ARIZONA STATE MEDICAID
HEALTH INFORMATION TECHNOLOGY PLAN
2019 Version 9.0

May 24, 2019
Jami Snyder, Director

AHCCCS initially submitted its SMHP in 2011. Each year AHCCCS has updated its SMHP. A summary of major changes is reflected below.

Version Number	Submission Date	Section	Comments
1.0	March 22, 2011	All	Submission to CMS for Approval
2.0	July 18, 2011	CMS Approval Letter for SMHP Version 1.0, Appendix A changes made	*Submission to CMS for Final SMHP Approval in response to 6/16/2011 Conditional Approval Letter 9/14/2011 via email.*
3.0	May 9, 2013	2013 program changes, e.g., patient volume	*Not approved*
4.0	July 22, 2013	*All*	*Submission to CMS for approval to implement 2014 Meaningful Use Stage 1 changes and update Arizona's current environment and HIT landscape. Approved November 19, 2013.*
5.0	*August 29,2014*	*All*	*Changes have been made throughout the document. Refer to Appendix B for a description of these changes including the addition of significant new information on the HIE vision, information on programmatic changes described in IAPD requests, new landscape assessment information, changes to program metrics and targets, and updates throughout.*
5.1	*December 10, 2014*	*Section C – Administer and Oversee the EHR Payment Program*	*Responding to questions 10, 15, 17, 18, 19, 22, 23, 26, 27, 28* *Section B question 10*

Version Number	Submission Date	Section	Comments
6.0	November 20, 2015	All	*Changes have been made throughout the document. Agency plans for EP Recruitment, MITA Assessment, Audit Support, Provider Satisfaction Survey, Expanded Functionality of ePIP for Administrative Workflows, Approval of EPs in HIE Onboarding, creation of state formula for Fair Share, CQM Consulting Support, Public Health MU Reporting Through the HIE, Behavioral and Clinical Health Integration and Use of the HIE, Revision of the Agency HIE Participation Agreement, Staff Augmentation for Administration and Programming Support*
7.0	November 2016	All	*Responses to questions from last year's approval letter have been added. A crosswalk is included to assist with finding responses. All tables and figures with available current data have been updated. HITECH funding requests have been included for approval for onboarding non-eligible Medicaid providers, (SMD #16-003) , new eRx campaign to stimulate increased use of e-prescribing, integrated IT Environment, MITA HITECH Roadmap development, eCQM reporting, SME Support future state of Public Health Reporting, inclusion of Prescription Drug Monitoring Database, onboarding of BH providers with non-HITECH funds, Staff Augmentation for Administration and Programming Support*
8.0	February 1, 2018	All	*Responses to questions from last year's approval letter have been added. A crosswalk is included to assist with finding responses. All tables and figures with available current data have been updated. HITECH funding requests have been included. This SMHP includes planning for program administration, auditing, eCQM support, environmental scan, audit strategy*

Version Number	Submission Date	Section	Comments
			update, new HIE onboarding rates and Connectivity of ADHS/EMS to the Health Information Exchange.
9.0	*May,24 2019*	*All*	*Updates to Section A landscape, new data for white space, eRX, payment and recruitment Section B HIE Governance Updates,Advisory Section C all updated Pre and Post pay operations and Section D Audit all updated.* *Section E Benchmarks and Goals are provided.*

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Introduction

Title IV, Division B of the American Reinvestment and Recovery Act (ARRA) established the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (now Promoting Interoperability Programs) as one component of the Health Information Technology for Economic and Clinical Health (HITECH) Act. Section 4201 of ARRA provides funding for the Arizona Health Care Cost Containment System (AHCCCS) to: 1) Administer the incentive payments to eligible professionals and hospitals; 2) Conduct adequate oversight of the program, including tracking meaningful use by providers and 3) Pursue initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information.

AHCCCS developed its SMHP using the guidance and template provided by CMS. The AHCCCS SMHP is divided into sections A through E, which also follow the SMHP template. These are preceded by this introduction addressing state and AHCCCS background. Each of sections A through E include references to the SMHP Companion Guide to demonstrate compliance with the required elements. Additional information in the appendices also helps to illustrate how the AHCCCS SMHP is in compliance with CMS requirements.

State and AHCCCS Background: Provides background information about the Agency and discusses how the State economy, budget and health care reform are affecting the Agency environment.

Section A: The State's "As Is" HIT Landscape: Describes the environmental scan and assessment conducted with CMS HIT Planning Advanced Planning Document funding and HIT activities impacting the Agency, members, and providers across the State.

Section B: The State's "To Be" HIT Landscape: Describes the vision of the HIT future over the next five years and identifies achievable goals, objectives and points of engagement needed to get the Agency from where it is now to where it wants to be in terms of adoption and use of certified EHRs as well as overall implementation requirements, strategic plans and tactical steps to successfully implement the program and its related HIT and HIE goals and objectives.

Section C: The Administration and Oversight of the Promoting Interoperability Incentive Payment Program: Describes Arizona's implementation plan and the processes to be employed to ensure that AHCCCS providers meet the federal and State statutory and regulatory requirements for the EHR/PI Incentive Program payments.

Section D: The State's Audit Strategy: Describes Arizona's audit controls and oversight strategy for the EHR Incentive/PI Program.

Section E: The State's HIT Roadmap: Provides a graphical and narrative pathway that shows migration from today ("As Is") to where it expects to be in five years ("To Be").

Section F: Appendices - Reference documents include:
- Acronyms
- A Description of AHCCCS Executive Offices and Divisions
- Flexibility Amendment Planning and Approval
- HIE Financial Statements (Submitted under separate cover)
- Statewide HIE Integration Plan – Top Priority Providers
- HIE Participants by Count and Type
- Health Current Strategic Plan

Administrative Structure

Arizona's Medicaid Promoting Interoperability (PI) Program is administered by AHCCCS, which is organized as described in Figure 1 below. Arizona has a state Health Information Technology (HIT) Coordinator who also serves as the Medicaid HIT Coordinator. The HIT Coordinator reports to the Deputy Director of Business Operations and provides leadership for the Agency's Promoting Interoperability Program and the development of the Agency's health information exchange (HIE) strategy.

Figure 1: Arizona Health Care Cost Containment System Organizational Chart
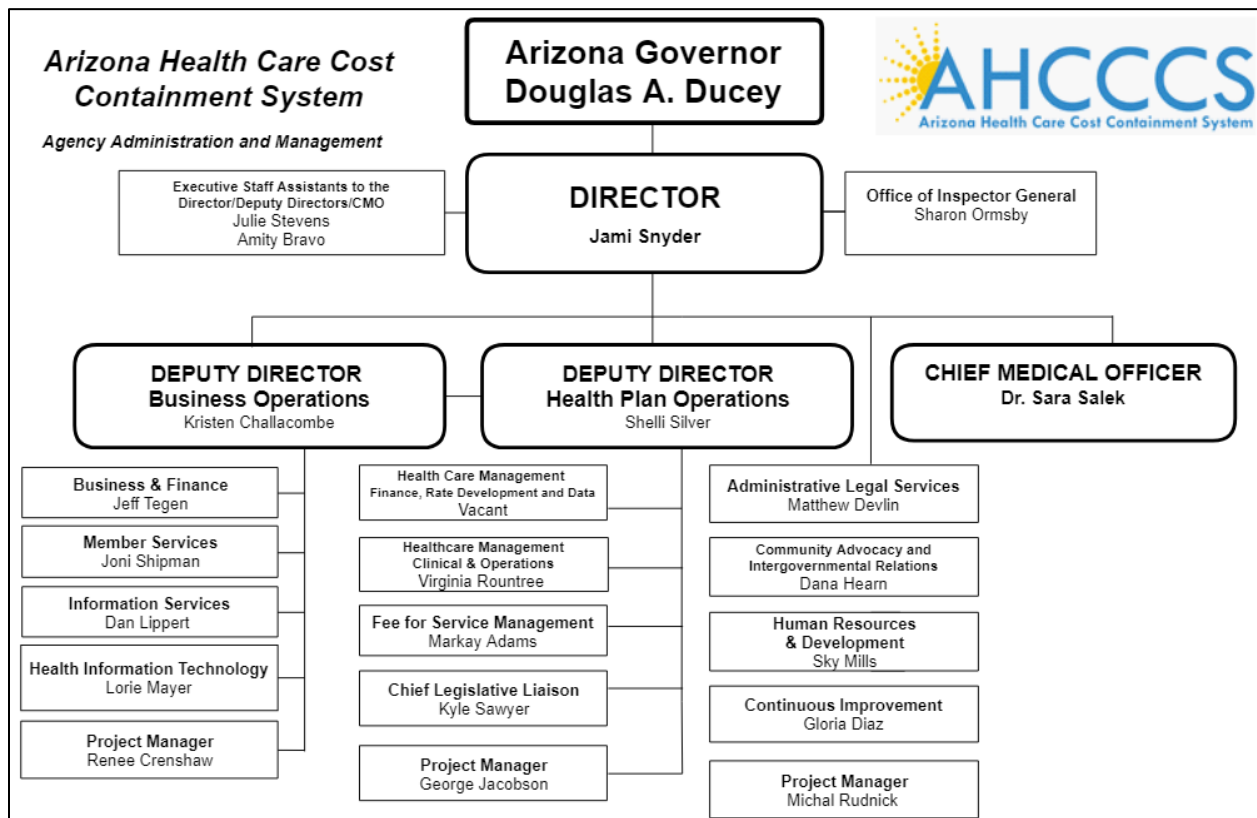
Data Source: AHCCCS OOD, May, 2019

Appendix F.2 describes AHCCCS Executive Offices included in the organizational chart above. For executive oversight of the PI Program (now Promoting Interoperability Incentive Program) and the Agency's HIT/HIE strategy development, the Agency updated how it is providing oversight of the Promoting Interoperability Incentive Program. The agency formed a smaller team made up of the Director, the Deputy Director of Business Operations and the Deputy Director of Health Plan Operations, the Chief Medical Officer, and the Agency HIT Coordinator.

This smaller team, called the Executive Health IT Team was formed to review recommendations, approve submission of documents and budgets, help set priorities, and ensure HIT/HIE is coordinated across all agency functions.

The Executive Health IT Team will review and approve major program changes to the AHCCCS Medicaid Promoting Interoperability Incentive Program. The members of the Executive Health IT Team are:

Table 1: AHCCCS Executive Health IT Team

Executive Health IT Team
- Director, AHCCCS - Deputy Director – Business Operations - AHCCCS - Deputy Director – Health Plan Operations - AHCCCS - Chief Medical Officer - Medicaid HIT Coordinator

Population Distribution

Arizona has fifteen counties, mostly rural, with population concentrations in Maricopa County (Phoenix), Pima County (Tucson), Coconino County (Flagstaff) and Yuma County (Yuma).. See the map below.

Figure 2: State of Arizona and Counties

Population Highlights

The AHCCCS Population Highlights provides detailed information regarding the number of members in the AHCCCS population receiving full Medicaid benefits. This category also provides statistics on those populations not eligible for full services, but fall into different categories of eligibility that receive limited health services through AHCCCS.

Table 2: AHCCCS Population Highlights

AHCCCS population:

	10/1/18	11/1/18	12/1/18	1/1/19	2/1/19	3/1/19
AHCCCS Complete Care	1,606,735	1,601,132	1,606,608	1,610,822	1,608,666	1,610,011
KidsCare	34,015	31,905	32,367	32,522	32,899	33,313
ALTCS [1]	63,250	66,374	63,758	63,999	66,191	64,356
Partial Services (FES, SLMB, QI-1,Transplant Option 1 & 2)	167,405	167,342	167,657	166,159	166,435	167,271
Total Population	1,871,405	1,866,753	1,870,390	1,873,502	1,874,191	1,874,951

[1.] Includes both the ALTCS population and the Freedom to Work (FTW) ALTCS members.

Data Source: AHCCCS Website: March, 2019

Agency's Priorities for Providing Comprehensive Quality Healthcare

AHCCCS has a multi-pronged strategy with numerous initiatives to address health care priorities. The four overarching agency priorities are:

1) Bending the Cost Curve While Improving the Member's Health Outcomes

2) Pursuing Continuous Quality Improvement

3) Reducing Fragmentation in Healthcare Delivery to Develop an Integrated System of Healthcare and

4) Maintaining a core organizational capacity, infrastructure and workforce

These efforts will accelerate the delivery system's evolution towards a value-based integrated model that focuses on whole person health throughout the continuum and in all settings. Each of the components of the Arizona strategy will improve population health, transform the health care delivery system and/or decrease per capita health care spending.

AHCCCS is also targeting efforts to specific areas where HIT and HIE can bring about significant change and progress: behavioral health; partnerships for integrated care; super-utilizers; American Indian care coordination; coordination between AHCCCS plans and Qualified Health Plans; and justice system transitions.

Further, AHCCCS recognizes that it must develop the mechanisms needed to incorporate electronic health information into clinical quality performance measures such as HEDIS measures, CHIPRA measures, Adult Core Measures and Meaningful Use measure validation.

Currently, the Agency receives administrative data in the form of encounters or claims from AHCCCS MCOs (Managed Care Organizations). However, the data that is in EHRs is richer and more actionable than what is currently available to AHCCCS. Certified EHR technology (CEHRT) will offer a much more robust and timely data source than administrative data, providing information such as laboratory values, indicating improvement in a member's health status or condition, and whether comprehensive preventive and follow-up services were provided during a visit, such as those required under the federal Early Periodic Screening, Diagnostic and Treatment Services (EPSDT) Program. Use of the data contained in EHRs may also provide an opportunity to focus intervention activities to improve clinical outcomes as well as enhance State and Federal reporting capabilities.

Section A The State's "As Is" HIT Landscape

A.1 Extent of EHR Adoption by Practitioners and Hospitals

(SMHP Companion Guide Question A #1)

Eligible Professional Participation in the EHR/PI Program

Arizona has made significant progress in administering the EHR Incentive /PI Program since the last submission of its SMHP in January of 2018. The table below represents, by year, the current number of new EPs registered with the Medicaid PI Program.

Table 3: Arizona EHR Incentive /PI Program by Provider Type

AHCCCS Providers Registered for PI Program by Registration Year										
Provider Type	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**Count**
CERTIFIED NURSE - MIDWIFE	35	18	9	14	9	28	23	9		145
DENTIST	57	62	48	72	68	76	78	5		466
DO-PHYSICIANS OSTEOPATH	44	57	62	81	52	76	50	11		433
MD-PHYSICIANS	456	542	445	458	357	655	442	146	7	3,508
PHYSICIAN ASSISTANT	7	25	4	11	8	10	11	1		77
REGISTERED NURSE PRACTITIONERS	134	162	179	147	162	217	292	52	6	1,351
Count Total by Calendar Year	**733**	**866**	**747**	**783**	**656**	**1,062**	**896**	**224**	**13**	**5,980**

Data Source: AHCCCS Pre-Pay PI Team, May, 2019

The table below represents the count and type of Arizona Hospitals registered in the Medicaid EHR Incentive /PI Program.

Table 4: Arizona Registered Eligible Hospitals

Hospital Type	IHS/638	Non-IHS/638	Count
Acute Hospital	7	53	60
Children's Hospital		3	3
Critical Access Hospital	2	12	14
Count Total by Calendar Year	**9**	**68**	**77**

Data Source: AHCCCS ePIP Registration Report, **May, 2019**

EP Program Attestations and Payments

There are 4,079 EPs that have achieved AIU and 1,577 EPs that have achieved MU Stage 1 and/or MU Stage 2 since the inception of the PI Program. See the table below.

Table 5: Arizona Promoting Interoperability Incentive Program Attestation Status – 2019

			Arizona Promoting Interoperability Program Attestation Status			
			Eligible Providers			
Type	Payment No.	Program Year	Stage	Attest	Attestations Submitted 2011 to May, 2019	Attestations Paid 2011 to May, 2019
AIU	1	2011, 2012, 2013, 2014, 2015, 2016	N/A	4,686	4,686	4,079
MU1	1	2012, 2013, 2014, 2015, 2016	Stage 1, Stage 2, Stage 2^M	148	1,919	1,552
	2	2012, 2013, 2014, 2015, 2016, 2017	Stage 1, Stage 2, Stage 2^M	1,768		
	3	2014	Stage 1, Stage 2	3		
MU2	2	2013, 2014, 2015, 2016, 2017	Stage 1, Stage 2, Stage 2^M	90	1,010	780
	3	2013, 2014, 2015, 2016, 2017	Stage 1, Stage 2, Stage 2^M	919		
	4	2014	Stage 1, Stage 2	1		
MU3	3	2014, 2015, 2016, 2017	Stage 1, Stage 2, Stage 2^M	40	491	360
	4	2014, 2015, 2016, 2017	Stage 1, Stage 2, Stage 2^M	451		
MU4	4	2015, 2016, 2017	Stage 2^M	23	254	178
	5	2015, 2016, 2017	Stage 2^M	231		
MU5	5	2016, 2017	Stage 2^M	3	82	19
	6	2016, 2017	Stage 2^M	79		
MU6	6	2017	Stage 2^M, Stage 3		0	0
			Total	8,442	8,442	6,968

Data Source: AHCCCS EHR Team, May, 2019

For the 2016 program year there was a special 1-day attestation limited ONLY to providers that experienced multiple issues that prevented them from attesting on or before the 2016 attestation deadline of June 30, 2017.

Eligible Hospital Program Attestations and Payment Summary

The following table is a summary of the payment history for every registered and eligible hospital since the inception of the EHR Incentive/PI Program in 2011. The table shows each hospital with the year they received first, second, third or fourth year payments.

Table 6: AHCCCS Payment Status of Eligible Hospitals as of May, 2019

Organization Name	dba (Alternate Organization Name)	Payment Years			
		PY1	PY2	PY3	PY4
Apache Junction Hospital, LLC	*Arizona Regional Medical Center*	2012	Term	Term	Term
Arizona Spine and Joint Hospital					
Banner Baywood Medical Center		2011	2012	2013	2014
Banner Boswell Medical Center		2011	2012	2013	Pend
Banner Del E Webb Medical Center		2011	2012	2013	2014
Banner Desert Medical Center		2011	2012	2013	2014
Banner Estrella Medical Center		2011	2012	2013	2014
Banner Gateway Medical Center		2012	2013	2014	Pend
Banner Goldfield Medical Center		2016			
Banner Good Samaritan Medical Center		2011	2012	2013	2014
Banner Health	*Banner Casa Grande Regional Medical Center*	2012	2013	2014	
Banner Health	*Banner Payson Medical Center*	2012	2013	2014	Rev
Banner Heart Hospital					
Banner Ironwood Medical Center		2014	Pend		
Banner Thunderbird Medical Center		2011	2012	2013	2014
Banner University Medical Center South Campus LLC	*(formerly University Physicians Hospital)*	2012	2014	2015	
Banner University Medical Center Tucson Campus LLC	*(formerly University Medical Center Corporation)*	2011	2013	2014	2015
Benson Hospital Corporation		2011	2012	2013	2014
Bisbee Hospital Association	*Copper Queen Community Hospital*	2011	2012	2013	
Bullhead City Hospital Corporation	*Western Arizona Regional Medical Center*	2012	2013	2014	Rev
Carondelet Heart & Vascular Institute		2011	Deny	Term	Term
Catholic Healthcare West	*Mercy Gilbert Medical Center*	2011	2013	2014	Pend
Catholic Healthcare West	*St. Joseph's Hospital and Medical Center*	2011	2013	2014	2015

Cobre Valley Regional Medical Center		2011	Pend		
community healthcare of douglas inc	*Southeast Arizona Medical Center*	2011	2013	Deny	Term
COMMUNITY HOSPITAL ASSOCIATION	*Wickenburg Community Hospital*	2012	2013	2014	Rev
DHEW IND HLTH SV HLTH SVS & MNTL	*Phoenix Indian Medical Center*	2011	2013	2014	
DHHS PHS IHS PHOENIX AREA	*Whiteriver Indian Hospital*	2012	2013	2014	
DHHS PHS IHS PHOENIX AREA	*Hopi Health Care Center*	2012	2014		
DHHS PHS IHS PHOENIX AREA	*Parker Indian Hospital*	2013	2014		
DHHS PHS NAIHS CHINLE COMPREHENSIVE HEALTH CARE FACILITY	*Chinle Comprehensive Health Care Facility*	2011	2012	2013	2014
Dignity Health	*Chandler Regional Hospital*	2012	2013	2014	Pend
Flagstaff Medical Center		2012	2014	2015	
Florence Hospital at Anthem, LLC		2015	Term	Term	Term
Florence Hospital, LLC					
Gila River Health Care Corporation	*(AHCCCS: Hu Hu Kam Memorial Hospital)*	2011	2013	2014	
Gilbert Hospital LLC		2013	Term	Term	Term
Hacienda Children's Hospital Inc.		2016			
Havasu Regional Medical Center LLC		2011	2012	2013	2014
HCH Tucson Holdings LLC	Holy Cross Hospital	2011	2012	2013	2014
Hospital Development of West Phoenix Inc	*West Valley Hospital*	2011	2013	2014	2015
Kingman Hospital Inc.	*Kingman Regional Medical Center*	2014	2015		
La Paz Regional Hospital, Inc		2011	2012	2013	
Los Ninos Hospital Inc.	*Hacienda De Los Niños*	2012	2013	2014	2015
Maricopa County Special Health Care District	*Maricopa Integrated Health System*	2011	2012	2013	Pend
Mayo Clinic Arizona	*Mayo Clinic Hospital*				
Mountain Vista Medical Center LP		2011	2012	2013	2014
MT Graham Regional Medical Center Inc.		2013	2014	Pend	
Northern Cochise Community Hospital Inc		2011	2012	2015	
Northwest Hospital LLC	*Northwest Medical Center*	2012	2013	Pend	Pend
Oro Valley Hospital LLC	*Northwest Medical Center Oro Valley*	2012	2013	2014	Rev

Orthopedic and Surgical Specialty Company, LLC	Arizona Orthopedic Surgical Hospital				
Page Hospital		2011	2012	2013	2014
PHC-Fort Mohave Inc	Valley View Medical Center	2011	2012	2013	2014
Phoenix Children's Hospital		2013	2014	2015	
RCHP-Sierra Vista Inc.	Sierra Vista Regional Health Center	2011	2012	2013	
San Carlos Apache Healthcare Corporation	(formerly DHHS PHS IHS PHOENIX AREA dba San Carlos Indian Hospital)	2013	2014		
Scottsdale Healthcare Hospitals	John C. Lincoln North Mountain Hospital	2012	2013	2014	2015
Scottsdale Healthcare Hospitals	Scottsdale Healthcare Osborn Medical Center	2011	2013	2014	
Scottsdale Healthcare Hospitals	Scottsdale Healthcare Shea Medical Center	2011	2013	2014	
Scottsdale Healthcare Hospitals	John C. Lincoln Deer Valley Hospital	2012	2013	2014	2015
Scottsdale Healthcare Hospitals	Scottsdale Healthcare Thompson Peak Medical Center	2011	Deny		
SMSJ Tucson Holdings LLC	St. Mary's Hospital	2011	2012	2013	2014
SMSJ Tucson Holdings LLC	St. Joseph's Hospital	2011	2012	2013	2014
St Luke's Medical Center LP	St Luke's Medical Center & Tempe St. Luke's Hospital	2011	2012	2013	2014
Summit Healthcare Association	Summit Healthcare Regional Medical Center	2013	2014	2015	
Surgical Specialty Hospital of Arizona LLC					
The Fort Defiance Indian Hospital Board, Incorporation	Fort Defiance Indian Hospital	2012	2013	2014	
TON SELLS HOSPITAL	Sells Hospital	2011	2012	2013	
TUBA CITY REGIONAL HEALTH CARE CORPORATION	Tuba City Indian Medical Center	2012	Deny		
Tucson Medical Center		2011	2012	2013	2014
Verde Valley Medical Center		2012	2014	2015	
VHS Acquisition Corporation	Abrazo Maryvale Campus	2011	2013	2014	Pend
VHS Acquisition Subsidary Number 1 Inc	Abrazo Scottsdale Campus (Paradise Valley Hospital)	2011	2013	2014	2015
VHS of Arrowhead Inc	Abrazo Arrowhead Campus	2011	2013	2014	2015
VHS of Phoenix Inc	Abrazo Central Campus (Phoenix Baptist Hospital)	2011	2013	2014	2015
White Mountain Communities Hospital Inc	White Mountain Regional Medical Center	2012	2013	2014	Rev
Winslow Memorial Hospital Inc	Little Colorado Medical Center	2012	2014	2015	
Yavapai Community Hospital Association dba YRMC Home Health Services	Yavapai Regional Medical Center West Campus	2012	2013	2014	Pend

| Yavapai Community Hospital Association dba YRMC Home Health Services | *Yavapai Regional Medical Center East Campus* | 2012 | 2013 | 2014 | Rev |
| Yuma Regional Medical Center | | 2011 | 2013 | 2014 | Rev |

Data Source: DHCM - EH Activity Report, May, 2019

Total Incentive Payments Received by EPs and EHs in Arizona

Payments have been withheld pending completion of the HHS OIG audit for all hospitals in the PI program regardless of their inclusion in the audit. That audit and appeals have now been completed and AHCCCS is proceeding with the payment procedures.

