



HIT IMPLEMENTATION ADVANCE PLANNING DOCUMENT (HIT I-APD)

For Alabama's
Registry and Payment Infrastructure for
Meaningful Use

Submitted

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Versions

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1.1	12/29/2010	Updated to respond to CMS questions/comments
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1/3/2011 NOTE: Alabama understands and recognizes that the purpose of this IAPD is to create the infrastructure necessary to implement, operate and oversee the meaningful use incentive payment program. Throughout this document, the term electronic exchange or health information exchange is used. Meaningful use is supported and achieved through the electronic exchange of information and that is the context in which this term is used. The entire section “Statement of Needs and Objectives” has been rewritten to focus on the requirements of the meaningful use program, but is discussed in context of the larger vision for Alabama including the electronic exchange of information.

I. INTRODUCTION

The Alabama Medicaid Agency (Agency) is submitting this Health Information Technology Implementation-Advance Planning Document (HIT I-APD) for Centers for Medicare and Medicaid Services' (CMS) review and approval. This I-APD is for the design, development and installation of the ASMA State Level System for Medicaid EHR Incentive Payment Administration under the American Recovery and Reinvestment Act of 2009. It represents the initial submission of Alabama's approach to design, develop and install an ASMA State Level System for Medicaid EHR Incentive Payment Administration under the American Recovery and Reinvestment Act of 2009. This document supports the implementation of the Alabama State Medicaid Health Information Technology Plan (A-SMHP).

Alabama has provided explicit plans for the immediate (up to 18 months) activities in order to implement the critical items first. This initial I-APD is separate and distinct from the ONC grant funding for the AHIE and is for the use of Medicaid funds for the ASMA State Level System. The purpose of this initial HIT I-APD is to secure funding for the system, staffing and technical assistance required to:

- Administer the incentive payments to eligible professionals and eligible hospitals.
- Conduct adequate oversight of the program, including tracking meaningful use by providers.

This initial HIT-I-APD also:

- Seeks funding for Medicaid activities to pursue initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information, including Medicaid's cost allocation responsibilities as they are identified related to the HIE infrastructure needed to exchange the information in order for providers to test and implement the exchange of information required to meet meaningful use requirements.

In addition, this HIT-I-APD is for the infrastructure for Medicaid portions of the statewide HIE to support the actual exchange of the information by providers in a meaningful way. This will not duplicate the ONC funding but will address the cost allocation responsibilities of Alabama Medicaid in relationship to the AHIE as appropriate. Through this arrangement, efficiencies are being realized between the work of the exchange and the establishment of the Meaningful Use Payment Incentive Program.

- Explains how the project supports Alabama's current MITA Assessment and meets the Agency's needs;

- Describes how the project advances the Alabama State Medicaid HIT Plan (A-SMHP), and
- Provides an estimate of the project budget and timeline.
- Provides an estimate of the project budget and timeline. (This includes one year funding for continuation of vendor, staff and travel costs of \$1,499,743, for continuation of QTool.)

II. SYSTEM OBJECTIVES AND CONSTRAINTS

A. System Objectives

The purpose of this project is to design, develop and implement the infrastructures to support the meaningful use of information by Medicaid eligible providers for Medicaid enrollees, including the ASMA State Level System for Medicaid EHR Incentive Payment Administration. The MU program will promote the adoption of EHR technology and electronic exchange of health information to support the meaningful use of information to improve the quality and cost of health care in Alabama. In order for providers, and more importantly patients, to fully realize the effect of utilizing health information technology, it will be necessary for there to be a robust exchange of information both locally, statewide and nationally. Alabama’s overall goal includes the rapid, thoughtful implementation of the State Level System to support the identification and enrollment of providers, monitoring of provider eligibility, payment to providers, appeals, auditing, reporting and evaluation such that physicians can maximize monies available while establishing their internal infrastructure for the adoption and utilization of health information technology.

As indicated above, the objectives of the ASMA State Level System are to support the following program implementation activities.

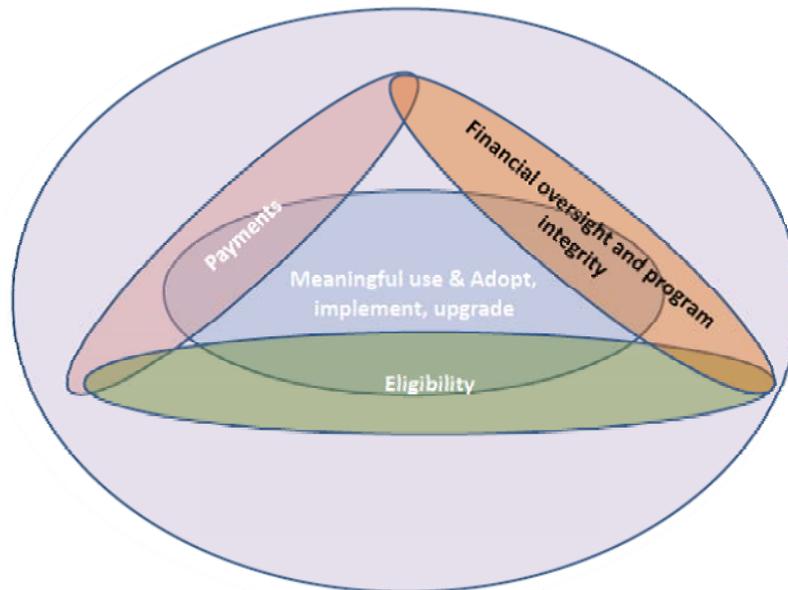
Program implementation activities



The specific objectives of this first of many I-APDs is to address two specific mechanisms the priorities for the next 18 months:

- Meaningful Use (MU) registration, payment and oversight infrastructure
- Infrastructure, both human resources and technical solutions, to create a framework for Medicaid meaningful use eligible providers and hospitals to exchange health information in a meaningful way.

It is anticipated that as the program matures, additional iterations will be submitted.



B. Constraints

The primary identified constraints are time, money and staffing resources, which are dependent on time and money. There is a short period of time for implementation, there is a lack of State resources both in number and skill set, competing projects for the limited resources available and the most daunting constraint to date has been the evolving, and changing, regulations. Clearly, the availability or non-availability of adequate funds will affect any project. The State and Federal governments must dedicate sufficient funds to allow for the project's completion. Also, compounding the uncertainty is the State's fiscal situation and the fact that legislative and executive funding priorities change from year to year.

The timing issue is obvious. Alabama needs the I-APD approved immediately; simultaneously working on completing the procurement process to get the needed contractors to complete the work. There are many moving parts from issuing procurements, educating providers and other stakeholders, timely testing connectivity with the National Level Registry (NLR); and developing the state level meaningful use (MU) support system concurrently with the establishment of the A-HIE initial phase. There is a balance between the need to do it correctly the first time with the need to get it done “yesterday”.

III. STATEMENT OF NEEDS AND OBJECTIVES

A. *Current Environment*

- QTool: Alabama Medicaid is currently operating QTool, an electronic health record, in partnership with ACS. QTool was developed and implemented with Medicaid Transformation Grant dollars. As a result, Alabama has a web-based electronic health record system that compiles claims-based information from both Alabama Medicaid and Blue Cross and Blue Shield of Alabama as well as certain physician-entered clinical information. This information is available through an end use application known as Q-Tool or through one-directional CCD exchange. Alabama’s current HIT system is a hybrid model, with Medicaid data centralized and other data sources pulled in at the time of query. The claims-based information is overlaid with clinical alerts indicating missed opportunities using national evidence-based standards of care. For example, physicians are reminded that diabetic patients need eye and foot exams or that asthma patients are seeking care in the emergency room or not taking medications appropriately. E-prescribing, including prescription history, electronic refill requests and history of fill status, is also available to physicians. In addition to clinical information, Medicaid eligibility information including managed care assignment and benefit utilization is available. Q-Tool has been offered to Alabama providers at no cost and since it is web-based there is no special hardware or software required. Alabama will move to the next level for statewide HIE by building on the work currently underway.
- Environmental Scan: An environmental scan was completed to establish the “as is” state for both the AHIES/OP and the A-SMHP, including explicit questions related to meaningful use status and plans with a specific focus on potential eligible hospitals (EHs) and eligible providers (EPs). The scan, completed in 2010 was submitted as an appendix to the AHIE/SOP. The previously submitted A-SMHP

also provided the detail of the Alabama “as is” state and identified areas of concern related to MU. For example, almost 70% of the responders to the environmental scan questionnaire indicated they were anticipating participating in the Medicare/Medicaid adoption incentive program, but participation rate for a significant number of the responders will be problematic as they do not serve a sufficient number of Medicaid enrollees to qualify. For providers in the state who responded to this survey who already use EHRs, nearly 70% had their EHRs for at least two years. Most users have sought CCHIT certified systems, but the limitation is those certifications were obtained prior to the new evolving certification requirements so it is unknown what their compliance status will be once the regulations are finalized. In addition, simply having a system does not mean it is being utilized in a meaningful way. Another potential sign of usage in a meaningful way is the ability to generate reports in order to manage specialized populations. Per the responses of providers who currently use EMR/EHR, they are able to generate reports about major clinical areas for children and adults, including asthma, cancer, COPD, congestive health failure and depression. However, the caveat is that the providers who were most likely to respond are also the providers who are mostly likely already engaged in the transformation to electronic based administrative and clinical business operations.

Since the submission of the AHIE S/OP, the state has pursued multiple approaches to gaining additional information related to provider readiness to use health information in a meaningful way. For instance, the Alabama Academy of Pediatrics completed a targeted survey in the largest county and was able to determine that 8 of the 28 pediatricians have EMRs.

While significant detail is provided from the multiple sources documented in Section 3 of the AHIE S/OP (Section 3 of Appendix 8.1), since the submission of the S/OP, the state has pursued multiple approaches to gaining additional information related to provider readiness to use health information in a meaningful way. Further information is provided below.

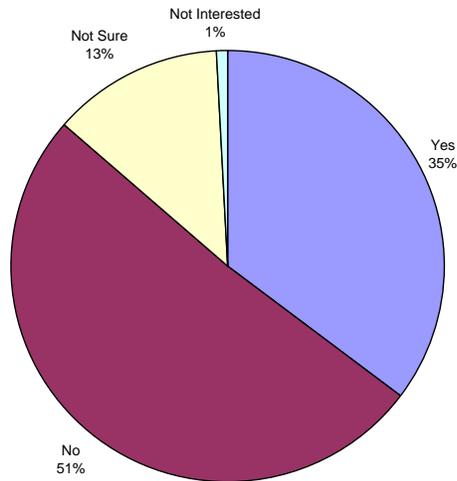
Provider Participation Rates

In order to ascertain additional information for planning, a follow-up survey was conducted on behalf of the Agency by Alabama State University (ASU). The survey was targeted to Medicaid-enrolled providers with a paid claim volume of 500 or greater. 1001 responses were received from a survey group consisting of general practitioners, pediatricians, dentists and nurse practitioners.

35% (354/1001) of the providers responding to the survey reported current use of electronic health records and therefore currently have the potential to take

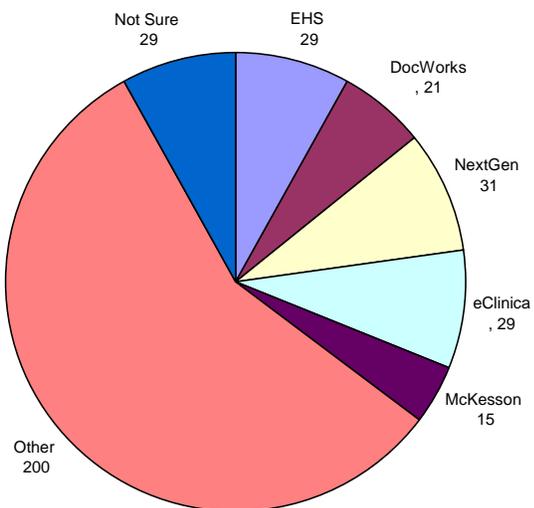
advantage of secure messaging with other providers through the AHIE when operational.

Current Users of EHR Among Surveyed EPs



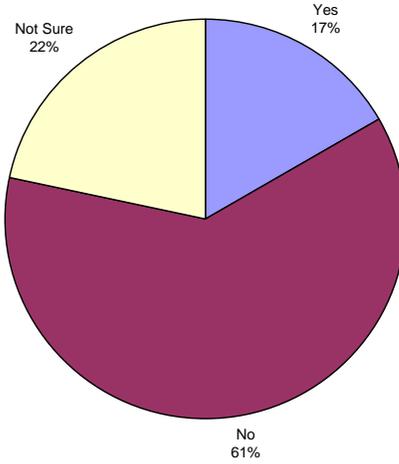
Amongst the current users of EHR technology, the selection by the providers of the vendors presented during the survey was almost even in that there were no clear standouts among the types/brands surveyed. In fact, the largest category of responses was “Other.”

EHR Vendors Currently In Use



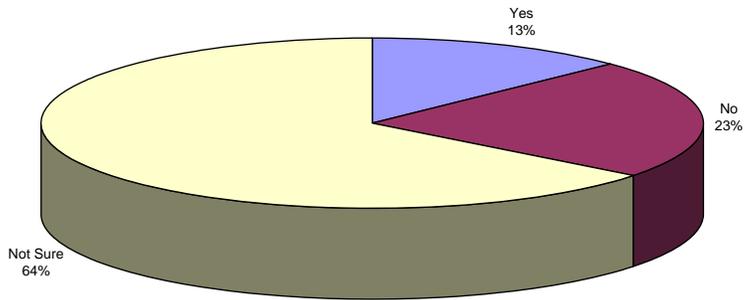
Currently 17% of providers using EHR technology are exchanging information. Interestingly, larger percentages (22%) of those providers using EHR technology were not sure whether they exchanged information or not.

Current EHR Users That Exchange Information in Some Manner



The ASU survey provided insight into providers' currently interest in participation in the incentive program, with 13% of the total group surveyed expressing an interest in applying for the incentive payments.

