STATE MEDICAID HEALTH INFORMATION TECHNOLOGY PLAN (SMHP) 2021
FINAL UPDATE INCLUDING 2021 ENVIRONMENTAL SCAN

Alabama Medicaid Agency

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VERSION HISTORY

Version	Approved	Notes
1	2010	Original Submission
2	November 5, 2012	Annual Update
3	February 5, 2013	Annual Update and Updated for PI Stage 1
4	April 1, 2013	Audit Strategy: AIU and PI State 1
5	February 27, 2014	Annual Update and Updated for PI Stage 2
6	May 12, 2014	Response to CMS Questions and Updated for One Health Record® A-HIE
7	April 13, 2016	Annual Update 2015-17 Modified Stage 2 & Stage 3 Final Rule
8	June 29, 2018	Annual Update and Updated for 2017 SMHP Addendum, OPPS, MACRA/MIPS, Final Rule
9	September 5, 2018	Annual Update, Final Rule
10	November 19, 2020	2020 Annual Update, Interoperability Final Rule
11	March 4, 2022	Final Update & 2021 Environmental Scan

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

1.1 PURPOSE
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As previously noted, Alabama made the decision early on that the development of our health-IT system had to be a primary initial goal in order for the Medicaid and other stakeholders to meet the demands of the fundamental changes going on in health care." This principle has been re-enforced and continues to guide acurrent Alabama Medicaid Commissioner Stephanie McGee Azar.

The A-SMHP was initially submitted in 2010, updated annually, concluding with this final A_SMHP update on February 28, 2022. , and approved as an update on February 5, 2013. It continues to

This annual update specifically addresses the Promoting Interoperability 2021-22 program changes and closeout   This update primarily focuses on addressing efforts, activities, and actions by the A-SMA that were implemented after January 1, 2021, activities of Alabama One Health Record. as i ctivities

Alabama State Medicaid Agency (A-SMA) agency continues to positively influence health outcomes of Alabama Medicaid enrollees in several ways, including:
   a. Transitioning from fee-for-service health care delivery to managed health care delivery through a managed care approach to improve management and care coordination
   b. Transitioning to paying for performance and value-based purchasing.
   c. Identifying sub-populations with specific needs.
   d. Supporting patient outreach and health education campaigns.
   e. Public reporting to enhance competition.
   f. Providing PI provider education, outreach, and technical assistance in EHR utilization.
   g. Creating infrastructure and processes to leverage clinical quality metrics and population health analytics.

On-going Implementation of One Health Record®, A-HIE to support A-SMA to improve health outcomes and achieve other program goals by providing the infrastructure and interoperability 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 ACHN's ACO's, Care networks, s, 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.

The specific provisions addressed in this final A-SMHP are as follows:
- Implementation of those provisions of the PI program 2021-22 r , specifically changes to meaningful use objectives and measures and CQM reporting. The specific changes are discussed in Section 4.
- Update of the "As Is" section of the SMHP to include the Final 2021 Environmental Scan.
- Update of the "To Be" section of the SMHP to incorporate the details of the One Health Record® implementation and HIE strategic vision.

A final HIT-IAPD update was approved by CMS on March 15, 2021 to to support:

- The remaining ongoing administration and operations of Alabama's PI EHR Incentive Payment Program, including post-payment audit functions, and the projected program spending through September 30, 2022. The HIT-I-APD focused on addressing efforts and actions by the Alabama State Medicaid Agency (ASMA) that will be implemented beginning October 1, 2020. .
- The management and oversight of the SLR activities. The current one-year extension of the contract with HealthTech Solutions (HTS) expires on July 31, 2022.

- Continued funding for ongoing and wrapping up of EHR Incentive Program staff and contract support, including vendor supported post-payment audit functions and collection and utilization of clinical quality measures (eCQM's), and analytics.

- Funding to support both on-boarding and HIE architecture for Medicaid providers within Health Care Authorities l that needs to connect to for purposes of demonstrating Meaningful Use. This includes Medicaid provider types such as behavioral health providers, substance abuse treatment providers, long term care providers, correctional health providers, pharmacies, laboratories, emergency service providers, and community-based Medicaid providers, as described and outlined in SMD 16-003, dated February 29, 2016, through September 30, 2021.

- Continued funding for the on-going implementation and promotion of Alabama's HIE, One Health Record® to support health information exchange and public health reporting through 9/30/2021

- Funding to support the initiatives for the electronic data submission and collection of clinical qualities measures to support population health analysis to support improved care outcomes and alternative payment models through 9/30/2022.

- Funding to support connectivity for patient Admission, Discharge, and Transfer (ADT) notifications for regional and emergency management care coordination through 9/30/2022.

1.2 SCOPE

Section 4201 of the ARRA provides 90% Federal Financial Participation (FFP) HIT Administrative match for four 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, the exchange of health care information the collection and utilization of electronic clinical quality measures (eCQM) for population health analytics.
- *Pursue implementation strategies to expand and facilitate the connections between EP's and other Medicaid providers* to promote their use of EHR/HIE technologies for the purpose of meeting the PI objectives.

In addition, new guidelines have been published to support connecting interoperable systems, EHR & HIE, infrastructure, and connectivity among other Medicaid providers to allow EP's and EH's to demonstrate interoperability and meet program objectives.

Alabama's updated SMHP updates 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 Promoting Interoperability (PI) Incentive Payments Program. Maintenance of Alabama's connection to CMS's Registration and Attestation System as needed until 7/31/2022.
- Automation of the provider appeal functions for EPs and EHs.
- Capacity to address PI measurement reporting, including collecting and using eCQM's
- Ongoing support for the development and dissemination of educational and engagement communication materials regarding the EHR Incentive Program and/or EHR Adoption/Meaningful Use.
- Completion of the 2021 environmental scans, gap analyses, provider needs assessments and multi-state collaborative efforts related to interoperability and health IT.
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- Conduction of adequate oversight of the Medicaid PI Incentive Payments Program, which requires IT and human resources (employees and contractors) support (90% FFP for systems and administration) for:
    - Final evaluation of the EHR Incentive Program and costs related to ongoing post payment audits, 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, certified EHR technology and PI 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 PI when used to support the Medicaid PI Incentive Payments Program, with continued focus` on the connectivity for PHI exchange and utilization among Medicaid providers and their networks, health homes, reporting the public health meaningful use objectives, and technical assistance for Medicaid providers to achieve PI.
    - On-going support of an enhanced enterprise data warehouse repository and data analysis capability, including access through One Health Record®, Alabama's Health Information Exchange (A-HIE) that will be used across state agencies with appropriate cost allocations.
    - Compliance with CMS final rule of Interoperability
- 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 PI provider'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 PI focused (such as therapies or nursing home care) or when they are used by providers who relate to providers receiving EHR Incentive Payments but are not in the PI program. This would include the Master Patient Index, Record Locater Service, Patient Access, 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. One Health Record® will act as the "hub" for the exchange of information intra- and inter-state, allowing providers to meet PI requirements.
    - One Health Record® remains under the governance of the Medicaid Agency and costs continues to be a "fair-share" approach in the future. A-SMA continues to

refine its "fair share" methodology for cost allocation as ALOHR moved into operational status with continued implementations.

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 (BCBSAL), CHIP (administered by BCBSA) the primary payers and managers of care delivered in the state —, along with other secondary payers will receive the benefits. 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/. Alabama is engaging secondary payers, such as VIA Health and CIGNA , as well as other ACO and Home Health entities to further support the long-term sustainability for One Health Record®.

The end goal remains to continue the transition of 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 has proven to work for Medicaid and for the rest of the payers in the State.

Timeframe
This final updated A-SMHP addresses the activities and responsibilities of the A-SMA related to continuing PI Stage 3, , health information exchange and Interoperability requirements in response to regulatory changes effective January 1, 2021..

The initial A-SMHP and I-APD provided the basis for funding for the Medicaid's PI-HIT program, which included the A-HIE One Health Record®. Therefore, this A-SMHP re-iterates the inclusion of the areas identified above in Section 1.2 under Scope and an final updated I-APD was submitted on January 20, 2021, n support of this A-SMHP. CMS approved Alabama's I-APD in a letter dated March 15, 2021.

1.3   REQUIRED VS OPTIONAL CONTENT

The A-SMHP has addressed all appropriate required and optional questions in the following sections using the final format provided by CMS to assure consistency and ease in review. The major focus of this A-SMHP is to provide a final update on the status of the health IT activities for Interoperability and the Promoting Interoperability Program.

1. 4   STAKEHOLDER ENGAGEMENT

Medicaid continues to engage 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.

Alabama Medicaid continues to provide leadership on other inter-state issues through the State Health Policy Consortium on Behavioral Health. Alabama is 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 (SGA), 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 and Civitas for Health.

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 promoting interoperability. . 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, interoperable way did not exist.

In the annual update in April 2016, Alabama provided an updated 2015 environmental scan which demonstrated the progress Alabama had made in implementing Health IT infrastructure.

A-SMA completed the 2021 Environmental Scan in December 2021 and has included the 2021 Environmental as a separate document. Since the 2011 & 2015 scans, Alabama has demonstrated significant progress expanding the health iT infrastructure and interoperable exchange. A summary of the high points are: .

- A 6-fold increase in Hospital participants (From 8 to 48)
- The number of provider clinical networks (FQHC's, RHC's, HIN's) has grown from 0 to 15.
- Connectivity to DoD, VA, and SSA for PHI exchange and health records retrievals.

- 3M+ Admission, Discharges & Transfer (ADT) received in CY 2021 with a re-distribution rate of 28% $(879{,}876)$ to provides and managed care entities.

- Connectivity to State's Rehab and Public Health Agencies for patient registration and interoperable exchange.

- 6 ACO/MCO plans and Medicaid's 7 Alabama Coordinated Health Networks (ACHN)

- 1 Municipality First Responders

- 309 varying CEHRT versions used or in use by 2,452 Medicaid Providers.

State IT Requirements: Although Alabama's state IT infrastructure requirements for networking and internet services are established through the Office of Information Technology's Information Services Division, there does not exist a defined statewide architecture.

One Health Record®, Alabama's State Health Information Exchange (HIE):

In March 2021 , One Health Record® released an RFP to re-bid the current HIE contract that was expiring on June 30, 2021.   CognoSante was awarded the new contract which became effective 9/1/2021. The new contract has a two-year term with 3 one-year options.

The State HIE program, One Health Record is managed byt the Health IT division under the Agency's Data Governance Office.

The PI Incentive Program is manage by MMIS operations division.

Alabama will continue with its ongoing analysis of readiness by geographic area to expand opportunities for One Health Record utilization with additional connectivity gateways any remaining HIE implementations, including the technical capability to support DIRECT, IHE, FHIR, and CONNECT. One Health Record® service stack provides patient access, secure messaging, a provider directory, DIRECT support and master patient index (MPI) so Medicaid providers statewide will be able to participate use health information in a improving outcomes across program populations. .

While many design, development and implementation activities have been completed and we are now "operational", our public and private support for One Health Record® remains strong and has continued to grow e throughout the process.
We will continue to identify significant implementation and operational realities in the "as is" health-IT environment. Please refer to the attached 2021 Environmental Scan for details.

2.02 EHR Adoption/EHR Incentive Program Promoting Interoperability:

1d: Implementation Activities

Implementation Activities		Date
Registration Implementation		04/14/2011
AIU Attestation Implementation		04/14/2011
Payments Implementation		04/14/2011
Audits Implementation		10/01/2011
PI Attestation	beginning on:	04/01/2012
AIU Recruitment		12/01/2015
PI Attestation – Modified Stage 2		08/01/2016
PI Attestation – Optional Stage 3		12/01/2017
PI Attestation – Stage 3		12/01/2018
PI Attestation Payment Completion		12/31/2021
PI Final Audits and Program Closeout		9/30/2022

Alabama Medicaid has disbursed $200,780,744 million to almost 2,363 EPs and 89 EHs.

The focus for 2011 was AIU and the focus for 2012 was attesting for PI 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®.

In 2013 and 2014, the focus continued on increasing attestations beyond AIU, streamlining PI processes, and provider utilization of their certified HER in a meaningful way.

In 2015, the PI Outreach included a focus on increasing the PI Stage 1 participation, with Medicaid seeing the AIU-to-PI migration rise as shown in the table below:

In 2016-17, the PI Outreach and Technical Assistance focused on maximizing our AIU participation, with Medicaid seeing an additional 311 AIU attestations. For both 2015 and 2016, AIU total participants were 489, which represents a 26% increase in year one participants.

In 2018-2021, the PI Outreach focused on supporting providers to maximize program retention of PI participants in Stage 3 and completing payments by 12/31/2021. The total number of payments to EP's for PY's 2018, 2019, 2020, and 2021 were 313, 132, 123, and 66 respectively.