Note:

"Rev" means that the payment is under review.

"Pend" means payment is pending at the submission of this document.

"Term" means that the Hospital's participation in the program is terminated. In most cases it was due to hospital closure.

"Deny" means the hospital has been denied payment.

Where payment year designation is blank for all four years, the hospital did not register to participate in the program.

Arizona Program Payments

As noted in the figure below, the total amount of Medicare and Medicaid EHR Incentive /PI Program payments that have been received by Arizona Eligible Professionals and Eligible Hospitals (including Critical Access Hospitals) equals $691,717,318 as of October, 2018.

This is the most current monthly detail report, by state, provided by CMS.

Figure 3: Arizona Total EH and EP EHR/PI Program Payments October, 2018

AZ PI Incentive Payment Totals
October, 2018

- Medicaid EP Payments: $108,699,436
- Medicare EP ,Payments: $159,111,555
- Total AZ EP Payments:
- **$267,810,991**

- Dually Eligible EH Payments: $408,936,468
- Medicare EH Payments: $3,059,472
- Medicaid Only EH Payments: $11,910,387
- Total AZ EH Payments: **$423,906,327**

Total AZ PI Program Payments: $691,717,318

Data Source: CMS January 2011 to October, 2018

Summary of AHCCCS EHR/PI Program Activity ePIP Dashboard Report

On a monthly basis the agency compiles an EHR Incentive /PI Program Activity report which summarizes program payments by EP and EH by Type of Payment (AIU or MU) and by Program Year. See Table 7: EHR Incentive /PI Program Activity Chart (following) to view April, 2019's report.

In the Month of April, 2019 the agency has disbursed a total of 7,106 payments since the program started in 2011. There were 4,154 AIU Payments made to both Eligible Professionals and Eligible Hospitals. There were a total of 2,952 MU payments made with 2,809 MU payments made to Eligible Professionals and 143 made to Eligible Hospitals.

The agency is also tracking the number of Recoupments it has made to both Eligible Professionals and Eligible Hospitals. As of the end of April, 2019 a total of 10 Provider recoupments have been made. The Net EP payment counts for the total number of payments was 6,888. The total number of AIU payments was 4,079, and the number of MU payments disbursed equaled 2,809.

Net Provider Incentive Payments from the beginning of the EHR Incentive /PI Program are as follows:

The total amount of EHR (PI) Incentive Payments and Number of Payments are as follows:

For Program Year 2011 the total amount of Payments = $36,996,604.76 for 34 payments.

For Program Year 2012, the total amount of Payments = $71,970,183.64 for 1,520 payments.

For Program Year 2013, the total amount of Payments = $54,423,036.84 for 1,347 payments.

For Program Year 2014, the total amount of Payments = $40,041,389.06 for 853 payments.

For Program Year 2015, the total amount of Payments = $34,427,354.50 for 665 payments.

For Program Year 2016, the total amount of Payments = $23,461,000.22 for 1,057 payments.

For Program Year 2017, the total amount of Payments = $12,162,576.23 for 744 payments.

For Program Year 2018, the total amount of Payments = $6,738,602.10 for 763 payments.

For Program Year 2018, the total amount of Payments = $2,549,439.97 for 123 payments.

Net Provider Payments $282,770,187.32 for 7,106 payments.

Please see the table below for more detail.

Table 7: PI Program Activity

ePIP DASHBOARD REPORT						
PROMOTING INTEROPERABILITY PROGRAM ACTIVITY						
AS OF APRIL 30, 2019						
PROGRAM TO DATE PAYMENT SUMMARY						
Eligible Providers	Number of Payments	Number AIU Payments	Number MU Payments	AIU Payment Amount	MU Payment Amount	Total Payment Amount
EP Disbursements	6,897	4,084	2,813	$86,524,346.00	$25,267,674.00	$111,792,020.00
EH Disbursements	219	75	144	$82,791,447.12	$99,905,730.59	$182,697,177.71
All Provider Disbursements	7,116	4,159	2,957	$169,315,793.12	$125,173,404.59	$294,489,197.71
EP Recoupments (Full)	(9)	(5)	(4)	($106,250.00)	($34,000.00)	($140,250.00)
EH Recoupments* (Full)	(1)	0	(1)	($5,409,109.79)	($6,169,650.60)	($11,578,760.39)
All Provider Recoupments	(10)	(5)	(5)	($5,515,359.79)	($6,203,650.60)	($11,719,010.39)
Net EP Payments	6,888	4,079	2,809	$86,418,096.00	$25,233,674.00	$111,651,770.00
Net EH Payments	218	75	143	$77,382,337.33	$93,736,079.99	$171,118,417.32
Net Provider Payments	7,106	4,154	2,952	$163,800,433.33	$118,969,753.99	$282,770,187.32

Data Source: AHCCCS EHR Team, Activity Report April, 2019

EHR Environmental Scan

Environmental Scan of Eligible Providers to Non Eligible Providers

In Arizona, if a provider has seen one Medicaid patient, that provider needs to enroll in the agency's provider registration system. Once a provider is enrolled they receive an AHCCCS ID number which allows them to bill for the delivery of clinical services. Consequently there are a very high number of Agency registered providers in the agency's provider registration system, but the large numbers of enrolled providers do not indicate patient volume eligibility for this program.

The agency currently has 30,395 MD's and DO's registered as AHCCCS providers in its Provider Registration System. According to our current PI Program Payment Registrations, only 13% of the total number of MD's and DO's registered with the agency have registered with the PI Program

As demonstrated in the table below, there are 6,615 Nurse Practitioners registered with the AHCCCS Provider Registration system and 1,351 have registered with the EHR Incentive /PI Program. There are 2,013 Dentists registered with the AHCCCS Provider Registration System and 466 have registered with the EHR Incentive /PI Program. There are almost 52.5% of AHCCCS Registered Certified Nurse Midwives participating in the EHR Incentive /PI Program while only 2.2% of Physician Assistants are participating due to the strict definition of needing to "so lead an FQHC". Overall, the percentage of AHCCCS Providers Registered for the PI Program compared to the Total Number of Active AHCCCS Providers is 14.0%.

Of the 5,980 Medicaid providers actively registered in the PI Program, 4,213 or 70.5 percent are receiving PI Program payments.

Table 8: Total Number of AHCCCS Registered Providers by type Compared to PI I Registered Providers

AHCCCS Providers Registered for the PI Program by Type					
Provider Type	Active AHCCCS Providers	PI Registered Providers	Percent of PI Providers Registered	ePIP Providers Receiving PI Payments	Percent of ePIP Providers Receiving PI Payments
Certified Nurse - Midwife	276	145	52.5%	105	72.4%
Dentist	2,013	466	23.1%	305	65.5%
DO – Osteopath Physician	3,131	433	13.8%	317	73.2%
MD – Allopath Physician	27,264	3,508	12.9%	2,724	77.7%
Physician Assistant	3,515	77	2.2%	10	13.0%
Registered Nurse Practitioner	6,615	1,351	20.4%	775	57.4%
Total	42,814	5,980	14.0%	4,236	70.8%

Data Source: AHCCCS Office of Business Intelligence March and DHCM May, 2019

Environmental Scan of MDs and DOs by the Arizona State University Survey of Historical Trends in Physician EHR Adoption

Through a comprehensive survey of all licensed physicians, the Center for Health Information and Research (CHiR) at Arizona State University (ASU) has been tracking provider feedback about their adoption since 2009. According to the March 2018 survey "Physicians Use, Exchange and Evaluation of Electronic Medical Records" the results show the percentage of Arizona provider use of key EHR functionality as well as the percent to which they are sending or receiving information to or from other providers through their EHR.

AHCCCS is focused on moving providers through the stages of Meaningful Use, promoting e-prescribing and working with the state Department of Health to facilitate Public Health reporting through use of the EHR and the state HIE. This figure (below) underscores the need for the SMA's ongoing support of onboarding providers through the state level HIE to assure that the use of key EHR functions is maximized by interoperability with other providers.

Figure 4. Summary Utilization of Available EMR Functions, 2016-2018
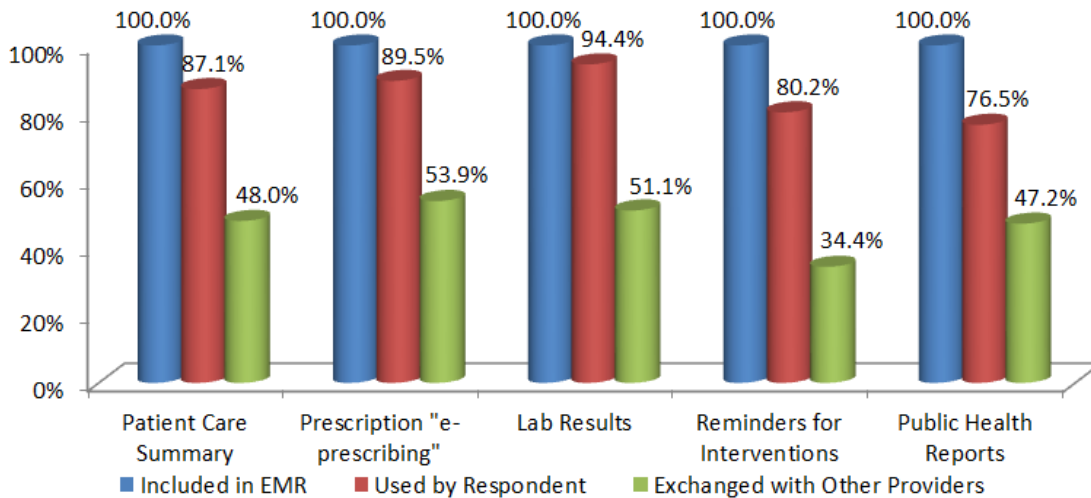
Source: AMB, ABOE Survey Data, April 2016–March 2018.

Note: The data in this table only include those physicians that answered *"Yes"* to the Include question for each EMR function. Furthermore, the data only includes those that answered both the Used and Exchanged questions for each EMR functions; if either question was left blank the physician was excluded from the table for that function.

The data exclude physicians in hospitals or hospital owned practices.

Other findings include:

- EHR use is the least prevalent among solo practitioners.

- There is little difference in the prevalence of EHR use between the two most urban counties and several rural counties.

- Many practitioners who use EHRs are actually <u>not</u> dissatisfied with their EHRs; rather physicians recognize their EHR can offer advantages not available from scanned records or paper medical records.

Other key findings are summarized in this Survey:

- There are 26,076 Total Physician License Renewals that were performed over the two year period

- Each Respondent Represents 3.2 physicians in active practice.

- There were 5,635 Survey Respondents excluding retired/semi-retired physicians.

- There were 3,656 AHCCCS Allopathic Physicians and 1,694 AHCCCS Osteopathic Physicians that completed the survey

- Based on 26,076 total physician license renewals as of August, 2018, the total licensed physicians employed in Arizona were 17,304 of which 14,995 were AHCCCS registered Physicians.

EHR Physician Use by Physician Practice Type

Physicians that are operating in physician owned solo practices were the lowest utilizers of EHR technology at 74.3%.

Community or Rural health Centers were slightly lower than the last survey achieving a utilization rate of 94.8% and Federal Government or Hospital or Clinics remained virtually the same at 97%.

The table below shows the EHR utilization rate by provider practice type. The physicians that are in Hospice, SNF, Mental Health and Independent Contractors recorded the highest EHR utilization rate at 100%.

Table 9: EMR Utilization by Type of Practice, 2016-2018 (N = 2,594)

Type of Practice	Utilization Rates
Physician Owned Solo Practice	74.3%
Physician Owned Group Practice	91.1%
Hospital/Medical School Group Practice	96.1%
Community or Rural Health Center	94.8%
Federal Government Hospital or Clinic	97.0%
Private Hospital System	94.0%
Non-Hospital Private Outpatient Facility	88.3%
Medical School/University Research Center	93.4%
Health Insurer/Health Related Organization that does not provide care	72.5%
City, State or County Clinic or Hospital System	86.2%
Other	84.9%
Hospice or SNF	100.0%
Independent Contractor	100.0%
Medical Consultant	91.6%
Mental/Behavioral Health	100.0%

Source: AMB, ABOE Survey Data, April 2016-March 2018.

Note: Rates = % of physicians within each practice type. 2,286 respondents were missing type of practice. 1,227 respondents were missing EMR utilization.

Description of Medicaid Provider Practice by Practice Setting Type

The table below is a summary of the actual numbers of Medicaid providers by the type of practice setting in which AHCCCS physician providers are providing care. Compared to all other providers, Medicaid practices follow the same trends as found in the general physician population.

Table 10: Type of Practice Setting of AHCCCS Physician Providers 2016-2018 (N=3,064)

Type of Practice	Number of Physicians	Percent
Physician Owned Solo Practice	494	16.1%
Physician Owned Group Practice	1,002	32.7%
Hospital/Medical School Group Practice	565	18.4%
Community or Rural Health Center	160	5.2%
Federal Government Hospital or Clinic	144	4.6%
Private Hospital System	225	7.3%
Non-Hospital Private Outpatient Facility	127	4.1%
Medical School/University Research Center	132	4.3%
Health Insurer/Health Related Organization that does not provide care	58	1.8%
City, State or County Clinic or Hospital System	29	0.9%
Other	127	4.1%
Hospice or SNF	5	0.2%
Independent Contractor	7	0.2%
Medical Consultant	29	0.9%
Mental/Behavioral Health	3	0.0%

Source: AMB, ABOE Survey Data, April 2016-March 2018.

Note: 2,286 physicians did not report type of practice (missing). Percentages are based on responses. The five practice types listed under the "Other" section are a subset of the total types included in the Other category.

Physician EHR Utilization by County

80% of the state of Arizona's population lives in two counties Maricopa County (Phoenix) and Pima County (Tucson). Physician practice locations parallel the general population where the largest number of physicians are in Maricopa County followed by Pima County. In the chart below, in a unique trend, some of the state's most rural counties have a higher percentage of Physicians that reported utilizing an EHR than compared to some of the metropolitan counties.

The figure below also shows the percentage of utilization of EHR technology of Medicaid physicians compared to non-Medicaid physicians. It should be noted that in the two most populous counties, Pima and Maricopa, the percentage of Medicaid physicians using EHR technology exceeds the number of non-Medicaid physicians.

Figure 5: EMR Utilization by County and AHCCCS vs. Non-AHCCCS, 2016- 2018

Source: AMB, ABOE Survey Data, April 2015-March 2017.

Note: For AHCCCS physicians, 2,432 respondents did not identify a method of storing medical records and 355 respondents did not identify their county. For Non-AHCCCS physicians, 243 respondents did not identify a method of storing medical records and 63 respondents did not identify their county. Pima and Maricopa Counties represent the urban areas. All other counties represent the rural areas. Greenlee County had no respondents. Graham and La Paz had no Non-AHCCCS respondents.

Provider Environmental Scan (continued): EHR Vendor Types

Eligible Professional Users by EHR Vendor

In physician groups greater than 130, the two vendors with the largest number of providers in Arizona are Cerner and Epic. Banner Health is the largest health system in the state and uses Cerner for its Hospital EHR systems. Banner Health completed the purchase of the University Physician's Hospital and University Medical Center and will be switching them from EPIC to Cerner. Yuma Medical, Mayo Clinic Hospital and HonorHealth hospital system all use Epic. Allscripts, NextGen and eClinicalworks are also popular with hospital and practice based physicians.

See the table below for a graphical demonstration.

Figure 6: Number of EMR Users by Vendor ≥ 130 Users, 2016 - 2018
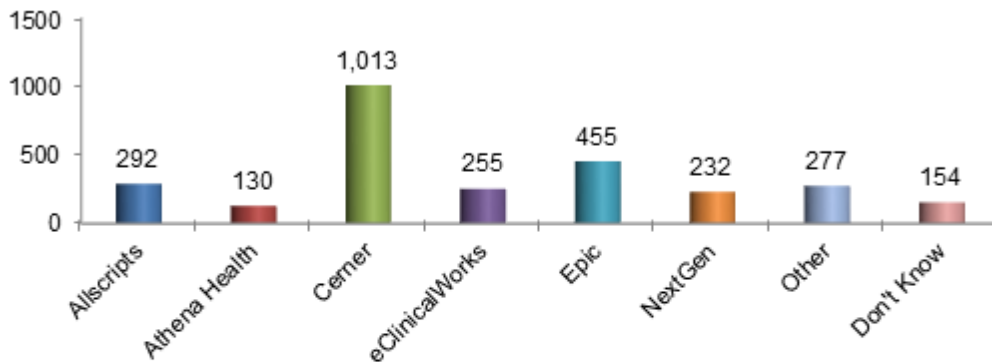
Source: AMB, ABOE Survey Data, April 2016-March 2018.

Note: The "Other" vendor excludes vendors contracted with government hospitals/clinics.

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Eligible Hospitals - Choice of CEHRT Vendor

The table below is a summary provided by Health Current as to the name of their participating Hospital and Hospital System and the EHR vendors they are using as of March, 2019**.**

Table 11: Health Current - Arizona Hospital CEHRT Vendors

Hospital/System	EHR System
Abrazo Community Health Network	Cerner Corporation
Banner Health	Cerner Corporation
Benson Hospital	athenahealth, Inc.
Canyon Vista Medical Center	
Carondelet Health Network	Cerner Corporation
Chinle Comprehensive Health Care Facility	Indian Health Service
Cobalt Rehabilitation Hospital	
Cobre Valley Regional Medical Center	Medical Information Technology, Inc.
Copper Queen Community Hospital	Cerner Corporation
Dignity Health	Cerner Corporation
Encompass Health Rehabilitation Hospital of East Valley	Cerner Corporation
Encompass Health Rehabilitation Hospital of Northwest Tucson	
Encompass Health Rehabilitation Hospital of Scottsdale	Cerner Corporation
Encompass Health Rehabilitation Institute of Tucson	Cerner Corporation
Encompass Health Valley of the Sun Rehabilitation Hospital	Cerner Corporation
Fort Defiance Indian Hospital - Tse'hootsooi' Hospital	
Gila River Health Care	NextGen Healthcare Information Systems, Inc.
Hacienda Healthcare	Healthland
Havasu Regional Medical Center	MEDHOST
HonorHealth	Epic Systems Corporation
IASIS Healthcare	McKesson
Kingman Regional Medical Center	Medical Information Technology, Inc.
La Paz Regional Hospital	Computers Programs and Systems, Inc. (CPSI)
Little Colorado Medical Center	Cerner Corporation
Maricopa Integrated Health System	Epic Systems Corporation
Mount Graham Regional Medical Center	Medical Information Technology, Inc.
Mountain Valley Regional Rehabilitation Hospital	
Northern Arizona Healthcare	Cerner Corporation
Northern Cochise Community Hospital	MEDHOST
Northwest Medical Center	Cerner Corporation
Phoenix Children's Hospital	Allscripts
Promise Hospital of Phoenix, Inc.	Medical Information Technology, Inc.
Rehabilitation Hospital of Northern Arizona	
Santa Cruz Valley Regional Hospital	Computers Programs and Systems, Inc. (CPSI)
Select Specialty Hospital - Phoenix	MEDHOST
Select Specialty Hospital - Phoenix Downtown	MEDHOST
Summit Healthcare	athenahealth, Inc.
TMC Healthcare	Epic Systems Corporation
Tuba City Medical Center	Allscripts
Valley View Medical Center	MEDHOST
Western Arizona Regional Medical Center	MEDHOST
White Mountain Regional Medical Center	Computers Programs and Systems, Inc. (CPSI)
Wickenburg Community Hospital	athenahealth, Inc.
Yavapai Regional Medical Center	Cerner Corporation
Yuma Regional Medical Center	Epic Systems Corporation
Yuma Rehabilitation Hospital	Cerner Corporation

Source: Health Current March, 2019

Eligible Professional White Space Analysis-2019

In order to maximize the number of Medicaid providers participating in the PI Program, the SMA, in the past, has conducted a white space analysis to determine the geographic location of non-participating providers. A data pull was conducted comparing the number of potentially eligible Medicaid providers, by county, that had not registered in the PI Program. This data was adjusted for EPs that were already participating in the Medicare Promoting Interoperability Program and filtered to include only those practices that had a minimum of 500 Medicaid office visits per year in the first three years of the analysis.

For this white space analysis the volume of Medicaid office visits per year in the most recent year (2018) was filtered at 800 Medicaid patient office visits per year and showed a moderate overall decline in the number of providers not participating in ePIP. This suggests that the larger the Medicaid patient volume in the practice, the more likely the Medicaid provider was to be participating in the PI Program and be registered in ePIP.

Since new registration in the Incentive Program has been closed since 2016, the decline in non-ePIP provider counts in the urban areas in 2018 is a reflection of the adjusted filter capturing more registered providers. We suggest that the (moderate) increase of Medicaid providers, not registered in ePIP, is due to outward migration of providers from urban to rural areas who are expanding their number of practice locations but were non-participants in the incentive program in other practice locations.
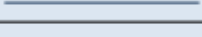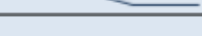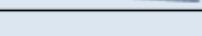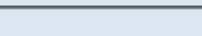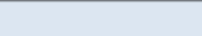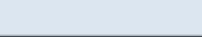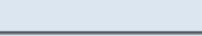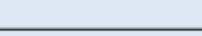
AHCCCS continues to fund an Education and Outreach program through its contract with Health Current, the former Regional Extension Center. The focus of this education and outreach is twofold:

- Expand the number of registered Medicaid providers moving through advanced stages of meaningful use.

- Expand the number of Medicaid providers engaged in interoperability through the health information exchange (HIE)

The 2019 MU objectives maintain a requirement for engaging in Health Information Exchange. As shown below in Table 12, the continued, overall decrease in eligible Medicaid providers not registered in ePIP demonstrates, in part, the effectiveness of education and outreach which has been ongoing since 2015.

Table 12: Eligible Non-participating Providers in the PI Program by County

County	2015	2016	2017	2018	Four Year Trend Line
Apache	4	5	3	2	
Cochise	19	13	7	9	
Coconino	9	11	7	9	
Gila	7	3	4	6	
Graham	7	3	0	3	
Greenlee	0	0	0	0	
La Paz	1	0	0	1	
Maricopa	480	442	304	290	
Mohave	31	32	28	27	
Navajo	10	10	6	8	
Pima	97	101	64	65	
Pinal	26	15	14	12	
Santa Cruz	8	4	4	3	
Yavapai	21	19	15	19	
Yuma	28	31	25	19	
Total	748	689	481	473	

Data Source: AHCCCS Office of Business Intelligence, April, 2019

Environmental Scan Actions

Since 2015 the SMA has been focused on improving communication and customer service to providers through the methods listed below:

- The SMA has completed its agency wide web redesign and as part of this, the PI team has already initiated work to improve the navigation for EPs for the PI program and has posted a portion of the updated education materials. It was completed by January, 2017 and updates are ongoing.