EPs That Intend To Apply For Incentive Payments

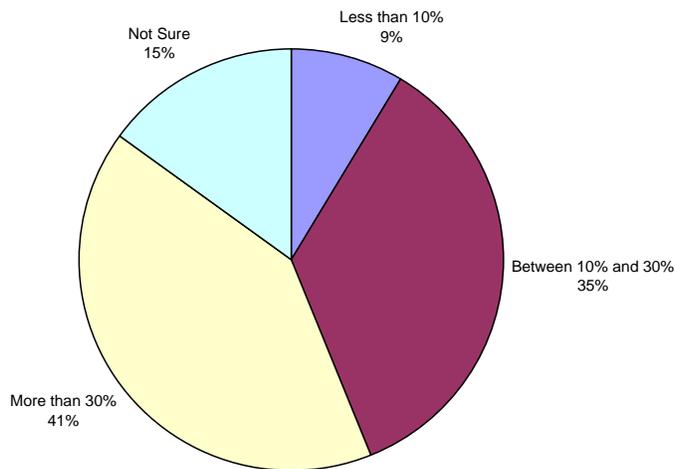


Given the data reported on the lack of current knowledge and interest in the incentive program within the provider community, outreach activities will be a critical component for success in program implementation. One other important statistic from the survey is information on the best method of delivery of information on the program to interested providers. Based on that data, it appears that the best means of communicating program information will be through printed information, live workshops and email. This is valuable input for the REC and the AHIE Communications Workgroup and will be incorporated into updates to the Communication Plan to assure that the allocation of resources is commensurate the voids identified to increase the potential success rates of adoption.

40% of respondents declared having more than 30% Medicaid patient volume and another 13% reporting that they were not sure. This is fairly consistent with data from the ASMA S/Ops and the updated assessment that have been previously provided to ONC and CNSM related to the “as is” state of Alabama related to MU which includes additional information obtained through the Alabama BC/BS effort. In that study, 33% of Family Practitioners had Medicaid patient volumes that would meet eligibility requirements for the EHR incentive program.

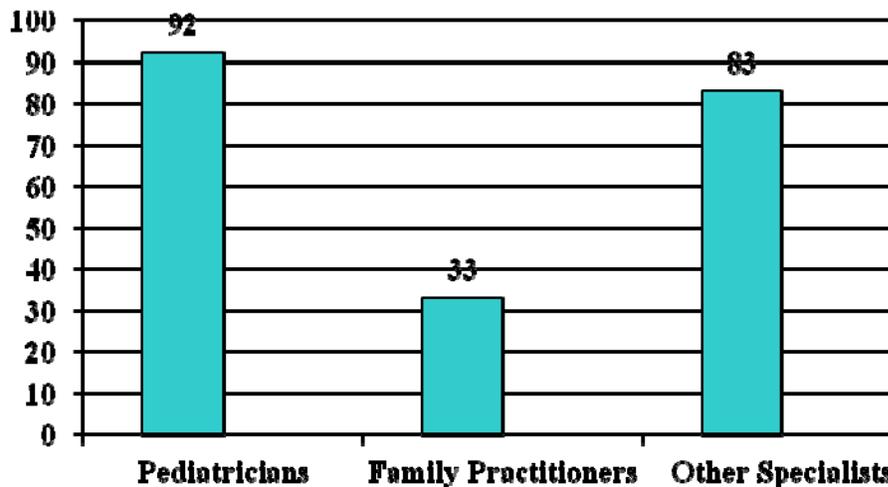
In the ASU study, based upon the question constructs, it was difficult to gauge the percentage of pediatricians who believed they met the 20% Medicaid patient threshold.

Respondent Medicaid Patient Volume



However, the Alabama BC/BS data showed that 92% of pediatricians surveyed would qualify for the adoptive incentive. Again, the role of the REC and the Communications Workgroup will be critical in educating providers about eligibility criteria, the Medicaid patient volume calculation, and the source data to be used.

Percentage of Physicians Who Qualify for Medicaid Adoptive Incentive



In addition, the Alabama Academy of Pediatrics completed a targeted survey in the largest county and was able to determine that 8 of the 28 pediatricians currently have EMRs.

Physicians' Use of e-Prescribing Tools

Alabama used SureScripts data to determine the baseline of physician's utilizing e-Prescribing in Alabama, completing an analysis that indicates that from 2007 to 2009 the Alabama physicians routing prescriptions went from 330 to 1221 and the number of community pharmacies activated for e-prescribing went from 790 to 1041. In 2009, total prescriptions routed electronically in Alabama were approximately 2.2 Million with 14% of total prescriptions represented by renewal response. Using SureScripts data to determine the baseline of physician's utilizing e-Prescribing in Alabama, the percentages of Alabama providers routing prescriptions electronically at year-end were: 5% in 2007, 9% in 2008, and 18% in 2009.¹ SureScript's State Progress Report on Electronic Prescribing, indicated that Alabama had an overall blended rate of 86% for all (not just Medicaid) community

pharmacies in 2009.² An increase is also anticipated with the activation of an e-prescribing portal as a part of the MMIS by the end of 2011.

Pharmacy Access

The Agency identified a list of all Medicaid-enrolled pharmacies in Alabama, including both chain and independent pharmacies. As of October 2010, this list identified 1,304 community pharmacies consisting of approximately 50% retail chain and 50% independent community pharmacies. These Medicaid pharmacies were then compared to the Surescript data to determine how many were activated for e-prescribing. It was determined that approximately 84% (1,099/1,304) of pharmacies across Alabama with activated capabilities for accepting electronic prescribing and refill requests. SureScript’s State Progress Report on Electronic Prescribing, indicated that Alabama had an overall blended rate of 86% for all (not just Medicaid) community pharmacies in 2009.

Alabama is a diverse state consisting of densely populated urban areas, such as Birmingham, Alabama, and large rural farming communities. Just under 32% of all Medicaid-enrolled pharmacies are located in the rural counties with 68% of the pharmacies located in the urban counties. When comparing e-Prescribing adoption for Medicaid-enrolled pharmacies in rural and urban counties, we have found that almost 14% of pharmacies in rural counties have not activated e-Prescribing, while 13% of pharmacies in urban counties have not activated e-Prescribing.

e-Prescribing

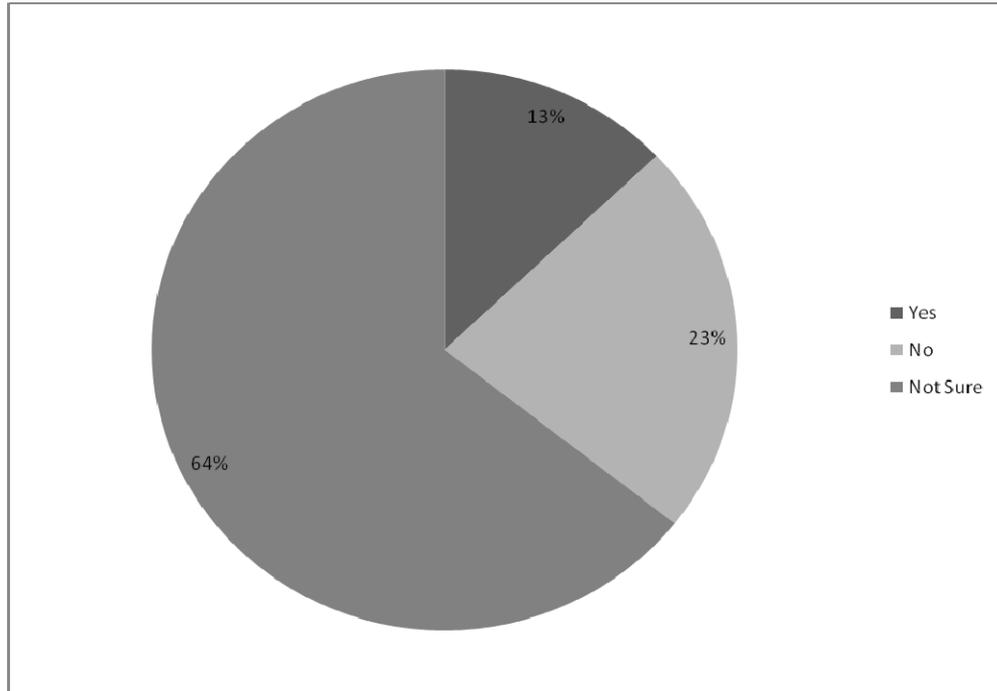
<i>Activity</i>	<i>Current State (December 2009)</i>	<i>Goal (July 2011)</i>	<i>Goal (July 2012)</i>	<i>Goal (July 2013)</i>
<i>Eligible Professionals use of e-Prescribing</i>	18%	25%	50%	75%
<i>Routing of Prescriptions</i>	7%	20%	40%	75%
<i>Pharmacy Access</i>	86%	<i>To Be Determined</i>	<i>To Be Determined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

As part of the Strategic and Operational Plan process, an environmental scan was conducted to assess current capabilities. The results are contained in Appendix 5 of the submitted plan (237 providers responded.) In order to ascertain additional

information for planning, a follow-up telephone survey was conducted on behalf of the Agency by Alabama State University. The survey was targeted to Medicaid-enrolled providers with a paid claim volume of 500 or greater. 1,001 responses were received.

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

Of those providers responding, almost 41% (409/1,001) indicated they have a Medicaid patient volume of 30% or higher. However, when surveyed whether or not the practice was planning to apply for Meaningful Use Incentive Payments, the blended responses were:



These examples are illustrative of the information provided in the updated assessment, SMHP and S/OPs that have been previously provided to CMS.

- Inter-state: Cross-state Medicaid issues have been highlighted through Alabama Medicaid's leadership in the Southeast Regional Collaboration for HIT and HIE (SERCH). For instance, the states of Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee and Virginia have completed activity grids to determine where they align in policy, approach and issues so they can move forward in a coordinated, structured way to address issues. Information has been collected on MU reporting (including system certification and provider attestation), audit and validation of provider payments and making payments and use of MMIS as part of the process. Additionally, information has been collected on methods to ensure MU components are in place (building, procuring, endorsing), and planned or completed work on components of a system of systems for meaningful use, including eligibility, registries, personal health records and medication management infrastructure. Alabama has also joined North Carolina and Florida in requests for RTI Technical Assistance and SERCH in another in order to standardize options and solutions.
- Role of Medicaid Related to AHIE: ASMA staffs the Statewide AHIE Advisory Commission, along with its workgroups for the Five Domains plus One, and will provide the staff support to the AHIE. The State HIT Coordinator and staff, as state employees, will administratively report to the Governor through the Medicaid Agency but will functionally report directly to the Advisory Commission.
- Role of MMIS: Alabama contracted with Fox, Inc., and completed the state's MITA Self-Assessment in December 2009. The state has traditionally equated MMIS to the claims processing (Fiscal Agent HP) and decision support systems, but has moved to the expanded MMIS terminology including all the systems that support Medicaid provider and enrollee activities, including the evolution of the current eligibility system which is run in-house at this time. The claims processing system will connect to the Alabama HIE, but they are both parts of the MMIS (see "To Be"). The claims processing system will also connect to the eligibility system, which is also envisioned as being a part of the MMIS. Eligibility is completed by state employees so there is no county enrollment/eligibility system.

Two separate APDs have previously been submitted: one for procurement of the new claims processing system (claims management) and one for a revised recipient subsystem (member management). Planning stages have already begun (IV & V APD already submitted to CMS) for the expanded recipient system. In addition, Alabama is in the process of addressing 5010 and ICD-10 with the intent to meet federal implementation requirements of January 2012 for 5010 and October 2013 for ICD-10. Alabama's P-APD for ICD-10 has been approved, but the I-APD has not been submitted. Reporting requirements for ARRA and ongoing Medicaid are through the current financial reporting systems. This I-APD includes funding for all components related to MU initial year, including any changes in federal reporting required by CMS.

B. Needs and Objectives

The purpose of this APD is to request enhanced FFP (90/10) for the design, development, implementation and ongoing operation for two initial activities under the A-SMHP submitted in draft to CMS previously.

i. Meaningful Use Information Technology Infrastructure

- Priority providers:

Eligible providers in Medicaid	
<u>ELIGIBLE PROFESSIONALS (EPs)</u>	
Physicians	
- Pediatricians have special eligibility & payment rules	
- Clarified physician for Medicaid = MDs, DOs, and optometrists in some states	
Nurse practitioners (NPs)	
Certified Nurse Midwives (CNMs)	
Dentists	
Physician Assistants (PAs) when practicing at an FQHC/RHC that is <i>so led</i> by a PA	
- Clarified "so led"	
<u>ELIGIBLE HOSPITALS</u>	
Acute care hospitals (including CAHs and cancer hospitals)	
Children's hospitals	

- Six Core Activities:

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

Program implementation activities



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

- Components:

- Registration of potentially eligible hospitals (EHs) and eligible professionals (EPs), including interoperability with the NLR and yet to be established Medicare systems as appropriate to assure no duplicate payments
- The NLR at CMS will collect and provide to Alabama the applicant EP or EH name, NPI, business address, phone, tax payer ID Number (TIN) (EHs must provide the CCN), EPs selection of Medicaid vs. Medicare (may switch once between programs before 2015) and selection of Alabama as the Medicaid state (may switch states annually). The State understands that the NLR will also collect email addresses as well. The ASMA State Level System will need to be able to interface with the NLR, collect and retain the data elements through an interoperable interface.
- Another example is as follows: The ASMA State Level System will interface with the NLR 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 NLR), use of certified EHR system (list of certified systems to be provided by CMS and cross-checked but additional modifications are required when EH or EP uses certified modules that the state must review and determine as a whole meet the certification requirements) and either meets the Adopt, Implement or Upgrade (AIU) or

meaningful use requirements in year one. The ASMA State Level System must be able to retain whatever documentation is required by the state to validate the acquisition and installation or upgrade to a certified system in the initial implementation and activation as that is the priority for 2010-11. The ASMA State Level System must be able to interface with the NLR to accommodate the deeming of Medicare approved EHRs, while allowing the state to make the determination for EPs and EHRs that are not within the scope of Medicare (e.g., children). In addition for the first year, the ASMA State Level System must be able to provide the infrastructure for EHRs that choose to become eligible under the AIU provisions but are not seeking Medicare certification until a later year. The state level system will interface with ONC to validate the provider's use of a certified EHR system (Alabama understands that CMS will provide the specifications in order for the state to interface with the ONC secure web to validate the certification of the provider's system). The state will then determine if the EP/EHR meets the Adopt, Implement or Upgrade (AIU) or meaningful use requirements in year one.