	YEAR 1 TO 2 RETURN	Year 1	Year 2	Return Percentage	CMS MAP Percentage as of Jan 2022	Percentage Not Returning	Volume
AIU to PI ONLY							
	Paid	2334	887	39%	31%		
	Invoice in Process	0	6				
	Subtotal	2334	715	39%			
	Submitted	0	17				
	Total	2344	732	39%		61%	1134

	YEAR 2 TO 3 RETURN	Year 2	Year 3	Return Percentage	CMS MAP Percentage as of Jan 2022	Percentage Not Returning	Volume
PI	Paid	709	324	46%	38%		
YEAR 2 to YEAR 3	Invoice in Process	6	13				
	Subtotal	715	337	47%			
	Submitted	17	14				
	Total	732	351	48%		52%	381

	YEAR 3 TO 4 RETURN	Year 3	Year 4	Return Percentage	CMS MAP Percentage as of Jan 2022	Percentage Not Returning	Volume
PI	Paid	324	108	33%	0%		
YEAR 3 to YEAR 4	Invoice in Process	13	7				
	Subtotal	337	115	34%			
	Submitted	14	28				
	Total	351	143	41%		59%	208

	YEAR 4 TO 5 RETURN	Year 2	Year 3	Return Percentage	CMS MAP Percentage	Percentage Not Returning	Volume

					as of Jan 2022		
PI	Paid			46%	38%		
	Invoice in Process						
YEAR 4 to YEAR 5	Subtotal			47%			
	Submitted						
	Total			48%		52%	381

	YEAR 5 TO 6 RETURN	Year 3	Year 4	Return Percentage	CMS MAP Percentage as of Jan 2022	Percentage Not Returning	Volume
PI	Paid			43%	%		
	Invoice in Process						
YEAR 5 to YEAR 6	Subtotal			43%			
	Submitted						
	Total			43%		57%	321

1e: EP Registered Providers

EP Registered Providers	Alabama Medicaid EP registered Providers who have met PI (12/31/2022)	Alabama Medicaid EP registered Providers met PI in 2021
2363	2,363	66

1f: EP/EH Promoting Interoperability

	Promoting Interoperability Alabama EPs/EHs (documented registration with Alabama SLR) as of 12/31/2021	Signed DURSA with One Health Record® and have validated operational connectivity as of December 31, 2021\:
EPs	2	603
EHs	89	48

*Provider Outreach*As mentioned previously, since 2018 focused on PI program provider retention through the end of PY 2021. At stated in the previous update, 489 new providers entered the program by end of 6/30/3017. For PY 2021, we retained 66 of the 489 new providers for a retention of 14% in the final year of the program.

A-SMA continues to support a partnered website with One Health Record®, Alabama's Health Information Exchange, (http://onehealthrecord.alabama.gov/) that links to federal and state sites, and contains information and answers to providers' questions concerning Interoperability.

As noted previously, Alabama conducted an initial environmental scan in 2010 with update in 2015. The 2021 Environmental Scan summary is noted earlier in this update. The detail 202 Environmental Scan report is located at Attachment A. ies

E-Prescribing:

Medicaid continues to sponsor an e-Prescribing initiative to provide connectivity to SureScripts through a Medicaid Agency sponsored web-interface.

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

Alabama latest HIE operations indicates that there are 4,738 varying provider groups using EHR capabilities to query and retrieve over 1.5M documents in CY 2021. Alabama estimates a 75% overall EHR adoption rate among Medicaid's primary providers as compared the national average of 72.3% (per NCHS). EHR adoption by Alabama Hospitals is 100%, with 54% of those hospitals connected to Alabama One Health Record and sharing clinical data. As noted above, Alabama currently sends over 55,000 ADT alerts per month to Medicaid providers and their care plans.

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 continuing A-SMHP has been the engagement of a broad set of stakeholders as indicated in the HIT-PI and HIE efforts.

Presentations: Since the last SMHP update, Alabama continues their HIT/E outreach to the various stakeholders throughout the state and nationally by the HIT Director and key staff. These recent opportunities have been focused on :

- *Federally Qualitfied Health Centers and Rural Health Clinics:* The state continues to expand the number of FQHC's (0 to 12) and RHC's (0 to 1) by demonstrating the value of ADT's and access to clinical documents. Medicaid is including this option within thje scope of their current contracts with FQHC's.
- *Medicaid's Alabama Coordinated Health Networks and Medicare ACO's. AHIE provides quarterly and monthly updates to Medicaid, Medicare, and Commercial payers and their corresponding care plan entities to identify various opportunities to leverage and further expand ALOHR activities to improve care coordination protocols, improve data integrity, and quality outcomes. This is includes seeking NCQA certification as HEDIS Data Aggregator beginning in 2/2022.*

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 under the authority and auspices of the Alabama State Medicaid Agency. As Medicaid transitioned ALOHR from HITECH into MES, the previous CIO Advisory Board was replaced by Medicaid's Executive Oversight Board (EOC). The EOC provides administrative and strategic oversight and works directly with the Agency's Chief Data Officer, who serves as ALOHR's Director. .

Since May 2017, the State HIE program operates under the   Heath IT Division of the Agency's Data Governance Office. The Medicaid team includes state employees Gary Parker, Chief Data Officer and Director of Health Information Technology, (100% Medicaid), HIE Program Manager (100% Medicaid) and contract support staff.   In December 2021, the PI EHR Incentive Program managed by Clay Gaddis,   completed the final PY 2021 EHR payments.   At present final administrative and audit functions are being supported by current staff until 9/30/2022. At that time, the PI EHR program will sunset and cease operations. .

Final PI post payment auditing,   will alos be handle hrough limited Medicaid contracted support.

Finance: As of October 1, 2021, One Health Record® successfully transition its operations under MES funding, receiving CMS SMC certification on 9/19/2022 and 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 their CMS MIPS program and interoperability needs. PI. A-SMA submitted its final HITECH I-APD in early CY 2021 which was approved to support components of the A-SMHP related to:

- Medicaid portion of contracted support from; GDH Government Services (policy and procedure consulting, auditing, implementation and operational support of the SLR and PI program wrap-up & administration,);

At the end of FY 2021, ALOHR transitioned its services platform into a MES component, receiving CMS certification for outcomes based measures that support the ACHN's with care coordination and data exchange. Effective 10/1/2021, AHIE began operations as a MES, with FPP 75/25 for ASMA portion with the "Fair Share" cost allocation being handle by the State and other Stakeholders

Geographic: A-SMA   participates in the CMS S-TAG State's only calls and One Health Record® continues as a member of CIVITAS for Health (formerly SHIEC).

Technical Infrastructure: One Health Record®, became the Health IT component of the Medicaid Enterprise System (MES) and Medicaid Management Information System (MMIS), is the gateway for individual or group entities within the state to connect with other state HIEs and Medicaid agencies, federal agencies, and the eHealth Exchange.

The technical infrastructure provides secure messaging, a Master Patient Index (MPI), a secure provider web site, privacy/security controls, Record Locater Service (RLS), gateways, health information technology infrastructure, provider directory, capacity to enable e-Prescribing, electronic reporting of structured laboratory data, clinical summary exchange, (ADT)

notifications, and interfaces for data (e.g., laboratory) aggregation. These capabilities remain as an important cornerstone to Medicaid providers to be fully successful in the health information exchange (HIE) environment. Value added services such NCQA DAV certification for Payer HEDIS CCD reporting is on the future roadmap.

The current contract for the HIE technical infrastructure, which was re-bid and awarded in September 2021 , expires at the end on August 31, 2023. Medicaid is expected to exercise all of its options years to carry the current agreement to August 30, 2026.

Technical and Business Operations: With the transition to MES, the focus of the One Health Record® Business and Technical Operations is a combination of expanding operational value-added services and Ambulatory implementations of One Health Record®, which is still needed to support providers in promoting, obtaining and reaching interoperability. and support the state in carrying out its oversight responsibilities.

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 PI, the state continues to workwith other states, 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 Interoperability, EHR utilization and One Health Record® to support Medicaid's service delivery transformation through Medicaid's managed care services. The One Health Record® website, and joint collaboration with the will continue to be important mechanism for ongoing communication, outreach, and education.

The Health IT communications, are comprehensive and include opportunities and requirements as well as the role of One Health Record® to support the exchange of information to properly achieve improved outcomes. ways. The comprehensive Communication and Marketing plan continues to addresse our diverse audiences that continue to expand including but not limited to Hospitals, CMHC's, FQHC's, EMS, ambulatory and specialist 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/, as well as the Agency website, www.medicaid.alabama.gov, provides information, pages, and links to documents and information specifically relating to Promoting Interoperability, http://onehealthrecord.alabama.gov/providers.aspx. . The goal is a consistent, focused message by all the partners/stakeholders working with providers to promote interoperability. As of January 1, 2022, the AHIE Website was being re-designed to directly address patient interoperable access to their health information maintained by ALOHR.

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 exists in Alabama is One Health Record®. The State HIE continues to expand its geographic reach through its stakeholder membership and it's partnership with eHx and our Federal/State partners. .

One Health Record® provides bi-directional and direct connectivity to those providers not part of a health system. Further, One Health Record® will support PI reporting of public health measures, and ADT alerting.

At present, a local exchange called Patient Bridge still partners with AHIE for bi-directional exchange using the eHealth Exchange gateways..

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

One Health Record® Leadership	FFY 17 (9/30/17)	FFY 17 (9/30/17)	
	Name	Medicaid	PH
Director, State HIE	Gary D. Parker	100%	
HIE Program Manager	Stella Stewart	100%	
ASMA Commissioner	Stephanie Azar, Medicaid Commissioner	Part of Medicaid Director Duties	
ASMA CIO	Mason Tanaka	CIO Duties	
ASMA HIE Executive Board	7 Member Board –	Advisory Role	

In the previously approved SMHP's, Alabama outlined the historical chronology of the significant Health IT activities since Medicaid became the SDE for ONC cooperative grant and subsequent funding through the Health IT   funding beginning FFY 2010-2021.

With the AHIE transition, A-SMA HIE staff still provide planning and preparation support under MES FPP funding for the One Health Record®. A-SMA staff under the PI program are providing admin support for the final PY 2020 & 2021 audits as well a program wrap-up functions to cease operations on 9/30/2022.

Finance: HITECH PI Administration,   remains a part of A-SMA throught the HITECH Act until 9/30/2022. Medicaid FPP funding continues to be an integral part of the financing mechanism for One Health Record®, however, this funding is apaprved through the MMIS umbrella effective 10/1/2021. The funding provides the infrastructure for providers to leverage interoperability. Due to Medicaid's 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 continues on its trajectory in 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 MES, MMISOBC (soon to-be Streamline Modular Certification –SMC), Alabama's State Medicaid's HIT Plan (A-SMHP), and Interoperability requirements serves as the means to provide the technical infrastructure for the transformation. . A-SMA has made it a priority to align the work strategy so the needs of the Alabama Medicaid managed care efforts can be met through the infrastructure of AHIE,   as well as for timely and appropriately promotion of interoperability. A-SMA MES Enterprise Architecture (EA) assessment includes the evolution of the A-SMA MMIS modularity process and inclusion of infrastructure to achieve inoperability of services and systems in health care delivery and information exchange

As noted earlier, a major focus of One Health Record® efforts continues to be capability to provide critical health information technology infrastructure to support Medicaid's Alabama Coordinated Health Network (ACHN) and the Medicaid providers who will be a part of these networks.

The state continues to expand the effort for e-Clinical Quality Measures (e-CQMs) particularly with intervention opportunities highlight by the certified outcome measures provide by ALOHR.

The State continues to develop open source tools to support the our clinical date integrations for other use case applications for eCQM analysis through FFY 2022 and beyond, we expect expand the population health data sets, notably the United States Core Data for Interoperability (USCDI) to monitor and support A-SMA 's ACHN, ICN, and Dual population programs.

The infrastructure for One Health Record® will continue to be leveraged to the extent possible for quality reporting and care management efforts of Medicaid providers and state staff.

As noted in the last update, A-SMA began pursuing opportunities to support the further adoption of Health IT in accordance with the recent release of SMD #16-003, dated 2/29/2016. This pursuit encompasses the development and implementation to various EHR gateway hubs for HIE connectivity, based on the "hub-and-spoke" approach, for Medicaid providers to exchange PHI. Under SMD# 16-003 and with CMS approval, Alabama issued five (5) grants to support HIE connectivity during the FFY's 2020-21. All grantees were successfully integrated into the AHIE network for data exchange. This program ended on 9/30/2021. .

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, continues to simultaneously manage multiple initiatives to reduce costs and transform health care. As mentioned above, The State will continue to leverage its

investment in Health IT services as a cornerstone of improving outcomes under the MES framework.

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.

Since the last update, there has not been any recent changes to State laws in the latest legislative sessions that have had an impact on the PI program.