- To improve agency timeliness for response regarding provider questions and payments, the SMA has:
  - Evaluated the ePIP portal for potential modifications for automated response to issues,
  - Hired additional temporary staff to assist with customer service and data research
  - Evaluated risk assessment criteria and training regarding pre-payment audits.
  - Updated EP Reference Guides
  - Monthly Provider Outreach Activities (webinars, newsletters, email blasts)
  - Added Peer Review Audit to Pre-Payment Audit process
  - Conducted MU Training for all staff

- Patient Volume and Medicaid Patient Encounter reporting requirements have been assessed in the context of improvement of provider education materials and format.
  - Through our Education and Outreach contract with Health Current, webinars have been conducted on Medicaid Patient Volume and Hospital Based Encounters. Copies of the Power Points have been posted on the AHCCCS website at the PI Program webpage.
  - Hospital Payment worksheets have been updated with the input from our Audit subject matter expert Myers and Stauffer.
  - An individual Patient Volume webinar has also been conducted and the PowerPoint posted. EP Reference Guides have been updated and placed on the AHCCCS website.

- To assist providers with attesting for Program Year 2016 (PY2016), Health Current conducted webinars providing information to providers on the attestation process including accessing ePIP system and reports needed, A copy of the Power Point was posted on the AHCCCS website until the close of PY2016.

- Program Year 2017 (PY2017) reporting requirements were reviewed in a webinar that was conducted that included tips on using health information technology in a meaningful way. A copy of the Power Point has been posted on the AHCCCS website at the PI Program webpage.

- AHCCCS has expanded the scope of work of the Education and Outreach contractor to allow for it to provide training and education in the use of electronic prescriptions to facilitate compliance with that MU measure.

- Health Current has conducted webinars on electronic prescribing and electronic prescribing of controlled substances. Copies of the Power Points have been posted on the AHCCCS website at the PI Program webpage.

- Additionally, Health Current, in working with the Health Plans, has produced information sheets on electronic prescribing which have been distributed to participating providers.

- AHCCCS has procured consulting services through its Education and Outreach contract to provide support for EP migration through MU stages.

In addition to this online survey of eligible professionals, the agency has gotten provider feedback from the staff that is performing the agency's Education and Outreach project. The feedback from the outreach matches closely with the online survey results.

A.2 Broadband Internet Access Challenges to Rural Areas

(SMHP Companion Guide Question A #2)

Broadband Internet Access Coverage

Arizona is largely rural with high speed broadband access concentrated in a couple metropolitan areas and a few smaller cities and towns. The two metropolitan areas of Phoenix and Tucson account for over 80 percent of the state's population. Broadband internet access does pose a challenge to the state's rural areas for HIT/HIE functionality. The Arizona Strategic Enterprise Technology Office, or ASET, is the agency who coordinates and implements broadband access.

. The table below shows the recommended minimum bandwidth speeds for a variety of physician group and medical facility sizes.

Table 13: Recommended Bandwidth Speeds for EHRs

Recommended Minimum Bandwidth Speeds	
Single Physician Practice	4 Mbps
Small Physician Practice (2-4 physicians)	10 Mbps
Nursing Home	10 Mbps
Rural Health Clinic (approximately 5 physicians)	10 Mbps
Clinic/Large Physician Practice (5-25 physicians)	25 Mbps
Hospital	100 Mbps
Academic/Large Medical Center	1,000 Mbps

Data Source: Health IT.gov (2019) https://www.healthit.gov/providers-professionals/faqs/what-recommended-bandwidth-different-types-health-care-providers

(Section A.2 Continued – Internet Access Challenges to Rural Areas)

The following table shows the percentage of county population that has access to 25 Mbps network speed. The average statewide speed is 38.8 Mbps but this is misleading due to the imbalance between Arizona's urban and rural population distribution. For the purposes of EHR utilization, there are very high speeds for 80% of the population and very low speeds for the rural population. As you can see from the chart below, not all counties have access to broadband network speeds to support a large physician practice at 25 Mbps. This could impact FQHC's that operate in rural areas and Critical Access Hospital's.

Table 14: Percentage of County Population with Broadband Speeds at 25 Mbps

Percentage of County Population With Broadband Speeds at 25 Megabits Per Second (Mbps)				
County	Population	Broadband Speed @ 25 mbps	Broadband Speed @ 100 mbps	Broadband Speed @ 1 Gbit
Apache	71,518	00.2%	00.1%	00.1%
Cochise	131,346	61.1%	55.4%	05.7%
Coconino	116,320	64.9%	63.1%	60.1%
Gila	53,597	72.0%	70.0%	31.0%
Graham	37,220	68.2%	68.2%	67.2%
Greenlee	8,437	59.8%	59.8%	59.6%
La Paz	20,489	48.1%	34.1%	03.5%
Maricopa	3,817,117	94.1%	92.7%	04.5%
Mohave	200,186	80.6%	79.3%	77.6%
Navajo	107,449	47.2%	47.2%	47.2%
Pima	980,263	93.1%	92.7%	02.5%
Pinal	375,770	72.4%	69.9%	33.9%
Santa Cruz	47,420	83.9%	82.5%	00.0%
Yavapai	211,033	88.3%	85.4%	68.4%
Yuma	195,751	91.6%	91.0 %	00.0%

Data Source: Arizona Association of Counties March 2019 and
Broadband Now http://broadbandnow.com/Arizona , March 2019

Broadband Availability

According to the figure below, Arizona has communities that experience a range of broadband speeds. The speeds range from 1.5 Mbps to greater than 1 Gbps. Since the last submission of the SMHP there has been no change to the speed map by county, below.

Figure 7: Arizona Broadband Speed Map by County
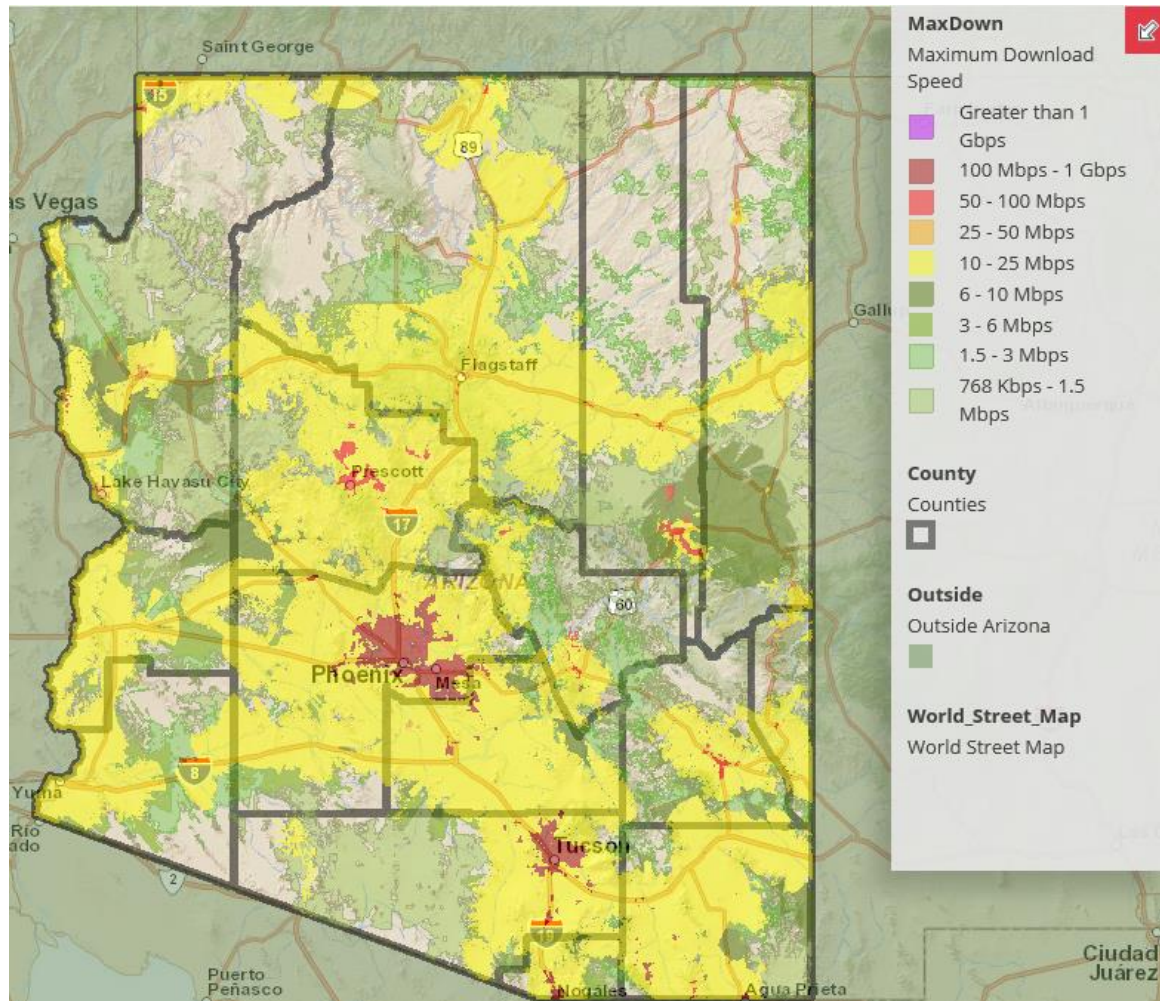
Data Source: Arizona Strategic Enterprise Technology, 2015
http://broadbandmap.az.gov/broadbandapp/Viewer.aspx#ajax/map.html

Broadband Availability and Hospital/Clinic Location

A comparison of the broadband speed coverage map (above) to the healthcare provider distribution figure (below) shows both Hospitals and Clinics in areas that could be experiencing problems in implementing HIT systems.

While the heaviest concentration of Hospitals and Clinics are in Phoenix and Tucson metro areas, which have adequate broadband coverage, lower broadband speeds are shown in the rural areas resulting in challenges to implementation and use of robust health IT systems.

Figure 8: Arizona Hospital and Clinic Locations Requiring Broadband
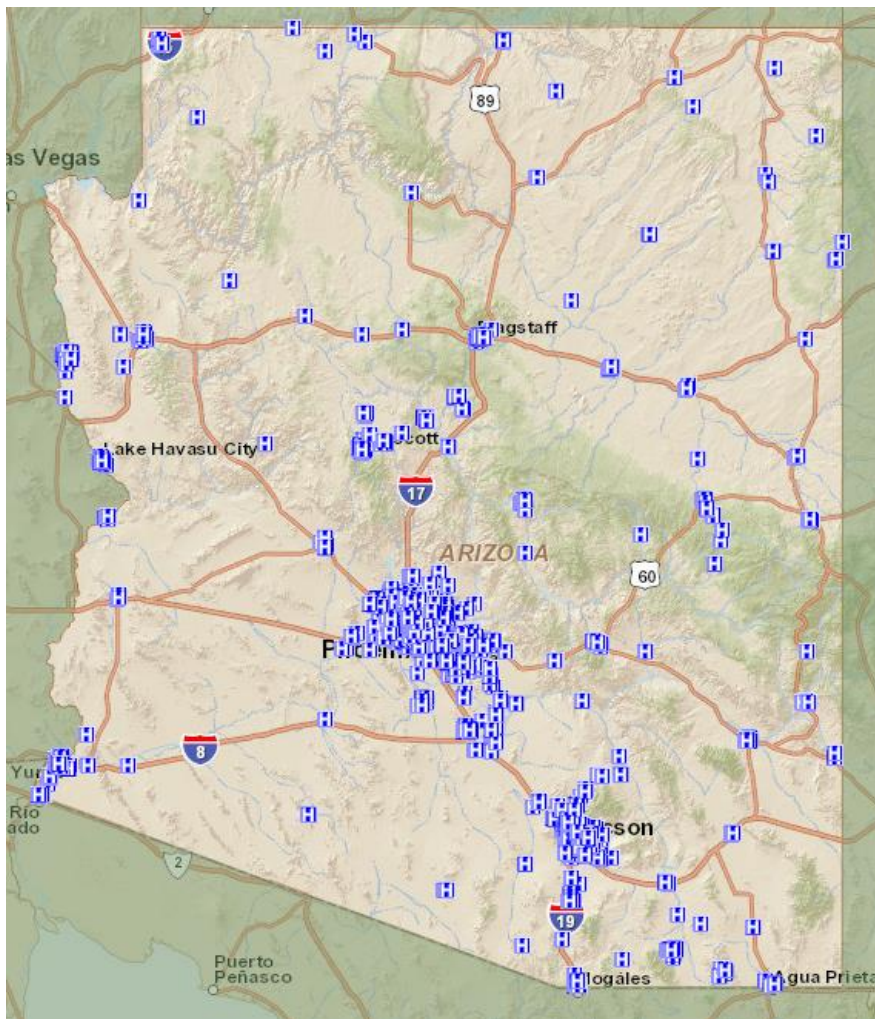
Data Source: All Broadband Speed Heat maps This Section - Arizona Strategic Enterprise Technology ASET), 2015 (http://broadbandmap.az.gov/broadbandapp/#ajax/map.html)

A.3 FQHC HIT/HIE HRSA Grant Funding

(SMHP Companion Guide Question A #3)

HRSA Grant Funding

AHCCCS has reviewed the open FQHC grant opportunities on the HRSA website for Arizona FQHCs for 2019. There are none directly related to HIT/HIE grants. For FFY 2018 there were 12 $5,000 grant awards given to Arizona FQHC's for "Electronic Health Record Reports" identified on the HRSA site.

Table 15: EPs in FQHCs Receiving Medicaid PI Program Payments

Federally Qualified Health Centers - 2019

FQHC/RHC Facility Legal Business Name	dba (Alternate Organization Name)	Facility Type	Attest	Paid	Number of EPs	Payment Years					
						1	2	3	4	5	6
Adelante Healthcare, Inc.		FQHC	✓	✓	60	25	21	14			
Ajo Community Health Center	Desert Senita Community Health Center	FQHC	✓	✓	10	10	0	0			
Canyonlands Community Healthcare		FQHC	✓	✓	16	16	0	0			
Chiricahua Community Health Centers, Inc.	Business Office	FQHC	✓	✓	51	35	15	1			
Circle the City *(FQHC effective 06.15.2015)*		FQHC	✗	☐	0	0	0	0			
County of Yavapai DBA Yavapai County Community Health Services	Yavapai County Community Health Services	FQHC	✓	✓	32	23	8	1			
El Rio Santa Cruz Neighborhood Health Center		FQHC	✓	✓	586	204	147	113	75	47	
Healthcare for the Homeless	Maricopa County Health Care for the Homeless	FQHC	✓	✓	1	1	0	0			
Horizon Health and Wellness, Inc. *(formerly Mountain Health and Wellness)*		FQHC	✓	✓	12	11	1	0			
Marana Health Center Inc.		FQHC	✓	✓	77	68	8	1			
Maricopa County Special Health Care District	Maricopa Integrated Health System	FQHC	✓	✓	570	245	144	92	55	34	
Mariposa Community Health Center		FQHC	✓	✓	34	17	11	6			
Mountain Park Health Center		FQHC	✓	✓	231	120	65	36	10		

Native American Community Health Center, Inc.	Native Health	FQHC	✓	✓	6	6	0	0		
Native Americans for Community Action, Inc.		FQHC	✗	☐	0	0	0	0		
Neighborhood Outreach Access to Health	Formerly Scottsdale Healthcare Hospitals dba Family Practice Center	FQHC	✓	✓	12	9	3	0		
North Country Healthcare Inc.		FQHC	✓	✓	141	80	42	17	2	
St. Elizabeth's Health Center *(FQHC effective 04.01.2015)*		FQHC	✓	✓	20	9	8	3		
Sun Life Family Health Center, Inc.	Sun Life Family Health Center	FQHC	✓	✓	39	34	5	0		
Sunset Community Health Center		FQHC	✓	✓	71	47	16	8		
Terros, Inc. *(FQHC effective 04.01.2015)*		FQHC	✗	☐	0	0	0	0		
United Community Health Center Maria Auxilladora Inc.	Continental Family Med.	FQHC	✓	✓	51	33	12	6		
Valle Del Sol, Inc. *(FQHC effective 04.01.2015)*		FQHC	✗	☐	0	0	0	0		
Wesley Community Center Inc.		FQHC	✓	✓	8	8	0	0		
					2,028	1,001	506	298	142	81	0

Data Source: DHCM Activity Report May, 2019

Table 16: Rural Health Centers 2019 Payment and Terminated Status

FQHC/RHC Facility Legal Business Name	dba (Alternate Organization Name)	Facility Type	Attest	Paid	Number of EPs	Payment Years					
						1	2	3	4	5	6
Bisbee Hospital Association	Copper Queen Community Hospital	RHC	✓	✓	50	23	16	8	3		
Cobre Valley Regional Medical Center	Cobre Valley Community Hospital	RHC	✓	✓	4	4	0	0			
Community Hospital Association Inc.	Wickenburg Community Hospital	RHC	✗	☐	0	0	0	0			
La Paz Regional Hospital, Inc.	La Paz Regional Hospital	RHC	✓	✓	3	2	1	0			
Mount Graham Regional Medical Center	Copper Mountain Clinic	RHC	✗	☐	0	0	0	0			
Northern Cochise Community Hospital Inc.		RHC	✗	☐	0	0	0	0			
Parker Medical Center, LTD *(RHC effective 12.14.2015)*		RHC	✓	✓	1	0	0	0	1		
San Luis Walk In Clinic, Inc.		RHC	✓	✓	24	18	6	0			
Summit Healthcare Association dba Summit Healthcare Specialty Physicians	Summit Healthcare RMC	RHC	✓	✓	4	2	1	1			
					86	49	24	9	4	0	0

Terminated RHCs											
Community Healthcare of Douglas Inc. (Terminated 09.29.2011)	Southeast Arizona Medical Center	RHC	✗	☐	0	0	0	0	0	0	0
Rightway Healthcare LLC (Terminated 06.01.2013)		RHC	✓	✓	2	2	0	0	0	0	0
River Cities Community Clinic Inc. (Terminated 12.30.2011)		RHC	✗	☐	0	0	0	0	0	0	0
					2	2	0	0	0	0	0

Data Source: DHCM Activity Report May, 2019

A.4 VA and IHS Operation of Electronic Health Records

(SMHP Companion Guide Question A #4)

Veterans Administration (VA) and Indian Health Services (IHS) EHR Adoption and Health Information Exchange Connectivity

Veterans Administration (VA) Facilities EHR Adoption and Health Information Exchange Connectivity

The VA operates three campuses with multiple clinical facilities in Arizona. The VA is currently participating in the Federal Health Architecture Work Plan and is using the eHealth Exchange (formally NwHIN Exchange and an initiative of The Sequoia Project) as its required transport for health data. All state HIEs must meet eHealth Exchange requirements before VA data will be made available to any other HIE.

Health Current has received eHealth Exchange certification with its current technology platform, Mirth, and is positioned to accept messages and exchange with approved federal partners including the VA and Social Security Administration (SSA). Health Current is leading outreach efforts, including data validation to meet national standards to exchange data, with the VA to secure their participation in the Arizona HIE.

The largest VA campus is in Phoenix, a clinical Level 1 facility, and which provides acute medical, surgical and psychiatric inpatient care as well as rehabilitation medicine, and neurological care. There are two other campuses – one in Prescott Arizona (Northern area) and a campus in Southern Arizona in Tucson.

Indian Health Service EHR Adoption and Health Information Exchange Connectivity

Current Indian Health Service HIT/HIE Initiatives - Arizona is home to over 350,000 American Indians, with approximately 150,000 of who are enrolled in AHCCCS. The IHS, tribal health programs operated under P.L. 93-638, and urban Indian Health Programs (collectively referred to as I/T/U) are the primary providers of health care to the majority of the estimated 117,000 American Indians enrolled in the American Indian Health Program as of March 2019.

Three IHS Area Offices oversee a number of hospitals and health care centers in the state of Arizona. There are approximately 9 medical hospitals and 23 health centers that are tribal health programs operated under P.L. 93-638. Additionally, there are a number of behavioral health programs operated under P.L. 93- 638 among the 22 tribes in Arizona. Three urban Indian health programs oversee four health centers that are located in the urban centers of the state – Phoenix, Tucson, and Flagstaff.

Indian Health Service Electronic Health Record

Many of the IHS clinical facilities use the Resource and Patient Management System (RPMS) record as their EHR system and have attested for Stage 1 of MU. RPMS is an integrated solution for the management of clinical, business practice and administrative information in healthcare facilities of various sizes. The RPMS has an ambulatory EHR, which most, if not all, facilities use. The RPMS also has an inpatient and emergency room component, which may be used by some IHS Facilities. The balance of the tribal sites use commercial EHR systems. Certain tribal health programs operated under P.L. 93-638 including urban Indian health programs may also use the RPMS.

The Phoenix Area Indian Health Service is still using the 2014 Edition of CEHRT. Conversation with Arizona IHS staff in April, 2019 informs us that they are in communication with Federal IHS staff and advocating for an exemption from the 2015 CEHRT requirement for 2019.

Due to the large number of American Indians in Arizona (235,000), it is really important that IHS participates with Health Current to ensure there is real time clinical data available for care coordination between IHS and tribally operated providers and the MCOs.

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(Section A.4 Continued – VA/IHS Operation of EHR's)

The table below is a summary, by IHS Region, of the HIT activity in Arizona and surrounding states.

Table 17: Arizona EHR Live Sites: Indian Health Service Active Site Listings 2019

Usage Key:
IP = Inpatient Utilization
eRx = ePrescribing Utilization
VI = VistA Imaging Utilization
BCMA = Bar Code Medication Administration

Navajo Area (15)

Location	City	State	Type	Affiliation	Usage
Tsehootsooi Medical Center	Fort Defiance	AZ	Hospital	Tribal	IP, VI, BCMA
Nahata Dzile Health Center	Sanders	AZ	Clinic	Tribal	
Chinle Comprehensive Health Care Center	Chinle	AZ	Hospital	IHS	IP, VI
Tsaile Health Center	Tsaile	AZ	Clinic	IHS	VI
Pinon Health Center	Pinon	AZ	Clinic	IHS	VI
Tohatchi Clinic	Tohatchi	NM	Clinic	IHS	
Gallup Indian Medical Center	Gallup	NM	Hospital	IHS	VI, IP
Kayenta Health Center	Kayenta	AZ	Clinic	IHS	VI
Inscription House Health Center	Shonto	AZ	Clinic	IHS	VI
Winslow Health Center	Winslow	AZ	Clinic	Tribal	VI
Northern Navajo Medical Center	Shiprock	NM	Hospital	IHS	VI, IP
Four Corners Regional Health Center	Red Mesa	AZ	Clinic	IHS	VI
Dzilthnahodilthe Health Center	Dzithnahodilthe	AZ	Clinic	IHS	
Crownpoint Healthcare Facility	Crownpoint	NM	Hospital	IHS	VI, IP
Pueblo Pintado	Pueblo Pintado	NM	Clinic	IHS	

Phoenix Area (32)

Location	City	State	Type	Affiliation	Usage
Hu Hu Kam Memorial Hospital	Sacaton	AZ	Hospital	Tribal	IP, VI
Gila Crossing Clinic	LaVeen	AZ	Clinic	Tribal	VI
Ak Chin Clinic	Maricopa	AZ	Clinic	Tribal	VI
Whiteriver Indian Hospital	Whiteriver	AZ	Hospital	IHS	IP, VI
Cibecue Health Center	Cibecue	AZ	Clinic	IHS	
Hopi Indian Hospital	Polacca	AZ	Hospital	IHS	IP, VI
Phoenix Indian Medical Center	Phoenix	AZ	Hospital	IHS	IP
West End Health Center	Yavapai	AZ	Clinic	Tribal	
Salt River Reservation Clinic	Scottsdale	AZ	Clinic	Tribal	
Parker Indian Hospital	Parker	AZ	Hospital	IHS	IP,VI
Chemehuevi IHS Clinic	Havasu Landing	CA	Clinic	IHS	
Peach Springs Indian Health Center	Peach Springs	AZ	Clinic	IHS	
Sherman Indian High School	Riverside	CA	Clinic	IHS	
Supai Health Station	Supai	AZ	Clinic	IHS	
Fort Duchesne Health Center	Fort Duchesne	UT	Clinic	IHS	VI
Reno Sparks Tribal Health Center	Reno	NV	Clinic	Tribal	
Fallon Health Center	Fallon	NV	Clinic	Tribal	
Wassaja Memorial Health Center	Fort McDowell	AZ	Clinic	Tribal	
Elko Indian Health Center	Elko	NV	Clinic	IHS	VI
Fort Yuma Service Unit	Yuma	AZ	Clinic	IHS	VI
San Carlos IHS Indian Hospital	San Carlos	AZ	Hospital	IHS	VI, IP
Bylas Health Center	Bylas	AZ	Clinic	IHS	
Washoe Tribal Health Center	Gardnerville	NV	Clinic	Tribal	
Pyramid Lake	Nixon	NV	Clinic	Tribal	
Nevada Urban Indian	Reno	NV	Clinic	Urban	eRx
Walker River Tribal Health Clinic	Schurz	NV	Clinic	Tribal	
Yerington Paiute Tribal Health Center	Yerington	NV	Clinic	Tribal	
Ft Mojave Health Center	Mojave Valley	AZ	Clinic	Tribal	
Native American Community Health Center	Phoenix	AZ	Clinic	Urban	eRx
Native American Community Health Dunlap	Phoenix	AZ	Clinic	Urban	
Paiute Tribal Health	Cedar City	NV	Clinic	Tribal	eRx
Owyhee Service Unit	Owyhee	NV	Clinic	Tribal	

Tucson Area (4)					—
Location	**City**	**State**	**Type**	**Affiliation**	**Usage**
Sells Indian Hospital	Sells	AZ	Hospital	IHS	IP, VI
Santa Rosa Health Center	Santa Rosa	AZ	Clinic	IHS	VI
San Xavier Health Center	Tucson	AZ	Clinic	IHS	VI
San Simon Health Center	San Simon	AZ	Clinic	IHS	VI

Confirmed March 2019

Data Source: Indian Health Service http://www.ihs.gov/ehr/index.cfm?module=gui_facilities

Continuity of Care Document Architecture

Regarding Continuity of Care Document Architecture enabling IHS to communicate to the national eHealth Exchange, Health Current (State Level HIE) has communicated with IHS. IHS has indicated that their focus was to connect to other federal agencies and departments before they established connectivity with non-federal organizations. Establishing connectivity to Health Current is not currently a part of the IHS Document Architecture plan for this year.