- Registration System Interactions: Medicaid EPs will register in the CMS Registration Module. The Registration Module and NLR must orchestrate several interfaces to support this process. First, the Registration Module must interface with NPPES to verify the NPI. Second, the Registration Module must interface with DMF and PECOS to determine the death status and any Federal exclusions of the Medicaid EP. Third, the Registration Module and NLR must interface to write a new record to the NLR's transactional database. Finally, the NLR must interface with the State to exchange registration information.
- The ASMA State Level System will make a determination of Compliance with patient volume requirements using Medicaid claims data as the data source for the determination and are able to accommodate fee-for-service (FFS), managed care (medical home), FQHC and hospital patient volume thresholds.

Entity	Minimum Medicaid patient volume threshold	Or the Medicaid EP practices predominantly in an FQHC or RHC—30% <i>needy individual patient</i> volume threshold
Physicians	30%	
- Pediatricians	20%	
Dentists	30%	
CNMs	30%	
PAs when practicing at an FQHC/RHC that is so led by a PA	30%	
NPs	30%	
Acute care hospitals	10%	Not an option for hospitals
Children's hospitals	No requirement	

$$\frac{\text{Total (Medicaid) patient encounters in any 90-day period in the preceding calendar year}}{\text{Total patient encounters in that same 90-day period}} * 100$$

The ASMA State Level System will also support the calculations by potential EP and EH in order to allow for the determination of eligibility for providers who serve only Medicaid FFS and those who participate in the medical home initiative as well as serve Medicaid FFS.

$$\frac{[\text{Total Medicaid patients assigned to the provider in any representative continuous 90-day period in the preceding calendar year with at least one encounter in the year preceding the start of the 90-day period}] + [\text{Unduplicated Medicaid encounters in that same 90-day period}]}{[\text{Total patients assigned to the provider in the same 90-day with at least one encounter in the year preceding the start of the 90-day period}] + [\text{All unduplicated encounters in that same 90-day period}]} * 100$$

The State Level System will support the efforts of the state of Alabama to assure providers who work predominantly in a hospital (90% of encounters are in hospital or emergency room (ER)) are not awarded incentive payments but that all FQHCs/RHCs are receiving their incentives as it is anticipated all of them will be eligible for payment. The State Level System will also provide support to the state in determining which providers within the FQHCs/RHCs are practicing predominantly within the FQHCs/RHCs and are thus eligible as providers individually. To establish if the provider is practicing predominantly in a FQHC/RHC, the state must validate that the clinical location is the site for over 50% of total encounters for that provider for Medicaid, CHIP or uncompensated care patients over a period of 6 months in the most recent calendar. This verification must include dentists as well as physicians. In addition, substantiation of physician assistance eligibility is also required, making the number and variation of calculations by provider type significant; therefore, requiring IT infrastructure to automate the process as much as possible.

- The ASMA State Level System will interface with the NLR 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 NLR), use of certified EHR system (list of certified systems to be provided by CMS and cross-checked but additional modifications are required when EH or EP uses certified modules that the state must review and determine as a whole meet the certification requirements) and either meets the Adopt, Implement or Upgrade (AIU) or meaningful use requirements in year one. The ASMA State Level System must be able to retain whatever documentation required by the state to validate the acquisition and installation or upgrade to a certified system in the initial implementation and activation as that is the priority for 2010-11. The ASMA State Level System must be able to interface with the NLF to accommodate the deeming of Medicare approved EHS, while allowing the state to make the determination for EPs and EHs that are not within the scope of Medicare (e.g., children). In addition for the first year, the ASMA State Level System must be able to provide the infrastructure for EHs that choose to become eligible under the AIU provisions but are not seeking Medicare certification until a later year.

The proposed IT infrastructure design must also be capable of adding the ability to validate that a provider has demonstrated meaningful use in future years without re-design; however, the actual detail design, implementation and operation to be

added after activation of this initial phase and will be included in a future I-APD as needed.

Appropriate payment to EPs, including voluntary assignment of their payments to state designated entities that must be enrolled Medicaid providers (yet to be recognized by the state) that are “promoting the adoption” of electronic health record (EHR) systems. This is one more example where the ASMA State Level System design must be flexible in order to address the detail of the policies that have not been totally defined in order to make payments in the April-May 2011 time frame with EHs on a fiscal year (FY) cycle and EPs on a calendar year (CY) cycle. Automated payments need to accommodate provider responsibility (15% of capped net average allowable costs) and provider specific start and stop dates up to and through 2021 for a potential of \$63,750 per EP.

ASMA State Level System must interface with the NLR to generated payments must also address EHs who are eligible for incentive as a Medicare approved EH and thus deemed eligible for Medicaid.

$$\begin{aligned} & \text{(Overall EHR Amount) * (Medicaid Share)} \\ & \text{Or} \\ & \{ \text{Sum over 4 years of [(Base Amount + Discharge} \\ & \quad \text{Related Amount Applicable for Each Year) *} \\ & \quad \text{Transition Factor Applicable for Each Year]} \} * \\ & [(\text{Medicaid inpatient-bed-days + Medicaid managed} \\ & \quad \text{care inpatient-bed-days}) / \{(\text{total inpatient-bed} \\ & \quad \text{days}) * (\text{estimated total charges} - \text{charity care}) \} \end{aligned}$$

The IT infrastructure must accommodate the deemed status but make the payments over a 3-6 year period that has not been established as of this date by Alabama and which may or may not align with the Medicare payment dates creating additional program integrity system infrastructure needs between the NLR and ASMA State Level System.

In addition, the ASMA State Level System must automate the notification back to CMS of the disbursement of the payment and have the ability to pay in non-consecutive years.

- Adequate oversight: Alabama Medicaid Agency (A-MA) will assure there is no duplication of payments to providers (between States and between States and Medicare) and seek recoupment of erroneous payments. The goal is to have more pre-payment edit structure limitations and exclusions than pre-payment manual activities or post-payment recovery; however, neither approach can totally be avoided.
- Manage Post Payment Operations: Post payment, Alabama will manage an appeals and auditing process. At the time of the publication of this document, CMS was still making policy decisions for appeals and auditing. This document assumes that the appeals function will allow program participants to dispute qualification and/or payment determinations. This document also assumes that the auditing function will implement pre and post payment controls to prevent and detect fraud, waste, and abuse.
- Help Desk Service: A-SMA will require the contractor to provide help desk services to answer questions about the basic program rules (e.g., how to meet meaningful use), assist participants with submitting information to register and qualify for the program, and answer questions about actual incentive payments.
- Reporting: The Recovery Act provides additional requirements on states related to reporting beyond traditional Medicaid. The contractor of the IT infrastructure must accommodate any and all changes required by CMS.
- *Anticipated System Requirements- Edits/Audits:*
 - EHs (Medicaid only, Medicare and Medicaid,) EPs (Medicaid, Medicare – not eligible for Medicaid)
 - Patient volume requirements continue to be met
 - EP practice predominantly in non-hospital
 - Practice predominantly FQHC/RHC
 - Provider met “MU”
 - Provider using certified EHR
 - Provider submitted quality measures (year 2 and year 3)
 - Numerator/Denominator
 - Provider Type (compared to current provider subsystem of MMIS)

- Check to NLR for incentive payments already made to provider
- *Anticipated System Requirements - A-SMA automated actions for denials, although some activities may be manual initially until system infrastructure has been implemented, tested and fully utilized:*
 - Denial or closure based on basis of ineligibility (not an eligible provider), not able to demonstrate IAU or MU, has not reported quality measures, etc. (manual)
 - Notice of denial to provider (automated)
 - Provider appeal rights sent. (automated)
 - Appeal process. (manual)
 - Post-appeal decisions incorporated and notification back to CMS. (automated)
- *Anticipated System Requirements - A-SMA automated activities to make payment:*
 - EP Limits Payment Yr 1 = \$21,250 EP Payment Yr 2 – Yr 6 = \$8,500 (automated)
 - Start date of incentive payment for provider specific stop date (automated)
- *Anticipated System Requirements- A-SMA automated calculation of payment for each provider:*
 - Hospitals: formula described in regulation
 - EPs: AAC/NAAC process described in regulation
 - System edits against sanctions/death files before payment
 - MMIS disbursement of payment to TIN
 - MMIS created report to notify NLR that a payment was made to EH or EP and amount. Alabama's understanding is that the system must be capable of providing the following to the NLR: provider eligibility daily; payment determination batch – weekly; after payment monthly.
 - MMIS created reports for internal management
 - Reports to Finance for Drawdown (37/64)
 - MMIS created Payment History By Provider
- *Anticipated System Requirements - A-SMA automated tracking of provider:*
 - Continued eligibility as a provider annually (some manual/some automated)

- Start date of incentive payment for provider and specific stop date (automated)
- A-SMA receives and utilizes data (some manual/some automated)
- *Anticipated System Requirements -Other Automated Activities:*
 - Oversight of e-prescribing (to be determined)
 - Involvement in structured lab and clinical exchange (automated)
 - Design and Implementation of reporting measures, oversight and feedback to providers based on the electronic specifications provided by CMS (mostly automated)
 - Inform the NLR of incentive payments made to Medicaid EHs and EPs.
 - Determine any MCO implications and if so implement adjustments

Alabama intends to procure a system that will have “hard stops” for some risk components and reports with “suspend” status for others depending on the appropriateness and timeliness of the next action by the provider, the state or the NLR.

The following Table 5 from A-SMHP provides the Proposed Medicaid Electronic Health Record (EHR) Incentive Process in the First Year

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

NLR Processing
The provider applicant enters information on NLR.
Information sent ASMA via a daily batch file.
ASMA retrieves daily batch files from the NLR
ASMA system may reject an entire file based on some parameters and if so file resolution will be required with NLR.
Upon receipt of file, ASMA system performs edits on SSN, CCN, State Code Program Type is MA, duplicate checking, determining whether the provider is present in the Medicaid Management Information System (MMIS) Provider file. If edits are not

passed, then the record will be suspended for: resolution of individual records with NLR (e.g., duplicates incorrect state code), ASMA to research, and exclusions sent from NLR for investigation by Program Integrity.

If edits are passed, email to the applicant will be generated with instructions on how to begin the application process. Suspended records will also generate an email to the provider that indicates the reason for the suspense (provider not enrolled, etc.) and who to contact.

Provider Applicant Verification

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

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

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

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

- NPI
- Provider Name
- Business Address/Phone
- Personal TIN
- Payee TIN
- Payee Address
- Agency (Medicare/Medicaid)
- State (if Medicaid)
- Legal Entity Name

- Payee Legal Entity Name
- CCN for hospitals
- Provider Type
- Email Address if provided by NLR)Most recent ICD information

Provider Applicant Eligibility Determination

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

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

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

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

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

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

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

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

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

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

Provider Applicant Attestation

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

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

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

- Upgrade: same as adopt
- Document Sources of funding (non state/local government) for payment calculation.
- Provider applicant will be required to report any other sources of funding for use in incentive payment calculation.

Confirmation of category of entity that payment is being assigned:

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

Provider Applicant Payee Determination

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

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

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

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

Application Submittal Confirmation/Digital Signature

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

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

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

Payment Determination and Confirmation

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

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

Payment Generation Utilizes MMIS Gross Adjustment (GA) process

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

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

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

Alabama started as a Group 1 state to connect with the National Level Repository (NLR) but is now planning to connect prior to the end of the first quarter in calendar year 2011 so the timeline is tight and the need for CMS approval of the SMHP and I-APD quickly cannot be overstated

- Proposed Medicaid Electronic Health Record (EHR) Incentive Process in the First Year

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

A web based application will support NLR interfaces and data exchanges and Alabama requirements for determining and issuing eligible provider incentive payments will seek to avoid state variation to improve administration across states. The application will have both a provider facing and a user support component.