A-SMA and One Health Record® continues to outline the policies and procedures for the operation of One Health Record® which became fully operational as an MES component on 10/1/2021. ,

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 States and others 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) in September 2012. Alabama was one of the first five State HIEs to become a certified eHealth Exchange participant and continues to be part of the e-Health Exchange and a member of The Sequoia Project. More recently, Alabama has opted-in as an eHx CareEquality participant, and is now exploring via the eHx Hub.
- *CIVITAS for Health (formerly known as SHIEC):* In March 2018, One Health Record® became member of the State Health Information Exchange Collaborative (SHIEC) and the SHIEC Patient Centered Data Home (PCDH) project, with a connection established to the Midwest gateway by December 2018. Alabama maintains its connectivity with eHealth Exchange, Georgia (GaHIN & GRACHIE), and Midwest Health Connection (Missouri), SSA, VA, and DoD Alabama is currently exploring connectivity with NAPHSIS's EVVE system for Vital Stats, as well as the FDA. *ONC Conference*: A-SMA staff
- *CMS State Technical Assistance Group (S-TAG) e Calls*: A-SMA staff participate in these State only calls to discuss issues and opportunities with CMS. Thecalls have provided opportunities for the state to better understand both Medicaid Director's and Statement of Operations (SHO) Letters, CMS Rules announcements and learn best practices and tools, including research on provider readiness for the interoperability and operations on various levels. .
- *AHRQ Medicaid Medical Directors Learning Network*: Alabama's Medicaid Assistant Medical Director, Dr. Melinda Rowe 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 newest focus areas are tele-medicine and expanding health homes services for individuals with chronic conditions. These are also priorities for A-SMA.

- *Medicaid Enterprise Systems Conference*: A-SMA Staff (MMIS HIE, and Data Governance) attend this conference on an annual basis.

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 CHIP data and EPSDT screening data is included in One Health Record®. ADPH continues to work with the One Health Record®, to allow Alabama providers to access and report public health (PH) immunization registry data, report lab, cancer and bio-surveillance data for purposes of PI through One Health Record®. In spite for efforts to move forward in the last several years, ADPH has to been able to leverage the framework offered by A-SMA. The recent initiatives offered by the CDC through the CARES Act are still works in progress in Alabama. there is renewed collaboration to meets the goals for FFY 2022 & 2023. One Health Record® continues to put additional effort in this area to focus of data analytics, infrastructure upgrades, and HIE connectivity for bio-surveillance using ADT's.

A Electronic case Reporting (eCR) and AHIE connectivity with Cancer Clinics have renewed discussions to engage work effort in these areas with the focus again on ADPH registry data collection and measure reporting to their specialized registries in the future. .

As noted previously, ADPH runs the county health departments in 65 of the 67 counties in Alabama and these local agencies are One Health Record® participants in information exchange as well as interoperable contributors across the State.

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: As A-SMA transitions away from HITECH, the goals and objective are still the same. The state continues with the approach 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 and state 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 service value and components to meet the gaps in HIE use capabilities for interoperability as a rule, including but not limited to provider directories, identify management, secure messaging, electronic clinical quality measures (eCQM's) and consumer engagement regarding their health care plans. More expansion into addressing disparities associated with substance abuse, mental health, and social determinants of health (SDOH) are the more recent added targets for HIE.

One Health Record® plans to be independently sustainable by 2025. We have developed a HITECH transition plan to continue implementations under the MES umbrella and working to identify more plausible means of funding including care plans PMPY/PMPM subscription fees and providing access to federal and reporting services transactional basis as allowed by law. Also, with the addition of the State's HHS agencies of ADPH, ADRS-CRS, and soon-to-be ADMH as live participants, a more diversified cost allocation approach is now achievable to reach LT sustainability. In addition, A-SMA still works with all providers in the state with the goal of connecting at least 75% of all providers to One Health Record®.

Alabama completed the transition away from HITECH effective 10/1/2021. The transition is demonstrated with the following milestones, which are again listed in Section E, Alabama Roadmap:

1. CMS approves HIE HITECH-to MES transition plan on November 19, 2020.
2. CMS certification for Outcome-Based Measures on 9/19/2021.
3. ALOHR and Gainwell completes final claims integration for USCDI claims rendering via the ALOHR phone app in September 2021.
4. ALOHR begins operations under the A-SMA MES on 10/1/2021.
5. CMS HIE IAPD-I approved for MMIS 75/25 FPP on 12/8/2021 for FFY's 2022-23.
6. ALOHR integration with the State's E&E system CARES to verify member enrollment.
7. ALOHR releases phone app and URL for Medicaid recipients to access their claims and

clinical information on March 8, 2022.

The core principles for the current Medicaid statewide HIT strategy remain as depicted in the following Figure 7 below becsue there are still applicable with this final update.

Figure 7: Core HIT Strategy Principles

There continue to be several components of the statewide strategy. Due to the Medicaid managed care transition, 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 include Cigna, Humana, United Healthcare, Complete Health, VIVA Health and Blue Cross Blue Shield (BCBSA), through the Alabama State Employees Insurance Board.

"To Be" Interoperability:

- *Internal Medicaid Agency:*

    - *Standard:* One clear internal state government goal is to effectively and efficiently purchase and manage the Medicaid Program. There are three specific objectives to support the goal. The first is to integrate the activities of the Health IT Programs organizationally into the broader Medicaid Agency.   In addition, the

Health IT programs - are currently included and very involved with MES strategy and meetings. ALOHR OBC will serve as an on-going value-add for the internal programs to support improved outcomes.

The second goal is to provide actionable, near-real time information to providers, state staff, the federal government, consumers and stakeholders. The supporting objective focuses on achieving interoperability for and improved care coordination and data exchange among the provider networks through various Health IT protocols so clinical information can be integrated as part of the enhanced data management/governance framework with analytic and data quality capabilities. On this framework, expanded governance, quality, and analytical tools are being implemented to access and analyze these new and currently available data sources.

The third objective now focuses on uses of data interoperability to providers and stakeholders for the "long-term" investment value in the health IT infrastructure, and the importance of patient care continuity/coordination in provider work flows and data integrity in their patient medical information. This goal was demonstrated in the data integration of ALOHR, CARES and ASMA claims processing systems to comply with the CMS Rule of Interoperability and Patient Access.

- *Methodology and Process:* A-SMA will continue to follow a strategy to expand on three specific areas through 2022-23; 1) Support Medicaid's managed care initiative , and 2) Demonstrate both the immediate and long-term value of Health IT and information exchange to other purchasers and participants, 3) Continue with expanding the geographical scope of data interoperability to include regional/national networks, and specialized participants

  - Expansion of HL7 capabilities, of One Health Record® to supplement the standard Continuity of Care Document Architecture, including ADT's, notes, lab results, prescription drugs, immunizations, cancer, orders, HL7 3.0, Fast Healthcare Interoperable Resources (FHIR) 4.0 and API's, US Code of Interoperability (USCDI) data elements and classes to address future CMS Rules of Interoperabiltiy.

  - Connecting and "on-boarding" the remaining Medicaid member Hospitals (25) and their integrated provider networks to One Health Record® by 9/30/2023 for both ADT notifications and bi-directional query exchange.

- Expansion of data collection processes from EHR's generated CCDA & USCDI data elements and classes to support A-SMA 's Interoperability and utilization of clinical and claims data for outcomes based quality improvement..

- Expand the CIVITAS for Health Patient Centered Data Home (PCDH) network in Southeast Region for both national and regional ADT notifications, CCD query exchange, disaster planning and recovery.

- Expand eHealth Exchange gateway connectivity to include national networks and regional networks and partners for the purpose of applicant medical record query and exchange as TEFCA objectives are identified

- Expand and maintain the eHealth Exchange gateway connectivity to broaden existing relationships with the VA, DOD, FDA, and SSA for data exchange with the Medicaid providers serving patients who utilize the state services for VA hospitals, DOD personnel and SSDI record retrieval.

- Expand interoperability among Medicaid providers by connecting and on-boarding their CEHRT's to One Health Record® through the development of single EHR vendor Hub interfaces.

- Develop data integration processes to import the Recipient member clinical health data from One Health Record® into A-SMA's data lake to maintain, support, and expand outcome based care planning and evaluation;

To continue with the multi-track strategy, Alabama will continue to move ahead to expand the implementation of connectivity of the remaining Alabama hospitals, provider networks, ACO, and others beginning in 1st quarter of 2022.

A-SMA and One Health Record® continue to l work in multiple geographical regions simultaneously rather than a single geographic region.

The updated approach will use the following criteria:
- The presence of an existing network of care coordinators through the Alabama Coordinated Health Network (ACHN), Heath Home program, or Integrated Care Network (ICN).

- Hospitals and associated provider networks or a set of referring providers and clinics that cover outpatient services including pediatrics and family

care, urgent care clinics, dialysis, rehabilitation, pharmacies, private clinics, skilled nursing facilities (SNF) and FQHC's.

- Engagement of other care participants, such as mental health centers, first responders, ACO's, and labs, who demonstrate the capability to utilize One Health Record®.

- Expanding utilization for more uses case with State HHS agencies such Alabama Department of Public Health (ADPH), Alabama Department of Rehabilitation Services (ADRS), Alabama Department of Mental Health (ADMH), and Alabama Department of Senior Services (ADSS).

- *Promoting Interoperability (PI) :*

  - *Standard*: With the final payments made in December 2021, the remaining activities of the PI program are focused on closeout. However, the efforts to move participants further along the health IT interoperable by expanding the utilization of One Health Record® services for care coordination and query, and to leverage the available eCQM's for benchmark analysis in improving health care outcomes will continue into FFY 2022-23.

As of 12/31/2022, a total of 2451 providers (2360 EPs and 91 EHs) were approved for AIU payments for a total amount of $114,314,499.74 ($49,747,685 to EPs and $64,566,814.74 to EHs). Another 2,953 (2,787 EPs and 166 EHs) were approved for PI payments of $86,444,995.10 (25,257,784 to EPs and $61,187,211.10 to EHs).

Methodology: As noted previously, Alabama PI participation peak in 2016 with 509 new AIU EP's. The focus continued to be on attesting for Stage III and interoperability of data for EP retention. As of 12/31/2021 , 66 of those 509 registered in 2019, completed all 5 years resulting in a relative retention rate of 13%. The state will continue to establish strategies, value and metrics to evaluate success and utilization of One Health Record and other Health IT investments.

Table 20: PI of Health Information Metrics and Goals

Program Priority	Report in last SMHP Update		Report December 2020		Report January 2022
	Status as of December 2017	Target for December 2018	Status as of December 2019	Target for December 2020	Status as of December 2021
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=100%	Yes	Yes	Yes	Yes
Immunization registries receiving electronic immunization data produced by EHRs. Data are received in HL7 2.5.1 formats using CVX code Yes/No or %	Yes=100%	Yes	Yes	Yes	Yes
Public health agencies receiving electronic syndromic surveillance hospital data produced by EHRs in HL7 2.5.1 formats (using CDC reference guide)Yes/No or %	Yes=100%	Yes	Yes	Yes	Yes
Public Health agencies receiving electronic syndromic surveillance ambulatory data produced by EHRs in HL7 2.5.1 Yes/No or %	Yes=100%	Yes	Yes	Yes	Yes
Public Health Agencies receiving electronic Cancer data produced by EHR's in HL7 2.5.1 Yes/NO or %	Yes=100%	Yes	Yes	Yes	Yes

- *Process:* The current goal is program closeout focused on final audits and SLR decommissioning   while continuing to promote the value of interoperable exchange.

- *One Health Record®:*

  - *Standard:* Medicaid continues to promote   providers to use One Health Record® for interoperable exchange of health information.   An ongoing analysis of readiness continues to provide the state with possible avenues for One Health Record® implementation, including the technical capability to support DSM, B-directional Query, ADT alerting, provider directory, DIRECT support and a master patient index (MPI) and the statewide infrastructure for providers to achieve proper   interoperability to coordinate and deliver care more efficiently and effectively.

- *Methodology:* Interoperability challenges continue to be less problematic as we move beyond 2021. While 59 % of the Hospitals are now connected, and Alabama's expects to reach a goal of 70% by the close of FY 2022 for all Alabama Medicaid Hospitals. As the Hospital implementaions wind down, there is now new energy driving renewed emphasis on ambulatory clinics including FQHC's, RHC's and CMHC's.

- *Process:* An Final HIT-I-APD was approved on 1/19/2021 to address specific activities to support PI program closeout, HIE activities, and CMS Rule Interoperability: :

  - Funding for costs associated with the Medicaid specific staffing, contracted personnel support, systems, and activities supporting One Health Record® planning, preparation and on-boarding. One Health Record® has connections to the Medicaid MMIS, CHIP claims, and the CARES eligibility systems. The core One Health Record® technical infrastructure, which includes DIRECT secure messaging, robust query exchange, and ADT alerting, and Patient Interoperability Access is operational.