(Section A.4 Continued – VA/IHS Operation of EHR's)

The map below identifies the location of IHS health care facilities in Arizona, by service type.

Figure 9: Indian Health Services Healthcare Facilities

Data Source: IHS, 2019 https://mapapp.ihs.gov/healthfacilities/
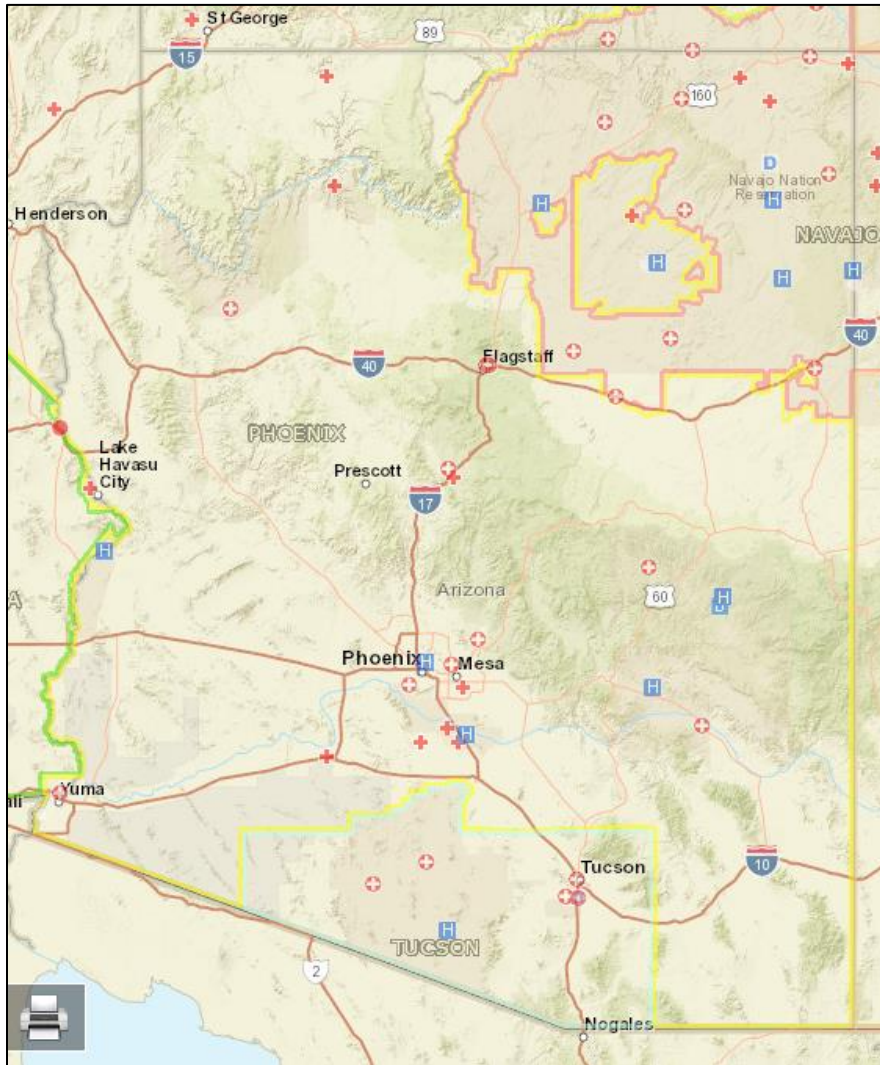
KEY	Hospitals H	Behavioral Health B	Health Center ⊕	Health Station ✚	Dental Clinic D	Other ◦
Navajo	7	1	18	7	1	2
Phoenix Area	6	2	22	23	0	22
Tucson Area	1	0	5	0	2	2

Summary of Arizona's Behavioral Health System for Discussion of State Run Psychiatric Health Facilities

Existing Medicaid Behavioral Health Infrastructure: Arizona only has two state run psychiatric hospitals, the Arizona State Hospital and the Arizona State Forensic Hospital. There are sixteen other psychiatric hospitals in the state but they are not managed by the state of Arizona. There are 520 licensed behavioral health facilities which include:

- Behavioral Health Inpatient Residential Treatment Centers

- Behavioral Health Residential Facilities for Adults and Children

- Inpatient Residential Treatment Centers Subacute Facilities

- Behavioral Health Respite Home

- Hospital – Psychiatric

History of Behavioral Health Integration in Arizona

In November 2017, the Agency issued a Request for Proposal (RFP) entitled AHCCCS Complete Care (ACC) to address the next generation of acute care Health Plan focus and program values. ACC was the largest state procurement in Arizona history. One of the ACC program values was the implementation of Health IT to facilitate communication and care coordination. Health IT adoption and use is one of the most important strategies that AHCCCS Health Plans and Medicaid providers will need to achieve in order to perform continuous quality improvement, promote evidence based practices and improve health outcomes.

In March of 2018**,** AHCCCS awarded managed care contracts to seven integrated managed care organizations (MCO's) that will coordinate the provision of physical and behavioral health care services to 1.5 million Medicaid members. The ACC contracts began on Oct. 1, 2018 and were awarded in the following geographic service areas (GSAs):

Central GSA (Maricopa, Gila and Pinal counties, excluding zip codes 85542, 85192, and 85550): Banner-University Family Care Plan, Care1st Health Plan Arizona, Health Choice Arizona (Steward Health Choice Arizona), Health Net Access, Magellan Complete Care of Arizona, Mercy Care, and UnitedHealthcare Community Plan.

South GSA (Pima, Cochise, Graham, Greenlee, La Paz, Santa Cruz, and Yuma Counties, including zip codes 85542, 85192, and 85550): Banner-University Family Care Plan, Health Net Access, and UnitedHealthcare Community Plan (in Pima County only).

North GSA (Mohave, Coconino, Apache, Navajo, and Yavapai Counties): Care1st Health Plan Arizona, Health Choice Arizona (Steward Health Choice Arizona).

Integrated health care delivery benefits members by aligning all physical and behavioral health services under a single health plan organization. With one plan, one provider network and one payer, health care providers are better able to coordinate care and AHCCCS members can more easily navigate the system, both of which ultimately improve health outcomes. AHCCCS members in every Arizona County are able to have a choice of health plans to enroll in.

On Oct.1, 2018 AHCCCS transitioned approximately 300,000 members to a new MCO in their geographic service area. Each new MCO contract awardee is responsible for:

- **Care coordination** at the system and provider levels across physical and behavioral health providers for Medicaid and Medicare benefits to directly manage the treatment team and ensure cross-specialty collaboration and care management;
- **Processes for targeting inventions for high-risk beneficiaries**, such as identification of and monitoring of cases for the top 20 percent of high-risk/high-cost beneficiaries with SMI and new tools for risk assessments and predictive modeling;
- **Prevention strategies** that reduce the incidence and severity of serious physical and mental illness;
- **Enhanced discharge planning** and follow-up care between provider visits; and
- **Health information technology** to promote physical and behavioral systems integration, and house linked Medicare-Medicaid data and a stratified patient registry to identify the highest risk beneficiaries.

Vehicle for Medicare-Medicaid Integration: Almost all Medicaid beneficiaries are enrolled in managed care for Medicaid physical health and Long Term Support Services (LTSS). Since 2006, Arizona has pursued an integrated delivery system for Medicare-Medicaid beneficiaries through a Dual Eligible Special Needs Plan (D-SNP) contracting platform by encouraging individuals to enroll in the same plan for Medicare and Medicaid services. Arizona recently required participating Medicaid MCOs to qualify as a D-SNP in all the various geographical areas where they have a Medicaid contract to offer the opportunity for all dually eligible beneficiaries to enroll in aligned plans.

A.5 Stakeholder Engagement in HIT/HIE Activity

(SMHP Companion Guide Question A #5)

Stakeholder Involvement in HIT/HIE - In 2006, Arizona published it's first HIT/HIE roadmap the "Arizona Health-e Connection Roadmap" (referred to as *Roadmap 1.0*). Medicaid was a very active participant and supported the creation of AzHeC/ now Health Current which is a public/private partnership and nonprofit organization that drives the adoption and optimization of HIT/HIE.

A second state Roadmap was completed and published in February, 2014 (*Arizona's Health IT Roadmap 2.0*) and since then Health Current has gone on to lead an inclusive stakeholder focused strategic planning effort that resulted in an updated business plan for the organization that covered 2016- 2019. Health Current is launching its next strategic planning cycle to update its strategic business plan and to identify future service needs of its participants.

Since its inception AHCCCS has been a permanent members on the Health Current board to facilitate state support and planning for information technology and exchange. The SMA sits on the Health Current Board only; the agency does not sit on any other HIE or Regional HIE board. A full listing of Health Current Board Members, showing the diversity of their representation is detailed in the table below.

Table 18: Health Current Board of Directors 2019

Health Current Board of Directors - 2019	
Abrazo/Carondelet William Ellert, MD Chief Medical Officer	**Collaborative Ventures Network (CVN)** Ginny Roberts COO
Arizona Care Network (ACN) David Hanekom, MD, FACP, CMPE CEO	**Dignity Health** Sean Turner Sr. Director, Interoperability & Population Health IT
Arizona Complete Health Paul Barnes CEO	**District Medical Group** Jeff Weil CIO
Arizona Department of Health Services (ADHS) Paula Mattingly Assistant Director & CIO	**El Rio Health** Nancy Johnson, RN, PhD CEO
Arizona Health Care Association (AHCA) David Voepel CEO	**Innovative Care Partners** David Baker Chief Technology Officer
Arizona Health Care Cost Containment System (AHCCCS) Jami Snyder Director	**Maricopa Integrated Health System (MIHS)** Kelly Summers SVP & CIO
Arizona Hospital & Healthcare Association (AzHHA) Ann-Marie Alameddin President & CEO	**Mercy Care** Lorry Bottrill CEO
Arizona Medical Association (ArMA) Libby McDannell, CAE Executive Vice President	**Partners in Recovery** Christy Dye, MPH President & CEO
Arizona Osteopathic Medical Association (AOMA) Pete Wertheim, MS Executive Director	**Sonora Quest Laboratories** Dave Dexter President & CEO
Banner Health Deanna Wise CIO	**Tucson Medical Center** Frank Marini SVP & CIO
Banner University Health Plans Kathleen Oestreich VP & CEO	**UnitedHealthcare** Karen Saelens COO, UHC Community Plan
BlueCross BlueShield of Arizona Sheri Jackson Chief Nursing Officer, VP Operations Engineering	**Yuma Regional Medical Center** Fred Peet CIO
Care1st Health Plan Arizona, A WellCare Company Scott Cummings State President, Arizona	

Data Source: Health Current April, 2019

REC Affiliation of Health Current

Health Current (formally AzHeC) received both Regional Extension Center (REC) funding and HIE Cooperative Agreement funding from the ONC office. The REC was officially a four (4) year project that was extended by ONC for two (2) years and two (2) months. ONC offered two (2) no-cost extensions (NCE). The terms of the original REC grant and extensions were:

- Original project: 4/6/2010 – 4/5/2014
- NCE One: 4/6/2014 – 4/5/2015
- NCE Two: 4/6/2015 – 6/5/2016

Health Current took the lead in gathering stakeholders to provide input into a new state Health IT Roadmap that was published in February 2014. The name of the most current Roadmap is *Health IT Roadmap 2.0* and is available for download here https://healthcurrent.org/wp-content/uploads/2016/03/arizona_health_it_roadmap_2.pdf.

In the past Health Current has been the lead organization in our state to engage external stakeholders and Medicaid stakeholders when community input is needed for developing Health IT/Health Information Exchange. AHCCCS has added contract language to its contracts with Medicaid Contracted Organizations (MCOs) requiring them to join Arizona's state level HIE operated by Health Current.

Health Current Stakeholder Development – In March of 2017 Health Current published its updated strategic plan and updated its current logo, tag line and governance structure. Results of its strategic plan are found below.

Health Current implemented a three-year strategic plan based on four pillar of success:

- **Data Integration**
  Data integration involves acquiring more complete information and working closely with HIE participants and their workflow processes to ensure that they integrate more complete patient information with the delivery of care.

- **Data Acquisition**
  Data acquisition includes continuing to add new data sources to include new types of organizations as well as new types of data such as claims data and medication fill history data

- **Data Quality**
  Data quality means working to normalize and standardize the data that is shared in the HIE, including utilizing accepted data coding to make data more meaningful, comprehensive and actionable.

- **Value-Added Services**

  Value-added services involves working closely with HIE participants to review and adopt new services that will best serve participants. This includes a broad range of potential services from services ranging from population health management to image sharing to consent management & identify proofing.

AHCCCS has received CMS approval to use HITECH 90/10 funds to help support Hospitals, FQHCs/RHCs and physician groups with Medicaid providers that have received a Medicaid PI Program Payment to onboard with Health Current for the purpose of improving care coordination, meeting MU measures and eventually achieve more robust clinical data sharing.

With authorization from SMD# 16-003 in February 2016, AHCCCS expanded the Medicaid provider types that it allowed the HIE to recruit as participants beyond payed PI Program providers. Health Current is working with the Arizona Department of Health Services (ADHS) to include Public Health Reporting for the MU Program. ADHS is also a member of Health Current's Board of Directors.

Private Accountable Care Organizations (ACOs)

There are a number of private HIEs, including those being developed by Accountable Care Organizations (ACOs) and other payer management organizations) that are forming across the state. AHCCCS has no governance relationship with any private HIE entities.

Stakeholder Incorporation in Meaningful Use – AHCCCS has leveraged its relationships with stakeholders to provide sustainable funding for HIE development, specifically in regards to onboarding of eligible hospitals, physician groups and FQHCs/RHCs to the HIE.

A.6 SMA HIT/HIE Relationship with Other Entities

(SMHP Companion Guide Question A #6)

Stakeholder Engagement in HIT/HIE Activities

AHCCCS maintains an active and mutually supportive HIT/HIE relationship with multiple organizations and with our state level HIE coordinating organization, Health Current. Because of Health Current's broad based representation on its board, it is inclusiveness in its stakeholder engagement and the history of its work, AHCCCS works most closely with them as a public/private partnership to improve Health IT/HIE.

SMA Relationships with Other HIT/HIE Entities

All of the organizations below are entities that the SMA has relationships with that include a focus for improving HIT/HIE. Some are at the county level, university level, or at the state government level.

Health Current – Originally created by executive order by Governor Napolitano, this non-profit provides statewide HIT/HIE expertise. Health Current (formally AzHeC) was selected by ONC to be the state REC and is the parent of the state level HIE. AHCCCS has selected Health Current to conduct education and recruitment of non-participating EPs and EPs not progressing through Meaningful Use.

ADHS – The Arizona Department of Health Services, Division of Public Health is coordinating its Health IT plans through Health Current to ensure it can meet MU and eventually move to population health reporting and analytics.

ASU/CHiR – The SMA contracts with Arizona State University Center for Health Information Research (CHIR) conducts an annual environmental scan of all licensed state physicians in cooperation with the Arizona Board of Medical Examiners to assess physician adoption of EHR Technology.

IHS- Indian Health Services, AHCCCS works closely through its Division of Fee for Service Management (DFSM) and through the HIE, with IHS to ensure it is going to be able to send and receive clinical data for its Fee For Service Members and exchange with its federal partner.

MCC – Maricopa County Corrections is working with AHCCCS to determine how their EPs can successfully participate in the PI Program.

MCOs – As part of their contractual requirements for serving as a Medicaid Managed Care Organization (MCOs), AHCCCS has asked that Managed Care Organizations be participants in the HIE. MCOs and Hospitals provide funding to Health Current to support its ongoing operations.

PCC- Pima County Corrections is also working with AHCCCS to determine how their EPs can successfully participate in the PI Program

SMA HIT/HIE Entity Relationships and State Goals for MU Capabilities and HITECH Systems

AHCCCS is using its relationships with its stakeholders (above) to develop strategies that will be able to accept more reporting and data from its registered providers electronically and in real time. Currently the agency receives claims and encounter information but does not receive clinical information routinely from providers or AHCCCS Health plans. The agency's 2019 Strategic Goals are:

1.) AHCCCS must pursue and implement long term strategies that bend the cost curve while improving member health outcomes.

2.) AHCCCS must peruse continuous quality improvement.

3.) AHCCCS must reduce fragmentation driving towards an integrated sustainable health care system.

4.) AHCCCS must maintain core organizational capacity, infrastructure and workforce planning that effectively serves AHCCCS operations.

 These goals require the agency to accelerate the delivery system's evolution towards a value-based integrated model that focuses on whole person health throughout the continuum and in all settings, and each of the components of the Arizona strategy will improve population health, transform the health care delivery system and/or decrease per capita health care spending.

Relationships with Health Current, the Arizona Department of Health Services/Public Health, Indian Health Services, the Veterans Administration, and the Managed Care Contractors are all

being coordinated to support more timely clinical data sharing among providers and more comprehensive patient information to support better care outcomes.

Plans to Improve HIT/HIE Entity Relationships

The SMA communicates frequently with all of its stakeholders to ensure it is communicating its vision and priorities and provides resources if possible to ensure its providers can be successful in adopting and implementing health IT and reaching MU milestones. The agency is transparent in its dealings with all participants.

One vehicle for SMA communication with stakeholders is its permanent seat on the Board of Directors for Health Current. A demonstration of the variety of stakeholder relationships is provided in Table 18. Through its participation as a permanent member of the Board of Directors for Health Current, AHCCCS has an opportunity to expand relationships with organizations that have a broad and shared interest in a number of those HIT/HIE subject areas. The figure below provides a graphic representation of some of those organization types.

Health Current has 3 different Councils to support and inform its strategic decision making. AHCCCS has a representative on each of these 3 councils:

• Data Governance Council

• The Privacy and Security Council and the

• Clinical Advisory Council.

Description of Health Current

Health Current functions as a Network of Networks. It has direct connections with hospitals, health plans, community health centers, providers, etc. It has connections with other provider based networks including Accountable Care organizations, (ACOs) Integrated Delivery Networks (IDNs) clinically integrated networks, other Health Information Exchanges, etc. and connects to the eHealth Exchange in order to access data from our federal partners including CMS, VA, SSA, DOD, out of state HIEs and in the future, Indian Health Services.

For a complete list of participants please go to: https://healthcurrent.org/hie/the-network-participants/. In this document, refer to Appendix 6 for a current listing of participants by type.

A graphic of Health Current collaborations is provided below:

(Section A.6 Continued – SMA HIT/HIE Relationship with other Entities)

Figure 10: Collaboration of HIT/HIE Community Resources

Data Source: Health Current April, 2019

Comparison of Arizona to Other States for Electronic Sharing of Information in Physician Offices https://www.cdc.gov/nchs/fastats/electronic-medical-records.htm

The CDC/National Center for Health Statistics recently published a report "State Variation in Electronic Sharing of Information In Physician Offices: United States, 2015". The report uses the 2015 National Electronic Health Records Survey (NEHRS) to describe the extent to which physicians can electronically send, receive, integration, and search for patient health information.

Key Findings from the Report show that:

- In 2015 the percentage of physicians who had electronically sent patient health information ranges from 19.4% in Idaho to 56.3% in Arizona
- In 2015, the percentage of physicians who had electronically received patient health information ranged from 23.6% in Louisiana and Mississippi to 65.5% in Wisconsin.
- In 2015, the percentage of physicians who had electronically integrated patient health information from other providers ranged from 18.4% in Alaska to 49.3% in Delaware
- In 2015, the percentage of physicians who had electronically searched for patient health information ranged from 15.1% in the District of Columbia to 61.2% in Oregon.

The table below shows how the State of Arizona compares to the National percentage for each of the four key measures.

Table 19: Arizona Ranking to National Averages in Physician Sharing

NCHS Data Brief: State Variation in Electronic Sharing in Physician Offices (2015)		
Data Measure	**National Percentage**	**Arizona Percentage**
Percentage of Physicians that electronically sent patient health information to other providers.	38.2%	56.3%
Percentage of office based physicians who received patient health information from other providers	38.3%	40.6%
Percentage of office based physicians who electronically integrated patient health information from other providers	31.1%	44.1%
Percentage of office based physicians who electronically searched for patient health information from other providers	34%	37.6%

Data Source: CDC, National Center for Health Statistics, November, 2016

The map below is a snapshot showing Arizona as the only state that was identified as having been "statistically significantly greater than the national percentage" for the measure of physicians who sent patient health information electronically to their providers.