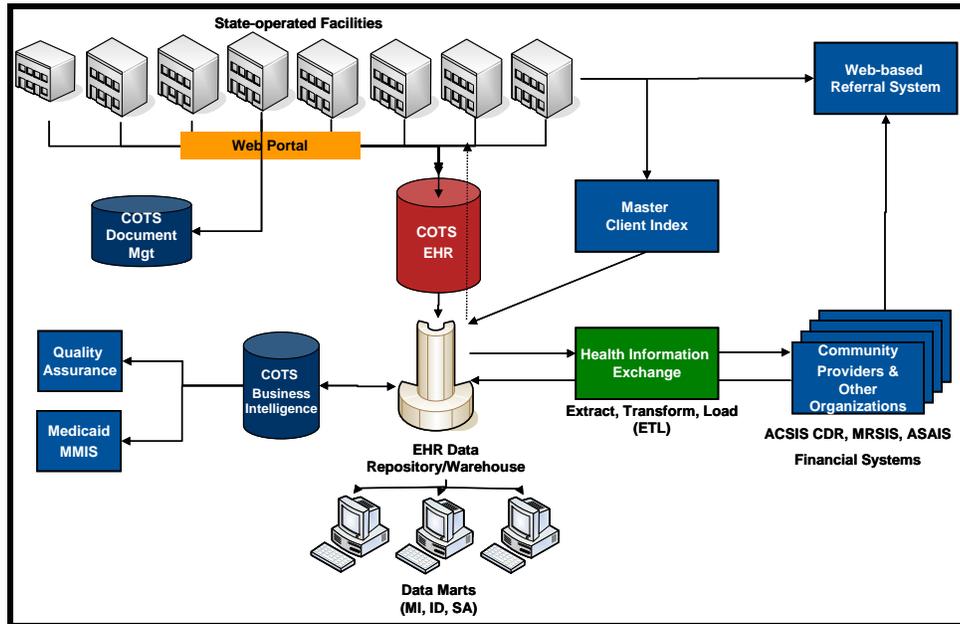
Either as a part of the web based system or separately the state will:

- Address the steps of the provider application process, including provider applicant eligibility determination, attestation, and payee determination; application submittal confirmation/digital signature or secure confirmation; Medicaid payment determination (including NLR confirmation) and payment generation;
- Support the applicable requirements as published by CMS;
- Interface with the NLR;
- Receive and store MMIS provider enrollment and summarized claim information;
- Allow providers and AMA users secure access through the Internet;
- Provide Medicaid EPs and EHs the ability to register, apply for, and view their incentive payment information;
- Maintain provider specific information;
- Send automated emails to providers based on various statuses of the application;
- Maintain a repository of all Medicaid EHR Incentive Payment Program activity (eligibility, payment, denial, appeals, etc.);
- Allow for certain data to provide additional information;
- Provide capability for links to be displayed for information such as a guide that provides users with instructions on completion of the application;
- Ability for the provider to navigate, view, and print or download to a PDF (finished), but not alter the data;

- Display provider Identification information (NPI, TIN, Payment Entity, etc.) on all screens and printed pages to provide clarity to the provider and user;
- Display remaining percent or a graphic depiction of how much is left to complete;
- Provide the capability for the provider to print their application (attestation, information from the NLR, contract information);
- Support the completion of required fields before allowing the provider to proceed to the next field;
- Allow AMA to enter notes and attach/upload documents to provider records through secure portal;
- Allow providers to send incentive program information request emails to a mailbox;
- Produce incentive payment records and send them to the MMIS for processing or to a report;
- Monitor provider incentive payment processing through a user view;
- Calculate the proper incentive payment at the proper time;
- Ensure inappropriate payments are not generated;
- Ensure that payments are not automatically issued to providers that are under exclusion/sanctions, or for duplicate payments;
- Track a provider's appeal of eligibility and payment denial determinations;.
- Produce management level reports on provider participation, total incentive payments, and provider inactivity;
- Make data available for output in a common format to be used for data analysis (i.e., data warehouse, decision support, etc.);
- collect and process information related to "Entities Promoting the Adoption of Electronic Health";
- Connect for file exchanges with the NLR;
- Audit reporting;
- Physician Quality Reporting Incentive (PQRI) and ePrescribe incentive program;
- Issuance of provider incentive payments and associated tracking (remittance advices and 1099s); and
- Provider appeals tracking.

The schematic for the data warehouse system architecture to support the future Medicaid MH MU Quality Measures follows.

Architecture to Support the future Medicaid MH MU Quality Measures



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

This I-APD includes the funding request for the contract for the IT infrastructure and the state personnel to support and oversee this MU effort. Both the IT infrastructure and state personnel needs were address in the A-SMHP.

ii. AHIE Infrastructure to Exchange HIE in a Meaningful Way

Per statute, a provider must be able demonstrate meaningful use by:

- Use of certified EHR technology in a meaningful manner such as e-prescribing;
- Connection of certified EHR technology in a manner that provides for *the electronic exchange of health information* to improve the quality of care; and
- In using this technology, the provider submits to the Secretary information on clinical quality measures and such other measures.

The development of the A-HIE is the mechanism for the statewide IT infrastructure in order for providers to complete bullets two and three above and allow Alabama providers who serve Medicaid enrollees, particularly small Medicaid providers, to exchange information in a meaningful way with other providers and report the clinical quality measures and other required measures to CMS, Alabama Medicaid and eventually Public Health. While the AHIE will not provide e-prescribing, it will provide a mechanism to support e-prescribing as well.

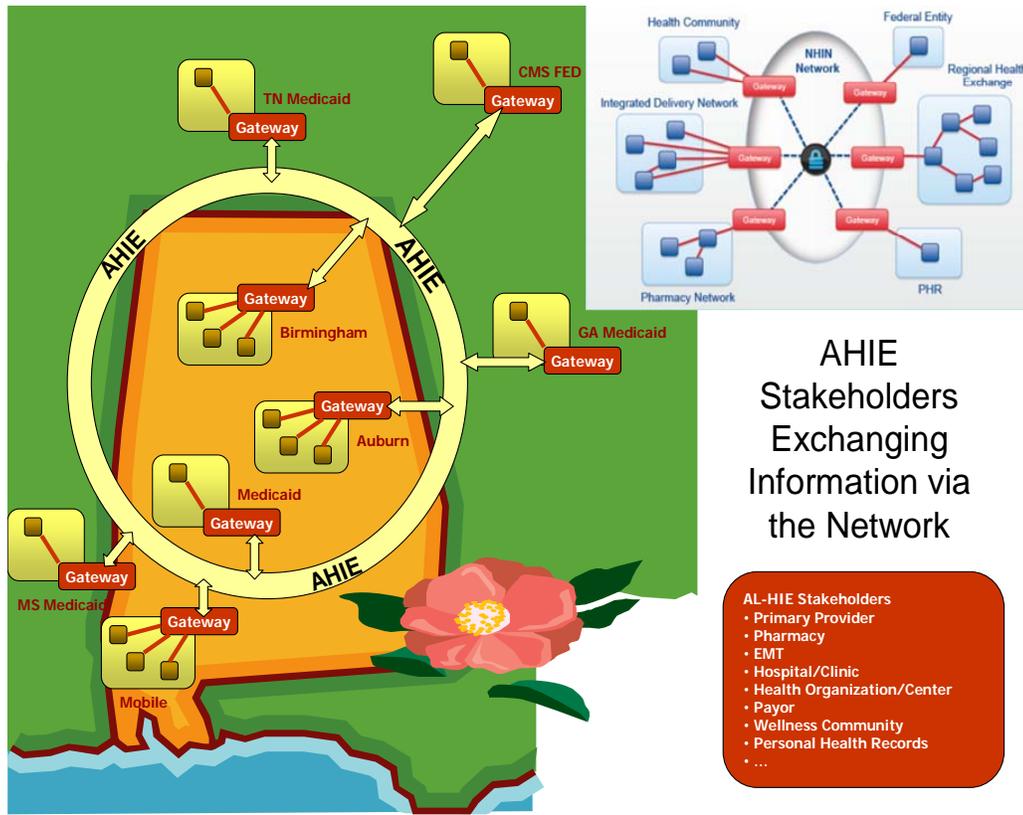
The AHIE as designed through the AHIE Strategic/Operational Plan (AHIE S/OP), has made the meaningful use requirements the basis for the core requirements for stage one (2011 and 2012) that include the ability to report on 20 of 25 MU objectives for 90 days for the first year and a full year subsequently. It is also the intent of the Alabama Medicaid Agency (A-MA) to potentially use this mechanism to meet federal requirements related to quality measures for children (CHIPRA) and adults (PPACA). (MITA Level 4).

Building off the NHIN model, the AHIE is envisioned as the gateway for individual or group entities (primary providers, pharmacies, EMTs, hospitals, clinics, organized health systems, payers, consumers for Personal Health Records (PHRs) and government institutions), within the state to connect with other state HIEs and Medicaid agencies, federal agencies, and the NHIN. In order to minimize the number of queries, which should be speedy, performed by a user of the system and assure the data is standardized, timely, high quality and assembled into an integrated record across episodes of care, the AHIE will abide by the ONC transport and content standards (technical, semantic and process). For example, transport of data to and from electronic destinations will require the use of general industry recognized transport types (e.g., Internet Protocol Version 6) and authorized recipients' technical capability (e.g., EHR, fax, or printer).

Standards will support various statewide HIE services, privacy and security policies (e.g., patient consent or special procedures for sensitive information), and connection to the Nationwide Health Information Network (NHIN). The statewide HIE will be built on NHIN Connect and NHIN Direct standards to enable both intra- and inter-state health information exchanges. Participants of the statewide HIE, generally through their associated health IT vendor(s), are expected to adhere to the national standards as they are finalized by ONC.

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

AHIE Exchanging Information



“To Be” Future State of Statewide HIE to Support the Exchange of Information for Meaningful Use: The technical functionality, required to support the meaningful use of information by Medicaid and Medicare Incentive Program providers, will be available through the AHIE, which is provided below. While the functionality is created for and supports MU providers, the technical infrastructure will exist for use for other Medicaid providers and other public and private providers as needed.

AHIE Technical Functionality
Core HIE Services: Phase I
<p>Provider Registry/Directory: The proposed design calls for a centralized provider registry that will allow providers to register into an account, update, and interface with other providers through a secure web-interface. The provider directory capability will include information from one or more sources that will have the ability to identify provider (individuals or organizations), The directory will include specific levels</p>

AHIE Technical Functionality

of security, including authentication and access controls and necessary firewalls. The provider directory and secure web-based service will include both technical functionality and administrative functionality. The provider directory creates a webservice for providers to log in or to interface with through their EHR. Through this web service, which will be based on NHIN standards and protocols. Each provider will have an account interfaced with a robust provider directory that enables secure, authenticated messaging. This service will allow providers to exchange basic health information through direct messaging or email attachments. The provider directory will be populated with information from Medicaid, Blue Cross and Licensure (both as a source of information and as a checkpoint). The provider directory will update per provider "hit" with the most current e-mail from the initiator who has logged in through his/her account.

The administrative functionality will include and support the establishment and management of the provider "account", communication and coordination with Regional Extension Center (REC) to educate providers on how to fully utilize the state's web service, and assuring the Medicaid "meaningful use" providers the mechanism needed to receive the appropriate incentives. The web service will include administrative and technical validation of the eligibility of the provider to participate [authentication], validation of their status as a provider [data sources to include: Medicaid, BCBS, and licensure boards], and agreement to comply with the privacy and security rules of engagement through an agreement that aligns with the national DURSA agreement.

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

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

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

Security: Support for the "Four A's": authentication, authorization, access, and audit. In addition, support for messaging, system, and network security protocols. System must support immutability of audit

AHIE Technical Functionality

entries as it relates to access and disclosure of patient health information (PHI) and supports and/or provides two-factor authentication.

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

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

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

Core HIE Services: Phase II

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

Consent Registry: Based on the access consent policy that Alabama utilizes, patient consent policies need to be linked and accessible in order to operate in an NHIN exchange model. These consent policies should provide a consistent source of a consumer's preferences, thereby enabling patient engagement and provider access to clinical information. The registry should be able to connect to existing consent registries and provide a consent registry if one is not available.

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

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

AHIE Technical Functionality

and trust models in the proposed solution should be provided.

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

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

Core HIE Services: Phase III - TBD

The Alabama system that will be funded under this proposal will be the receiving system responsible for communicating with the sending system using agreed upon protocols, sending confirmation as required, sending and receiving messages for any transmission errors, verifying and validating any data as required and returning appropriate message, storing data as required, interpreting and displaying any messages contained in the returning data, and maintaining an audit trail to demonstrate date and time of receipt and response, as appropriate.

iii. Continuation of QTool

QTool was developed through Medicaid Transformation Grant dollars to serve as a testing round of provider use of and effect of electronic health records. QTool primarily uses Medicaid's claims and eligibility information to provide a source of information to providers not otherwise available. QTool predates HITECH/ARRA thinking but has become a widely accepted information tool and a starting point for other state initiatives. Alabama is aggressively working on the establishment of a Statewide Exchange that will operate on behalf of all Alabamians. The Alabama Medicaid Agency is the State Designated Entity (SDE) and is coordinating the efforts. Through this arrangement, efficiencies are being realized between the work of the exchange and the establishment of the Meaningful Use Payment Incentive Program. The Agency views QTool as that avenue to keep providers

engaged, as a learning tool to the benefits of using electronic health information and as the first step in helping providers achieve meaningful use.

C. Vision

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

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

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

A-SMA has taken ONC National Coordinator and CMS leadership seriously and has made the patient in the center, built from what the state has today, created a bold vision but an implementation plan that is incremental starting with infrastructure (policy, technical and operational) to support MU incentive payments, fostered innovation, but balanced that with the need to “watch out for the little” through plans to contract with the REC for Medicaid specific support beyond the RECs responsibilities under their ONC contract.

The Alabama Medicaid Agency's vision is to build upon the lessons learned, the technologies employed to date and the provider momentum as we move towards the establishment of a statewide "clinical" health information exchange to support meaningful use. This vision will only become a reality in building upon steps taken thus far including adherence to the Medicaid Information Technology Architecture (MITA) 2.01 Framework.

Medicaid Provider Incentive Repository (MPIR): For the Medicaid EHR incentive program, the I-APD will fund the establishment of the MPIR module accessed through the MMIS provider internet portal to allow providers to apply for incentive payments. The MPIR system will both track and act as a repository for information related to payment, applications, attestations, oversight functions, and to interface with the National Level Repository (NLR). The MPIR system will interface both with the MMIS and NLR for provider information (provider files, sanctions, licensure, claims), information related to restrictions, incentive program participation in other states and Medicare, etc., and information collected from providers as they apply to participate in the incentive (NPI, Payee Tax Identification Number). In addition, MPIR will contain a series of edits and checks that will be used during the provider application process, e.g., confirmation of NLR information, patient volume, and attestations.

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

NLR Processing

The provider applicant enters information on NLR.

Information sent A-SMA via a daily batch file.

A-SMA retrieves daily batch files from the NLR

A-SMA system may reject an entire file based on some parameters and if so file resolution will be required with NLR.

Upon receipt of file, A-SMA system performs edits on SSN, CCN, State Code Program Type is MA, duplicate checking, determining whether the provider is present in the Medicaid Management Information System (MMIS) Provider file. If edits are not passed, then the record will be suspended for: resolution of individual records with NLR (e.g., duplicates incorrect state code), A-SMA to research, and exclusions sent from NLR for investigation by Program Integrity.

If edits are passed, email to the applicant will be generated with instructions on how to begin the application process. Suspended records will also generate an email to the provider that indicates the

reason for the suspense (provider not enrolled, etc.) and who to contact.

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

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

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

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

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

Provider Applicant Eligibility Determination

Alabama Medicaid provider status eligibility will be determined as a first step. Providers must be currently

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

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

Applicant confirms HITECH provider type. If the provider does not indicate any types, the application will be considered incomplete, and the provider will need to contact A-SMA. If the provider type entered by the applicant does not match the provider type on the MMIS file, the provider information will be placed on a report.