    Funding included for onboarding of certain participant types to One Health Record® for purposes of reporting to PH for PI were revised. The requirements for One Health Record® connection to participants for purposes of Medicaid PI reporting include the following:
    - An improved web site that ADPH and One Health Record® can view and download project status for each provider who has contacted the vendor regarding onboarding connectivity to ADPH through One Health Record®.

    - National transport and content standards with an automatic upgrade to national standard upgrades.

    - One Health Record® administraion 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 and gateway for direct reporting to the PH registries via One Health Record®.

    - Provide an electronic means for Pi participants 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 ADPH.

- 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 as appropriate.

- Support connectivity for PI participant'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 participants.

- 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, cancer, and PDMP registry information.

- Support the quality assurance of the reported registry data and other eCQM registry data, such as vital and death statistics for population health analytics.

- *Eligibility:*

  - *Standard:* The Alabama Medicaid eligibility system (CARES) is now operational, effective, and federally compliant, and consumer centric effective. Connectivity to One Health Record was completed as of 12/31/2021 to support CMS Rules of Interoperability and Patient Access in accordance with the 21st Century Cures Act.

  - *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) the Medicaid final policy rule, and the E&D population. 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, 2023.

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® system functionality is basically the same in 2021   with adaptations/upgrades to accommodate enhance platform performance, health-IT, FHIR 4.0 capabilities, health care and health care delivery changes. The difference is that the expanded "vision" is operational "reality". Alabama continues to build 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, ADT alerts, query, patient access, and interoprability.

"To Be" Future State Functionality and Systems Architecture:
- *"To Be" Future State of PI Identification, Validation, Payment, Audit and Appeals HIT:* The current SLR contract was renewed until 7/31/2022 to to allow close out the PI program and provide any audit services required. A final HITECH IAPD-U was submitted in December 2021 to address costs associated with PI close and FY 2022 program audit operations. CMS approved the IAPD-U on 1/19/2021.

  The following chart identifies the IT functionality required by year for PI. 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 21: PI IT Functionality by Year

Feature	Detail
Year 4 PI Modified Stage 2 Functionality (July 1, 2016 to accommodate Modified Stage 2 changes as a result of PI Final Rule) ****The functionality listed is based on the current SLR platform, which switch vendors.	
Program Year 2015 Modified Stage 2 Meaningful Use Measures (EP and EH)	In addition to the functionality described above, a system re-design was utilized to increase EP's and EH's ease of use. Incorporates the data set of objectives and eCQMs for Modified

Feature	Detail
	Stage 2 as defined in the Final Rule into the SLR attestation process (EP and EH).
Re-designed workflow and drop-down functional directories; format removes redundancy and increases ease of use.	A new stream-lined re-design of the system is the primary modification with increased configurable items document drop down list, prefilled checks, and that the attestation process is quicker and less cumbersome.
Year 5-6 PI Modified Stage 2 Functionality (December 1, 2016 to accommodate Modified Stage 2 changes as a result of PI Final Rule).	
Review, Sign, and Submit Attestation	Alabama implemented electronic signatures to improve system workflow and document retention.
Incorporated and Improved workflow with reduced documentation uploads	A new stream-lined work flow that reduce the number of manual save activity, less documentation on EP, and a single upload requirement on submission only.
System change prevent concurrent PY attestation submission.	Edits implemented only allow a single attestation to be submitted until D-18 from the previous year has been recorded in the SLR.
Year 7 Modified Stage 2 & Optional Stage 3 (December 1, 2018 to accommodate Modified Stage 2 Option Stage 3 changes as a result MACRA/MIPS Final Rule, including release OPPS rule & QPP.	
Years 8-10 - Stage 3	**Improved reporting for Stage 3 changes for Final years, final audits, program close out and SLR decommissioning.**

2013-2021 Program Changes

Alabama submitted a description of EHR Incentive Program Changes for prior years in the previous SMHP dated December 19, 2020 which CMS approved on 3/19/2021 .

SLR Contract Awarded

As noted previously, HealthTech Solutions (HTS) was awarded the SLR effective August 1, 2016, with a termination date of July 31, 2021.   The contract was be extended to July 31 2022 to accommodate PI closeout, audit services, and decommissioning.

2020 Tail Period

The State began accepting Program year 2020 attestation on December 1, 2020. The deadline for Program Year 2020 ended at 11:59 PM CT on February 28, 2021.

2021 Tail Period

The State began accepting Program year 2021 attestation on July 1, 2021. The deadline for Program Year 2021 ended at 11:59 PM CT on August 31, 2021.

- *"To Be" Future State of One Health Record® to Support the Exchange of Information for Promoting Interoperabillity:* The overarching goal of One Health Record® is the development and facilitation of technology that will enable providers to exchange health information

  One Health Record® is envisioned as the primary gateway for individual or group entities within the state to connect with other state HIEs, Integrated Health Networks, State HHS agencies, federal agencies, the eHealth Exchange, and other interoperable systems. To achieve that goal, Alabama continues to use a staged multi-track implementation that allows for each phase to be fully implemented and integrated with the prior and/or concurrent phase. The purpose of a multi-track staged implementation is to allow for a period of time of response and flexibility and most importantly, provider engagement, education, technical assistance, and value.

  The web service offerings continues to include administrative and technical validation of the eligibility of the provider to participate [authentication], validation of their status as a provider and agreement to comply with the privacy and security rules of engagement through an agreement that aligns with the national DURSA agreement.

  The state focuses on the hybrid technical design with the capability to collect information into a secure repository and enable access to providers for integration into their EHRs. One Health Record® serves as the nexus of these gateways, capable of PHI exchange among all HIE participants, and orchestrating interoperability according to business rules needed to deliver interoperable 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 to clinical data via their native EHR interface or with a secure Web browser in order to meet the requirements of promoting interoperability.

  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 CMS Final Rules on Interoperability, including all specified content, vocabulary and privacy and security standards. One Health Record® also utilizes standardized code sets and nomenclature. 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), and HITRUST certification.

The state continues to evaluate the capabilities and risks associated with various encryption approaches including the ability of the private sector to implement the proposed algorithms. 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-2), as specified by NIST, is used, to verify that electronic health information has not been altered in transit

In previous SMHP updates Alabama has provided updates to infrastructure and core functions. The infrastructure, core functionalities, and capabilities will remain constant and consistent through FFY 2018-2021.

As referenced in CMS's Final Rule of Interoperability, published on May 3, 2020, A-SMA l leveraged One Health Record®, along the CARES E&E system, in collaboration with the MMIS Fiscal Agent, Gainwell (FKA DXC), to provide patient access to their health data through ALOHR phone app and URL, upgraded HIE FHIR 4.0 platform and standardized API's. The l required an HIE infrastructure upgrade that was completed in April 2021 to ISC HealthShare version 2020.2. A detailed Interoperability plan was approved by CMS in January 2021and Alabama went live with a limited Patient Access release in July 2021.

Moving forward beyond FY 2021 , One Health Record® implementations continue to be focused on the following:

EHR Hub development The AHIE continues to use a single front-door gateway connection to EHR vendor "hub" web service where available. The A-SMA providers are on-boarded to the HIE, as each individual EHR installation's "back door" is opened by the EHR vendor. However, beginning in 2018, our recent experience still shows that very few vendors support this approach or make it very cost prohibitive to achieved . Alabama is still currently working with various EHR vendors , but are having the most success with Athena, CureMD, Imagetrend, EPIC, Medictech, and Netsmar. Cerner, Allscripts, Greenway, SMS, , CPSI, ECW, and others have made this approach extremely difficult for Alabama providers wanting direct connectivity to ALOHR.

eHealth Exchange expansion: Alabama continues to expand its gateway connections information exchange by leveraging in newest migration to the eHealth Exchange Hub (eHx). This gateway connection continues to afford One Health Record® the capability to expand its exchange scope with connectivity to our Federal partners including, VA and DoD ted Alabama has is a participant to CareEquality t. Alabama is completed its first SSA integration in August 2021 with SSA for Query and Exchange.

ADPH: The State will continue to work with ADPH to expand the HIE reporting capability to the ADPH registries to promote interoperability. Alabama still has plans to move forward to develop a gateway interface for PDMP-HIE integration access for provider queries and reporting. As noted, ADPH is exchanging C-CDA formatted clinical information through their CureMD connectivity to One Health Record®.

CIVITAS for Health: As a new member in CIVITAS, One Health Record® continues its role to include servicing as a possible Southeast Region gateway for the Patient Centered Data Home for regional and national ADT alerting, C-CDA exchange, and disaster preparedness. Alabama continues plans to partner with CIVITAS to support expansion of HIE connectivity to utilize the PCDH initiative.

Disaster Preparedness: One Health Record® has partnered with City of Mobile to implement a pilot implementation to provide PHI access and exchange EMS first responders through mobile devices. This pilot is focused on Mobile's Fire & Rescue first responders and went live in in January 2021.

Patient Access: ALOHR developed a mobile device app and URL to allow Medicaid recipients and patients access to the PHI in ALOHR. The future, expanded interoperable strategy will include Payer Care Plan exchange, PA's, and Patient Demographic updates to CARES.

Population Health eCQM's: A-SMA and One Health Record® partner to provide and collect clinical and HL7 information on their Medicaid recipient population from the state-wide HIE. This foundation will support future program endeavors such as QA, program OBC reporting, and intervention activities.

- *"To Be" Future State of Other Health Information Technology to Support the Interoperability of Health Information:* With the ACHN effort expanding, the state continues its approach in its health care transformation. A-SMA is simultaneously developing health-IT to support these new changes, which encompass payment reform, changes in service delivery, document exchange, analytics and care coordination for all individuals, particularly members with chronic illnesses and co-morbidities 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, electronic case reporting (eCR), state enterprise wide data warehouse/repository with analytical capabilities, MES business models and the Medicaid eligibility system, CARES. Many of the technologies developed and implemented for One Health Record® will continue to 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 23: 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, patient interoperability, and query. ADPH & ADRS are active exchange provider participants.
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, and eCQM data collection.
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.
MITA 3.0 Self –Assessment is completed and Health-IT enhancements are included in all phases where applicable.
Health IT infrastructure to serve as a SE gateway for disaster preparedness, patient ADT and emergency notifications, and resident evacuations on national, regional, and state landscapes.
CMS Outcomes Based Certification (OBC) criteria to integrate into Medicaid Enterprise System (MES) framework. Certified on 9/19/2021. .
CMS Final Rule on Interoperability for Patient Access completed. CMS Final Rule for Care plan exchange and Prior Authorizations. eCR data aggregation from AIMS for Public Health.

3.4 The state has contracted with Gainwell (fiscal agent) for its claims and provider management **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 PI have always been under the auspices of A-SMA. As with many new initiatives, the Medicaid Agency team to focused on PI and on the initial design, development and implementation of the state HIE technical, technical and business operations, governance, finance and legal/policy areas.

A-SMA will continue the HIE integrations of its Medicaid's provider networks as as A-SMA interoperability needs and opportunities continue to grow and expand. A CMS approved HITECH-to-MES HIE transition planintegrated the A-HIE services into the MES effective 10/1/201. The corresponding IAPD was approved 12/8/2021.

The transition allows A-SMA to continue the AHIE DDI and operations for an interim time through FY 2023, with primary governance be addressed by A-SMA. This governance approach will continued for the foreseeable future.

The Medicaid Executive Board provides administrative oversight, operating through the Chief Data Officer, who also functions as the AHIE/Health IT Director. Current contract staff has migrated as full time employees of One Health Record® with the transition.

Medicaid Health IT division, operating under the Agency's Data Governance Office, continues to be led by A-SMA's Chief Data Officer and Health IT Director, Gary D. Parker and still addresses A-SMA's Health IT interoperability activity, funding needs, and requirements. The Promoting Interoperability program completed the EHR payments in December 2021 and is currently working to complete audit activities and SLR decommissioning with HIT-PI staff. , Table 9 provides the key staff and consultants along with their roles.

Table 24: Key Staff/Consultants and Roles

Staff/Contract Support	Roles
Chief Data Officer & Director, Health IT: Gary D. Parker	Provides leadership, direction, administration, and coordination for all Health IT, Interoperability, & Data Governance activities under the Medicaid Program.
Clay Gaddis, MMIS Director	Manages all activities for MMIS operations, PI EHR Incentive payments audits.
PI Associate Director, Manager, Provider Audit: Janice Miles	Coordinates the efforts set forth by CMS for the Provider Audit in the Medicaid system
HIT-PI Associate Director, Operations Manager: Connie Simington	Coordinates the efforts by CMS for the implementation and adoption of criteria in the Medicaid system, including CMS reporting and SLR decommissiing.
HIT-PI Analyst Avis Stallworth	Assists other HIT Staff in Provider Post payment Audit activities.
GDH Government Services (GDH)	Assists in the post payment Audits. ®

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, and has been updated as needed or required. The I-APD was approved as well as all of the I-APD updates since 2012. The last update was submitted on 9/26/2019 and approved by CMS in a letter dated 10/13/2019. An update to the I-APD was submitted in January 2021 to cover changes related to the FY 2022 PI_HIT operations and CMS Rule of Interoperability, announced on May 3, 2020 with approval received on 3//19/2021 for

both FFY's 2021-22. All relevant contracts have been submitted to CMS for review and approved with the latest approval letters received March 15, 2021, July 13, 2021, and August 5 2021.

