1st Quarter (Oct - Dec)				
EH AIU	24	\$ 1,000,000.00	\$ 24,000,000.00	Average 8 EH Submissions/Month, \$736k Payment
EP AIU	600	\$ 21,250.00	\$ 12,750,000.00	Average 130 EP Submissions/Month+ End of Year Submissions
Subtotal			\$ 36,750,000.00	
1st Quarter Total			\$ 63,087,500.00	
Second Quarter 2012 Jan-Mar				
EP AIU	100	\$ 21,250.00	\$ 2,125,000.00	Assume providers will be reluctant to submit
EP Stage 1	375	\$ 8,500.00	\$ 3,187,500.00	
EH AIU	25	\$ 1,000,000.00	\$ 25,000,000.00	Average 8 EH Submissions/Month, \$736k Payment
EH Stage 1	25	\$ 500,000.00	\$ 12,500,000.00	Average 8 EH Submissions/Month, \$442k Payment
2nd Quarter Total			\$ 42,812,500.00	
Third Quarter 2012 Jan-Mar				
EP AIU	100	\$ 21,250.00	\$ 2,125,000.00	Assume providers will be reluctant to submit
EP Stage 1	375	\$ 8,500.00	\$ 3,187,500.00	
EH AIU	10	\$ 1,000,000.00	\$ 10,000,000.00	22 Remaining hospitals in State, \$736k Payment

	Volume	Average Payment	Budgeted Amount	Assumptions
EH Stage 1	25	\$ 500,000.00	\$ 12,500,000.00	Average 8 EH Submissions/Month, \$442k Payment
3rd Quarter Total			\$ 27,812,500.00	
Fourth Quarter 2012 Jan-Mar				
EP AIU	100	\$ 21,250.00	\$ 2,125,000.00	Assume providers will be reluctant to submit
EP Stage 1	375	\$ 8,500.00	\$ 3,187,500.00	
EH AIU	10	\$ 1,000,000.00	\$ 10,000,000.00	10 Remaining hospitals in State, \$736k Payment
EH Stage 1	25	\$ 500,000.00	\$ 12,500,000.00	Average 8 EH Submissions/Month, \$442k Payment
4th Quarter Total			\$ 27,812,500.00	
FY 2012 Total			161,525,000.00	

Table 25: 2013 MU Incentive Payment Projections

	Volume	Average Payment	Budgeted Amount	Assumptions
First Quarter 2013 Jan-Mar				
EP AIU	300	\$ 21,250.00	\$ 6,375,000.00	Residual percentage of new providers that will apply
EP Stage 1	750	\$ 8,500.00	\$ 6,375,000.00	Existing providers submitting attestations
EH AIU	1	\$ 1,000,000.00	\$ 1,000,000.00	
EH Stage 1	30	\$ 400,000.00	\$ 12,000,000.00	1/2 of EH will attest to Year 2 (30%), 1/2 will attest to Year 3 (20%)
1st Quarter Total			\$ 25,750,000.00	
Second Quarter 2013				
EP AIU	300	\$ 21,250.00	\$ 6,375,000.00	Residual percentage of new providers will apply
EP Stage 1	750	\$ 8,500.00	\$ 6,375,000.00	Existing providers submitting attestations
EH AIU	1	\$ 1,000,000.00	\$ 1,000,000.00	
EH Stage 1	30	\$ 400,000.00	\$ 12,000,000.00	1/2 of EH will attest to Year 2 (30%), 1/2 will attest to Year 3 (20%)
2nd Quarter Total			\$ 25,750,000.00	
Third Quarter 2013 Apr-Jun				
EP AIU	300	\$ 21,250.00	\$ 6,375,000.00	Residual percentage of new providers will apply
EP Stage 1	750	\$ 8,500.00	\$ 6,375,000.00	Existing providers submitting attestations
EH AIU	1	\$ 1,000,000.00	\$ 1,000,000.00	

	Volume		Average Payment	Budgeted Amount	Assumptions
EH Stage 1		30	\$ 400,000.00	\$ 12,000,000.00	1/2 of EH will attest to Year 2 (30%), 1/2 will attest to Year 3 (20%)
3rd Quarter Total				\$ 25,750,000.00	
Fourth Quarter 2013 Jul-Sep					
EP AIU		300	\$ 21,250.00	\$ 6,375,000.00	Residual percentage of new providers will apply
EP Stage 1		750	\$ 8,500.00	\$ 6,375,000.00	Existing providers submitting attestations
EH AIU		1	\$ 1,000,000.00	\$ 1,000,000.00	
EH Stage 1		30	\$ 400,000.00	\$ 12,000,000.00	1/2 of EH will attest to Year 2 (30%), 1/2 will attest to Year 3 (20%)
4th Quarter Total				\$ 25,750,000.00	
FY 2013 Total				\$103,000,000.00	

Table 25a: AIU Provider Types and Practices

<i>AIU Provider Types and Practices</i>	
Provider Type	Total Providers
Physician	1017
Nurse Practitioner	287
Dentist	175
Optometrist	0
Certified Nurse Midwives	9
Pediatricians – reported under physicians – not separately reported	
Physician's Assistant practicing predominantly in a FQHC or RHC that is led by a physician's assistant	10
Acute Care Hospital	87
Critical Access Hospital	0
Children's Hospital	2
Total Number of locations with CEHRT which have been paid AIU	1017