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

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

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

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

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

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

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

If percentage is over 30% or over 20% for a pediatrician, the provider instructed to proceed to "Provider Applicant Attestations". If less than 30% (or 20% for a pediatrician), suspend/reject. Provider applicant will not be able to proceed

Provider Applicant Attestation

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

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

- Confirmation of registration / request for specific state Medicaid incentive program at the NLR
- Confirmation of EP provider applicant NOT pursuing payment in another state
- Confirmation of no sanctions pending against provider applicant
- Confirmation of compliance with HIPAA laws for electronic data
- Confirmation of license to practice in state.
- Confirmation of Adoption, Implementation, or Upgrade
- Adopt (Acquiring or installing system): Is system certified? Yes – proceed No – flag for suspense
- Is it certified EHR technology (drop down of certified systems provided by CMS): applicant selects a system in drop down – Proceed; if not suspend
- Did organization perform a readiness assessment? (data collection only): Yes or No - proceed

- Implementation: same process as Adopt up to implementation tasks then indicate task. you've completed in the last year – If applicant selects from drop down – proceed and if Other or suspend
- Upgrade: same as adopt
- Document Sources of funding (non state/local government) for payment calculation.
- Provider applicant will be required to report any other sources of funding for use in incentive payment calculation.

Confirmation of category of entity that payment is being assigned:

- Self
- Hospital

- FQHC/RHC
- Group Practice
- Other (required to enter information in text box) – flag for suspense to MA HIT for outreach (manual review for final application approval)

- Confirmation of voluntarily assigning payment to the entity indicated on the information from the NLR and entity is a Medicaid enrolled provider.
-
- Yes – proceed
- No – flag for suspense for outreach (manual review for final application approval)

Provider Applicant Payee Determination

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

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

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

Application Submittal Confirmation/Digital Signature

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

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

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

Payment Determination and Confirmation

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

- If NLR returns duplicate payment: Flag to deny payment – send email to provider applicant indicating payment has already been made and they should contact the NLR with any questions.
- If NLR returns exclusions: Suspend to Program Integrity for review and send email to provider applicant indicating additional information received from NLR and that the information is being reviewed.

- If approved:
 - Flag record as “Ready for Payment”
 - Send email to provider indicating payment has been approved and that they can expect payment within 30 days.
 - Lock record from internal users.

Payment Generation Utilizes MMIS Gross Adjustment (GA) process

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

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

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

Alabama originally was a Group 1 state, however, the timing of approval and other limitations that connect with the National Level Repository (NLR) has increased constraints. The time line is tight and the need for CMS approval of the SMHP and I-APD quickly cannot be overstated. As the Department sees a need for using other functions supported by other state or national agencies, they will define the business case, communicate their needs, partner for solutions and govern the process for implementation and use.

Provider engagement is critical for success so over the next year, the Department will be working in collaboration with other statewide efforts to further inform potential EHs and EPs about opportunities available to them for HIT adoption via the Medicaid HIT Incentive Program. The state anticipates that the contractor selected through the procurement process will play a role in this outreach and education along with the current fiscal Agent as well as Alabama’s Regional Extension Center. Potential MU providers will be informed about:

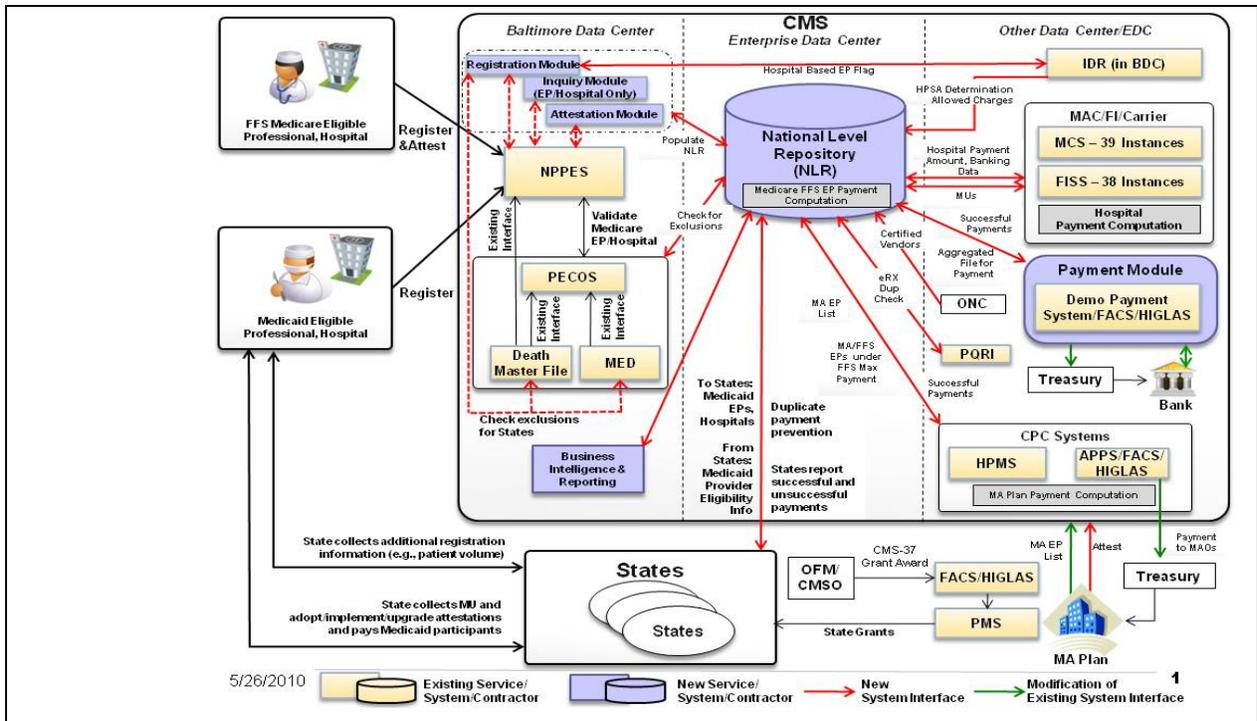
- Alabama’s HIT Goals and Vision with emphasis on increasing quality through adoption of certified EHR and transforming care through HIT;
- Eligibility criteria:
 - Registering with the NLR

- Gathering data on patient volume
- Unique criteria for various provider types
- Choosing Medicare or Medicaid
- General discussions on the payment structures (Year 1, Year 2, etc.)
 - Discussion on various strategies regarding Year 1 and incentives for providers to participate early in the program
 - Discussion on meaningful use criteria and stages in connection with Year 1
 - Discussion on the payment structure and ceilings;
 - Overview of the system and interfaces; and
- Education and outreach to encourage the adoption and meaningful use of Federally certified EHRs.

The state will require all entities participating in the marketing and education efforts to tailor outreach and distribution mechanisms based on the nature of the issue and the volume of providers or stakeholders with these concerns. A-SMA will continue to utilize Quick Tips, website information, updates to provider materials, and in-person and virtual training sessions. CMS and ONC will be initiating communications strategies on the Medicaid EHR incentive program and HIE. The Department will coordinate with ONC and CMS on timing and messaging.

A-SMA anticipates provider communications efforts will be coordinated with outreach efforts directed by CMS, the ONC, and others. The state also anticipates the contractor working closely with the RECs to benefit from lessons learned and working closely with their vendors to further relay their messages to providers and consumers.

A-SMA anticipates that, once the SMHP and I-APD are approved by CMS, the state will release information to the providers describing the Medicaid EHR incentive program, including program requirements, provider types eligible, the NLR, program oversight, and the application and attestation process. The high level systems concept is as follows:



Alabama is also requesting 90 percent FFP match for activities related to the administration of the incentive payments as authorized in section 1903(t)(9) of the Act as Alabama is in compliance with three specified criteria:

- The funds are for purposes of administering the incentive payments, including the tracking of meaningful use of certified EHR technology by Medicaid providers;
- The funds will be used to conduct adequate oversight of the incentive program, including routine tracking of meaningful use attestations and reporting mechanisms; and
- The funds are required to support Alabama's pursuit of initiatives to encourage adoption of certified EHR technology to promote health care quality and the exchange of health care information under Medicaid, subject to applicable laws and regulations governing such exchange, while ensuring privacy and security of data provided to its data exchange partners.

The A-SMHP has been submitted in draft prior to the submission of this I-APD and is consistent and integrated with the AHIE S/OP developed under section 3013 of the PHS Act.

D. Problems or Deficiencies

Since this is a new opportunity for providers and a new responsibility for the state, the lack of infrastructure (human and IT) is the deficit and a problem. Failure to fund and support the design, development, implementation and operation will have major political and practical implications for the Alabama Medicaid Program as potentially eligible providers (EPs and EHs) will not be able to receive Medicaid MU Incentive Payments. The impact on the overall system would also be distressing as the network to support the exchange of health information in a meaningful way, addressing the needs of Medicaid enrollees, would not be available to improve the health care delivery and quality. The cost efficiencies anticipated through these efforts would also not become a reality.

E. Assumptions

Batch data interfaces with CMS will include a header and a trailer record on each file. The header and trailer will contain, at a minimum, the file name, number of records on the file, and a transmission date.

This I-APD also assumes that EPs and EHs attempting to register with the NLR will enter, at a minimum, the following information into the Registration Module and will be transferred to the I-APD developed system:

- Legal Name
- NPI
- CCN (for hospitals)
- Personal Taxpayer Identification Number (TIN)
- Payee Taxpayer Identification Number (TIN)
- Business Address
- Business Phone
- State (for Medicaid EPs)
- E-Mail Address

The MU system developed as a result of this I-APD will send an automated response that indicates if the transfer was successful or unsuccessful back to the NLR and the NLR will be capable of real time interfaces.

F. Opportunities

HITECH provides the potential – this I-APD provides the opportunity needed by Medicaid providers to ready themselves for the meaningful use of health information through electronic exchanges. Providers are beginning to understand the benefits of electronic

health information exchange and the value of the information. This understanding and acceptance is the first step to achieving meaningful use. This is critical to stimulate the development and use of e-HIE in an efficient and effective manner, decrease costly administrative paper functions, decrease the potential for medical errors, and improve patient engagement.

IV. ALTERNATIVES CONSIDERED

A. MAPIR for Meaningful Use Infrastructure

A-SMA has been a part of a group of states working together with Pennsylvania Medicaid; all who currently contract with HP as their fiscal agent, to jointly purchase one system from HP for Meaningful Use infrastructure. The benefit being that the core system can be purchased once and used by many states; however, this approach is being limited to the “core” system, which will interface with the NLR. Each state must then amend their current contract with HP and submit a separate I-APD for their state specific changes.

An additional consideration is the timelines required to activate in order to make incentive payments in the April-May 2011 time frame. The ability to implement “on time” is at risk due to the two-stage process required. While this approach has the advantage of leveraging across states and creating a standardized approach for the “core”, Alabama potentially loses leverage with the contractor for the additional state specific components. State law also requires competitive procurement so the state authority to use the Pennsylvania group product was not determined to be a legal option at this time.

B. Alabama Specific Meaningful Use Infrastructure Using the Standardized “Model” of MAPIR

As the current MMIS system does not include the capability to register, validate eligibility, pay and/or do financial and quality oversight, the state has determined to achieve standardization by aligning with the approach and specifications of the MAPIR effort, but putting the contract out for competitive procurement. The state gains the ability to leverage the joint work they have done with the other states and the competition in the marketplace by other potential contractors, who may be willing to do both the core and state specific at a competitive price and include innovations not yet considered.

The procurement has been released simultaneous to the submission of the I-APD, but will not be awarded until prior approval of the funding has been received by CMS. The state does not have the option to move forward sequentially and still meet the timelines required.

C. *Ranking of the Alternatives and Selection of Alternative for Meaningful Use Infrastructure*

The second alternative, the Alabama specific meaningful use infrastructure, was selected due to legal requirements of the state; however, the benefit to the state and CMS is that it brings for the best of the cross-stage initiative with the ability to leverage at both the “core” and “state specific” components and meet the timelines required.

D. *Competitive Procurement for Exchange of Information for Meaningful Use Infrastructure (AHIE)*

Since the AHIE is part of the ONC AHIE S/OP process, the state reviewed various other state options and the NHIN model for design and implementation but is not able to joint purchase through the NHIN so determined the only option for the state was to competitively procure the statewide AHIE. As there are no statewide HIE’s to “join”, the state did the next best thing in working through SERCH with border states on the policies and procedures to standardize as much as possible inter-state as well as intra-state. Due to the state legal requirements (indicated above), the state moved forward on a competitive procurement as other alternatives do not exist. Additional detail information provided in the A-SMHP submitted previously.

V. COST BENEFIT ANALYSIS

There is no infrastructure in Alabama for either the statewide HIE or meaningful use, therefore the fiscal impact is on the cost of not doing versus the cost of doing. The budget implications are provided in the following information and the cost of not doing is not an administrative budget impact, but a significant Medicaid Program cost impact; cost of credibility with providers, the federal government and Medicaid enrollees; political cost; cost to providers of loss of potential incentive payments, and cost to the system as there is an expected correlation between the incentive funding through Medicaid and the improvement of the health care system.

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

VI. PROJECT MANAGEMENT PLAN

A. Nature, Scope, Methods, Activities, Schedule, and Deliverables (Due to the delay in having the contract ratified by the State's Contract Review Committee, the start date has been pushed back to February 1, 2011. Timelines will be updated based on the new contract start date when determined.)

The scope of work of these two contractors for the two initiatives has been addressed previously, but for the meaningful use infrastructure, the specific scope of work for the contractor encompasses the technological design, development and implementation of the infrastructure and staff support for the CMS EHR Incentives Program including registration, bi-directional connectivity to CMS's National Level Registry, connectivity to the MMIS claims management and provider management system for identification and payment, and audit and oversight functionality.