"To Be" Future State of the Alabama Health IT- Division: The Health Information Technology Division is still administered under the Agency's Data Governance Office. The Data Governance Office, the Health IT Division, and PI EHR program remain) within A-SMA Department of Information Services and Technology (IST).

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 PI Stage 1 and from PI Stage 1 to PI Stage 2 and ultimately to Stage 3 of the promoting interoperability program.

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 PI 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 PI and increased automation. It is evolving from an office that handled all components of the efforts for One Health Record® and PI 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 and A-SMA is initiating a pilot to submit eCQMs directly to the Medicaid agency.

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 PI measures.

An addendum will be submitted once the Program Year 2018 system updates have been completed and screens can be submitted.

The State of Alabama has acquired a new vendor since the last SMHP submission. A contract with HealthTech Solutions, herby referenced as HTS, went into effect on August 1, 2016. The new vendor was put into place and first utilized for Program Year 2015. The State recently finished

accepting applications for Program Year 2017. The deadline for Program Year 2017 was approved by CMS and extended until 11:59 PM CT on May 15, 2018. An addendum was previously submitted and approved to outline the modifications made to the system for Program Year 2017, including both Modified Stage 2 and Optional Stage 3. The State began accepting Program year 2018 attestation January 7, 2019. The deadline for Program Year 2018 ended at 11:59 PM CT on March 31, 2019. The State began accepting Program Year 2019 application on January 6, 2020. Due to the COVID-19 virus disruption, the deadline for Program Year 2019 was approved by CMS and extended twice, with the final extension being until 11:59 PM CT on April 30, 2020. The State began accepting Program year 2020 attestation on December 1, 2020. The deadline for Program year 2020 ended at 11:59 PM CT on February 28, 2021. The State began accepting Program Year 2021 attestation on July 1, 2021. The deadline for Program Year 2021 ended at 11:59 PM CT on August 31, 2021

CQMs have not changed for Program Year 2015, but changes occurred PY 2017 which are discussed in the 2017 SMHP addendum, approved on 2/13/2017; the screens, previously submitted, were approved on 3/23/2017. The state has created and separated the confidential Promoting Interoperability (PI) Program Audit Requirements and Procedures and previously provided it to CMS as a separate, stand-alone document. The State's Audit Strategy has been updated to address Modified Stage 2 Objectives and measures and Stage 3 Objectives for Program Years 2017 and 2018 is provided in Section 5, which will be submitted separately

The state has developed multiple tools to enable eligible providers and hospitals to establish that they have satisfied the minimum requirements. Since the changes in the 2017 Program Year are primarily those associated with the Modified Stage 2 PI Objectives and an Optional Stage 3, none of the Eligibility or Certification tools are part of this update to the SMHP.

Pre-payment Processes: The high-level steps of pre-payment processes (Attachment 8.9) are:
- The provider or hospital successfully registers with the CMS Registration and Attestation System.

- After successful registration at the CMS Registration and Attestation System, notification is sent to the state via an electronic data transmission including notification if there are federal or state exclusions precluding payment to the provider or hospital. This file is known as a B-6.

- After 24 hours, the provider may commence the State Level registration and attestation process in the SLR.

- As the potential EP/EH completes the on-line SLR attestation (Attachment 8.8) the system applies checks and balances that will not allow the EP and/or EH to complete the registration process without submitting the requested documentation or answering all questions.   As the following screen shots provided in Figure 26 indicate, certain documentation is required and must be attached as a part of the registration and

attestation process. Screen shots of the entire process are provided in the previous submission of the last updated SMHP.

- 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 five (5) distinct steps in the state registration and attestation process:
- Account Creation
  Step 1: Identification and Eligibility
  Step 2: Medicaid Eligibility
  Step 3: PI – Promoting Interoperability 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.	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. Changes to the Stage 1 requirements effective January 1, 2013 related to the definition of hospital based physician have been addressed.	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.	None

Attestation Component	System Validation	State Action	Provider Action
Professional License Number and Provider Status	SLR will validate the provider's License Number on the Provider Master File & current status including: • 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.
Medicaid Eligibility: Provider must meet patient volume of at least 20% Medicaid encounters for pediatricians and 30% for all other designated providers	Numerator and denominator information entered by provider must be at least 20% of pediatrician patient volume and 30% of all other providers' total encounters. 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 The expanded definition of encounters from previous 12 months to previous 24 months were implemented to attestations submitted for program year 2013 forward.	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. 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.	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. 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.

Attestation Component	System Validation	State Action	Provider Action
Total Encounters	Medicaid Patient Volume/Total Patient Volume > or = 30%, 20% for pediatricians	The summary report from the provider's practice management 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.)	SLR System will not allow provider to proceed if volumes do not meet criteria. 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.
Additional Medicaid Encounters	None	Same as State Actions under "Medicaid encounters" above	
Provider practices in an FQHC/RHC	None	Verification of an express statement from the provider of employment status on the attestation agreement and a letter from CMS identifying the FQHC/RHC status.	Check section of attestation agreement identifying that the EP is employed by an FQHC/RHC and submission of a letter from CMS confirming the status of the facility.
Medically Needy Patient Volumes	Only applicable to providers attesting to practicing in an FQHC or RHC. Changes as a result of the MU Final Regulation have been incorporated effective 1/1/13.	The summary report from the provider's practice management system is reviewed to substantiate the Medically Needy patient volume.	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.
Alabama Medicaid Volume Hospital Demographics Information	The SLR system validates that the percentage of Medicaid patients is 10% or above. Changes as a result of the MU Final Regulation have been incorporated effective 1/1/13	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	Correct attestation data and resubmit.

Attestation Component	System Validation	State Action	Provider Action
		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.	
The provider must attest to the promoting interoperability of CEHRT for the appropriate Stage.	Based upon the previously submitted attestation, the system calculates the appropriate MU Stage, Payment Year, Attestation Period (90 days or 1 Year), to which the provider may attest.	Vendor Letter containing the EHR description, version, and ONC certification or Product ID number.	Upload acceptable attestation document
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 electronically sign the Attestation Agreement.		Review and confirm that: • Entries pre-populated from the SLR match information submitted by provider. • Electronic signature of EP of record or EH representative of	No additional documentation as required since this is an electronic process now.

Attestation Component	System Validation	State Action	Provider Action
		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.	

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

Table 15: EP SLR System Validation Process

Provider Place of Service (POS) Report
EP Workbook
Practice Management Summary Report Supporting Provider's Denominator
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 PI final regulation effective payment year 2013, will be reviewed by the reviewer. As of December 31, 2019, AMA has completed all its validation for EHs.

Table 16: EH SLR System Validation Process

Cost Report Data submitted to Medicaid Internal Audits Section
EH Workbook
Attestation Agreement
Other Documents that May Be Submitted by Provider:

- Approval: The SLR contains verification steps for all requirements against which the reviewer reviews provider's submission and related documentation to validate provider's attestation to all eligibility requirements.

- In reviewing the aforementioned checklist or if the information submitted is inadequate or unclear, the application will be 'unlocked," 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 prior to PY 2015.

- 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. Upon obtaining a new vendor on August 1, 2016, Alabama proceeded to use contract support staff in assisting Medicaid with SLR activities and verifications which are required in order for the state to issue complete timely and accurate incentive payments to Alabama providers.   HTS provides an Alabama-specific SLR Provider Support Lead and 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 and in rare instances rejection of an application. 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 in a previous A-SMHP. The guidelines are updated as program requirements change and the most recently updated version for Program Year 2017 Modified Stage 2 objectives and the optional Stage 3 objectives were approved by CMS and are provided in a previous Program Year 2017 Addendum.

A-SMA has augmented state resources, beginning August 2018, with 3 Agency state staff members to perform attestation review and will not continue to use contract resources for this purpose. Utilizing state resources results in fewer handoffs, a more cohesive administration of the program and retains institutional program knowledge within the agency.

HTS does not review EH attestations due to the complexity and high dollar value of the EH incentive payments.

- In the past, Alabama has utilized the option to have CMS perform all hospital audits. However, since CMS no longer offers that assistance, the State of Alabama will begin auditing hospitals beginning with Program Year 2016. The specifics of this plan will be discussed in detail in our Audit Strategy, which is submitted separately. A-SMA herby agrees that Alabama: 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;

The following diagram is a high-level overview of the process for the meaningful use incentive program. This document has included the processes for attesting to and demonstrating AIU or Meaningful Use of EHR technologies. Figure 27 is the Process Overview.

Figure 27: Process Overview
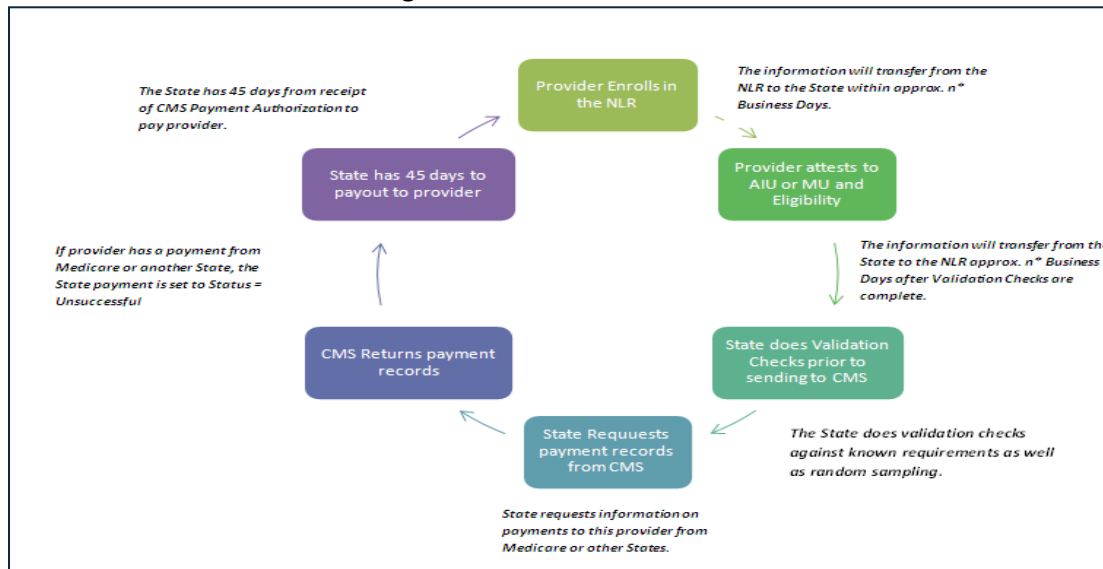
Incomplete Registrations: There are two categories of incomplete registrations. There are registrations with exceptions due to stops and registrations/attestations that have been completed up to a certain point. The state monitors incomplete registrations and, if a registration remains incomplete, the state contacts the provider to inquire the reason and offer assistance. After further research, these "incomplete" applications have a final determination made upon discussing with the provider, such as either an approval or rejection. The outcome of the communication 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 (DXC). 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. In special circumstances in which the provider cannot be paid through the standard method of payment, the Check Write process, a paper check is still utilized.

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
The focus of the post payment audit are those areas that the agency is unable to validate during the pre-payment validation, including: • *Place of Service for Non-Medicaid Encounters* • *Total Encounters by all payers* • *Certified EHR System is as reported*	*The providers or hospitals selected for audit will be based upon the following categories:* • *A statistically valid sample or minimum of 10% Random Sample of all providers and all hospitals electing to receive incentive payments for AIU* • *All submissions identified as "flag for post payment audit*	The method of review/audit will include on-site visits by contracted staff. Alabama has taken the option for CMS to complete the EH audits and handle any subsequent appeals of whether a EH is a "meaningful user" on behalf of the state

Statewide Infrastructure Assurance: In order to adequately oversee and efficiently manage the EHR Incentive Program as it moves to Stage 3 and beyond, 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 PI 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 PI Stage 3, operation and implementation of Medicaid managed care transition where PI 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 Promoting Interoperability (PI) Program.

Target Date	Description
1/1/2019	• EP Modified State 2 and Stage 3 for Program Year 2018
1/1/2019	• EH Modified State 2 and Stage 3 for Program Year 2018.