Figure11: Percentage of Office- based physicians who sent patient health information electronically to other providers by state: United States 2015
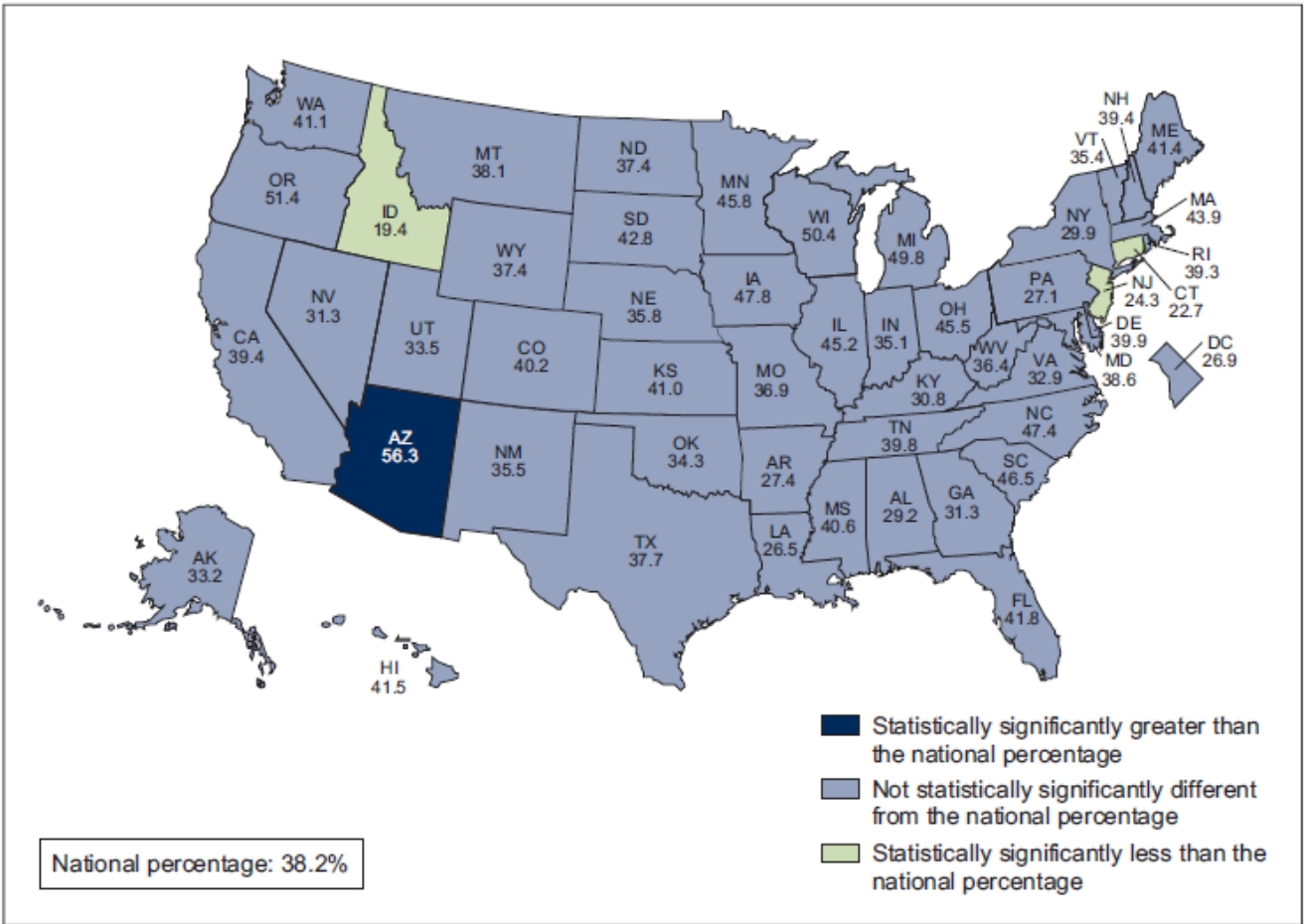
NOTES: Significance tested at *p* < 0.05. Access data table for Figure 2 at: http://www.cdc.gov/nchs/data/databriefs/db261_table.pdf#2.
SOURCE: NCHS, National Electronic Health Records Survey, 2015.

A.7 Health Information Exchange Governance Structure
(SMHP Companion Guide Question A #7)

The Health Current board is comprised of 27 organizational representatives which includes the Director of the SMA. Health Current serves as our statewide governance entity for HIT/HIE.

Board Composition - The Health Current board members are recruited from across the state and oversee all functions of this non-profit organization. The board is a state level board and has a statewide geographic scope representing the following areas:

- Hospitals

- Health Plans

- Universities

- Employers

- Large Reference Laboratories (i.e. Sonora Quest)

- Other state government representatives

- Community Health Centers

- Physicians

- Nurses

- Pharmacy

- Behavioral Health

- Long Term Care

- Quality Innovation Network (QIN) – Quality Improvement Organization (QIO)

Board Function - The board and the staff are involved in HIT/HIE activities including recruitment for Health Current to get more participants to join the HIE, they support the annual education and outreach conference hosted by Health Current and, they oversee the funding of the education programs and the HIE by approving an annual budget.

Health Current has three advisory councils to provide additional subject matter expertise and input.

- The Clinical Advisory Council

- The Data Governance Council

- The Privacy and Security Council

Organizational Chart

The Health Current organizational chart is presented in Figure 13. Health Current uses a matrixed organizational structure to ensure collaboration and to maximize team member expertise.   This results in the organization's ability to efficiently and consistently deliver our services.

Figure 12. Organizational Chart – Health Current
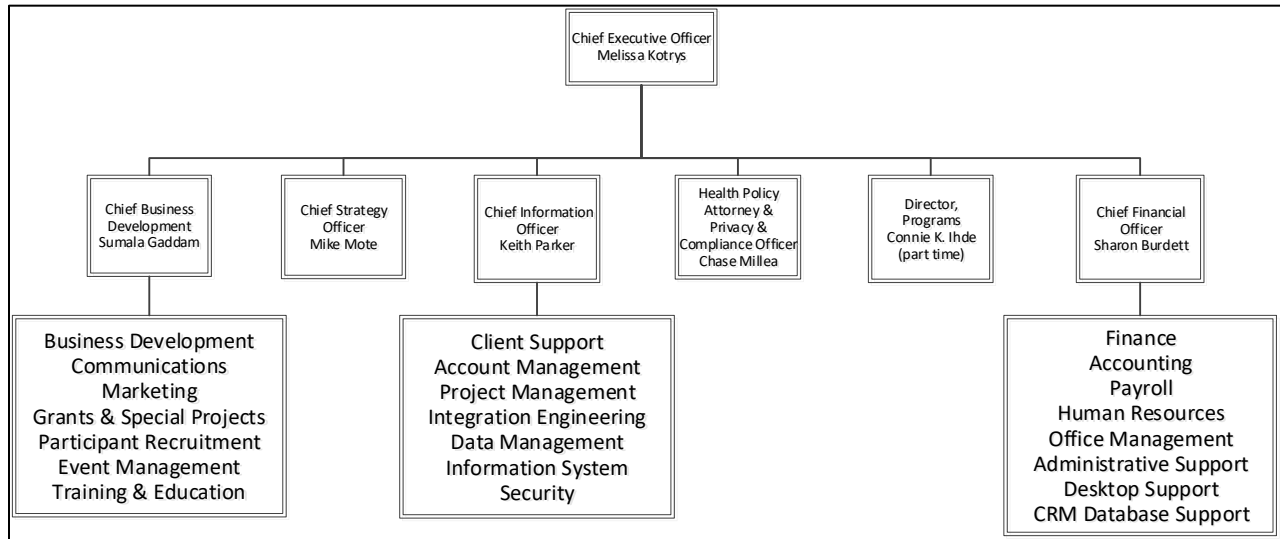
Data Source: Health Current April, 2019

Health Current is governed by a Board of Directors comprised of Arizona's leading healthcare executives and leaders, with representation from government agencies (3), health plans (5- 7), hospitals (5-7) and other key healthcare stakeholders (up to 10 at-large). A current list of the Health Current Board of Directors in Section A.5 of this document. A listing of current Advisory Council Members is provided below.

Supporting the Board are three advisory councils:

Clinical Advisory Council - The Health Current Clinical Advisory Council provides a clinical and workflow perspective to Health Current as it procures and implements technical services related to the statewide HIE. This Council is responsible for the development of recommendations regarding the use of health information technologies and information to improve workflow and clinical decision making.

Data Governance Council - Health Current Data Governance Council is charged with developing and supporting data governance processes that address the cross-enterprise needs of all HIE Participants for data quality including use of industry standards and accepted normalized values, related to data accuracy, completeness, timeliness, consistency, and accessibility. Areas considered by the Council include but are not limited to consideration of new use cases for and enforcement of the Permitted Use Policy and establishment of processes to identify data needs, provide access and ensure overall data quality and integrity.

Privacy and Security Council - The Health Current Privacy and Security Council is charged with advising Health Current's management and Board of Directors with respect to policies, audits, compliance, and best practices used by the organization pertaining to privacy and security. The Council is responsible for oversight of the privacy and security program, in areas including but not limited to Federal and state laws and regulations, industry standards, and their application to health information exchange with respect to the confidentiality, integrity and availability of PHI.

Figure 13 provides the Health Current governance structure. A current list of the Advisory Council participants can be found below.

Figure 13: Health Current Governance Structure
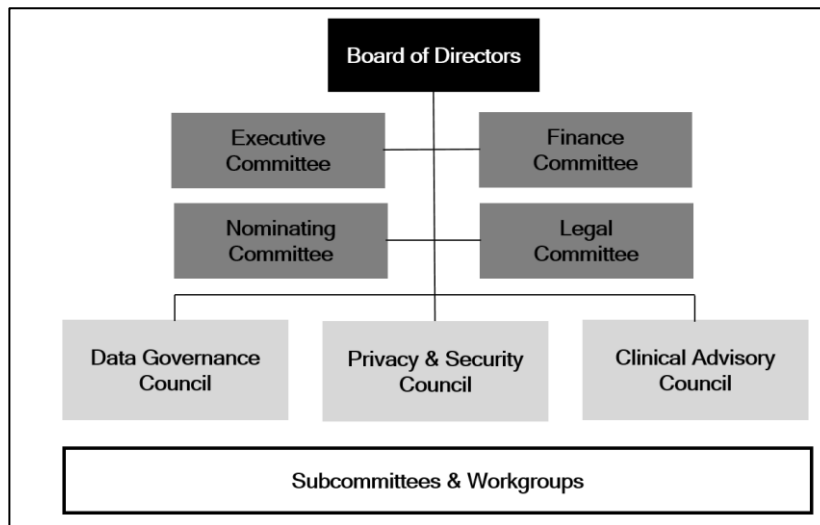
Data Source: Health Current April, 2019

 AHCCCS added its Chief Information Officer to the Data Governance Council l and added a representative to the Clinical Advisory Committee and the Privacy and Security Council in December, 2016. The HIT Coordinator serves on the Public Health Workgroup.

Table 20: Health Current Advisory Councils

Current Advisory Council Members - 2019

Clinical Advisory Council	
Arizona Alliance for Community Health Centers **Shelli Ross**, Sr Director of Quality and Data Management	Maricopa County **Tristian Pico**, Chief Privacy Officer
Arizona Department of Health Services, Bureau of EMS and Trauma System **Terry Mullins**, Bureau Chief	OptumCare Arizona **Thomas Cheek, MD**, Manager Data Analytics and Informatics
Arizona Health Care Cost Containment System (AHCCCS) **Erik Tack,** MCH EPSDT Program Manager	Partners In Recovery **Christy Dye**, President/CEO Pima County Health Department **Francisco Garcia, MD**, Assistant County Administrator & CMO
Arizona Complete Health **Seth M. Dubry, MD**, Chief Medical Director, Arizona Plans	Southwest Behavioral & Health Services **Heather Genovese**, VP of Crisis and Opioid Services
Arizona Hospital & Healthcare Association **Sandy Severson,** VP Care Improvement	Surprise Fire-Medical **Jesus Rivera**, Battalion Chief
Banner Health **Geoffrey Duke**, Vice President IT Clinical Applications	Tucson Fire **Brian Thompson**, Director Information Technology
Banner University Health Plans **Yamini Sabesan, MD**, Medical Director	United Community Health Center **Wendy Kibby**, RN, BSN, Chief Operations Officer
Carondelet St. Joseph's Hospital/Pima County Sheriff Dept **Tammy Kastre, MD**, EM attending SJH, Medical Director Pima County Sheriff Dept, Director of Utilization Management Correct Care Solutions	
	United Healthcare Community Plan (Arizona)

Chandler Primary Care
Rama Devineni, MD

CODAC Health, Recovery & Wellness
Amy Mendoza, Associate Vice President for Utilization Management

Dignity Health
Donald Kane, DO, FAAP

Anthony Dunnigan, MD, Chief Medical Information Officer

Steve Chakmakian, DO, Chief Medical Officer

University of Arizona Health Plans, Banner University of Family Care
Susan Benedetti, RN BSN, ALTCS Administrator

Native American Connections
Stephen J. Weiss, Director of Clinical Services

Data Governance Council	
Arizona Complete Health **Cathy Karson**, Director, Reporting & Business Analytics	Equality Health **Chandra Merica,** Vice President Analytics
Arizona Health Care Cost Containment System (AHCCCS) **Dan Lippert,** Chief Information Officer	Jewish Family & Children's Services **Robin Trush,** Director Business Intelligence
Arizona Hospital and Healthcare Association **Vicki Buchda,** Director, Care Improvement	Kingman Regional Medical Center **Sandra Savage,** RN BSN, Manager Data Analytics and Informatics
Arizona State Department of Health Services **Raghuraman Ramaswamy,** Chief Technology Officer	Lifewell Behavioral Wellness **Bryan M. Colby**, Chief Information Officer
Banner Health **David Coe,** Sr Director Population Health Technology	Mt. Graham Regional Medical Center **Debra Stuart,** Director of Quality & Patient Safety
Banner University Health Plans **Thomas Ball, MD**, Chief Medical Officer	RI International **Brandi Ryan-Cabot,** Director, EHR Operations
Benson Hospital **John Roberts,** Director of IT	
CODAC Health, Recovery & Wellness **Rafael Arechaga,** VP of Information Systems	Southwest Network **Katrina Noyes,** Director of Quality Improvement
Crisis Response Network **William Taylor,** VP of Technology Operations & Development	Valle del Sol, Inc. **Paul Decker, III,** EHR Program Manager
	Yavapai Regional Medical Center **Tim Roberts,** Chief Information Officer
Dignity Health **Sean Turner,** Sr Director, Interoperability and Population Health IT	Yuma Regional Medical Center **Fredrick Peet,** Chief Information Officer

Privacy & Security Council	
Arizona Health Care Cost Containment System (AHCCCS) **Kathryn Greene**, Privacy Compliance Officer Arizona Care Network **Tracey Craig,** Compliance Manager Centene **Cheyenne Ross,** VP Compliance & Regulatory Affairs CODAC Health, Recovery & Wellness **Nora Navarro-Hernandez,** Sr. VP of Compliance and Outcomes Crisis Response Network **Andrew Erwin**, Chief Compliance Officer, VP of SMI Eligibility and Care Services Jewish Family & Children's Services **Keven J. Rhode,** Chief Technology Officer MHC Healthcare **Clint Kuntz**, CEO	Open Hearts Family Wellness **Jaye Williams**, Chief Administrative Officer OptumCare Arizona **Lynn Allen,** Director of Managed Care Contracting Phoenix Medical Group **Leslie Maxwell,** CEO Southwest Network **Danielle Griffith,** Corporate Compliance Director Valle del Sol, Inc. **Lynne Emmons,** Director of Quality, Corporate Compliance & Privacy Officer Yuma Regional Medical Center **Rhonda Novak,** Chief Compliance Officer

Data Source: Health Current April, 2019

Health Current and Meaningful Use

Health Current is leading the public health reporting aspects of Meaningful Use with our Arizona Department of Health Services. They have engaged the Mirth HIE Platform vendor to be able to deploy a public health meaningful use gateway and are piloting the submission of immunizations electronically. Mirth has since converged with Next Gen. Health Current will move to the Next Gen platform in Summer of 2019.

AHCCCS contracts with Health Current to perform MU Education for all MU objectives including e-prescribing.

Mercy Care Plan (MCO), Mercy Maricopa Integrated Care Plan (MMIC-RHBA) and Health Current (formerly AzHeC) were awarded a CMS Transformation of Clinical Practice Grant (TCPI) that has enrolled 2,500 clinicians in receiving help in improving their care delivery. Through this grant, Health Current has purchased tools that will enable the clinicians to better understand their members, improve care delivery and reduce costs. One such tool is a population health program that can provide predictive analytics and views of a practice's population. The second tool is a data analytics tool which allows for member generated data and reports and provider reporting.

State Innovation Model Planning Grant - Transition to Targeted Investments

AHCCCS received a State Innovation Model Planning Grant (SIM) totaling $2.1 million in May, 2015 to identify new payment and service delivery models to advance broad based health system reform. The purpose of SIM was to spur state-led healthcare innovation that improves system performance, enhances quality of care, and reduces costs for beneficiaries.

Arizona's Innovation Plan centered on three main initiatives that ultimately focused on enhanced coordination for vulnerable populations; specifically those served by the American Indian Health Program, individuals transitioning out of incarceration and into the community, and individuals with physical and behavioral health needs.

For each of the vulnerable populations identified, AHCCCS and its stakeholders identified statewide goals, action steps to achieve the goals and an approach to test whether the model designed has a positive impact in closing the identified gaps in the delivery system. A key theme that emerged was the need to expand the Health Information Technology and enrollment in the Arizona Health Information Exchange (Health Current) in order to improve the delivery system statewide, and in particular, support the implementation of care coordination models for vulnerable populations.

Through the SIM Model Design, Arizona sharpened its focus on how the State's HIT policies and infrastructure must be developed to support new delivery system and payment models. The barriers and solutions needed to improve the coordination and delivery of care includes:

1. Expansion of exchange of clinical information on a real time basis, and

2. The provision of data and analytical capability to support providers, payers and other relevant organizations.

On December 31, 2016 AHCCCS received approval from CMS to launch a Targeted Investments Program to transform health care through integration of behavioral health and physical health providers. The Targeted Investments (TI) Program is AHCCCS' strategy to provide financial incentives to eligible AHCCCS providers to develop systems for integrated care. In accordance with 42 CFR 438.6(c) and the 1115 Waiver, managed care plans will provide financial incentives to eligible Medicaid providers who meet certain benchmarks for integrating and coordinating physical and behavioral health care for Medicaid beneficiaries. AHCCCS will incorporate these payments into the actuarially-sound capitation rates. Please see the AHCCCS TI Home Page here for additional information:

https://www.azahcccs.gov/PlansProviders/TargetedInvestments/

The TI Core Components for each of the eligible provider types includes the need to connect and share clinical data using Health Current and adopting health information technology in order to produce high risk registries and perform population health analytics on a provider's panel of members. Providers receive payments based on their completing a range of milestones that include adopting screenings, hiring care managers, performing "warm handoffs", following Opioid Use Guidelines and participating in bidirectional health information exchange with Health Current.

Statewide Health Integration Plan (SHIP)

Back in 2016, Health Current was tasked by the State of Arizona to produce an integrated Physical and Behavioral Health Plan for HIE. Health Current created a statewide plan to integrate physical and behavioral health providers to information exchange under one infrastructure. The goal was to improve quality and outcomes for Arizona patients who receive physical and behavioral health care. The state level HIE model supports providers in developing integrated service delivery models and must contain these essential elements:

- A single HIE infrastructure managed by Health Current

- One marketing and communication and messaging strategy for the Integrated HIE for all physical and behavioral services; and

- One financial model that encompasses a single fee for physical and behavioral health care stakeholders to sustain the integrated physical and behavioral health network.

The plan called for the integration of behavioral health information into the statewide HIE. The three RBHAs funded Health Current to connect the high priority behavioral health providers to the HIE in May 2018.

As of November, 2017 there were 78 High priority provider organizations and 12 High priority hospitals (Psychiatric) bringing the total number of SHIP organizations to 90. Behavioral Health Providers have subsequently been onboarded to the HIE under the expanded criteria of SMD16-003.

Health Current currently supports a standard data set:

- Hospital Admissions Discharges and Transfers (ADT) transactions (problem lists, allergies, procedures, insurance, etc.)

- Medications

- Lab Results

- Transcribed Reports

- Radiology Reports

The figure below is meant to show the mixture of funding sources that are coming into Health Current and the services or programs they are implementing to support the needs of their membership. Health Current continues to operate as a one stop shop for Health IT and Health Information Exchange for its stakeholders.

Figure 14: Health Current Community Funding and Services (2019)
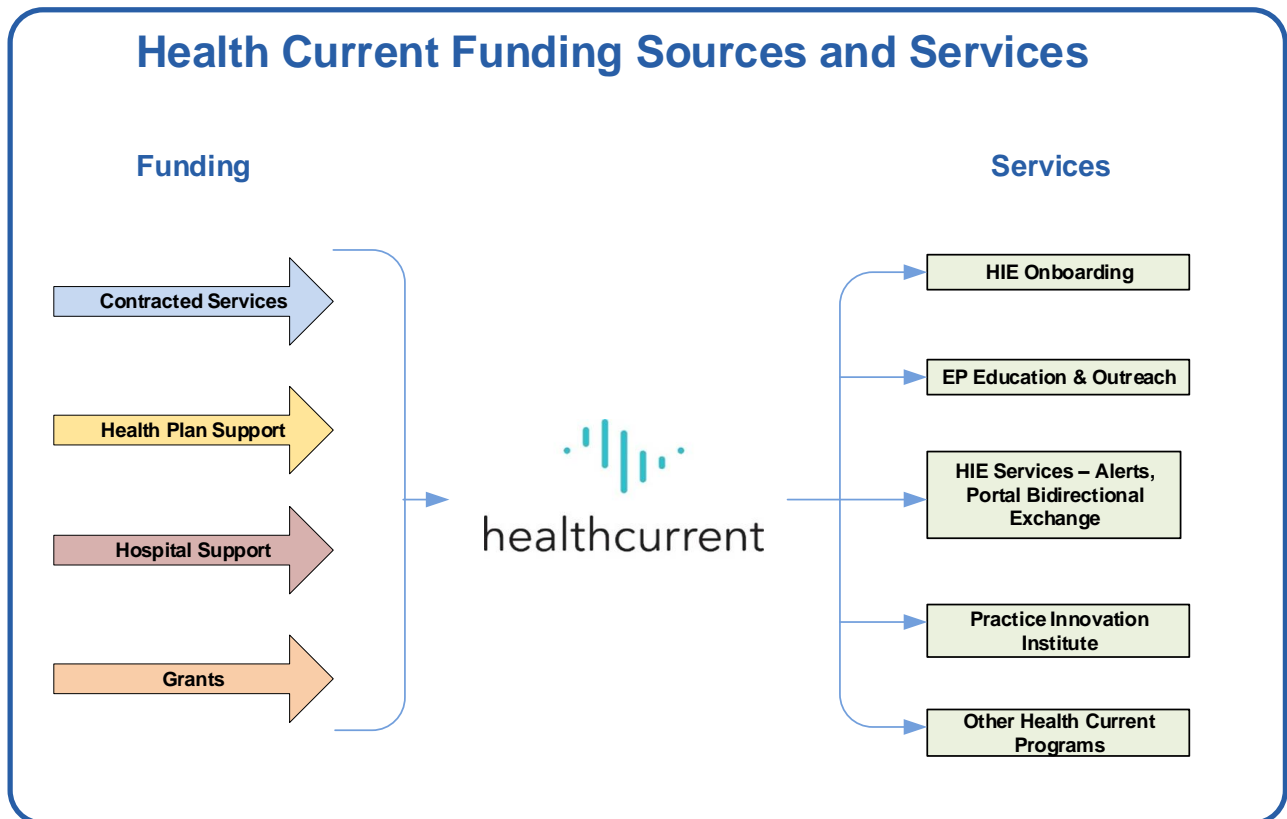
Data Source: Health Current Aril, 2019

A.8 The MMIS Role in the Current HIT/HIE Environment

(SMHP Companion Guide Question A #8)

Roles of MMIS in the SMA Current HIT/HIE Environment

Summary of Phase I AHCCCS MITA 3.0 SS-A Findings – The Agency completed a MITA State Self-Assessment in the Fall of 2016. The following is a summary of Phase 1 AHCCCS MITA 3.0 Findings: AHCCCS is generally operating at a Level 2 and a few areas are operating at a Level 1, with most maturity level scoring impacted by fragmented systems, processes and data. While technology improvement projects such as HEAplus, have provided significant capability improvements in some business areas, AHCCCS continues to have data and processes fragmented across programs and business areas.

For this reason AHCCCS seeks to standardize and automate to the fullest extent of MITA Level 2 and will explore MITA Level 3 standards as they are developed and adopted by CMS. The Agency is going to initiate an update to the MITA State Self-Assessment in 2019. At this time there is no HITECH Scope of Work anticipated for this initiative, rather HITECH activities and strategic planning is expected to be running parallel to the agency wide MITA State Self-assessment.

Summary of Phase II HITECH MITA 3.0 SS-A Findings: **-** During Phase II of the SS-A project, the team analyzed the variety of AHCCCS programs, initiatives, and applications ranging from ePIP and Health Current solutions to the Payment Modernization and Care Coordination Strategies. The findings for Phase II are similar to Phase 1 relative to current and target MITA maturity levels for each business area**.**

The diagram in the figure below: **Integrated Medicaid IT Environment (Current Status 2019)** represents a current snapshot of the member and provider interfaces with the agency. It includes the HITECH-related systems and PMMIS, which is primarily a mainframe system with several supporting modules on the network.

Medicaid providers who register and attest for the PI Program may be qualified to receive Incentive Payments. They access the Federal and State portals to register and attest.

1. Providers register first at the Federal level with CMS for either the Medicare or Medicaid program using the National Level Repository (NLR). AHCCCS has an electronic relationship with the NLR as part of the administration of the PI Program.

2. Next or second, providers register for the Medicaid program with the State. Arizona providers use the state level repository named ePIP, where they also may attest and view their status. The ePIP system validates the providers and their requests and creates the payment requests for the financial system.