- Interface with the National Level Repository (NLR)
 - Because all eligible providers must initially register with the National Level Repository, an interface process to send and receive data is necessary. Contractor should note that there is at a minimum an initial interface for provider registration as well as a backend validation process. In addition, payment information must be supplied to the NLR once generated.
 - Contractor solution must support all current and future applicable requirements as published by CMS. It should be noted that August 24, 2010, is the most recent version of the Interface Control Document (ICD).
- State-Level System Requirements: After registering with the NLR, providers must have access to a state level system (Alabama is requiring a web portal) that continues and completes the registration and attestation process. Over the various stages of meaningful use, the web portal must expand and accommodate added sets of information and attestations.

- Web Portal Components: At a minimum, the web portal allow for providers to complete the application process, view their information and track payment information. The web portal system (or separate support system) must perform and/or include:
 - Email notification to the Provider of receipt of data from the NLR.
 - Pre-populated information from the NLR.
 - Receive and store current Alabama MMIS provider enrollment and summarized claim information.
 - Address all requisite steps of the provider application process, including provider applicant eligibility determination, attestation, and payee determination; application submittal confirmation/digital signature or secure confirmation; Medicaid payment determination (including NLR confirmation) and payment generation – including 1099.
- Create a repository of all registration and attestation data.
- Allow for documents to be uploaded and attached to a provider file to provide additional information.
 - Allow for secure email functionality directly from the system to ask questions.
 - Allow for certain authorized users (e.g. state staff) to enter notes at various stages of the process. Functionality should be enabled to allow notes to be hidden from general views.
 - Allow for print or download capability in an unalterable format.
 - Allow for functionality that will track application progress and notify provider of remaining items to be completed (along with necessary information required), either through screen notification or email notification if application is dormant for a period of time.
 - Allow for “help” functionality throughout the process that providers can link to for clarification or additional information.
 - Display a provider identifier on each screen and printed pages.
- Specific Payment Functions
 - Maintain a repository of all Medicaid EHR Incentive Payment Program activity (eligibility, payment, denial, appeals, etc.);

- Contractor should have system functionality that calculates the correct payment methodology based on eligible provider status and type and stage and year of participation of meaningful use.
- Payment system (Contractor should propose model) that is able to interface with the MMIS system for payment issuance and data absorption into general accounts receivable system. Because payments will be subject to general liens and other payment holds and will be captured for 1099 reporting, it is critical that payment information is accurate and available.
- Ensure that inappropriate payments are not calculated or made.
- Ensure that payments are not automatically issued to providers that are under exclusion/sanctions, or for duplicate payments.
- Allow for payments to be designated to other entities as allowable under the regulations.
- Fraud and Abuse, Audits and Appeals
- The system shall allow “start and stop” capability for audits to be conducted at various key points through the system.
- The system should identify potential areas of concern throughout the process.
- The system should allow for provider appeals including state oversight functions and resolution.
- Contractor will be responsible for recommended policies and procedures for fraud prevention based on experience with other states.
- General Requirements
 - Allow providers to send incentive program information request emails to a mailbox.
 - Information from the system should be available for analysis and reporting. At a minimum, the following reports must be available with the recognition of the need for ad-hoc reporting as well:
 - Registration Summary (including provider specific demographics)
 - Attestation Summary (including complete and noncomplete)
 - Payment Summary
 - Audit Activity
 - Clinical Meaningful Use Measures (Contractor will be expected to require with CHIPRA reporting requirements for States).

- Audit Triggers/Trends
- Support Services
 - A provider “call center” must be maintained with phone and email capability to assist providers through the process. Call Center hours are to be 7:30 am – 6 pm central on all working days. Nationally recognized holidays are excluded.
 - The “on-line” help feature should provide connection to the call center should the provider not be able to navigate the application.
 - “Calls” must be answered based on the following metrics:

Calls	80% answered within 30 seconds; all calls should be answered within 5 minutes
Emails	90% responded to within 6 hours, within working hours
Abandoned Calls	10% or less of call volume
First Call/Email Resolution	80% or higher

- Contractor will be responsible for creating an on-line and written manual for use by providers utilizing the system
- Contractor will be responsible for creating communication and marketing material (text, screenshots) to be used in the State communication Plan. All marketing for the program will be conducted under State branding and with prior approval of the State
- Future Functionality Guarantee the State and Contractor recognize that the MU Incentive Payment Program is an evolving process that will entail system modifications and additions throughout the process to accommodate published regulations. The State is only interested in those Contractors whose pricing and program design are such that all future modifications are included in the firm and fixed pricing. The State is only interested in those Contractors who provide a guarantee that their product will allow providers to capture the necessary information in the prescribed timeframes necessary to receive MU Incentive Payments.
- Fiscal Agent Interfaces:

Contractor should be prepared to work with Medicaid's current fiscal agent to obtain necessary claims and provider specific information. These interfaces are necessary to perform the necessary validation activities required by CMS.

Contractor should propose a system that is able to get the necessary information in accordance with Alabama InterChange Interface Standards Document, included in the RFP library. The current MMIS Contractor will be required to provide the necessary interfaces.

- System Performance
 - The system must be available to providers at a minimum 21 hours per day, seven days a week.
 - A report of system performance, to include at a minimum call and email tracking; system downtime; system issues with resolutions must be provided weekly for the first 90 days of system go-live, then monthly thereafter.
 - Contractor must provide for a secure hosting facility with back-up provisions. Responses should describe Contractor's approach.

Contractor requested to propose a project management system that will track key milestones and report progress throughout the process. Below is an estimate of the milestones that will need to be met at minimum to meet program timelines:

(Due to the delay in having the contract ratified by the State's Contract Review Committee, the start date has been pushed back to February 1, 2011. Timelines will be updated based on the new contract start date when determined.)

TASKS	DATE	NOTES
Post Contract Meeting	NLT 11/9/10	For introductions, finalization of project plan including due dates
Workflow Diagram	11/12/10	
Screen Design	Initial: 11/19/10 Final: 12/7/10	Contractor will propose screen designs to capture adopt, implement and upgrade information initially but these will be the basis for future enhancements as well.
Identified Interfaces	11/19/10	Contractor should be prepared to work with the current FA (HP) to determine necessary interfaces & timeframes for testing & implementation.
NLR Testing	TBD	

TASKS	DATE	NOTES
System UAT	12/28/10	
1 st draft Training Materials	TBD	This will include all provider notifications as well as general training materials
Provider Use for State Registration	2/15/10	
Requirements Documents for Stage One of MU	4/1/2010	This will include the additional fields that are necessary
First Payments to Providers Generated	May 2011	

B. State Scope of Work

The most critical activities that will be managed by the state directly for which federal funding will be required under this I-APD include:

- MITA Program Management, including contract/procurement development and management for the System Designs (preparing solicitations and awarding contracts for contractor support services, hardware, and software);
- MITA Contract Management, including oversight of the contract and contract negotiations through development and implementation of the appropriate plans (conversion plan, test management plan, installation plan, facilities management plan, training plan, users' manuals, and security and contingency plans), development and testing of software, and overall testing and training of internal staff and external stakeholders.

Meaningful Use Infrastructure Procurement Proposed Timeline

RFP Issued	9/17/2010
Deadline for Submission of Questions	9/28/2010
Answers to Questions Posted As Available	9/18/10 – 9/28/10
Final Posting of Questions and Answers	10/1/10
Letter of Intent to Submit a Proposal*	10/1/2010
Proposals Due by 5 pm CT	10/7/2010

Evaluation Period	10/8/10 – 10/13/2010
Contract Award Notification	10/15/2010
**Contract Review Committee	10/28/2010
Official Contract Award/Begin Work	11/1/2010 **

**dependent upon Contract Review Committee

(Due to the delay in having the contract ratified by the State's Contract Review Committee, the start date has been pushed back to February 1, 2011. Timelines will be updated based on the new contract start date when determined.)

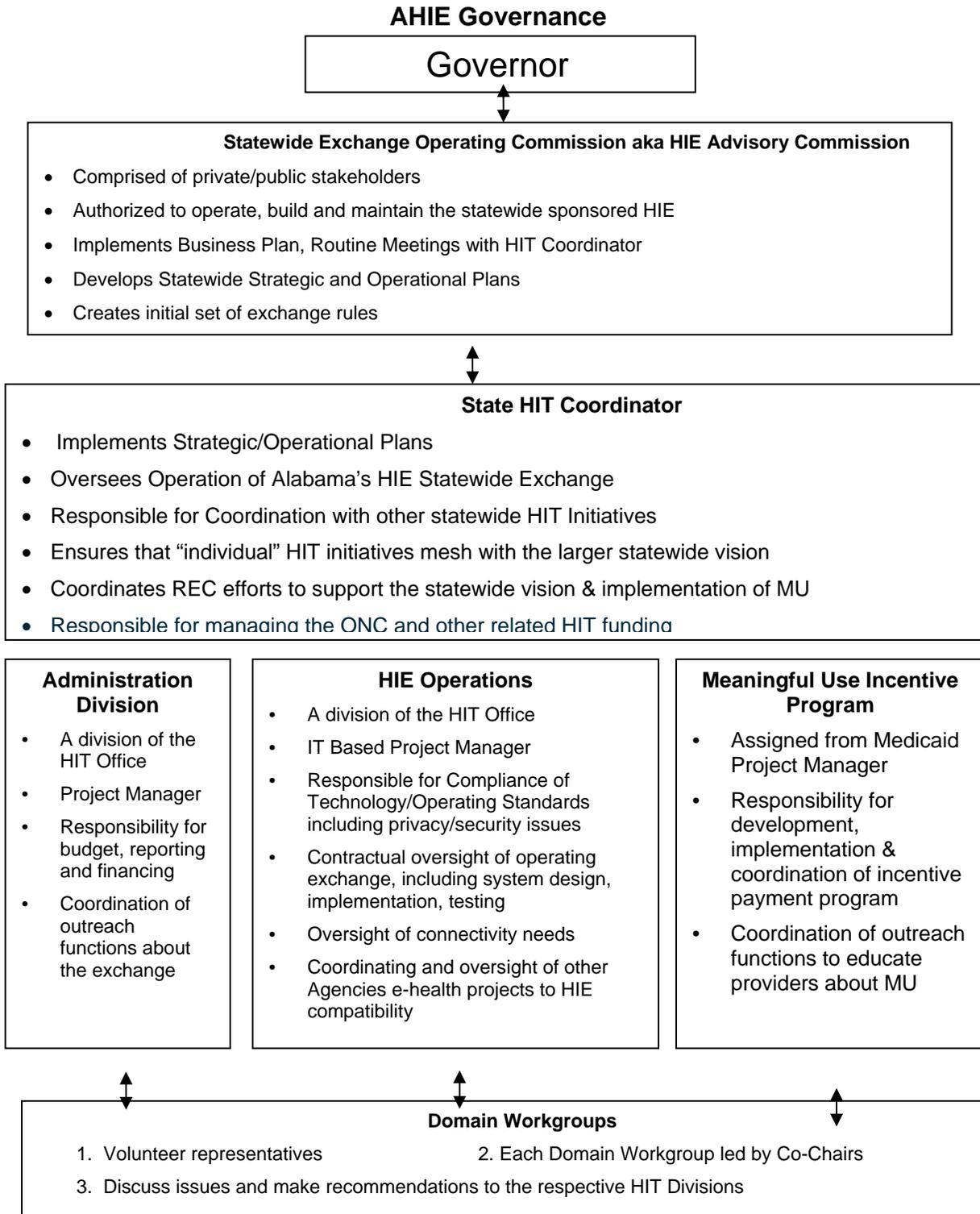
Examples of Additional Activities – Note Others Provided in SMHP

MU Policy Definitions (measures definitions)
Communication: Alabama rules to providers based on communication plan from S/OP
Contract with REC for on the ground communication with providers who are not covered under ONC contract through sole source contract
Hire MU Staff: SOW includes project management of MU, contract management of System's vendor, program management including federal reporting
Analysis planning for incentive payment delivery systems and audit tracking of payments to providers.
Planning provider education, outreach, training, provider surveys, & conferences.
Assess needs for provider public reporting on clinical quality outcomes.
Evaluation & planning for developing and setting up metrics and measures for providers to demonstrate meaningful use of electronic health records once defined through rulemaking.
Planning for the development of appropriate data agreements
Initial planning and preparation activities (e.g., preparation HIT planning documents), including the use of Medicaid IT Architecture (MITA) concepts and tools (i.e., conducting a MITA State Self-Assessment for HIT).
Preparation of a Request for Proposal for vendor and consulting services for HIT and associated procurement activities (i.e., proposal evaluation and contractor selection, detailed project schedules, etc.).
Specific initiatives related to interoperability, data exchanges, and system interfaces that are approved by Centers for Medicare & Medicaid Services (CMS).
Quality assurance activities, including use of contractor support and associated procurement activities, including Independent Verification and Validation.
Creation and on-going Governance for HIT Planning.
Outreach and Education Activities

Production of HIT publications.
Dedicated mailbox for inquiries and responding to provider inquiries.
Provider community education.

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

C. Project Organization and Personnel Resources



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

D. State and Contractor Resource Needs

This I-APD is for funding for two specific contractors (one for the MU infrastructure and one for the AHIE infrastructure to support the meaningful use exchange of information) as well as state staff and administrative functioning support (travel, computers, space, supplies, telephones, etc) as indicated in the chart in the following section.

E. System Life

As indicated previously, this I-APD is the first of many under the A-SMHP and covers the activation of the work for the next 18 months under Meaningful Use and AHIE, as well as set the groundwork for the 10 years of implementation and operation. It is anticipated that this I-APD will be amended and followed but sequential I-APDs on an ongoing basis in response to changes.

VII. THE ESTIMATED PROJECT BUDGET

Alabama is seeking through an open and competitive procurement process a contractor who, for a firm and fixed fee for the two year contract period and the three option years, will develop, implement and operate the MU Incentive Payment Program. It is expected

that as part of the ongoing costs, Contractor meets all CMS program design requirements for Stages One through Four. In determining pricing, Contractor should consider additional registration, validation and attestation fields. The Firm and Fixed Price of the first year of the proposed contract (implementation phase) and subsequent years (updating/ operation phase) must be separately stated.