With the implementation and use of a different vendor, HTS, new screenshots were submitted and addendums as necessary to show the new SLR platform's functionality in relation to the updated regulations. As of last, an addendum was approved for Program Year 2017 and included all applicable screenshots. This was submitted and approved by CMS. Program Year 2018 updates will be reflected in an upcoming addendum.

Prior SMHP Updates have included attachments that were approved by CMS and will not be resubmitted with this version.

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 PI 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
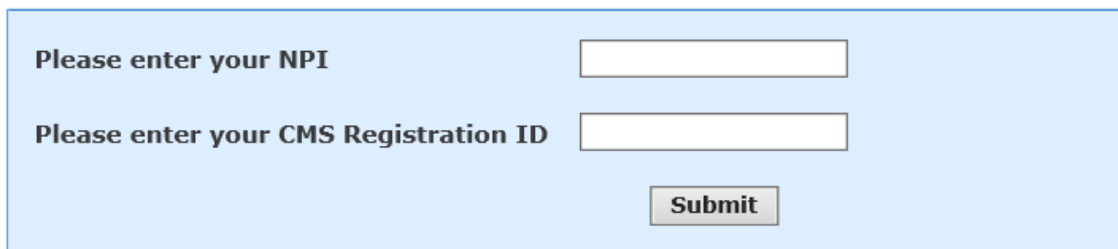
ordered by excluded parties, all current providers and providers applying to participate in the Medicaid program are required (Alabama Medicaid Provider Manual, Chapter 7, Sections 7.3.1) to determine whether their employees and contractors are excluded individuals or entities.

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 HTS, 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 PI 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 CMS Registration ID, 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 is status and 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

Figure 30: EH

4.2   HOW WILL THE SMA VERIFY WHETHER EPs ARE HOSPITAL-BASED OR NOT?

Standard: Hospital based as defined in the final regulation is an EP who furnishes 90 percent or more of his or her covered professional services in a hospital setting in the year preceding the payment year. The hospital-based exclusion is further defined as "90% or more of their covered professional services is in either an inpatient (POS 21) or emergency room (POS 23).

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 CAHA, 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.

Methodology: The SLR has a page that allows the provider to submit additional information that establishes the provider's eligibility to participate in the program, including that the physician is *not* hospital based and that the provider has a valid Medicaid status. A setting is considered a hospital setting if it is a site of service that would be identified by the codes used in the HIPAA standard transactions as an inpatient hospital, or emergency room setting. The codes are: 21 for inpatient hospital and 23 for emergency room – hospital.

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 and/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 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 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.

  The definition of encounters for Medicaid enrollees on a panel assigned to an EP 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 allow the 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 was 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, the provider checks the status on the attestation agreement and A-SMA verifies the provider's employment in an FQHC/RHC through the state's MMIS claims system and Provider Master File. The EP must also submit CMS documentation that the facility is an FQHC or RHC and a letter from the FQHC or RHC board stating the provider meets the "practice predominantly" criteria as set forth by CMS.

- *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 AMA verify 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 2017, all Certified EHR Technology must meet 2014 ONC certification requirements however A-SMA implemented CMS enacted regulations that allow a provider to be able to attest to the use of other than a 2015 Edition CEHRT if the provider is not ready to attest to the optional Stage 3. The provider can continue to attest to a 2014 CEHRT, a 2014/2015 combination system, or a 2015 CEHRT if the provider is attesting to the Optional Stage 3 requirements for Program Year 2017 and 2018.   The CMS approved addendum to the

SMHP on 2/3/2017. Beginning with the EHR reporting period in calendar year 2019, all providers are required to attest to using a 2015 Edition CEHRT.

- *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 previous SMHP has outlined our EH validation process. As of December 31, 2019 for Payment Year 2019, AMA has completed all its validation of EHs.

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.

Effective August 1, 2016 HTS, A-SMA contracted with HTS to provide staff and resources to directly support Medicaid in its administration of the Meaningful Use Electronic Health Record Incentive Program. As with the previous vendor, staff were contracted to conduct appropriate pre-payment reviews and payment/program reporting of EP attestations in accordance with A-SMA guidelines and submit recommendations to A-SMA for approval, rejection or further investigation by A-SMA. A-SMA staff perform secondary reviews attestations, apply policy decisions, determine whether the EP should be approved or rejected, and complete the payment process.

Figure 31: Pre-Payment Validation Checklist

			Immunization Registry – Registration/Testing/Production – Date Name of Specialized Registry – Registration/Testing/Production – Date MU Requirements Met
CQMs			Reporting Period Dates: Report Dates: CQM Requirements Met

NOTES:	
RESPONSE:	
Recommendation for Approval	Recommendation for Rejection

Employee Name: Name   Date Completed: Date

Approved by: Name   Date Approved/Rejected: Date

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 bi-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:
- *List of Providers Queue*: allows the user to search for, view, and review the progress of providers' EHR Incentive submissions.
- *Eligibility Check B7*: allows the user to verify that the provider is eligible to participate in the A.L. Medicaid EHR Incentive Program

- *Eligible Hospital Queue*: allows user to view an EH that has successfully submitted their attestation.
- *EHR Review Queue*: allows the user to take action on or record information about a provider's attestation.
- *EHR Reassignment* allows the user to re-assign active providers to a different staff for validation.
- *Overall Approval Queue*: allows the user to approve attestations for payment or reject them.
- *Make Payments* <u>allows the user to verify, approve, and adjust the Alabama EHR Incentive</u> *payment.*
- *Providers for Transmission*: allows the user to select providers that have no exceptions to be included in B7 or D16 data exchanges.
- *Audit and Appeals Queue*: allows the user to view existing audits and allows them to add new audits. It also shows a complete list of in process and completed audits. Manage appeals and communicate changes and results to CMS.
- *Adjustment (DFA)*: allows the user to view and recoup or adjust payment information for 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. The reviewer is also able to add Verification Items to alert other A-SMA staff to items that should be reviewed as part of the verification process, such as Pended items and whether the provider has been unresponsive to A-SMA efforts to request completion of the attestation.

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

EHR Review

Applicant National Provider Identifier(NPI):	1124214895		Name:	Elizabeth Thelan
Applicant TIN:	111111111		Address 1:	2051 Charlie Hall Blvd
Payee National Provider Identifier(NPI):	1851600896		Address 2:	
Payee TIN:	111111111		City/State:	Charleston /SC
Program Option:	MEDICAID		Zip Code:	29414-
Medicaid State:	SC		Phone Number:	8432844688
Provider Type:	Nurse_Practitioner		Specialty:	
Payee Medicaid ID:	GP4688		Payee Name:	COASTAL PEDIATRIC ASSOCIAT
Email:	covington@coastalpediatricassociates.com		CCN:	
			State Rejection Reason:	None
Rejection Reason State:	None		Rejection Reason Date:	None
Is a transfer record?	No			

EP Volume Review

		Comments/References
Does patient volume meet minimum threshold?	Select	
Is provider not hospital based?	Select	
Is incentive payment amount of $8500.00 Correct?	Select	
If group volume is used, is the data consistent with others from the group?	Select	

EHR Review

		Comments/References
CHPL attestation = EHR Certification ID?	Select	
Have you verified MU attestation?	Select	

Final Eligibility Review

Final Eligibility Review		Comments/References
Have you verified provider is licensed?	Select	
Is MMIS provider-type eligible?	Select	
Have you verified the EP and Payee have no sanctions?	Select	
Does the Payee NPI/TIN/Medicaid ID crosswalk in MMIS?	Select	

Please upload the document: [Browse...]   Please select the document type: --Select the type of a document--

[Upload]

Documents List

	Payment Year	File Name	User who uploaded	Is Internal	Document Description	Document Uploaded Date	Delete
View	3	Version 13.12.supporting d.docx	Elizabeth Thelan	False		5/28/2014 2:17:24 PM	Delete

[Save]   [Complete]   [Put On Hold]

Verification History
Friday, July 05, 2013: Unverified by acsopsAL   ➕ Add Verification

Item	Required	Description	Status	Exceptions
1	Yes	Place of Service	Passed by User	None
		Last Updated: MNewboldAL 7/10/2013 1:51:57 PM		
2	Yes	FQHC/RHC Status	Passed by User	None
		Last Updated: MNewboldAL 7/10/2013 1:52:22 PM		
3	Yes	Needy Individual Patient Volumes	Passed by User	None
		Last Updated: MNewboldAL 7/10/2013 1:52:55 PM		
4	Yes	Medicaid Encounters (Numerator)	Unverified	None
		Last Updated: acsopsAL 7/5/2013 1:22:12 PM		
5	Yes	Additional Medicaid Encounters (Numerator)	Failed by User	None
		Last Updated: lbarber1 11/14/2013 11:33:56 PM		
6	Yes	Total Encounters (Denominator)	Passed by User	None
		Last Updated: acsopsAL 7/15/2013 7:03:07 AM		
7	Yes	AIU Attestation Documents	Passed by User	None
		Last Updated: acsopsAL 7/15/2013 7:06:13 AM		
8	Yes	Attestation Agreement	Passed by User	None

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

Figure 31: SLR interface

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 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.
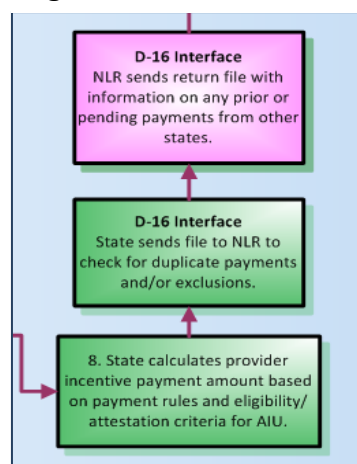
Providers confirm the Medicaid ID number of the designated Payee and, if there are more than one Medicaid IDs, they must select the Medicaid ID to receive payment. If the payment is to be made to the individual provider, it is made by a manual check and the provider is informed during the review process that 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 1st, then Medicare in same FY	Medicare 1st then Medicaid in same FY / Medicare 1st, then Medicaid in a later FY
1st payment yr.	AIU	AIU (Medicaid);	MU, 90 day reporting period
		MU, 90 day reporting period (Medicare)	
2nd payment yr.	Stage 1 MU, 90 day reporting period	Stage 1 MU, 12 month reporting period	Stage 1 MU, 12 month reporting period
3rd 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 2015, 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 with the last year to AIU being for Program Year 2016. 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, 91 Alabama 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. As of December 31, 2019, for Payment Year 2019, AMA has completed all its validation of EHs.

Figure 32: EH Guidance for Submission

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 2015. 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 of the calendar year in which the program year falls that the provider is attesting. In addition, an expanded definition of encounters has been implemented to attestations submitted for program year 2013 forward. 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 the 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. This significantly increases the efficiency and ease of accessing MMIS data, the accuracy and consistency of the data. Effective payment year 2013, Providers have the option to elect to use either a 3consecutive calendar month period in the previous calendar year or 12

months of the calendar year in which the program year falls that the provider is attesting. 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.

    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.

5. To ensure reporting the correct data from your cost report, refer to workbook tab "Cost Report References" for assistance.

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.

<u>CAUTION!</u>   If the EH finds that a 90-day Representative Period must be used, the cost report information and documentation must also be submitted to show that it is insufficient to satisfy the Medicaid patient volume requirement and justifies the use of the 90-day period. If that cost report information is not included, the attestation will not be approved and the attestation will have to be Pended so that it can be resubmitted with the complete documentation.
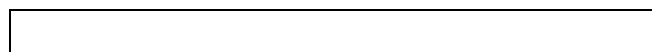
Start Date Of Representative Period		
End Date of Representative Period		

_____ Using hospital cost report data
and/or
_____ Using other hospital business records

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

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

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.

- *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).

4.6   WHAT DATA SOURCES WILL THE SMA USE TO VERIFY PATENT 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 also obtained from 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 have been 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 sometime 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 be able to identify 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. 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 be supported by data from the provider's Practice Management System report or a cost report must be submitted to support the Medically Needy volumes. Changes as a result of the Stage 2regulation for Stage 1 related to medically needy patient volumes has been incorporated into the A-SMA policy, SLR and business processes.

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. The agency validates the provider's employment in an FQHC/RHC. 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 with Medicaid encounters, then a determination of "predominantly at an FHQC/RHC" will be made. 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. Program Year 2016 is the final year a provider can attest for the first time and meet the eligibility requirements for AIU. All other subsequent years, the provider will attest to meaningful use until they complete the program.

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, CEHRT information exported from the SLR to the document matches information submitted by the provider, and the signature of EP of record or EH representative is present, the EP/EH is eligible for payment.

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 implemented 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	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. The current measure option will be retained: 30% of unique patients with at least one medication in their medication order entered using CPOE.	A-SMA: • 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.	SLR: The SLR was revised to allow this objective as optional as of January 1, 2013, for 2013 onward.
Additional e-Prescribing Exclusion	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	A-SMA: Required for 2013 forward for EPs attesting to Stage 1 of MU. Information on the State website and SLR have been revised to incorporate the change.	SLR: The SLR has been revised to support this requirement for EPs attesting to Stage 1 of MU.