Table 25b: MU Provider Types and Practices

<i>Section 1.4: MU Provider Types and Practices</i>	
Provider Type	Total Providers
Physician	289
Nurse Practitioner	86
Dentist	1
Optometrist	0

<i>Section 1.4: MU Provider Types and Practices</i>	
Provider Type	Total Providers
Certified Nurse Midwives	1
Pediatricians – reported under physicians – not separately reported	
Physician's Assistant practicing predominantly in a FQHC or RHC that is led by a physician's assistant	1
Acute Care Hospital	75
Critical Access Hospital	0
Children's Hospital	2
Total Number of locations with CEHRT which have been paid MU	289

**Table 25c: EP/EH Counts and Amount Paid
(Total since start of program)**

EP/EH	Paid	Counts
EP AIU Counts		1463
EP AIU Paid Amount	\$ 30,805,430.00	
EP MU Counts		344
EP MU Paid Amount	\$ 2,901,339.00	
EH AIU Counts		89
EH AIU Paid Amount	\$ 62,916,248.15	
EH MU Counts		77
EH MU Paid Amount	\$ 30,050,157.81	

6.2 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 for inclusion or exclusion of any outcome and/or performance measure is that the measure provide day-to-day operational usefulness and support the evaluation of the effort at the individual, population, initiative and statewide level from the perspective of consumers, providers, and purchasers/payers. Outcomes and/or performance benchmarks are consistent for evaluation of “success” for MU and for the ONC Cooperative Agreement. Alabama focused on 3 priority areas for MU: e-Prescribing, Lab Exchange and Care Summary Exchange.

The program priority areas are provided in the table below and provide the status as of December 2011 and the targets and status for December 2012 and 2013. E-Prescribing is based on SureScripts data which is compared on an annual percentage improvement from a baseline zero. Data is provided by both pharmacy and provider zip code. The performance progress measure/target for lab exchange is based on state collected data and compared to a baseline of no connection to the State Lab (Public Health), LabCorp and Quest (largest private providers). The

performance progress measure/target for patient care summaries was established through the 30-60-90-120 day roadmap engagement with the One Health Record® vendor.

Table 25d: Performance Progress Measures/Targets

Program Priority	Status as of December 2011	Target for December 2012	Status as of December 2012	Target for December 2013	Status as of December 2013
% of labs sending electronic lab results to providers in a structured format	50%	55%	53.2%	55.5%	53.2%
% of labs sending electronic lab results to providers using LOINC (Documentation of discrete data using controlled vocabulary, creating fixed fields within a record or file, or another method that provides clear structure to information (is not completely free text)).	36%	40%	40.3%	42.5%	40.3%
Public Health agencies receiving ELR data produced by EHRs or other electronic sources. Data are received using HL7 2.5.1 LOINC or SNOMED (Yes/No or %)	Yes	Yes	Yes	Yes=100%	Yes
Immunization registries receiving electronic immunization data produced by EHRs. Data are received in HL7 2.3.1 or 2.5.1 formats using CVX code (Yes/No or %)	Yes	Yes	Yes	Yes=100%	Yes
Public health agencies receiving electronic syndromic surveillance hospital data produced by EHRs in HL7 2.3.1 or 2.5.1 formats (using CDC reference guide) Yes/No or %	No	Yes	No	Yes=100%	No
Public Health agencies receiving electronic syndromic surveillance ambulatory data produced by EHRs in HL7 2.3.1 or 2.5.1 Yes/No or %	No	Yes	No	Yes=100%	No
% of pharmacies participating in e-prescribing	91.4%	93%	94%	96%	96%
% of hospitals sharing electronic care summaries with unaffiliated hospitals and providers	39.2%	44%	41%	44%	44%

Program Priority	Status as of December 2011	Target for December 2012	Status as of December 2012	Target for December 2013	Status as of December 2013
% of ambulatory providers electronically sharing care summaries with other providers	14.5%	18%	2.14%	20%	20%

7. ACKNOWLEDGEMENTS

The State of Alabama thanks the many members of the Alabama One Health Record® Health Information Exchange Advisory Commission and Workgroups for their ideas, expertise and time in developing the Alabama Strategic Plan for Health Information Exchange (A-S/OP) and Alabama State Medicaid HIT Plan (A-SMHP). The enormous amount of volunteer commitment has been extraordinary and has resulted in a concrete A-S/OP and A-SMHP that will meet the needs of the state, providers and consumers.

Alabama One Health Record® HIE & A-SMHP Advisory Commission Members

Stephanie Azar, Chair, Acting Commissioner, Alabama Medicaid Agency
Donald Williamson, MD, Vice-Chair, State Health Officer, ADHP
Mark Jackson, Medical Association of the State of Alabama
Linda Lee, Executive Director, Alabama Chapter American Academy of Pediatrics
Jeff Arrington, Executive Vice President, Alabama Academy of Family Practice Physicians
J. Michael Horsley, President, Alabama Hospital Association
Louise F. Jones, Executive Director, Alabama Pharmacy Association
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