3. Providers receive PI ProgramPayments in their designated bank account electronically by the Arizona Financial Information System (AFIS). Several entities including providers and payers, along with the agency access the Health Information Exchange named Health Current. They view patient records and receive healthcare alerts for their members. They also exchange health care data using HIPAA transactions.

4. Users access the AHCCCS On-Line portal to verify Medicaid patient eligibility and enrollment information, to check on claims status, to update their demographics. They may also submit claims for the Fee for Service Program.

5. Users submit patient immunization records, and other patient health data to the public health registries. At this time, ADHS does not accept the majority of its information electronically but is interested in developing the interfaces and electronic capacity by working closely with Health Current and its participants. At this time most of the hospitals may have some type of electronic relationship with ADHS for one aspect of the MU program, such as lab reporting, however, that electronic reporting is still a combination of manual and electronic processes, which is being looked at to be improved under the MU program.

6. Users access the HIE to view their members' healthcare data and receive alerts.

7. Users exchange HIPAA transactions using the EDI process. Larger providers use EDI to submit their claims and verify eligibility for their members. Health plans use EDI for the submission of encounters and the agency sends them lots of information through this mechanism. Applicants and members apply for and update healthcare and social services benefits using HEAplus, SSA, or the Federally Facilitated Marketplace FFM).

8. Applicants access HEAplus to apply for health and human services programs; HEAplus is an online eligibility determination system that collects applicant data to determine eligibility for Medicaid, CHIP, ALTCS, SNAP, and TANF programs. Eligibility for Medicaid and CHIP is currently determined in HEAplus; for ALTCS, SNAP, and TANF.

9. Applicants can also apply for Arizona health insurance coverage through the Federal Facilitated Marketplace at HealthCare.gov and, if they appear to be eligible for Medicaid, their eligibility information is sent to HEAplus for consideration.
    SSA determines Medicaid eligibility when applicants participate or apply to the Social Security Administration (SSA) for supplemental security income (SSI).

Figure 15: Integrated Medicaid IT Environment (Current 2019)
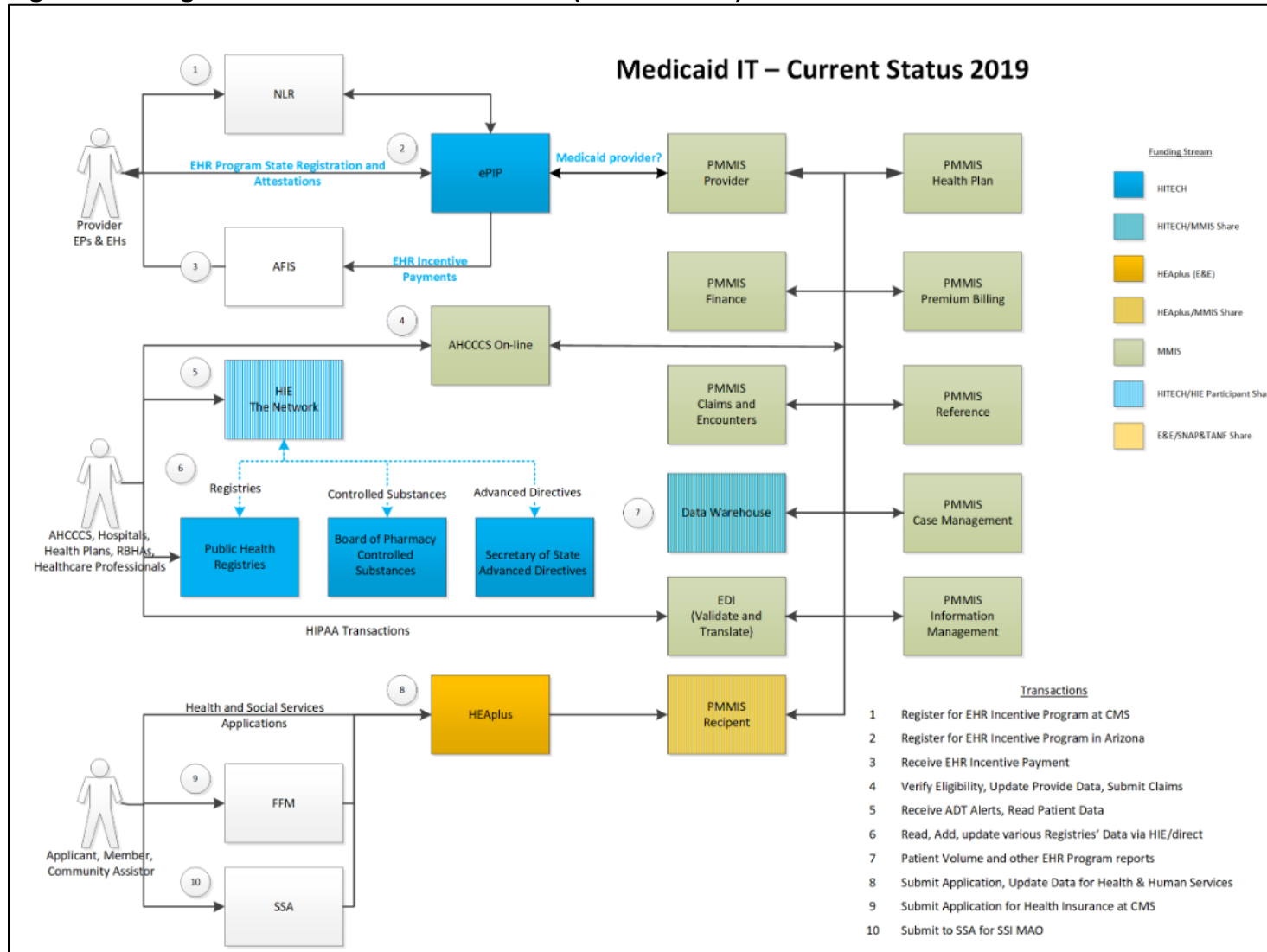
Data Source: AHCCCS ISD, March, 2019

A.9 State Activities Underway to Facilitate HIT/HIE Adoption
(SMHP Companion Guide Question A #9)

State Activities Underway and In Planning for MU Growth and HIE Adoption

AHCCCS was required by the State Procurement Office (SPO) to go out to RFP for HIE Services. AHCCCS opened the RFP on July 5, 2017 and selected Health Current as it's HIE vendor effective January 1, 2018 for up to 5 years. The RFP was reviewed and approved by CMS prior to posting. The contract was awarded to Health Current and the contract approved by CMS October 18, 2017.

AHCCCS currently has two different scopes of work with Health Current to support Medicaid providers to connect to the HIE and to use clinical data by using HITECH funds- one SOW for education and one SOW for HIE onboarding services.

1. **Education and Outreach ($975,000 per FFY)**

Since 2015, Health Current has provided education and training services to AHCCCS' Medicaid Electronic Health Record (EHR) Incentive Program participants to increase program participation and advancement between the Meaningful Use stages. Under this agreement with AHCCCS, Health Current continues to provide education, outreach, recruitment, and consulting services to assist AHCCCS in achieving its program goals. The contract includes providing education, training and technical assistance on all aspects of technology adoption and education about the Objectives and measures found in the program including eligibility, document retention, auditing, meaningful use objectives and measures.

Monthly activities and calls and technical assistance is provided and shared with AHCCCS staff prior to approval of invoices.

2. **HIE Onboarding Services (Current approved amount is $7 million per FFY)**

Since 2013, Health Current has held the current AHCCCS contract to provide HIE Onboarding Services. The purpose of this contract is to support Medicaid providers and hospitals in achieving bi-directional connectivity to Health Current to improve care coordination, to improve Medicaid member patient outcomes, and to assist providers and hospitals in achieving Meaningful Use. Effective January 1, 2018 a new Health Current contract started that was awarded through the open RFP Process mentioned above.

As of mid-April, 2019, Health Current had recruited a total of 594 organizations to the HIE Onboarding Services program, including 79 Behavioral Health Providers, 279 community providers, 53 hospitals/Health Systems, 21 federally qualified health centers, 17 Health plans, 16 ACO's, 97 Long term care and sub-acute organizations, 7 state and local government organizations, and others. Appendix 6 provides a full listing of all HIE participants. All of these organizations are at mixed stages of unidirectional and bidirectional communication.

Up until recently, eligibility for the HIE Onboarding Services program was limited to providers participating in the AHCCCS PI Program. In June 2017, eligibility for the HIE Onboarding Services program was expanded to include other Medicaid providers ("non-eligible Medicaid providers" or providers not participating in the PI Program) that can assist Medicaid providers in the PI Program ("eligible providers") in meeting Meaningful Use objectives by participating in the HIE and facilitating transitions of care and medication reconciliation.

There are other activities that the agency is engaged in to encourage HIE participation and use including:

Differential Adjusted Payment (DAP)

Starting in 2016, AHCCCS created value based payments for select hospitals, Nursing facilities and Integrated clinics for dates of service beginning October 1, 2016. The purpose of the Value Based Payment programs like DAP is to distinguish providers which have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth.

Participation and use of the HIE was one of the measures hospitals and other provider types had to meet in order to receive the adjusted rates. The most current DAP Announcement is located here on the agency website and bi directional data exchange between hospital and the HIE with comprehensive data sets was a target for this cycle: https://www.azahcccs.gov/AHCCCS/Downloads/PublicNotices/rates/AHCCCS_DAP_CYE2020_ Final_Public_Notice_April_30_2019.pdf

Targeted Investments

The Targeted Investments Program (TI), is a 5-year incentive program to help registered AHCCCS providers develop clinical processes that integrate physical and behavioral health care delivery, announces provider participants.

There are currently more than 515 locations have been accepted from six specialty categories: Adult Behavioral Health, Pediatric Behavioral Health, Adult Primary Care, Pediatric Primary Care, Hospitals, and Justice. All participants are currently working to complete Year Three

program milestones which include meeting Bi- directional data exchange requirements in order to meet one of the program milestones and to get paid for that milestone.

Social Determinants of Health – The agency has becoming more involved in understanding the link between improving health outcomes by identifying and linking members with support services such as housing, employment, food resources, etc. Treating the whole person has been an important concept baked into Arizona's move to integrate physicial and behavioral health care, so recognizing and addressing social determinant issues is beoming more important. The agency is currently considering how it will use its upcoming 115 Waiver to make investments into SDOH related services and organizations in order to ensure the whole person is being cared for. An internal SDOH workgroup has been formed and meetings are underway between the agency and the Vitalyst Community Foundation, where it is researching other state Medicaid waivers, other state data sharing and referral platforms and needs of communities and their support organizations.

Section 5042 of the SUPPORT Act for Patients and Consumers- based on recently released CMS guidance, AHCCCS is working with Health Current and the Arizona Pharmacy Board that operates its Prescription Drug Monitoring Program (PDMP) to see if there are any projects or needs that we have to improve any of the processes and data sharing that the PDMP does with our stakeholders. Meetings are scheduled over the next few weeks to better understand the guidance and if there are any agency, HIE or PDMP related projects that could benefit from the focused funding over the next 18 months. .

Updating the Agency's Clinical Quality Strategy – AHCCCS is working with its Health Plans to update its clinical reporting strategies and performance measures. The agency is looking ahead to the 2024 CMS requirements where it will need to report out on CMS Core Measures and making plans about how it will envision that happening within the context of our current Managed Care Plans. The agency is aware of the CMS led movement away from process measures to outcomes based measures. The agency also wants to use some of its value based payment programs to reward more outcomes based measures vs process measures in order to better align with the national CMS strategy and expectations. Discussions and demonstrations by vendors that provide population health and quality measures are being planned.

Health Current Strategic Direction, Services and Programs

Health Current is our vendor to integrate health information exchange technology and care delivery to improve the health and wellbeing of individuals and communities in Arizona. In 2017, the organization went through a nearly year-long process of assessment and engagement with

regional healthcare communities around the state, state and federal healthcare agencies, other HIEs across the nation, and executives and staff from participating organizations to create its four priorities (see below) Health Current is currently in the process of updating their strategic plan for 2019 and beyond.

The current plan had four pillars or focus areas:

- **Data Integration -** Data Integration involves working closely with HIE participants and their workflow processes to ensure that they integrate more complete patient information with the delivery of care, in a way that drives value to their organization.
- **Data Acquisition -** Data Acquisition involves acquiring more complete information, including both adding new data sources to include new types of organizations as well as new types of data such as claims data, social determinants of health and medication fill history data. Data Acquisition also includes closing any gaps in current data feeds to ensure consistent and comprehensive data from all data suppliers.
- **Data Quality -** Data Quality means working to normalize and standardize the data that is shared in the HIE, including utilizing national standard terminology sets for (e.g. CPT,ICD10, HCPCS, SNOMED, and Rexnord) data coding to make data more meaningful, comprehensive and actionable.
- **Value-Added Services -** Value-added services involves working closely with HIE participants to review and adopt new services that will best serve participants. This includes a broad range of potential services ranging from population health management to diagnostic image sharing to consent management and identify proofing.

HIE Services

Health Current offers a range of HIE services designed to integrate more complete patient information into the care delivery of HIE participants including:

Alerts - Alerts are sent to designated clinicians or individuals based upon a patient panel. A patient panel is a practice or payer provided list of patients/members they wish to track. Alerts can include:
- **Inpatient Alerts -** Alert the organization that a specific patient/member has been admitted to or discharged from an inpatient facility.
- **Emergency Department (ED) Alerts -** Alert the organization that a specific patient/member has been registered at or discharged from an emergency department.

- **Ambulatory Alerts -** Alert the organization that a specific patient/member has been registered at an ambulatory facility or practice.
- **Clinical Result Alerts -** Alert the organization when a specified type of clinical result or document has been received by the HIE for a specific patient/member. The actual result or document is attached to the Alert.
- **Patient Centered Data Home™ (PCDH) Alerts -** Alert the organization that a specific patient/member has been admitted to or discharged from an inpatient facility or has been registered at or discharged from an emergency department outside of Arizona. A PCDH Alert uses zip code mapping to send the alert from an out-of-state HIE to the organization through Health Current.

Direct Email - Direct Email is a HIPAA compliant, secure email account that provides the means for registered users to exchange patient protected health information with other Direct Trust- certified email accounts. Direct Email is often used to receive Alerts.

Portal Access - The Portal provides secure web-based access that allows selected patient/member data to be viewed online. Examples include:

- A Portal User associated with a healthcare provider organization would be able to view data from physical health providers and behavioral health providers for general mental health, but providers would need to obtain a patient consent to view any Part 2 related data.
- Federally- recognized substance abuse treatment programs. Additionally, with a patient/member's 42 CFR Part 2 Consent or with a licensed medical provider declaring a medical emergency, users would be able to view information from behavioral health providers that do have federally-recognized substance abuse treatment programs.
- Portal User associated with a health plan would be able view data from physical health providers and behavioral health providers that do not have federally-recognized substance abuse treatment programs. Additionally, these Portal Users would not have access to a patient's "self-pay" information.

Data Exchange - Data Exchange involves electronic interfaces between patient tracking systems and the HIE. Data exchange services include:

- **Unidirectional Exchange -** Electronic interface between patient tracking systems and the HIE with information flowing in only one direction.
- **Bidirectional Exchange -** Electronic interfaces between patient tracking systems and the HIE with information flowing in both directions.

Sending and Exchanging Clinical Summary - A Clinical Summary is a comprehensive Continuity of Care Document (CCD) containing up to 90 days of the patient's/member's most

recent clinical and encounter information. Clinical Summaries include:

- **Automated Clinical Summary -** In response to the receipt of an Alert, Discharge or Transfer (ADT) transaction containing an inpatient admission, emergency department registration or an ambulatory encounter registration, a comprehensive CCD containing up to 90 days of the patient's most recent clinical and encounter information is returned to the treating organization. May be patient panel triggered, too.

- **Query/Response Clinical Summary -** In response to the receipt of a standard compliant machine-to-machine patient query, a comprehensive CCD containing up to 90 days of the patient's most recent clinical and encounter information is pushed back to the requesting organization.

- **Patient Centered Data Home™ (PCDH) Clinical Summary -** Similar to a Query/Response Clinical Summary, this summary pushes a comprehensive CCD containing up to 90 days of the patient's most recent clinical and encounter information to requesting organization, including out-of-state information, as the result of a PCDH Alert (see above).

New for this year, AHCCCS is requesting additional resources for Health Current for the remainder of FFY 2019, FFY 2020 and FFY 2021.

Planning, Education and Outreach for Medicaid Providers (adding additional dollars for consulting hours and planning)

Since 2015, Health Current has provided services to AHCCCS' Medicaid Electronic Health Record (EHR) Incentive Program participants to increase program participation and advancement between the Meaningful Use stages. Under this agreement with AHCCCS, Health Current continues to provide education, outreach, recruitment, and consulting services to assist AHCCCS in achieving its program goals. The contract includes providing education, training and technical assistance on care coordination and information exchange, e-prescribing and transitions of care – three of the Meaningful Use requirements.

Additional Meaningful Use Consulting Service Hours
Due to continued interest among Medicaid providers in achieving Meaningful Use and receiving related incentives, the requests for Meaningful Use Consulting Services that are provided under the Education & Outreach Program have increased. As a result, at the current rate of service provision, Health Current expects to exceed the allocation for consulting services by May 2019. These services are billed as incurred, so the additional funding will ensure that the program can assist any interested Medicaid provider, but will only be expended if needed.

Funds that will be requested for additional MU Consultant Hours

Year	Amount
FFY2019	$50,000
FFY2020	$50,000
FFY2021	$50,000
Total	**$150,000**

New for FFY 2019, FFY 2020 and FFY 2021 – Increased amounts for Strategic Planning for Health Current to meet the Agency's evolving requirements

Strategic Planning to Meet New Agency and Health Plan HIE Functionality Requirements
The HIE Onboarding Program has been able to date to assist over 300 Medicaid providers with improving care coordination and transitions of care by accessing and sharing data through the HIE. The HIE program has the capacity to assist several hundred more providers connect and begin to learn how to use and send electronic health data in the coming several years. As the Agency begins its own strategic planning for its 1115 waiver , it is important that our HIE contractor, Health Current, be able to assess the priorities and determine if it has the staffing and technical capacity to meet our evolving HIT/HIE contractual requirements for the MCOs and providers in the Promoting Interoperability Program.

In addition to the Waiver application to CMS, the HITECH funds are set to sunset at the end of FFY2021, it is important for AHCCCS and Health Current to work collaboratively to ensure that these critical services are not eliminated or unsustainable post-HITECH funding. AHCCCS wants to request funds for Health Current to ensure they will be able to offer services that meet our evolving business requirements before September 30, 2021

Funds that will be requested for Planning

Year	Amount
FFY2019	$150,000
FFY2020	$200,000
Total	**$350,000**

Adding Additional Funding for HIE Onboarding Program for FFY 2019, FFY 2020, and FFY 2021

Through its next HITECH IAPD, the agency will be requesting funding for milestones under the HIE Onboarding Program be increased from $7 million to almost $9 million per federal fiscal year. The actual and/or projected aggregate fees related to milestone achievements for each quarter in FFY2019 is projected in the tables below:

Aggregate Fees Per Milestone (Estimates) for 2019

Milestone	FFY 2019				
	Q1	Q2	Q3	Q4	
1	N/A	$345,000	$1,125,000	$930,000	**Grand Total**
2	N/A	$320,000	$840,000	$1,360,000	
3	N/A	$360,000	$900,000	$760,000	
4	N/A	$80,000	$210,000	$415,000	
TOTAL	**$1,200,000**	**$1,105,000**	**$3,075,000**	**$3,465,000**	**$8,845,000**

The reasons for the significant increase expected in the second half of FFY 2019 and in FFY 2020 and 2021 relate to the following:

- Focusing recruitment efforts on Medicaid providers that have been identified by AHCCCS as medium-high and high volume providers will result in up to an additional 287 entities participating in Health Current.

- Continued CYE 2020 DAP Final Public Notice alludes to the intention of AHCCCS to provide DAP incentives to outpatient behavioral health clinics for HIE participation and data use. This will result in up to an additional 193 behavioral health outpatient entities participating in Health Current and implementing data use services (likely Portal and Alerts).

- Areas of implementation focus in 2019 for Health Current currently relate primarily to the AHCCCS Targeted Investments Program HIE data submission deadline of September 30, 2019 and both AHCCCS CYE 2019 and CYE 2020 DAP HIE milestones. The projections related to these implementations are included in the Milestone 2, 3 and 4 projections in the table above and will extend into FFY2020 and FFY2021.

Health Current has also recognized over time that interfaces built several years ago do not include the comprehensive data set that is now requested by both the community and more specifically, the AHCCCS TI and DAP programs. To ensure that Medicaid providers have comprehensive information available when performing care coordination and transition of care activities related to Meaningful Use, Health Current respectfully requests that several "conversion" milestones be approved as part of the HIE Onboarding Program.

New for FFY 2019 and FFY 2020 Health Current Security Certification(s) Gap Analysis

The agency has been developing its Privacy and Security standards and since last month, it has been recommended to Health Current to become MARS- E Certified. To ensure that a robust infrastructure with all appropriate privacy and security safeguards is in place, AHCCCS has requested that Health Current achieve HITRUST and MARS-E certifications.

AHCCCS will be requesting a total of $350,000 to be included in the next HITECH IAPD in order to cover the costs for our contractor to perform a gap analysis to understand what it will need to do and complete in order to achieve MARS E Compliancy by the end of FFY 2020. We expect to split the funding between FFY 2019 and FFY 2020, as the certification process is anticipated to take from 12 – 18 months, including preparation work, the actual auditing and certification process and any needed remediation. The split of funds is anticipated to be as follows:

Year	Amount
FFY2019	$100,000
FFY2020	$250,000
Total	**$350,000**

New for FFY 2019, FFY 2020 and FFY 2021 ADHS and HIE Connectivity

Advanced Directives- AHCCCS is working with the HIE and our Arizona Department of Health Services to implement two different projects. The first is supporting the standing up of the Advanced Directives registry which used to be housed at the Arizona Secretary of State's office, but was a paper based and older system which was not meeting the needs of the Arizona hospitals or citizens. In 2019, a bill was approved where the Department of Health Services would provide the oversight to Health Current as the custodian of the registry. This is still being developed at this time and more information will be contained in the HITECH IAPD about how the team envisions the new registry to work and the infrastructure that is needed to make it happen.

Master Patient Index - The second project that the DHS is interested in starting is a Master Patient Index as a service for its registries and systems. Starting with the ASIIS Immunization Registry, ADHS and Health Current want to collaborate on establishing an MPI provide a positive link to an individual's information across health care and non-healthcare settings and databases. The MPI as a service is available to Health Current Participants via APIs and assigns a unique electronic community patient identified (eCPI) to each individual by Health Current to link and access records across the ADHS ecosystem.

New for FFY 2019 and FFY 2020

PDMP and the Support Act- The agency is reviewing the SUPPORT Act for PDMP improvements and connectivity for facilitating integration of PDMP into workflow , DDI for PDMP functionality with Board of Pharmacy and Health Current and ADHS.

Health Current Technical Infrastructure and Capabilities

Health Current hosts a comprehensive longitudinal patient health information relational database that supports the integration of physical health and behavioral health data. Health Current utilizes Mirth as the foundation of it's HIE technology platform. Mirth's HIE technology currently powers more than 30 HIEs nationwide and its interface engine Mirth Connect is utilized by thousands of organizations worldwide. Starting in 2019 Health Current is updating its Mirth platform to NextGen/Mirth Results with transition expected to be completed by Q1, 2020.

Health Current has more than 200 active channels supporting the exchange of patient and provider information between the HIE and the EHR of Health Current participants. It utilizes an integration engine to develop and support these interfaces that can support all national interoperability standards including HL7 v2.x, HL7 v3.x, C-CDA Continuity of Care Documents (CCD), and IHE ITI profiles including:

- ATNA - Audit Trail and Node Authentication

- BPPC - Basic Patient Privacy Consents

- XCA - Cross-Community Access

- XDM - Cross-enterprise Document Media Interchange

- XDR - Cross-enterprise Document Reliable Interchange

- XDS - Cross Enterprise Document Sharing

Current and Planned Agency Contracts

Table 21 summarizes the activities the SMA is engaged in or planning to be engaged with to facilitate HIT/HIE Adoption for FFY 2019, FFY 2020, FFY 2021.