Attestation Component	System Validation	State Action	Provider Action
	10 miles of the EP's practice location at the start of his/her EHR reporting period.	Provider Outreach includes e-mail, webinars, website updates, and dissemination of information to provider associations,	
Vital Signs Addition of Alternative Age Limitations	A-SMA has accommodated this optional measure for 2013 and made 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 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.	The definition for a second denominator has been added with the ability for the user to indicate which denominator they are using for reporting. • 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.	SLR: The SLR has been revised to support this option for 2013 only for EPs attesting to Stage 1 of MU.
Vital Signs Exclusions Change	A-SMA has accommodated the following optional modifications to the exclusions for 2013 and make them mandatory 2014: • 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	A-SMA: • 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,	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.

Attestation Component	System Validation	State Action	Provider Action
	• 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.		

The changes to the Core and Menu measures and CQMs identified in the Final Rule that were effective in Program Year 2014 were included 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 CMS on 9/26/2013.
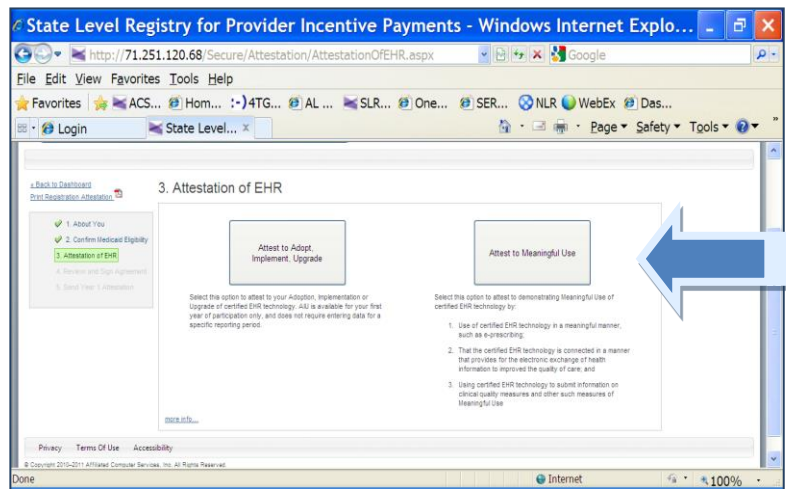
Figure 42: Screenshot to Attest to PI

A-SMA has engaged in a similar process for the changes to the core and menu measures effective in Program Year 2015. The screen shots, previously submitted to CMS by the State of Alaska, have been approved. Figure 42 demonstrates the opening screen. Screenshots for changes for Program Year 2016 and 2017 have been submitted and approved as of (date). Screenshots for changes for Program Year 2018 are incomplete at the time of this update and will be submitted when available.   After the last submission that addressed 2015-2016 and Stage 3 changes, an addendum was submitted and approved for all Program Year 2017 updates. An addendum will again be submitted for Program Year 2018 but those modifications and system changes are not yet available at the time of this submission.

Process: CQMs are reported during the attestation process along with the meaningful use 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.

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.

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.

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.

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.

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

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 documentation is submitted for attestation. For Program Year 2015-2017, valid documentation is a vendor letter from the EHR vendor that includes the vendor, product, and version of the certified EHR.

- *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 measurers? 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. For subsequent years, the reporting period would be the full calendar year. However, the exceptions are 2014, 2015, 2016, and 2017 in which the reporting period is 90 days. The reporting period remained 90 days for program years 2018 through program year 2021.

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 certified EHR technology (CEHRT) validating the denominator and numerator.

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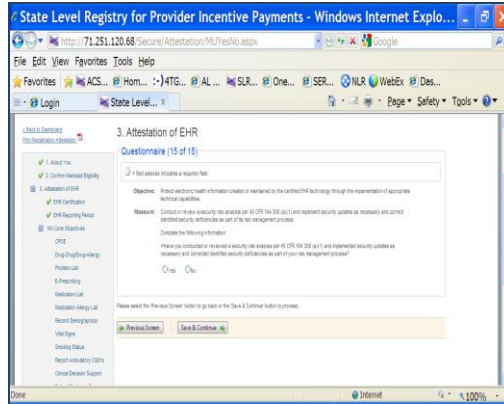
4.13 * HOW WILL THIS DATA COLLECTION AND ANALYSIS PROCESS ALIGN WITH THE COLLECTION OF OTHER CLINICAL QUALITY MEASURES DATA, SUCH AS CHIPRA?

Standards: A chart of all the quality measures by program, including MU, is was provided the last SMHP update.

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 managed care PCN 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 long-term goal of A-SMA through its PCN's 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, PCNs 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 (HTS as vendor), interfaces with the MMIS claims and provider systems (HP fiscal agent as vendor), and as of 2012 interfaces with One Health Record®.

Methodology: To meet initial timelines, some processes were manual for the initial year. As of June 2013 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 three scenarios that require incentive payments to be processed manually through the new state finance system. These scenarios deal with two state medical school entities and those instances when they payment is issued to an EP as an individual.

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 6aSystem changes for those provisions of the regulations that became effective in 2016 and 2017 as approved by CMs in the SMHP 2017 Addendum have been implemented. Any changes for PY 2018 will be completed and implemented by January 1, 2019.

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 up load.

- 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 (HTS) 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 were implemented January 1, 2014 for EH and April 1, 2014 for EP. One Health Record® went "live" in April 2012.   The changes to the SLR required for the Flexibility Rule were implemented in September, 2014. As discussed above, the changes to the SLR for the 2015 and 2016 Program Years are dependent upon the successful completion of the procurement process for the SLR. 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
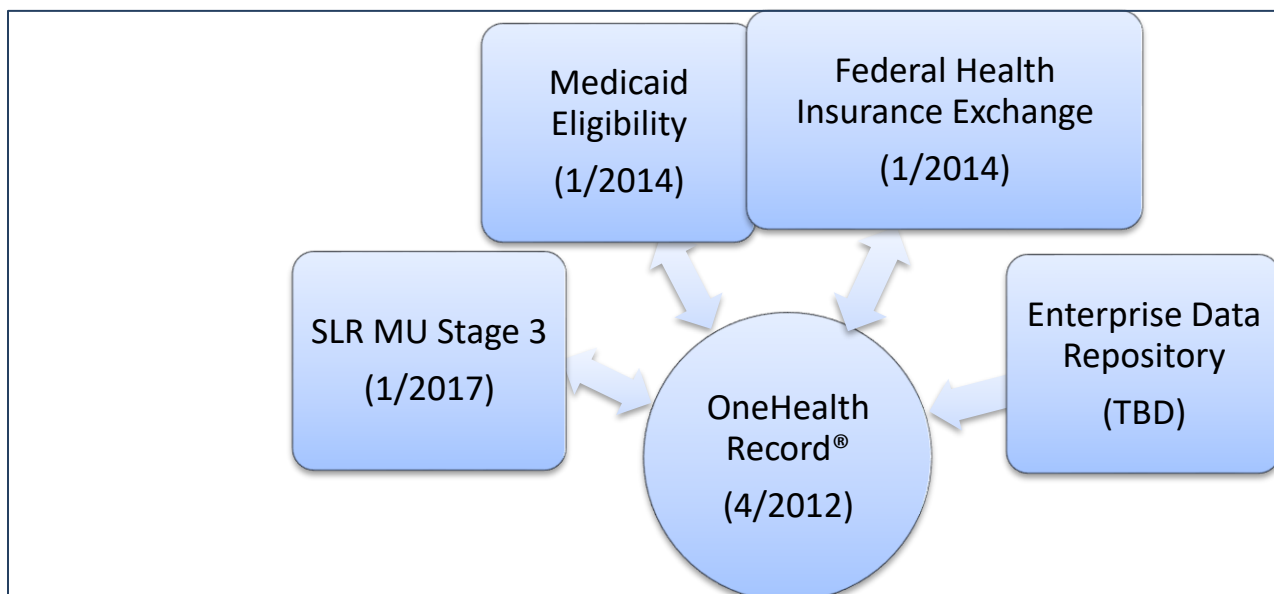
4.17 WHEN DOES THE SMA ANTICIPATE BEING READY TO TEST AN INTERFACE WITH THE CMS REGISTRATION AND ATTESTATION SYSTEM?

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 NLR. 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 EHs 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 future program changes.

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:

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 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, HTS, 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) and is a resource for providers as part of the contracted attestation review and validation services. 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.

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
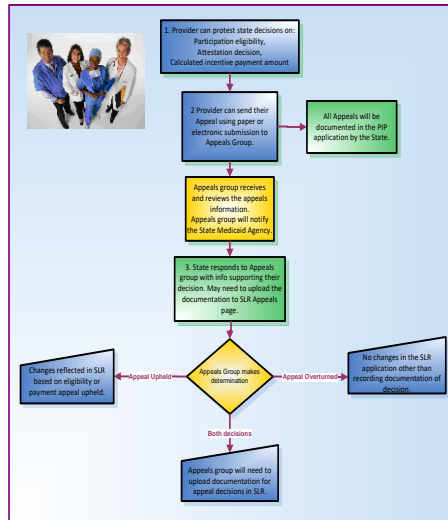
4.23 WHAT WILL BE THE PROCESS TO ASSURE THAT ALL FEDERAL FUNDING, BOTH FOR THE 100 PERCENT INCENTIVE PAYMENTS, AS WELL AS THE 90 PERCENT HIT ADMINISTRATION MATCH, ARE ACCOUNTED FOR SEPARATELY FOR THE HITECH PROVISIONS AND NOT REPORTED IN A COMMINGLED MANNER WITH THE ENHANCED MMIS FFP?

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: When an EP or EH completes all 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 generally on a biweekly basis unless special handling is required. The payment schedule (referred to as the Check Write Schedule) is updated annually, based on the state's fiscal year, and is posted on the Alabama Medicaid Agency website under the "Providers" tab. In this way, the anticipated payment date is always available to the provider. AMA anticipates making its final incentive payment on December 24, 2021 and we will conclude the Promoting Interoperability Program at the completion of the audits for Program Year 2021.

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 (DXC), the former Medicaid Transformation Grant contractor who is now the contractor for the SLR (Xerox- formerly ACS), and the One Health Record® contractor (Truven) were engaged in the implementation of the EHR Incentive Program as they all involved in critical components for which success is dependent. Both contracts for these services are in the procurement process and the outcome will determine the contractor going forward. Other contractors that remain involved and their roles have been identified previously and include GDH Government Services to provide support for program and policy, auditing, and data analytics.

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 PI, 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.

AMA will make its final incentive payment on December 24, 2021 for Program Year 2021. AMA will begin auditing Program Year 2021 in January of 2022, with a completion date of April 30, 2022. AMA will work with Health Tech Solutions to develop a plan for the decommission of AMA's State Level Registry (SLR) in accordance with State rules and CMS guidance. The decommission will be completed prior to September 30, 2022.

5. SMHP SECTION D: ALABAMA'S AUDIT STRATEGY FOR

5.0 ALABAMA AUDIT STRATEGY

Alabama's Audit Strategy 2021 update, dated on June 21, 2021 was approved by CMS in a letter dated August 11, 2021.

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

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

Figure 58: Medicaid Health-IT Roadmap
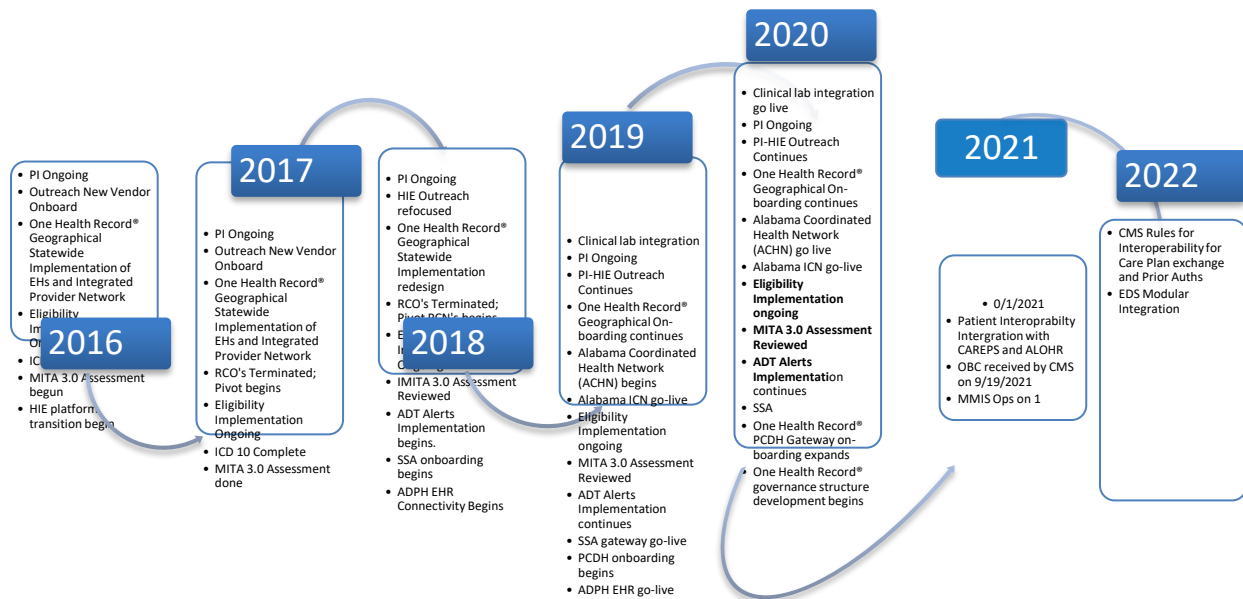
Alabama is transforming the way the state purchases and oversees publicly funded health care, including Medicaid. It is simultaneously addressing both the evolution of health and the innovations within health care delivery. The relationship between the activities through the ONC State HIE Cooperative 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 was evident in timing, as well as impact, over the last few years.