Cost Category	Year 1			Year 2			Grand
	Enhanced	Regular	Total	Enhanced	Regular	Total	Total

Meaningful Use EHR Incentives							
Direct Personnel	153,776	0	153,776	153,776	0	153,776	307,552
Contract Services	717,421	0	2,217,164	2,217,164	0	2,217,164	2,934,585
Operation of Qtool	1,499,743			0			1,499,743
System Hardware	5,000	0	5,000	0	0	0	5,000
System Software	100,000	0	100,000	0	0	0	100,000
Training	345,000	0	345,000	345,000	0	345,000	690,000
Overhead	0	0	0	0	0	0	0
Supplies	0	0	0	0	0	0	0
Other	23,000	0	23,000	18,000	0	18,000	41,000
Yearly and Grand Total	2,843,940		2,843,940	2,733,940		2,733,940	5,577,880

AHIE: Medicaid Responsibilities							
Direct Personnel	153,776	0	153,776	153,776	0	153,776	307,552
Contract Services	1,567,164	0	1,567,164	1,567,164	0	1,567,164	3,134,328
System Hardware	0	0	0	0	0	0	
System Software	0	0	0	0	0	0	
Training	0	0	0	0	0	0	
Overhead	0	0	0	0	0	0	
Supplies	0	0	0	0	0	0	
Other	0	0	0	0	0	0	
Yearly and Grand Total	1,720,940	0	1,720,940	1,720,940	0	1,720,940	3,441,880

Funds Expended (As of 10/31/10)

<u>Description</u>	<u>Federal Share</u>	<u>State Share</u>
<u>Travel Expenses (Out of State)</u>	<u>\$1,127.52</u>	<u>\$125.28</u>

<u>Travel Expenses (In State)</u>	<u>\$155.25</u>	<u>\$17.25</u>
<u>Conference Fees</u>	<u>\$355.50</u>	<u>\$39.50</u>
<u>Project Support</u>	<u>\$1,167.34</u>	<u>\$129.70</u>
<u>Total</u>	<u>\$2,805.61</u>	<u>\$311.73</u>

Funds Encumbered

<u>Description</u>	<u>Federal Share</u>	<u>State Share</u>
<u>Contractuals – FourThought (Year 1)</u>	<u>\$262,868.08</u>	<u>\$26,283.92</u>
<u>Project Support – Qtools Communications Line</u>	<u>\$9,091.00</u>	<u>\$909.00</u>

VIII. PROSPECTIVE COST ALLOCATION: will be completed upon approval of ONC Strategic/Operational Plan

Estimated Implementation Phase Budget					\$
Federal / State Program	Program Share of Cost	Amount (\$)	FFP Rate	Federal Share (\$)	State Share (\$)
***ONC Funding					
TOTAL					

At this time the State does not anticipate having a subscription fee arrangement. In that we have not been able to gain approval from ONC on the model that Alabama will use for the “exchange of health information”, the State cannot determine a financial sustainability or cost allocation plan. It is understood the obligations of the State to only pay for any cost proportional to the population served. Until the model is finalized, an estimate is undeterminable.

IX. ASSURANCES

A. Procurement Standards (Competition/Sole Source)

Document: Title 45 Code of Federal Regulations, Part 95

Sec. 95.613 Procurement Standards.

- (a) Procurements of ADP equipment and services are subject to the procurement standards prescribed by Subpart P of 45 CFR Part 74

regardless of any conditions for prior approval. Those standards include a requirement for maximum practical open and free competition regardless of whether the procurement is formally advertised or negotiated.

- (b) Those standards, as well as the requirement for prior approval, apply to ADP services and equipment acquired by a state or local agency, and the ADP services and equipment acquired by a state or local Central Data Processing facility primarily to support the Social Security Act programs covered by this subpart. Service agreements are exempt from these procurement standards.

Document: State Medicaid Manual Part 11

Section 11267 REQUIRED ASSURANCES

² The State Medicaid Letter, dated December 4, 1995 is attached to this Guide as ATTACHMENT E. Version 1: 04/04/2002 Page 4 Health Insurance Portability and Accountability Act APD Guide For 90-percent, as well as for 75-percent funding, and 50-percent FFP where the threshold amounts found at 95.611(a) are exceeded, give CMS, with respect to each RFP and/or contract entered into for a system, assurance that:

- Procurements of ADP services and/or equipment for mechanized medical claims processing and information retrieval systems meet the provisions of 45 CFR 74, Administration of Grants; and
- Fair competition and public advertising are within Federal and state procurement standards. The Federal procurement standards are in 45 CFR 74, Subpart P and the December 4, 1995 State Medicaid Director letter (See Attachment E).

B. Access to Records

Document: Title 45 Code of Federal Regulations, Part 95 Sec. 95.615 Access to systems and records.

In accordance with 45 CFR part 74, the state agency must allow the Department access to the system in all of its aspects, including design developments, operation, and cost records of contractors and subcontractors at such intervals as are deemed necessary by the Department to determine whether the conditions for approval are being met, and to determine the efficiency, economy and effectiveness of the system.

Document: State Medicaid Manual Part 11 Section 11267 REQUIRED ASSURANCES

For 90-percent, as well as for 75-percent funding, and 50-percent FFP where the threshold amounts found at 95.611(a) are exceeded, give CMS, with respect to each RFP and/or contract entered into for a system, assurance that:

All deliverables, interim reports, data collection forms, questionnaires, and other working papers that support the final system acceptance will be made available on request to CMS. This applies to the prime contractor, any subcontractors, and other state or local agencies supplying services.

C. Software Ownership, Federal Licenses and Information Safeguarding

Document: Title 42 Code of Federal Regulations, Part 433 Sec. 433.112(b) (5) – (9):

Version 1: 04/04/2002 Page 5 Health Insurance Portability and Accountability Act APD Guide (5) The state owns any software that is designed, developed, installed or improved with 90-percent FFP.(6) The Department has a royalty-free, non-exclusive, and irrevocable license to reproduce, publish, or otherwise use and authorize others to use, for Federal Government purposes, software, modifications to software, and documentation that is designed, developed, installed or enhanced with 90-percent FFP.(7) The costs of the system are determined in accordance with 45 CFR 74.171.(8) The Medicaid agency agrees in writing to use the system for the period of time specified in the APD approved by CMS, or for any shorter period of time that CMS determines justifies the Federal funds invested.(9) The agency agrees in writing that the information in the system will be safeguarded in accordance with subpart F, part 431 of this subchapter.

D. Progress Reports

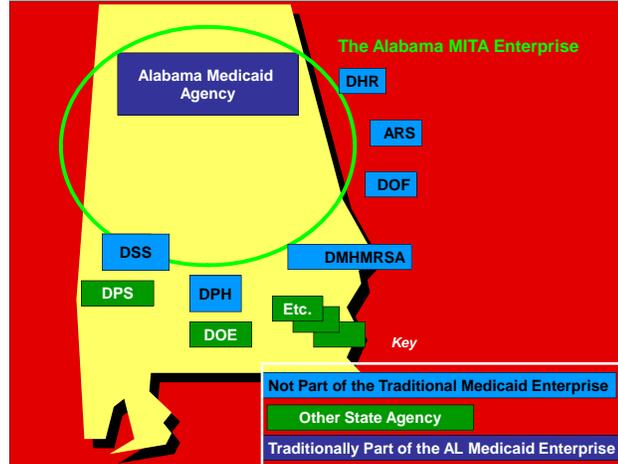
Document: State Medicaid Manual Part 11 Section 11267

REQUIRED ASSURANCES: For 90-percent, as well as for 75-percent funding and 50-percent FFP where the threshold amounts found at 95.611(a) are exceeded, give CMS, with respect to each RFP and/or contract entered into for a system, assurance that copies of progress reports, as requested, will be delivered to CMS.

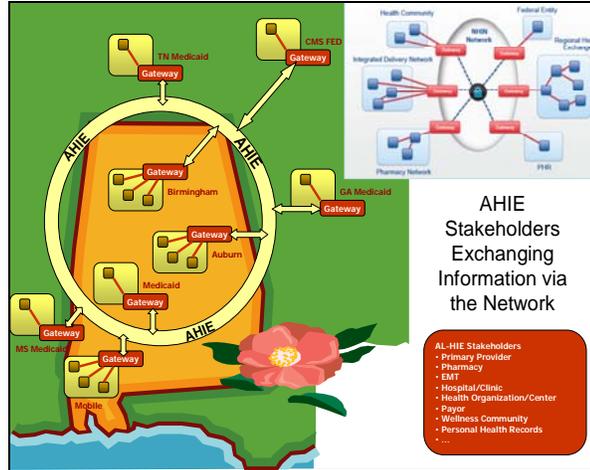
Appendix A – MITA State Self Assessment Results

I. TECHNICAL ARCHITECTURE:

“As Is”: MITA Enterprise



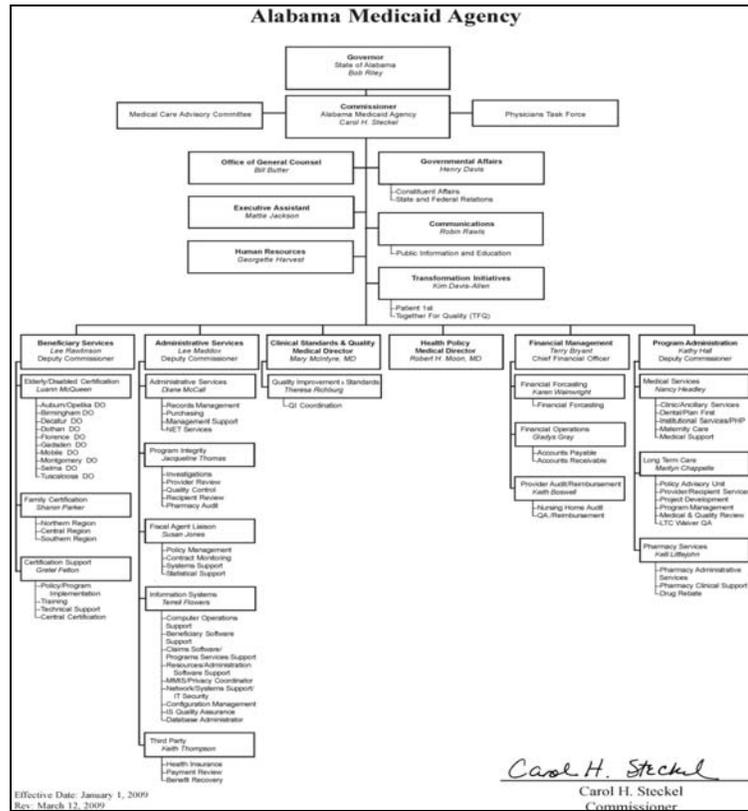
“To Be”: MITA Enterprise Post AHIE and Meaningful Use



AHIE is under the control of the Medicaid agency and DMH and DPH become gateways within the AHIE structure, moving them within the Medicaid Enterprise, expanding the Alabama Medicaid Enterprise and moving the Medicaid to Level 3 and then 4 with the potential to eventually move to Level 5.

II.GOVERNANCE

“As Is” for purposes of Medicaid HIT



“To Be” for purposes of Medicaid AHIE

For meaningful use administration of incentive payments the organization structure retains current structure; but for AHIE to support the meaningful use of health information, the governance structure moves to the following, which creates the organizational structure for statewide consistency within state government (Level 3) and the beginning of across public-private (Level 4) with movement to national (Level 5):

AHIE Governance

Governor

Statewide Exchange Operating Commission aka HIE Advisory Commission

- Comprised of private/public stakeholders
- Authorized to operate, build and maintain the statewide sponsored HIE
- Implements Business Plan, Routine Meetings with HIT Coordinator
- Develops Statewide Strategic and Operational Plans
- Creates initial set of exchange rules

State HIT Coordinator

- Implements Strategic/Operational Plans
- Oversees Operation of Alabama's HIE Statewide Exchange
- Responsible for Coordination with other statewide HIT Initiatives
- Ensures that "individual" HIT initiatives mesh with the larger statewide vision
- Coordinates REC efforts to support the statewide vision & implementation of MU
- Responsible for managing the ONC and other related HIT funding

Administration Division

- A division of the HIT Office
- Project Manager
- Responsibility for budget, reporting and financing
- Coordination of outreach functions about the exchange

HIE Operations

- A division of the HIT Office
- IT Based Project Manager
- Responsible for Compliance of Technology/Operating Standards including privacy/security issues
- Contractual oversight of operating exchange, including system design, implementation, testing
- Oversight of connectivity needs
- Coordinating & oversight of other Agencies e-health projects to HIE compatibility

Meaningful Use Incentive Program

- Assigned from Medicaid Project Manager
- Responsibility for development, implementation & coordination of incentive payment program
- Coordination of outreach functions to educate providers about MU

Domain Workgroups

1. Volunteer representatives
2. Each Domain Workgroup led by Co-Chairs
3. Discuss issues and make recommendations to the respective HIT Divisions

MITA GOALS AND OBJECTIVE

“As Is”: See the Alabama MITA Self-Assessment in the SMHP previously submitted.

“To Be”: MITA goals and objectives met through this I-APT for the registration, payment and oversight of the meaningful use incentive payments and AHIE infrastructure to support meaningful use initiative are identified using the original chart. The specific capability improvements and goals met are in bold and italics.