Table 21: Current and Planned State Activities to Facilitate EHR/HIE Adoption

Current and Planned State Activities to Facilitate EHR/HIE Adoption			
Activity	**Description**	**Contractor**	**IAPD Status**
Annual MD/DO Environmental Scan	Survey of all MDs and DOs conducted at the time of re-licensing regarding adoption of Electronic Health Record technology	Arizona State Univ./ Center for Hlth. Information Research	**To be Included in FFY 2019, FFY 2020, FFY2021**
Planning, Education and Outreach	The SMA has contracted with Health Current to recruit Medicaid providers, provide resources and education and SME access to providers in the MU program. Additional resources are being requested to support providers who need consulting support, training on data utilization and use and support for Medicaid providers to adopt clinical decision support, e RX, HIE, public health reporting, coordination of care and other MU measures. Resources are envisioned to support Health Currents planning for Medicaid providers to identify HIE sustainability and future needed services by Medicaid providers.	Health Current	**To be Included in FFY 2019, FFY 2020, FFY2021**
Health Current Security Gap Analysis	To ensure that a robust infrastructure with all appropriate privacy and security safeguards is in place, AHCCCS has requested that Health Current achieve HITRUST and MARS-E certifications. It is requested that the funding be split between FFY 2019 and FFY 2020, as the certification process is anticipated to take from 12 – 18 months, including preparation work, the actual auditing and certification process and any needed remediation.	Health Current	**To be included in FFY 2019, FFY 2020**
Project Administration and support of the PI Program	The SMA has contracted with a SME to assist with EHR Program administration which can include prepayment peer reviews, post payment support, MU education, audit training, staff education, project management and updates to its Audit Toolkit and processes to ensure CMS compliance. This can also include SMHP Updates and IAPD updates to CMS. This also includes any help in Administrative Appeals processes as needed.	Myers and Stauffer	**To be Included in FFY 2019, FFY 2020, FFY2021**

Temporary Services – Legal, IT and Customer Service/Adminis tration	Temporary Staff can be accessed if needed to support the agency administration and oversight of the EHR Program and can be done to supplement IT, legal, customer service, etc. to assure timely payment and strong program integrity.	Knowledge / Services	**To be Included in FFY 2019, FFY 2020, FFY2021**
HIE Onboarding of Medicaid Providers	The agency has been funding HIE Onboarding for Eligible Medicaid providers including Hospitals, FQHCs and Physician Groups to the Statewide HIE and received approval in 2017 to onboard other Medicaid EPS as allowed under as allowed under SMD 16-003	Health Current	**To be Included in FFY 2019, FFY 2020, FFY2021**
Standing up electronic Advanced Directives Registry	The agency is planning to collaborate with ADHS and Health Current to stand up an electronic repository of patient Advanced Directives for use by the Hosptals and citizens This is a specialized registry as identified in the HITECH program.	ADHS/ Health Current	**To be Included in FFY 2019, FFY 2020,**
Public Health Master Patient Index Project	ADHS wants to engage Health Current to create an MPI for its multiple registries starting with the ASIIS Immunization Registry.	ADHS/Health Current	**To be included in FFY 2020, FFY 2021**
Emergency Service Providers/ Public Health Data Repository	Emergency Service Providers who can be Medicaid providers need a way to communicate with MU Hospitals about incoming patients and to share clinical data prior to hospitalization that all first responders can view.	ADHS/ Health Current	**To be Included in FFY 2019**
PDMP and SUPPORT ACT	New CMS guidance to allow for qualified PDMPs for state expenditures to do DDI to faciliatate a qualified PDMP for Medicaid agencies and providers	Board of Pharmacy ADHS/ HealthCurrent	**To be included in FFY 2019, FFY 2020**

Data Source: AHCCCS HIT May, 2019

Current Non-contracted Services

The following activities in the following table were initiated and completed in 2019 in-house, in support of the PI Program and did not require external contractual support.

Table 22: Current State Activities to Facilitate HIE/EHR Adoption – Non-Contracted Services

Current Agency Activities to Facilitate HIE Adoption - Non-Contracted			
Activity	**Description**	**Contractor**	**IAPD Status**
White Space Analysis - Review and Update	The SMA extracted data from the National Level Repository to identify EPs, by Geographic location, that have not participated in the PI Program.	Performed by SMA Staff	Not Applicable

Data Source: AHCCCS HIT April, 2019

SMA Role in Facilitating HIE Participation and MU Progress

AHCCCS has a multi-pronged strategy with numerous initiatives to facilitate HIE and EHR Adoption. Using the HITECH IAPD enhanced funds; the agency is deploying resources to participants and staff that are a part of the PI Program in 3 different ways.

EHR Program Administration

Within the agency, AHCCCS has increased the number of fulltime FTEs that work on the program, particularly in our Information Technology area. There are now 3.5 fulltime FTEs who help with resolving technical problems with our electronic provider incentive portal (ePIP) and who do all the programming and security for this project. The agency builds and operates its own PI Program portal called ePIP which stands for Electronic Provider Incentive Payment System.

Across the agency, other divisions including OOD, DHCM, OALS, DBF, DMS, OIG and DFSM contribute staff time to the administration and oversight of the PI/EHR Incentive Program.

Through its staffing, the agency handles all aspects of administering the EHR program including recruiting and registering non-participating providers, providing pre and post-payment attestation reviews, handling customer service in coordination with Health Current for the EHR program participants, performing audits, and managing communication with providers related to the program. AHCCCS Office of Inspector General provides grievance and appeals for the participants, receives reports of fraud and abuse, and performs and oversees post pay audits.

The Agency Uses Contractors as needed for its EHR Program Administration

As detailed in the table above, the agency contracts with several organizations or specialized subject matter experts to support the EHR program. Through contracts with temporary staffing firms or specialized contractors, the agency meets the administrative and oversight requirements of the EHRs program. The agency has used temporary IT staffing to upgrade security and to assist with building ePIP changes to accommodate rule changes or improve security. The agency may hire other additional temporary administrative help to accelerate the processing of provider attestations and payments, if needed.

The agency has had an Interagency Service Agreement (ISA) with the researchers at Arizona State University and the Center for Health Information and Research (CHIR) to perform an annual survey and assessment of physicians EHR Adoption and Use trends. This survey is conducted during the physicians' annual license renewal cycle at the Arizona Board of Medical Examiners

and the Osteopathic Board. Findings from this part of the agency's ENVIRONMENTAL SCAN are located in this Section A. The agency also has contracts with Myers Stauffer for training, project management, education, report writing, auditing SME, and contracts with Health Current for expansion of Education and Outreach, HIE workflow, E-prescribing, and HIE onboarding.

Describe REC or Other Similar Entities Continuing to Operate

The agency has continued to have a relationship with Health Current which ran the ONC funded Regional Extension Center (REC) Program. The agency secured a non-compete contract with Health Current to continue outreach and education for those EPs that are not progressing through meaningful Use as well as EPs that are progressing through Meaningful Use but need specialized assistance. Health Current is targeting high volume Medicaid providers that have received at least one payment from the Medicaid PI Program.

The figure below shows the growth and participation by a variety of Medicaid stakeholders. Of the 586 participants, 350 Medicaid providers (59%) have been onboarded using HITECH funds.

Note that Health Systems with multiple hospitals count as one participant. There are 73 behavioral health organizations that have been onboarded using funds from the Regional Behavioral Health Organizations.

For a complete listing of all HIE participants, click on the following link:

https://healthcurrent.org/hie/the-network-participants/

Figure 17: Cumulative Health Current Participants by Year
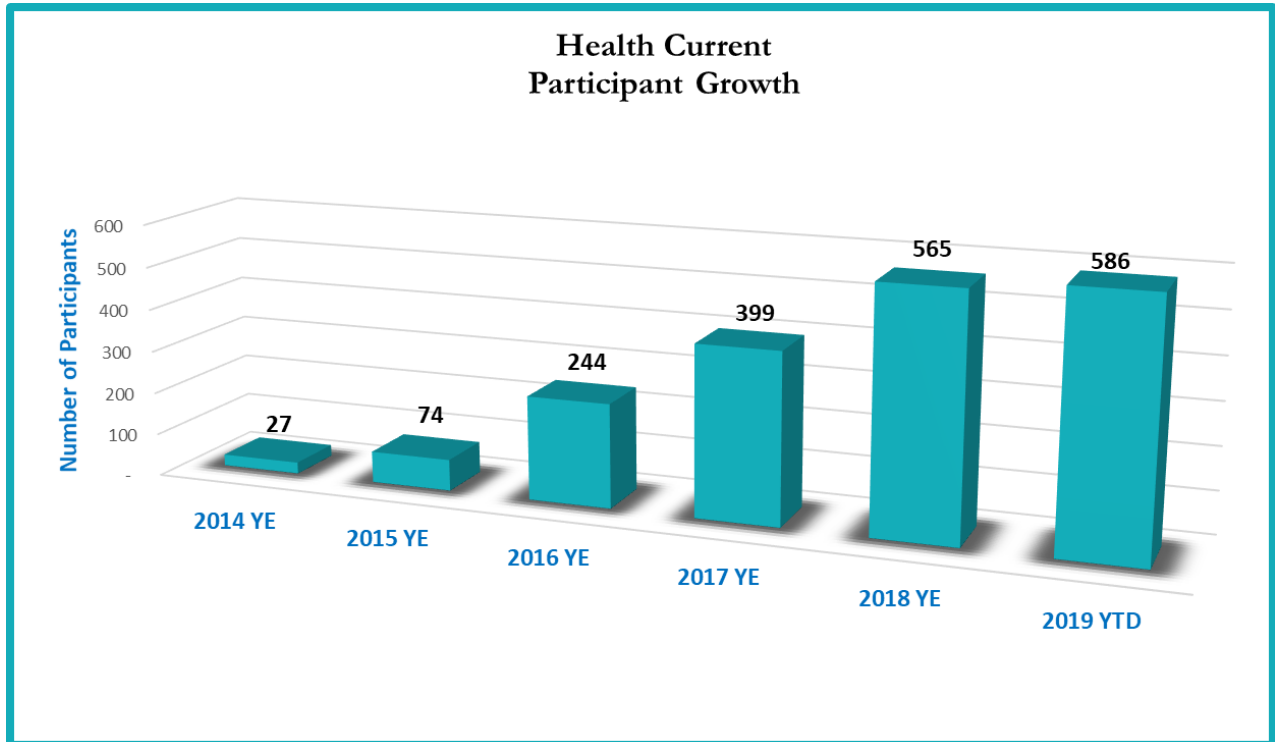
Data Source: Health Current April, 2019

HIE Adoption Plans and the Role the SMA Plays

AHCCCS has added a contract requirement to the MCO Acute Care plans requiring them to participate with Health Current. It is expected that the Medicaid MCOs will be able to improve their care coordination abilities by getting access to real time clinical data that is available at the HIE. As of April, 2019, 586 organizations have joined Health Current and are in various stages of completing their interfaces.

The following table illustrates the year to date transaction volumes for transactions received by the HIE. Health Current has over 8 million patients with clinical data and over 7 million transactions are processed monthly.

Table 23: Year to Date Transaction Volumes - Inbound Totals to Health Current (HIE) as of February, 2019:

Transaction Type	3-Month Rolling Average
Alerts Sent	6,616,415
ADT, Clinical Results & Clinical Documents Received	17,427,580
Coordination of Care Documents (CCDs) Received	553,460
Total	24,597,455

Data Source: Health Current February, 2019

Fee Structure for Health Current (HIE)

Health Current updated its fee structure in 2015 which has resulted in a lot more organizations joining. Health Current eliminated any fees to community providers who want to join the HIE. Health Plans and Hospitals each pay 50% of the ongoing operational fees which are offset by any grants or other funding Health Current receives.

After other funding sources are incorporated, hospital and health plans split Health Current's operational costs 50-50
- Hospitals pay based on discharges (per discharge rate)
- Health plans pay based on allocated share (agreed upon by plans)

Fees for other stakeholder types are under consideration. Health Current is able to keep their rates low based on continued availability of AHCCCS HIE funding and Federal grant funds.

There are significant statewide HIE benefits for participants:

- one connection,

- access to new patient Information,

- timely clinical information to assist with care coordination,

- medical histories from Out of State Sources and

- secure communication between participants.

The table below represents the updated Milestone descriptions for the HIE onboarding that will be included as a new amendment to the existing agency contract and sent to CMS for approval once funding is approved by the HITECH IAPD.

Table 24: Proposed 90/10 Onboarding Program Milestones – 2019

healthcurrent
HIE Onboarding Program
FFY 2019 through FFY 2021   **Milestones & Options**
Milestone 1: Recruitment   Recruitment of Medicaid Provider   Includes all recruitment activities, fully executed agreements, patient consent guidance, and individual organization's assessment and options for bi-directional HIE connectivity with workflow review and redesign support.   A Milestone 1 payment will be made to the Contractor once a Medicaid Provider signs a Participation agreement with the Contractor.
Milestone 2: Participant Data to the HIE (One-Way Interface Development)   A Milestone 2 payment (options A-H below) will be made to the Contractor when one-way connectivity between a Medicaid Provider (Participant) and the Contractor has been established, resulting in the submission of data from the Participant to the HIE. If the Medicaid Provider is an entity that operates more than one electronic health record ("EHR") system or one or more instance of the same EHR, resulting in the implementation of multiple interfaces, then multiple Milestone 2 payments (options A-H below) may be made. A Milestone 2 payment (options I-O below) will be made to the Contractor when the Medicaid Provider that already has an established interface needs adjustments to the interface to be completed to send more comprehensive and complete data to the HIE, or to make other adjustments to be in compliance with Medicaid HIE requirements. If multiple adjustments need to be made to multiple interfaces within a single entity, then multiple Milestone 2 payments (options I-O below) may be made.

A.	Interface Development: HL7 v2 Data Feed for all transactions types
B.	Interface Development: HL7 v3 or CCDA Data Feed for all transactions types
C.	Interface Development: HL7 v2 Data Feed for ADT transactions only plus Interface Development of Query Response (non-eHealth Exchange) to supply the remaining laboratory, radiology and transcription transactions
D.	Interface Development: HL7 v3 or CCDA Data Feed for ADT transactions only plus Interface Development of Query Response (non-eHealth Exchange) to supply the remaining laboratory, radiology and transcription transactions
E.	Interface Development: HL7 v2 Data Feed for ADT, laboratory and radiology transactions plus Interface Development of Inbound using XDS.b protocol for all transcribed documents

F.	Interface Development: HL7 v3 or CCDA Data Feed for ADT, laboratory and radiology transactions plus Interface Development of Inbound using XDS.b protocol for all transcribed documents
G.	Interface Development: Direct Secure Email with CCDA/CCD encounter summary
I.	Conversion from A to B: (A) HL7 v2 Data Feed for all transaction types → (B) HL7 v3 or CCDA Data Feed for all transaction types
J.	Conversion from A to C: (A) HL7 v2 Data Feed for all transaction types → (C) HL7 v2 ADT transactions only plus Interface Development of Query-Response (non-eHealth Exchange) to supply the remaining laboratory, radiology and transcription transactions
K.	Conversion from A to D: (A) HL7 v2 Data Feed for all transaction types → (D) HL7 v3 or CCDA - ADT transactions only plus Interface Development of Query-Response (non-eHealth Exchange) to supply the remaining laboratory, radiology and transcription transactions
L.	Conversion from A to E: (A) HL7 v2 Data Feed for all transaction types → (E) HL7 v2 for ADT, laboratory and radiology transactions plus Interface Development of Inbound using XDS.b protocol for all transcribed documents
M.	Conversion from A to F: (A) HL7 v2 Data Feed for all transaction types → (F) HL7 v3 or CCDA for ADT, laboratory and radiology transactions plus Interface Development Inbound using XDS.b protocol for all transcribed documents
N.	Conversion from C to E: (C) HL7 v2 for ADT transactions only plus Interface Development of Query-Response (non-eHealth Exchange) to supply the remaining laboratory, radiology and transcription transactions → (E) HL7 v2 for ADT, laboratory and radiology transactions plus Interface Development of Inbound using XDS.b protocol for all transcribed documents
O.	Conversion from C to F: (C) HL7 v2 for ADT transactions only plus Interface Development of Query-Response (non-eHealth Exchange) to supply the remaining laboratory, radiology and transcription transactions → (F) HL7 v3 or CCDA for ADT, laboratory and radiology transactions plus Interface Development of Inbound using XDS.b protocol for all transcribed documents

Milestone 3: HIE Data to the Participant (One-Way Interface Development or Service Implementation)

A Milestone 3 payment (options A-G below) will be made when an interface is developed to allow HIE data to flow to the Participant's EHR or when the Alerts & Notifications service is implemented. If the Medicaid Provider is an entity that operates more than one EHR system or more than one instance of the same EHR system, then multiple Milestone 3 payments may be made. A Milestone 3 payment (options H-I below) will be made to the Contractor when a Medicaid Provider that already has an established interface needs adjustments to the interface to be completed to receive more comprehensive and complete data from the HIE, or to make other adjustments to be in compliance with Medicaid HIE requirements, or if the Participant desires an interface to receive HIE data in addition to having established Alerts & Notifications.

A.	Interface Development: HL7 v2 Data Feed (all transaction types)
B.	Interface Development: HL7 v3 or CCDA Data Feed (all transaction types)
C.	Interface Development: eHealth Exchange Query-Response
D.	Interface Development: Non-eHealth Exchange Query-Response
E.	Alerts & Notifications: Direct Secure Email & HIE Portal included, but not required
F.	Interface Development: Direct Secure Email with CCDA/CCD encounter summary
G.	Interface Development: Vendor hosted cloud-based service receiving a CCDA/CCD encounter summary via a single interface
H.	Conversion from E to C: (E) Alerts & Notifications (may include Direct Secure email & HIE Portal) → (C) eHealth Exchange Query-Response

I.	Conversion from E to D: (E) Alerts & Notifications (may include Direct Secure Email & HIE Portal) → (D) Non-eHealth Exchange Query-Response

Milestone 4: Participant Administrative Offset Payments

The Contractor will receive administrative offset payments to be passed through directly to the Medicaid Providers upon achievement of Milestones 1, 2 and 3.

AHCCCS will pay the Contractor, based upon the payment schedule below, and the Contractor shall pay this entire amount in a one-time administrative offset payment directly to the Medicaid Provider. The Contractor shall retain NO PORTION OF THIS PAYMENT.

For the purpose of the HIE Onboarding Program for Medicaid, Milestone 4 payments are dependent on the number of providers within an Eligible Participant organization. A "provider" is defined as a doctor of allopathy (MD), doctor of osteopathy (DO), nurse practitoner (NP) or physician assistant (PA). Other types of Medicaid Providers may be considered in these calculations, upon written approval by AHCCCS. AHCCCS can adjust these payments as it deems necessary. Offeror does not need to provide pricing for this Milestone. The Participant Administrative Offset Payments are as follows:

A.	Hospital Administrative Offset Payment
B.	FQHC, FQHC Look-Alike & Rural Health Clinic Administrative Offset Payment
C.	Community Provider Administrative Offset Payment (practices of 1 to 10 providers)
D.	Community Provider Administrative Offset Payment (practices of 11 to 25 providers)
E.	Community Provider Administrative Offset Payment (practices of 26+ providers)

Milestone 5: Optional Meaningful Use Support Services

The optional Milestone 5 payment will be made when an Eligible Medicaid Provider establishes one or more of the optional connectivity services listed under "Milestone 5: Optional Meaningful Use Support Services". Multiple Milestone 5 payments may be made for each Eligible Medicaid Provider, as long as the Eligible Medicaid Provider requires multiple connection options under Milestone 5 to meet Meaningful Use requirements.

A Milestone 5 payment (Options A-G below) will be made if documented by the Contractor based on the need of the Medicaid Provider. A Milestone 5 payment (option H below) will be made if documented by the Contractor based on the need of the Medicaid Provider and approved by AHCCCS in writing. Anything with a price marked "TBD" must be approved in writing by AHCCCS prior to billing.

A.	Direct Accounts Only (for transport between providers)
B.	Public Health: Immunizations
C.	Public Health: Reportable Labs
D.	Public Health: Syndromic Surveillance
E.	Public Health: Disease Registries (per registry)
F.	Specialized Registries (ie. Controlled Substances Prescription Drug Monitoring, Advanced Directives, etc)
G.	Miscellaneous Service - TBD

Data Source: Health Current Proposed Milestone Table May, 2019

Agency Use of HIE Policy Levers

The agency established a requirement that each Program Contractor had to join Health Current (HIE) in order to fulfill one its contractual requirements. It is expected that each Program Contractor will be accessing real time clinical data that is a part of the HIE for the purpose of improving care coordination and using real time clinical data to improve member care. Each program contractor has signed an HIE Participation Agreement and has agreed to work towards bi-directional data exchange.

The agency has also required each Program Contractor to monitor the e-prescribing rates of its providers and to raise those by 15% - 20% by the end of 2016. The formula is calculated as the prior year baseline + the Peak Quarter the plan achieved the result.

Below is a summary of the e-prescribing benchmarks for each of the AHCCCS Acute Plans through 2018. It shows each of the health plans 2014 -2018 baselines and shows their overall 5 year trend in reaching the goals.

Note that the drop in participation for three plans simply reflects a drop in reporting for the three organizations whose contractual relationship changed with AHCCCS when AHCCCS realigned its contractual relationships with MCO's under AHCCCS Complete Care. All other MCO's have demonstrated a continued increase.

Table 25: E- prescribing and Health Plans

Health Plan	2014 Baseline	2015 Baseline	2016 Baseline	2017 Baseline	2018 Baseline	5 Year Trend
Acute	42.22%	45.20%	49.10%	54.20%	62.20%	
CARE 1ST ARIZONA	40.57%	45.20%	49.10%	53.30%	59.10%	
HEALTH CHOICE AZ	43.34%	43.80%	45.20%	50.00%	62.00%	
HEALTH NET ACCESS	34.58%	42.30%	48.30%	53.90%	62.40%	
MARICOPA HEALTH PLAN	39.67%	43.70%	47.40%	52.90%	25.00%	
MERCY CARE PLAN	40.06%	42.80%	45.60%	49.10%	55.40%	
PHOENIX HEALTH PLAN	40.16%	45.10%	49.40%	53.40%	11.80%	
UNITED HEALTHCARE	43.70%	48.00%	52.80%	58.90%	65.90%	
UNIVERSITY FAMILY CARE	47.28%	49.80%	55.40%	62.30%	68.50%	
DCS/CMDP	46.57%	50.20%	55.10%	59.40%	63.90%	
CRS	41.82%	49.00%	57.00%	63.90%	63.70%	
LTC	23.76%	25.00%	28.30%	31.30%	35.50%	
BRIDGEWAY - LTC	20.70%	21.20%	22.90%	26.50%	15.90%	
MERCY CARE PLAN - LTC	23.49%	24.30%	27.80%	32.80%	39.30%	
UNITED HEALTHCARE LTC	25.98%	28.30%	31.50%	34.60%	38.80%	
Banner University LTC				0.00%	28.50%	
RBHA			54.90%	62.80%	70.20%	
MERCY/MARICOPA INTEGRATED	31.97%	38.26%	51.50%	57.40%	63.80%	
HEALTH CHOICE INTEGRATED			54.50%	64.30%	71.80%	
CENPATICO INTEGRATED CARE			58.80%	66.70%	75.00%	

Data Source: AHCCCS DHCM, March, 2019

How are Regional Extension Center Operations assisting Medicaid Eligible Providers Ongoing Role and Provider Targets for Education and Outreach?

The REC Program was successful in assisting hospitals and providers to adopt EHR and achieve success in being able to attest to Adopt, Implement, Upgrade and Meaningful Use Stage 1. The REC assisted over 3,000 Medicaid Providers in Arizona. Since the grant funding has ended, AHCCCS has contracted with Health Current to provide a small resource for Education and Outreach first for unenrolled but eligible Medicaid Professionals and then for those enrolled but not progressing.