The One Health Record® Commission and the A-SMA continue to make 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 (PI) can be addressed timely and appropriately.

As the figure above indicates, the "target" in 2018 expands 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 PI 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 PI, handle any potential appeals if they arose, integrate PI 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 directors 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 pursed 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 (DSM) 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 DSM/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, PI 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.

- *2016-17*: As the figure indicated, 2016 & 2017 was to be a continuation of 2015 targets, with goals of expanding on the implementation of the health-IT functionality in place for increasing the meaningful exchange of health information. However, many of these objectives were stalled due to a HIE platform transition that 9 months to complete and the termination of the RCO initiative in August 2017. In September 2017, a revised Health

IT strategy was completed and launched in November 2017. Medicaid continues to be a core funder and major benefiter, but not sole participant, as demonstrated by ADPH's increased involvement and improvement in the IMZ data quality & PI reporting initiatives.

- *2018:* As the figure indicates, 2018-19 will include to be a continuation of 2017 targets, with goals of expanding on the implementation of the health-IT functionality in place for increasing the meaningful exchange of health information. Medicaid continues to be a core funder and major benefiter, but not sole participant, as demonstrated by ADPH's increased involvement and improvement in the IMZ data quality & PI reporting initiatives.

  Operationally, One Health Record®, completed the regionalized "proof-of-concept". Use case benefits and interoperability continue to be challenges. The core principles for Alabama's One Health Record's® strategic focus remain as modified in 2017, but strategic changes to the implementation will follow more of short-term value for long-term investment. The new emphasis of that focus will be:

- Recruiting provider participation for Health IT utilization for PHI exchange by leveraging ADT notifications in local markets to improve care coordination.
- Expanding patient "data" interoperability (access & extraction) to support the business case for population health analytics for manage care programs.
- Expand HIE connections to 50% (40) of the remaining hospitals and their integrated networks by the end FY 2020.
- On-going stakeholder communication and involvement.
- Development of a permanent governance and sustainability plan by 12/31/2019.
- Continuing into 2019-20, the major initiative in Alabama is the leverage ADT notifications and PHI exchange for care coordination in the implementation of the Alabama Care Health Network (ACHN) with a "go-live" date of 10/1/2019.
- Expand geographical reach of Alabama One Health Record® by establishing itself a SE regional gateway for ADT alerts, disaster preparedness, and CCDA exchange.
- One Health Record® efforts will to continue provide and expand the planning and preparation for critical health information technology infrastructure to support the Medicaid providers who will be a part of the ACHN network.
- Updates to One Health Record® website and enhancements to the PI pages have more user friendly and more timely, usable information.

The accompanying 2021 Environmental provides the latest quantified data, so it will not be the highlight here.

Going forward into FY 2022 and beyond, the focus on the post-HITECH pathway for A-SMA's Health IT investment is to continue and leveraged this foundation under MES.

As mentioned previously, A-SMA transitioned the Alabama HIE, One Health Record® (ALOHR) from HITECH into Alabama's MES framework as a MES component driving data interoperability. This transition included the following milestones:

1. CMS approves HIE HITECH-to MES transition plan on November 19, 2020.
2. CMS certification for Outcome-Based Measures on 9/19/2021.
3. ALOHR and Gainwell completes final claims integration for USCDI claims rendering via the ALOHR phone app in September 2021.
4. ALOHR begins operations under the A-SMA MES on 10/1/2021.
5. CMS HIE IAPD-I approved for MMIS 75/25 FPP on 12/8/2021 for FFY's 2022-23.
6. ALOHR integration with the State's E&E system CARES to verify member enrollment.
7. ALOHR releases phone app and URL for Medicaid recipients to access their claims and clinical information on March 8, 2022.

The next steps for post-HITECH MES integration will include the following objectives in the next 2-5 years:

1. NCQA DAV certification for HEDIS reporting via CCD's for ALOHR.
2. ALOHR phone app development for:
   a. Care Plan exchange,
   b. Prior Authorizations,
   c. Patient updates on demographics such as mailing address.
3. ALOHR clinical data integrations into A-SMA's future Enterprise Data Services (EDS) Module,
4. Continued HIE DDI for integration with program partners, such as FOHC's, RHC's and Certified Community Behavior Health Clinics (CCHBC), and
5. State-wide utilization of our ALOHR Peer Specialist application for Opioid /SUD Screenings, MAT programs, and Mobile Crisis facilities.

This focus also includes a maturing data governance process to provide data integrity and quality reporting on clinical outcomes to improve the effectiveness of both the ACHN and ICN managed care programs.

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

Activity	Year	Approach
Technical Architecture		

Activity	Year	Approach
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 PI Infrastructure as expanded MMIS	AIU Completed PI SLR Completed Completed	MMIS architecture built to interoperability, privacy and other Modified PI Stage 2 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 PI quality measurement reporting, oversight and payment completed. A-SMA is currently re-bidding SLR contract with a new go-live set for 8/1/2016. Current SLR contract will end on 7/31/2022 with PI program termination.
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 no longer submitted to ONC effective 6/30/14. Strategy incorporated into in A-HIE operational policies where needed, and A-SMHP/I-HIT-IAPD.
PI	Completed,	Development and implementation of technical and business operations to support PI, ADT, VBP, and Population Health Analytics aligned with federal and other states. PI program ending, so emphasis in on data access interoperability.
Governance Activities/Approaches		
One Health Record® Operating Commission Charter, By-Laws and Policies/Procedures	Ongoing	Revised and adopt using examples from other states and private organizations. Periodic review continues.
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 by FY 2020.
Finance Activities/Approaches		
Long-Term Sustainability for One Health Record® A-HIE	Completed	ALOHR began operations under the MES framework on 10/1/2021 with cost allocation plan in place.

Activity	Year	Approach
Cost Benefit Analysis of statewide HIE	Completed, but Ongoing	Updated analysis conducted by Myers & Stauffer as part of the HITECH-to-MES transition plan.
Business Case for Participation in One Health Record®	Completed	Alabama State University conducted this analysis. Updated analysis conducted by Myers & Stauffer as part of the HITECH-to-MES transition plan.
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	A-SMA identify and fully utilize federal funding through MU authority, Affordability Act authority, CHIPRA authority and ongoing MMIS authority. A-SMA submit additional I-HIT-APDs and I-MMIS-APDs to support public, mental health, structured lab integration, PDMP, and geographical PHI exchange activities. ALOHR began operations under the MES framework on 10/1/2021 with cost allocation plan in place. HIE MMIS IAPD with OBC 75/25 Ops match was approved on 12/8/2021.

Policy and Legal Activities and Approaches to Activities
Legislative Requirements

Activity	Year	Approach
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®** & PI 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, but Ongoing	Research and identify federal regulations to compare to Alabama state legislation for conflicts, potential updates, or missing legislation. Compare the eHealth exchange business agreement and DURSA and identify potential areas of concern/follow-up for comparison with Alabama state law. Continue to refine Develop an Alabama specific DURSA and Business Agreement. Review Current Law & Regulations/laws to determine from "as is" to "to be" for both federal and state authority: • missing and needs to be added

Activity	Year	Approach
		• exists and no longer appropriate • exists and needs to continue • exists and needs to change but outside authority of state to change (federal law) Areas of Focus: • 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 • CMS Rules of Interoperability • Other
Identify policy issues and establish recommended policy	Ongoing	Medicaid Agency to develop with assistance from Legal and Policy Workgroup.
Privacy and Security		
Examine the federal privacy and security requirements for data security and integrity related to the exchange of heath information	Completed, but Ongoing	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.	Completed but 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. Development of ALOHR phone app in accordance with the 21 Century Cures Act.
Review Health Information Security and Privacy Collaboration (HISPC) work in the area relating to privacy and security	Completed	• There is no HISPC for Alabama. • Alabama Medicaid will investigate local policies.
Development of Exchanges with Other States		

Activity	Year	Approach
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.	Completed, but Ongoing	Alabama Medicaid coordinates with the CIVITAS (formerly know as Strategic Health Information Exchange Collaborative (SHIEC)). Alabama Medicaid completed work with Missouri 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. Alabama is expansion this gateway connection to include the SSA (SSDI) and VA (V-LER & Direct)
Policy and Procedure Development		
Identify recommended legal policies and procedures related to a statewide policy development process	Completed,	Legal to identify.
Determine One Health Record® operational policies and procedures in relationship to University Education: medical education & informatics with AHIE participants & Stakeholders	Completed	Legal in conjunction with Governance will identify and develop outline of issues.
Incorporate recommended legal policies and procedures	Completed	Alabama Medicaid Agency to receive issues Legal
Establish recommended priority policies	Completed-	Alabama Medicaid Agency will continue to develop and modify implementation framework
Oversight and Risk Mitigation		
Establish risk mitigation policies	Completed, but Ongoing	Legal 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 Legal
Communication and Marketing		
Progress reports and details on AHIE system issued via association publications, HIE Web site;	2010 – 2021	By audience: Providers, (Hospitals, Physician, Laboratory, X-ray, Pharmacy, Ancillary Services, Rural and Safety Net and Other); Healthcare Payers, Purchaser, State Agencies

Activity	Year	Approach
Establish and publicize mechanism for regular progress updates and feedback via Web site Creation of provider-specific "tool kit" for CEO/CIO use with hospital CEOs/boards/medical staff (e.g. fact sheets, FAQs, white paper, slide presentation, sample articles, emails, brochures); available via Web site Scheduled presentations to providers at their location, society and other state and regional meetings Physician outreach and education activities in coordination with REC Development of CME-based educational activities for physicians	Ongoing	• 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 5-6 • Development CME Activity for physicians – Year 2 (Physicians) • Dissemination of news articles for patient publications – Years 2-6 • MU Outreach and TA strategy for 2016-17 Provider Recruitment & Migration – years 5-6 • Retention and wrap-up - Years 6-10

6.3 DESCRIBE THE ANNUAL BENCHMARKS FOR EACH OF THE SMA'S GOALS THAT WILL SERVE AS CLEARLY MEASURABLE INDICATORS OF PROGRESS ALONG THIS SCENARIO.

An overarching principle for inclusion or exclusion of any outcome and/or performance measure is that the measure provides 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 Interoperability . As stated in the previous SMHP update, Alabama previously identified 6 priority areas for PI : e-Prescribing, Lab Exchange and Care Summary Exchange Stage 1-to-Stage 3 migration, Public Health reporting and data quality, and eCQM's analysis. In this final update, Alabama has added a 7th priority area to measure future success of it health IT investment: Patient Access and Utilization for Interoperability

The metrics for those program priority areas, including the newly added are provided in the table below and provide the status as of December 2021. 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 were originally established through the 30-60-90-120-day roadmap engagement with the One Health Record® vendor. These measures continued to support the progress and utilization of Health IT across Alabama.

Table 25d: Performance Progress Measures/Targets

Program Priority	Status as of December 2019	Status for December 20209	Status as of December 2021	Target for December 2022	Status as of December 2023
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 %	Yes	Yes	Yes	Yes=94%	Yes
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%	Yes
% of hospitals sharing electronic care summaries with unaffiliated hospitals and providers	20%	80%	55%	75%	100%

Program Priority	Status as of December 2019	Status for December 20209	Status as of December 2021	Target for December 2022	Status as of December 2023
% of ambulatory providers electronically sharing care summaries with other providers	15%	20%	55%	75%	85%
Patient PHI Access and Utilization for Interoperability. (1.2M Medicaid Members using either the ALOHR phone app, URL, or both.)			Yes	1%	5%

7. ACKNOWLEDGEMENTS