Business Area	MITA Capability Improvements	Alabama Goals
Provider Management	<ul style="list-style-type: none"> • <i>One-stop shop for enrollment & credentialing</i> • Automated credential updates • <i>National enrollment data standards</i> • <i>Provider network meets community needs</i> • <i>Pay for performance & quality of care</i> 	<ul style="list-style-type: none"> • <i>Provide a centrally located, Provider Web portal to enroll, validate, update, and share information across all agencies</i> • <i>Incorporate National Standards</i> • <i>Increase participation rate performance with better data access and reliability</i> • <i>Health Care Quality through High Performance Program Management</i>
Member Management	<ul style="list-style-type: none"> • No wrong door • National enrollment data standards • <i>Patient empowerment/ decisions</i> • Preventive care • Universal coverage – the states will have to understand how the healthcare reform is to be managed. • <i>Access to quality care</i> 	<ul style="list-style-type: none"> • Build a screening and referral Web portal that will be a single point of entry to all state services, via Family Resource Centers • Enhance Camellia to expand shared, outreach and screening function by expanding to an electronic rules engine using national enrollment data standards • Develop Applicant/Beneficiary Self-Service Web Portal

Business Area	MITA Capability Improvements	Alabama Goals
Care Management	<ul style="list-style-type: none"> • Medical home • Access to clinical data at point of care management • Supports patient empowerment • Interoperable data sharing via HIE 	<ul style="list-style-type: none"> • Enhance patient quality of care with service coordination tools and effective provider communication • Continue to educate and encourage the use of the electronic clinical support tool • Develop Applicant/Beneficiary Self-Service Web Portal • Develop a universal case view across all agencies

Business Area	MITA Capability Improvements	Alabama Goals
Business Relationship Management	<ul style="list-style-type: none"> • <i>Collaboration of Medicaid with Public Health, Behavioral Health, local, other states, and federal agencies</i> • Secure, de-identified HIE nationally • Service Level Agreements for HIE 	<ul style="list-style-type: none"> • Sharing of eligibility verification and validation information across state and federal agencies and programs via standard interfaces • <i>Expand the Medicaid/Public Health network to interface with other state and federal agencies</i> • <i>Develop a partnership with providers and other non provider public sites</i>
Program Management	<ul style="list-style-type: none"> • <i>Instant access to accurate, timely clinical & admin data via secure HIE</i> • Dash board decision support information • <i>Data supports strategic planning</i> • Changes in eligibility, enrollment, benefit plan, and service rules are instantly implemented 	<ul style="list-style-type: none"> • Develop electronic case, retrieval and document management system with access to all state, federal, and • <i>Improve Interfaces/Matches/Transmissions Processes</i> • Provide for efficient access to the information needed by Enterprise processes. For example, to determine eligibility, determine availability of TPL resources, view Program Integrity actions, and view legal actions.

Business Area	MITA Capability Improvements	Alabama Goals
Operations Management	<ul style="list-style-type: none"> • Streamline transaction processing through access to clinical data; use of HIE • Move from transaction focus to strategic action • Adopt MITA SOA to streamline maintenance & enhancements, reuse components 	<ul style="list-style-type: none"> • Paperless – Convert 50% of internal systems to paperless by FY12 • Continue to educate and encourage use of electronic clinical support tool • Reengineer Application and Eligibility • Create Electronic Case Record and Retrieval and Document Management System • Implement Service Oriented Architecture (SOA) to provide flexibility in business process design and stability in infrastructure by adhering to industry standards
Program Integrity	<ul style="list-style-type: none"> • Focus on preventing problems and rewarding quality • Integrity, quality permeate all operations • Appropriate model for managed care • Shifting focus from daily operations to strategic focus on how to meet the needs of the population within budget 	<ul style="list-style-type: none"> • Enhance QI and Utilization management to detect fraud and abuse • Enhance secure electronic access to information • Develop a comprehensive statistical profile for delivery and utilization patterns • Use of current State operations that Medicaid has duplicated freeing up experienced staff for business analysis; i.e. using student interns or graduate students which may lead to full time employment.
Contractor Management	<ul style="list-style-type: none"> • Integrate MITA principles • Promote SOA • Measure performance of Service Level Agreements 	<ul style="list-style-type: none"> • Utilize electronic standards to communicate with administrative and health services contractors (e.g., Maternity Care contractors) • Seamless interface with all contracted entities into state dashboard • Integrate enterprise-level analysis and reporting

IV. **SUMMARY OF BUSINESS ASSESSMENT “AS IS” (PURPLE) to ‘TO BE’ (Darker Blue) IMPACT OF MU AND HIE TO SUPPORT MU : MOVING TO MATURITY 4 INCREMENTALLY**

Business Area Name	Maturity Level 1	Maturity Level 2	Maturity Level 3	Maturity Level 4	Maturity Level 5
Member Management – 8 Business Processes <ul style="list-style-type: none"> no change in maturity level Improved manage member information 	8 (100%)	0	0	0	0
Provider Management – 7 Business Processes: improved those related to MU <ul style="list-style-type: none"> Unified enrollment, disenrollment, inquire and manage provider information and communication, adds provider appeal process, manages provider information and performs provider outreach Moves to maturity level 2 and starts level 3 	7 (100%)	2	0	0	0
Contractor Management – 9 Business Processes <ul style="list-style-type: none"> Produce, Award and Manage Administrative Services RFP Considered cross-state contract but settled on standardized cross-state approach – Moves to maturity level 3 for this one component 	9 (100%)	0	2 (small percent)	0	0

Business Area Name	Maturity Level 1	Maturity Level 2	Maturity Level 3	Maturity Level 4	Maturity Level 5
Operations Management – 21 Business Processes <ul style="list-style-type: none"> Claim/MU Incentive Payment, Remittance Advice, Provider EFT, Inquire Payment Status, Manage Payment Information For MU management, the 5 areas are cross-state approach and aligned with federal NLR so would be level 3 but only as related to MU (does not change overall rating) 	16 (76.2%)	5 (23.8%)	5 (small percent)	0	0
Program Management – 19 Business Processes <ul style="list-style-type: none"> Develop Agency Goals and Initiatives, Develop and Maintain Program Policy, Maintain State Plan, Manage FFP for MMIS, Manage F-Map, Manage State Funds, Manage 1099s, Generate Financial and Program Analysis Report, Manage Program Information, Perform Accounting Functions, Develop and manage Performance Measures and Reporting and Monitor Performance and Business Affecting 11 of the 16 (of 19) that relate to Alabama for MU and HIE with some at Level 2 and some at Level 3 	16 (84.2%)	3 (15.8%)	0	0	0
Business Relationship Management – 4 Business Processes <ul style="list-style-type: none"> Manage new business relationship for AHIE and MU support 	4 (100%)	2	0	0	0

Business Area Name	Maturity Level 1	Maturity Level 2	Maturity Level 3	Maturity Level 4	Maturity Level 5
Program Integrity Management – 2 Business Processes <ul style="list-style-type: none"> Unknown – creating oversight but undefined at this time 	2 (100%)	2	0	0	0
Care Management – 3 Business Processes <ul style="list-style-type: none"> Connectivity and addition of registry is future, not this IAPD AHIE address 3 business processes for better care to Level 2 and moving to level 3 	3 (100%)	2	0	0	0

V. MITA MATURITY MATRIX BASED ON MU AND AHIE CHANGES

STATE BUSINESS PROCESS	AS IS MATURITY LEVEL	TO BE MATURITY LEVEL		
		MMIS “TO BE” FOR MU INCENTIVE INFRASTRUCTURE AND HIE SUPPORT COMPONENT	BPR NEAR TERM	MITA LONG TERM
PM01 Enroll Provider for purposes of MU and the exchange of health information	1	3	2	3
PM02 Disenroll Provider	1	2	2	3
PM03 Inquire Provider Information	1	2	2	3
PM04 Manage Provider Communication	1	2	1	3
PM05 Manage Provider Grievance and Appeal	1	2	2	3
PM06 Manage Provider Information	1	2	1	3
PM07 Perform Provider Outreach	1	2	1	3

STATE BUSINESS PROCESS	As Is MATURITY LEVEL	To Be MATURITY LEVEL		
		MMIS "To Be" for MU Incentive Infrastructure and HIE Support Component	BPR Near Term	MITA Long Term
CONTRACTOR MANAGEMENT				
<i>CO01 Produce Administrative or Health Services RFP</i>	1	3	2	3
<i>CO02 Award Administrative or Health Services Contract</i>	1	3	1	3
CO03 Manage Administrative or Health Services Contract	1	1	1	3
CO04 Close-out Administrative or Health Services Contract	1	1	2	3
CO05 Manage Contractor Information	1	1	2	3
CO06 Manage Contractor Communication	1	1	1	2
CO07 Perform Contractor Outreach	1	1	2	3
CO08 Support Contractor Grievance and Appeal	1	1	2	3
CO09 Inquire Contractor Information	1	1	2	3
OPERATIONS MANAGEMENT				
OM01 Authorize Referral	N/A	N/A	N/A	3
OM02 Authorize Service	1	2	2	3
OM03 Authorize Treatment Plan	N/A	N/A	N/A	3
OM04 Apply Attachment	1	1	2	3

STATE BUSINESS PROCESS	AS IS MATURITY LEVEL	TO BE MATURITY LEVEL		
OM05 Apply Mass Adjustment	1	1	1	3
OM06 Adjudicate and Price/Value Claim/Encounter	1	1	1	3
OM07 Adjudicate and Price/Value Claim/Encounter	1	1	1	3
OM08 Adjudicate and Price/Value Claim/Encounter	1	3	1	3
OM09 Prepare Remittance Advice/Encounter Report	2	3	2	3
OM10 Prepare Provider EFT/Check	1	3	1	3
OM11 Prepare COB	N/A	N/A	2	3
OM12 Prepare REOMB	1	1	1	3
OM13 Prepare Home and Community Based Services Payment	2	2	2	3
OM14 Prepare Premium EFT/Check	1	1	1	3
OM15 Prepare Capitation Premium Payment	1	2	2	3
OM16 Prepare Health Insurance Premium Payment	1	1	2	3
OM17 Prepare Medicare Premium Payments	1	1	1	3
OM18 Inquire Payment Status	2	3	2	3
OM19 Manage Payment Information	1	3	1	3
OM20 Calculate Spend Down	N/A	N/A	N/A	N/A

STATE BUSINESS PROCESS	As Is MATURITY LEVEL	To BE MATURITY LEVEL		
OM21 Prepare Member Premium Invoice	N/A	N/A	N/A	3
OM22 Mange Drug Rebate	2	2	2	3
OM23 Manage Estate Recovery	1	1	1	3
OM24 Manage Recoupment	2	2	2	3
OM25 Manage Cost Settlement	1	1	1	3
OM26 Manage TPL Recovery	1	1	1	3
STATE BUSINESS PROCESS	As Is MATURITY LEVEL	To BE MATURITY LEVEL		
PROGRAM MANAGEMENT		MMIS "To Be" for MU INCENTIVE INFRASTRUCTURE AND HIE SUPPORT COMPONENT	BPR NEAR TERM	MITA LONG TERM
PG01 Designate Approved Service and Drug Formulary	2	2	2	3
PG02 Develop and Maintain Benefit Package	2	2	3*	3
PG03 Manage Rate Setting	1	1	2	2
PG04 Develop Agency Goals and Initiatives	1	1	1	3
PG05 Develop and Maintain Program Policy	1	1	1	3
PG06 Maintain State Plan	1	1	1	3
PG07 Formulate Budget	1	1	1	3
PG08 Manage FFP for MMIS	1	2	1	2
PG09 Manage F-MAP	1	2	1	2
PG10 Manage State Funds	1	2	1	3

STATE BUSINESS PROCESS	AS IS MATURITY LEVEL	TO BE MATURITY LEVEL		
<i>PG11 Manage 1099s</i>	2	2	2	3
<i>PG12 Generate Financial and Program Analysis/Report</i>	1	2	2	3
<i>PG13 Maintain Benefits/Reference Information</i>	1	2	1	3
<i>PG14 Manage Program Information</i>	1	2	2	3
<i>PG15 Perform Accounting Functions</i>	1	2	1	3
<i>PG16 Develop and Manage Performance Measures and Reporting</i>	1	2	1	3
<i>PG17 Monitor Performance and Business Activity</i>	1	2	1	3
<i>PG18 Draw and Report FFP</i>	1	2	1	3
PG19 Manage FFP for Services	1	1	1	2
Business Relationship Management		MMIS "TO BE" FOR MU INCENTIVE INFRASTRUCTURE AND HIE SUPPORT COMPONENT	BPR NEAR TERM	MITA LONG TERM
BR01 Establish Business Relationship	1	2	2	3
BR02 Manage Business Relationship	1	1	2	3
BR03 Terminate Business Relationship	1	1	2	3
BR04 Manage Business Relationship Communication	1	1	2	3

Program Integrity Management		MMIS "TO BE" FOR MU INCENTIVE INFRASTRUCTURE AND HIE SUPPORT COMPONENT	BPR NEAR TERM	MITA LONG TERM
PI01 Identify Candidate Case	1	1	2	3
PI02 Manage Case	1	1	2	3
Care Management		MMIS SHORT TERM	BPR NEAR TERM	MITA LONG TERM
CM01 Establish Case	1	2	2	3
CM02 Manage Case	1	2	2	3
CM03 Manage Medicaid Population Health	1	2	1	3
CM04 Manage Registry	N/A	Potentially 2	N/A	N/A

II. SUMMARY OF TECHNICAL ASSESSMENT FOR MU INFRASTRUCTURE AND HIE TO SUPPORT MU

Technical Area Name	Maturity 	Maturity 	Maturity 
Business Enabling Services – 11 Technical Functions	11 (100%)	0	0
Access Channel – 2 Technical Functions The technical functions within this area are at the following levels:	2 (100%)	2	0
Interoperability Channels – 5 Technical Functions The technical functions within this area are at the following levels:	5 (100%)	5	0
Data Management and Data Sharing – 2 Technical Functions (THROUGH NPI FOR PATIENT) The technical functions within this area are at the following levels:	2 (100%)	0	0

Technical Area Name	Maturity 	Maturity 	Maturity 
Performance Management – 2 Technical Functions The technical functions within this area are at the following levels:	1 (50%)	1 (50%)	0
Security and Privacy – 6 Technical Functions The technical functions within this area are at the following levels:	5 (83.33%)	1 (16.67%)	0
Flexibility - Adaptability and Extensibility – 4 Technical Functions The technical functions within this area are at the following levels:	3 (75%)	1 (25%)	0

¹ SureScripts. “State Progress Report on Electronic Prescribing.” Data as of December 2009. <http://SureScripts.com/about-e-prescribing/progress-reports/state.aspx?state=al&x=22&y=11>

² SureScripts. “State Progress Report on Electronic Prescribing.” Data as of December 2009. <http://SureScripts.com/about-e-prescribing/progress-reports/state.aspx?state=al&x=22&y=11>