Health Current has targeted to support non-progressing Eligible Professionals into the AHCCCS Promoting Interoperability Program by the end of Program Year 2019. Health Current provides webinars, monthly newsletters, and phone technical assistance to those seeking to attest and advance through Meaningful use and participate in interoperability through the HIE.. Health Current is providing comments or feedback to AHCCCS as it talks with providers with ideas and suggestions of ways the agency could improve its customer service to those EPs that experienced problems and successfully attested and to outreach to those that are not progressing. This contract started in mid-year 2015 and is continuing.

SMA Provider Support to Use EHRs for Other Purposes

On December 31, 2016 AHCCCS received approval from CMS to launch a Targeted Investments Program to transform health care through integration of behavioral health and physical health providers. The Targeted Investments (TI) Program is AHCCCS' strategy to provide financial incentives to eligible AHCCCS providers to develop systems for integrated care. In accordance with 42 CFR 438.6(c) and the 1115 Waiver, managed care plans will provide financial incentives to eligible Medicaid providers who meet certain benchmarks for integrating and coordinating physical and behavioral health care for Medicaid beneficiaries. AHCCCS will incorporate these payments into the actuarially-sound capitation rates. Please see the AHCCCS TI Home Page here for additional information:

https://www.azahcccs.gov/PlansProviders/TargetedInvestments/

The TI Core Components for each of the eligible provider types includes the need to connect and share clinical data using Health Current and adopting health information technology in order to produce high risk registries and perform population health analytics on a provider's panel of members. Applicants are required to have a CEHRT as part of the program.

Award letters were sent out in December 2017 letting providers know if they were accepted into the program and some of the early deliverables were due in the spring of 2018. More information about this program will be shared as it advances.

Prior to receiving a Targeted Investments program, AHCCCS had received a State Innovation Model (SIM) Planning Grant in 2015. The agency received a SIM Model Design planning grant which identified gaps or challenges providers have when trying to share or provide real time clinical quality data in a transformational plan that assessed different payment and care delivery

models that improve the patient experience (including quality and satisfaction), improve the population health and reduce per capita costs of healthcare in the strategic focus areas are below:

1. Enhance coordination and integration between physical health and behavioral health providers for adults and children.

2. Improve justice system transitions through development of HIT/HIE infrastructure and health plan interfaces to coordinate coverage and care with Arizona Department of Corrections (ADOC), county jails and probation systems.

3. Enhance and develop regionally based care coordination models for the American Indian Health Plan (AIHP) members, including data sharing capacity, collaboration with Indian Health Services, 638 Tribally operated, and non-tribal providers to support provider infrastructure development and reduced delivery system fragmentation.

One of the deliverables of the SIM transformation plan was a Health IT plan that will support communications and real time data exchange among the EPs that make up the care network for each of the 3 target populations. Health Current hosted and coordinated stakeholder engagement activities needed to develop the Health IT components of the SIM grant.

Statewide Behavioral Health Integration Plan (SHIP)

Back in 2016, Health Current was tasked by the State of Arizona to produce an integrated Physical and Behavioral Health Plan for HIE. Health Current completed the Statewide Behavioral Health Integration Plan or SHIP that had a strategy for onboarding organizations that are integrating physical and behavioral health information exchange under one infrastructure. The goal was to improve quality and outcomes for Arizona patients who receive physical and behavioral health care.. The SHIP had these three advantages:

- A single HIE infrastructure managed by Health Current
- One marketing and communication and messaging strategy for the integrated HIE for all physical and behavioral services; and
- One financial model that encompasses a single fee for physical and behavioral health care stakeholders to sustain the integrated physical and behavioral health network

Health Current delivered the SHIP to the state in the summer of 2016. The plan included a list of the high priority behavioral health organizations that were targeted to connect to Health Current by May, 2018. Funding for this onboarding project was from the Behavioral Health Plans. These were non-HITECH Funds. The program ended in 2018.

A.10 SMA's Relationship to the State HIT Coordinator

(SMHP Companion Guide Question A #10)

The State HIT Coordinator

The HIT Coordinator who oversaw the ONC HIE Cooperative Agreement Program for the State of Arizona also serves as the Medicaid HIT Coordinator. The State HIT Coordinator sits in the Office of the Director in the Medicaid agency. The Regional Extension Center (REC) Program was never a part of the SMA, and has always resided outside of state government. The Medicaid agency oversees all aspects of the Medicaid PI Program.

A.11 SMA Activities to Influence PI Program and Use of HIT/HIE and Data

(SMHP Companion Guide Question A #11)

The direction of the EHR Program over the next five years will be to keep as many providers who attested to AIU, MU1 and MU2, and MU3 participating in the PI Program. Through collaboration with the HIE, the agency is focused on getting as many providers onboarded and sharing data using the statewide infrastructure that is at Health Current.

Description of other activities underway that will influence the PI Program

Statewide HIE Integration Plan (SHIP) for Behavioral Health Providers & Hospitals

In 2016, the Regional Behavioral Health Plans contracted with Health Current to onboard to the HIE their priority BH providers. The RBHAs identified their high priority behavioral health providers by region of the state. The SHIP called for integration of behavioral health information into the HIE and was expected to connect the top 90 BH providers by May, 2018.

The prioritization was generally based on the following priorities:
1. Crisis Network data suppliers and data users
2. Priority Providers as identified by each RBHAS
3. Priority Providers shared between multiple RBHAs and
4. Any remaining Priority Provider

At the end of the Program in April 30, 2018 :
There were 89 Priority Providers on the Targeted High Provider list

- 62 Community Providers
- 11 Federally Qualified Health Centers (FQHCs)
- 5 Correctional Health Facilities
- 11 Behavioral Health Hospitals

Number of providers that signed an agreement – 87 (97%)

The number of organizations using the HIE Portal = 58 (89%)

The number of organizations receiving ALERTS = 53 (82%)

The number of organizations with an inbound to the HIE Interface = 48 (74%)

The number of organizations with an outbound interface = 14 (22%)

Throughout 2018, Health Current was able to continue to provide services and progress towards bidirectional connectivity. They finalized development of an "integrated view" of all data available from the HIE for those who have appropriate access and consent (integrates all data together). Health Current has offered Part 2 webinars in August/September 2018 and is supportive of any federal policy changes that would allow for more sharing between integrated care givers and data sharing.

In 2019, Health Current is continuing to work with those High Priority providers that had not yet completed connectivity. They are working to provide serves and help organizations reach bi-directional data exchange. Health Current is collaborating with the Regional Behavioral Health Organizations and the AHCCCS Complete Care (ACC) MCOs to support plan access to behavioral health information in HIE.

Linking Health Information Exchange Participation with Value Based Payment

Hospital Achievement of MU to Value Based Payment

On December 3, 2015 AHCCCS released a proposed rule that would allow AHCCCS to pay a 0.5% increase to registered Hospitals which met the Agency established value based performance metrics requirements of having achieved a Medicare MU Stage 2 payment and be submitting data to the HIE including admission, discharge, and transfer information inclusive of emergency department services.

Since 2016, the Differential Adjusted Payment program has resulted in about $90 million in extra payments based on providers meeting the HIE connectivity and data sharing requirements of the program. .

Improving Agency Operations by Establishing Agency Connectivity to Health Current (HIE)

AHCCCS Agency Connectivity and Use of the HIE

The AHCCCS Division of Fee for Service Management (DFSM) established connectivity to the HIE to assist with care coordination for its members who are enrolled in the American Indian

Health Program or AIHP. The DFSM care managers are receiving Hospital Admissions, Discharges and Transfer alerts (ADT) to initiate coordination of care for their AIHP members. The interface was completed testing in July, 2016. Since then the division has organized itself to be able to receive Hospital ADTS on 200 of the HN/HC (high needs/high costs) members and to provide care coordination for them. The connectivity was paid for with non-HITECH Funds.

Current enrollment numbers for AIHP:

Chinle : 11,923

PIMC: 3,296

Winslow: 1,587

Whiteriver: 174

American Indian Medical Home

In September 2016, the AHCCS American Indian Health Program (AIHP) established connectivity with the HIE to support care coordination for a small number of its AIHP members. AIHP is receiving ADT alerts from the HIE when one of its High Needs/High Costs members is hospitalized and the care coordinators are able to view labs and images from any of Health Currents' participants. The AIHP is for members enrolled in the American Indian Health Plan which is operated by the AHCCCS Division of Fee for Service Management.

Information about the American Indian Medical Home (AIMH)

IHS and Tribal 638 facilities may choose whether or not to provide an American Indian Medical Home Program. In order to receive the per member per month (PMPM) rate for services provided by their Medical Home, facilities must submit evidence of meeting the Medical Home criteria initially, and annually thereafter to the AHCCCS Division of Fee For Service Management (DFSM).

The AIMH Program is a voluntary program for individuals who are participating in the Fee For Service (FFS) American Indian Health Program (AIHP). AIHP members will have the option to decline participation, dis-enroll, or switch AIMHs at any time. Reimbursement will be based upon only those members that are formally part of the medical home. To ensure there is choice given, the AHCCCS FFS member must sign a form at the facility stating they are in agreement to be empaneled to that particular facility. An AHCCCS FFS member may also call in to AHCCCS Member Services to become empaneled to a particular facility of choice.

Provider Payments are being linked to Case Management and HIE
The American Indian Health Program (AIHP) has worked in conjunction with Tribes and IHS Facilities to determine the cost of delivering a Medical Home, which would reimburse for Primary Care Case Management, a 24 hour call line and care coordination among sites. A baseline PMPM payment of $13.26 with an annual increase of 4.6% is based on an average annual

increase of the outpatient all-inclusive rate over the past 10 years. There are 4 AIMHs that have been approved:

Chinle Comprehensive Health Care – Tier 4

Phoenix Indian Medical Center – Tier 2

Winslow Indian Health Care Center – Tier 3

Whiteriver Indian Hospital – Tier 2

For approved Medical Homes providing diabetes education pursuant to guidelines established with that model, an additional $2.00 PMPM with an annual increase of 4.6% would be available. For sites also participating in the state Health Information Exchange (HIE), an additional $7.50 PMPM with an annual increase of 4.6% would be available. PMPM payments will be made with 100% FFP dollars and will only be available for IHS and tribally operated 638 facilities for FFS AIHP members. Due to the approved payment methodology, payments are prospective only.

Table 26:   Per Member Per Month Payment Example

AIMH Level	PMPM Rate	PCCM	24 hour Telephonic Access to the Care Team	Diabetes Education	State HIE
1	$13.26	✓	✓		
2	$15.26	✓	✓	✓	
3	$20.76	✓	✓		✓
4	$22.76	✓	✓	✓	✓

In AHCCCS there are 3 different divisions that have established connectivity with the HIE for the purpose of care coordination. These units include the Children's Rehabilitative Services (CRS) unit in DMS who must place already enrolled AHCCCS members into the appropriate Health Plan. The AHCCCS staff must review medical records, mostly from hospitals, to ensure that the child has a qualifying illness and then places them into the correct health plan.

Within the Division of Health Care Management (DHCM), there are 3 units that help respond to Quality of Care concerns. These 3 units are Quality Management, Clinical Resolution and Medical Management who are all tasked with responding when a concern is raised regarding care that was provided and did not meet a professionally recognized standard of health care. Quality of Care concerns can also stem from the failure to deliver care and services in the manner dictated by the AHCCCS contract and policies.

The DMS Arizona Long Term Care Program (ALTCS) is responsible for determining member eligibility for its Long Term Care Program, partially based on a member's physical status. The assessment it uses is called a PASS assessment and partially relies on medical information on that member in order to qualify for the ALTCS program. This is considered an underwriting exercise at this time and is not currently permitted at Health Current.

Importance of Data Sharing and Connectivity for Justice Involved Individuals

AHCCCS works with its local justice system providers including the State Department of Corrections and most county jails to suspend Medicaid member enrollment while members are incarcerated. The SMA suspends enrollment when a member goes into corrections and now it is working to ensure that treatments or clinical services that are delivered during incarceration can be recorded and made a part of a patient's record to ensure continuity of care when that member leaves correctional health and goes into the community.There are five different Justice organizations participating in Targeted Investments with 12 different locations across the state.

AHCCCS has plans to work with this population more to ensure that care delivered while incarcerated is available to primary care providers upon release and that health plan enrollment is completed prior to release. Justice providers are a part of the Targeted Investments program and are expected to gain more connectivity and use of clinical data upon a members release from prison and jails.

A.12 State Laws or Regulations Impacting the PI Program
(SMHP Companion Guide Question A #12)

Changes to State Laws/Regulations and Their Impact on the PI Program; Expand focus to include broader HIT/HIE activities

The Governor signed a bill in February 2019 which retroactively cancels the waiver provisions that were found in the earlier e-prescribing of controlled substances (ECPS) bill .The new bill delays the EPCS mandate until January 1, 2020 (for all counties) and outlines possible options for "exemptions" due to the mandate that all providers have to use e-prescribing for controlled substances and does not offer many specifics on how providers may be granted a waiver from the requirement.

The original Arizona Controlled Substance Prescription Monitoring Program (PMP), passed by the Arizona Legislature in 2017, required that medical practitioners register with the PMP and obtain a patient utilization report before prescribing an opioid analgesic or benzodiazepine controlled substance listed in schedule II, III, IV for a patient. This patient utilization report includes a patient's prescription drug history for the preceding 12 months from the program's central database tracking system.

This year, 2019, Health Current ran an update to the Health Information Exchange Organization (HIO) statute bill which included changes to make it more aligned with HIPAA and to simplify and modernize legislation to accommodate more diverse data sources, data recipients, and expanded

HIO services. It has passed out of both house and senate health committees and is awaiting a full floor vote and is expected to pass.

The Arizona Hospital Authority supported a bill that would transfer the statewide Advanced Directives Registry from the Secretary of State's office to a "qualifying health information exchange organization (Health Current). This would make the information related to end of life decisions more available through electronic database vs the current paper storage process that is in place. The secretary of State supports the transfer of the registry to Health Current and it is awaiting full floor vote and is expected to pass. There are currently funding discussions underway with elected officials to see if there are any funds that could be provided to help establish the electronic registry. As of today no decision has been made.

Broader HIT/HIE Activity Related to Progress Accessing Super Protective Information using HIE

Currently the HIE is <u>receiving</u> 42 CFR Part 2 protected information from 47 different behavioral health providers who are Part 2 providers. They are currently working with other additional behavioral health providers to start receiving their information as well. Health Current has finalized its consent gathering process and is now able to share 42 CFR Part 2 information with providers and payers that have appropriate consent.

SAMHSA Grant

Back in 2016, Health Current received a SAMHSA grant to pilot the sharing of opioid treatment data through health information exchanges in cases of care discontinuity. In the use case, Health Current had to ensure that the 42 CFR Part 2 Regulations privacy protections were maintained. Health Current completed the project and delivered their findings to SAMHSA in October, 2016.

The primary objective of the grant was to facilitate a clients' ability to share medication dosing information in cases of care disruption that was compliant with the 42 CFR Part 2 regulations pertaining to access to substance abuse information. The project included multiple Arizona Opioid Treatment Provider (OTP) sites, each of which had their own electronic health record (EHR) system, that provided the OTP treatment information to the HIE which allowed clients to share their dosing information with other providers when needed and in compliance with 42 CFR Part 2 requirements.

SAMHSA Grant Participants

The study included the following partners/systems:

- Health Current which operates Arizona's statewide HIE
- Maricopa County Correctional Health Services (CHS) – CHS provides integrated health and restoration services to patients in the jail system in Maricopa County within Arizona. Two CHS sites participated in the study: 4th Avenue Jail and Estrella Jail. Both sites used *TechCare* as their EHR.
- Southwest Behavioral & Health Services – SB&H provides behavioral health services throughout the state of Arizona. The EHR utilized by SB&H was *HIMS.*

- Valle del Sol – VDS provides primary healthcare and mental health services in the metro Phoenix area. The EHR used by VDS was ***NextGen.***
- Zen Healthcare IT – The Zen team has many years of real-life, hands-on experience with Mirth and other interoperability tools, interface design and management, third-party integrations, and health information exchange technical projects. Zen was utilized to provide the technical support for ***Mirth***, the system behind Health Current (Arizona's HIE).
- Consent Management – The electronic consent management software that was utilized was ***Consent2Share***.

SAMHSA Grant Objectives

The objective of the grant was to leverage an existing HIE to support the exchange of opioid dosing information between OTPs in a manner that adhered to federal, state, and local privacy requirements. The grant needed to demonstrate that one of the OTP sites could serve as a dosing site when the other site(s) were unavailable through the use of the HIE's online secure portal in a test environment.

The pilot needed to demonstrate how an electronic consent process can manage the sharing of patient health information based on client selected privacy preferences, by The HIE obtaining the patient consent preferences from Consent2Share (C2S) and delivering the appropriate patient information through a secure provider portal in a test environment.

Findings about Sharing Super Sensitive Information

The objective and goals of the grant were met as it was successfully demonstrated that opioid dosing information could be shared amongst the participating OTP sites utilizing the HIE and based on the patient consent preferences captured electronically. The proof-of-concept was conducted in a controlled test environment. Based on lessons learned, the following findings outline should be considered by others when moving this process to a production (aka "live") environment.

1) **EHR Record Information** – Multiple challenges were encountered in obtaining usable record information from the EHR systems to be consumed by the HIE. To move to production the following would need to be managed:

   a) EHR vendor availability – scheduling and prioritization needs to be aligned
   b) Consistency of information – Vendors will need to produce continuity of care document (CCD) records that are consistent in format and content. The information should be standard, coded and predictable.

2) **Treatment Information Identification** – To move to production, it will be important for the OTP clinics to ensure they are capturing all treatment information in their EHRs and coding the treatments and medications correctly.

   2) **Value Sets** – the value sets in Consent2Share need to be expanded to include Medi-Span drug coding data and other medical vocabularies and terminologies which are not already

included in the Consent2Share Value Sets. This effort is expected to require 15 to 18 months working with substance abuse treatment providers in Arizona.

4) **Natural Language Processing (NLP)** – To ensure all references to protected information are identified and managed correctly, the process cannot rely simply on coded information. It was identified that there are instances of non-coded references to opioid treatment in written documents (notes) within the CCDs. To identify this information, NLP should be acquired and utilized to identify these references and allow for the proper consent handling.

5) **Registration** – For the purpose of the proof-of-concept, patients were manually registered in Consent2Share.   In this controlled study this did not cause any issues, however, to move this effort to the production environment this process would most likely prove to be inefficient for the provider sites. During the course of the intake process at each OTP site the patient is registered in the OTP's EHR system. The registration record is then sent to the HIE. For the OTP site to also register the patient in Consent2Share would necessitate duplicate work for the OTP staff. Rather, a process needs to be enabled that allows the registration information received by the HIE to be passed to Consent2Share. In order to accomplish this, a process needs to be developed to identify which registrations received by the HIE need to also be sent to Consent2Share (as not all patients registered in the OTP's EHR may be receiving OTP treatment).

6) **Patient Identification** – Consent2Share needs to be enabled to accept the electronic identification (EID) from the HIE to improve and ensure patient identification matches between Consent2Share and the HIE.

7) **Patient Access to C2S** – During multiple points in the proof-of-concept concerns regarding patient internet access was expressed. While this was controlled in the study, consideration (and potential workarounds) will need to be addressed regarding lack of patient internet access. This can occur both at the OTP sites (such as limited computer terminals) and outside the clinics (lack of patient accessibility to internet). At all points in this process the challenges of internet accessibility need to be taken in to consideration. Below includes some specific areas of concern.

   a)   **Email** – The Consent2Share process involves emailing the sign on and verification information directly to the patients. This poses challenges that need to be addressed.
      i)   Email Accounts – The participating OTP sites each expressed that much of their patient population does not have email accounts. An alternate methodology of providing the sign on and verification information may need to be identified.

      ii)   Email accessibility – Circumstances may not permit or allow for the patient to access their email account. While this was a specific constraint that was identified for incarcerated individuals, there may be other situations where this may occur. Another methodology of providing the sign on and verification information may need to be identified.

   c) **Computer/Internet Access** – The participating OTP sites reported that in many cases the population that they treat does not have access to a computer. A work around for this

is to make computers available in the OTP sites; however, this then puts challenges on the clinics themselves.

c)   **Computer Usage** – It cannot be assumed that the patients involved in the process have the knowledge necessary to use a computer and be able to complete the necessary navigation steps. To move to production, the process will need to account for the assistance that will be necessary to facilitate patient use of Consent2Share. This burden will most likely fall on to the OTP sites themselves which will likely affect staffing requirements and costs.

d)   **Authorized Representative/Guardianship –** Whether due to diminished capacity, age (minor), or other reason, there are many instances where OTP patients have an authorized representative or guardian.   Currently Consent2Share does not have a methodology to allow for these representatives to establish consent on behalf of the patient.   To move to production this will need to be accounted for.

e)   **Accessible Comprehension** – A review of all patient-facing information will need to be conducted in order to confirm the information is written in a way that allows it to be easily understood by the average person seeking OTP treatment. This includes any help hints or descriptions in Consent2Share and any literature that is provided to the patients. It is advised that this information be written at the 6.5 grade level or below.

f)   **Written Consent** – The process must take in consideration that there may be instances where a patient cannot access Consent2Share to provide an electronic consent and that a written (paper) consent would be signed. A method needs to be developed that would allow the OTP clinic to provide a copy of the signed consent to Consent2Share and/or the HIE which would thereby allow the provider to view the needed OTP data in the HIE Portal.

A.13 HIT/HIE Activities Crossing State Borders
(SMHP Companion Guide Question A #13)

HIT/HIE Activities Crossing State Borders

Due to Arizona's geography, most of the health services are delivered within the borders of Arizona. However, there are instances where accessing care out of state is the standard as the Arizona residents are physically closer to a more robust services delivery system in a neighboring state. For example, most people living in the far North West corner of Arizona get specialized hospital care in Las Vegas, Nevada. Also, AHCCCS has a requirement that the health plans have Primary Care, Dental and Pharmacy contracts with providers in Kanab, Utah because it is the closest place for people who live north of the Grand Canyon. Aside from these geographic imperatives, AHCCCS also contracts with some out-of-state hospitals for the provision of covered transplant services that are not available in Arizona.

Significant State line Crossings by Medicaid Beneficiaries

The most important care coordination from other states is related to our Medicaid enrollees that are a part of the Indian Health Services. These members travel frequently between New Mexico if they are Navajo and across the other parts of the state. From a care coordination perspective, AHCCCS recognizes that there could be great value in being able to send and receive health records from IHS and the VA as two examples of federal partners.

AHCCCS has let Health Current take the lead in getting eHealth Exchange certified in order for the providers to be able to share more successfully with other providers from other states, including federal partners like Indian Health Services, the VA and the Social Security Administration for Social Security Disability payment processing. The HIE has completed the certification for Healtheway with its testing with its HIE technology partner Mirth.

It is our understanding that at this time IHS has preferred to focus on establishing connectivity between themselves and other federal agencies verses coordinating and data sharing with state health information exchanges.

Patient Centered Data Home Project

Health Current has established a Patient Centered Data Home project (PCDH) which is a cost effective, scalable method of exchanging patient data among different Health Information

Alerts, which notify providers that a hospital care event has occurred outside of the patient's "home" HIE, and confirms the availability and the specific location of the clinical data. This enables providers to initiate a simple query to access real-time information across state and regional lines and the care continuum.

The PCDH is an initiative of the Strategic Health Information Exchange Collaborative (SHIEC) where clinical data can become part of the comprehensive longitudinal patient record in the HIE where the patient resides. There are currently other Health Information Exchanges participating in the PCDH project with Health Current including our neighboring states of Colorado, Utah, 2 different HIEs from California, Nebraska, and Nevada. There are 41 different other HIEs that participate with HealthCurrent .

A.14 Current Interoperability of State Immunization/Public Health
(SMHP Companion Guide Question A #14)

The Current Interoperability Status of the State Immunization Registry

ADHS is a separate state Agency from the State Medicaid Agency. The Director of ADHS reports to the Governor and for the PI Program, Medicaid is totally dependent on making ADHS successful in establishing the functionality needed for EPs and EHs to meet Meaningful Use. The Arizona Department of Health Services link is: http://azdhs.gov/index.htm. ADHS has already established web pages to support providers in meeting Meaningful Use, located at: http://www.azdhs.gov/meaningful-use.

Immunizations

The Arizona Department of Health Services operates the Arizona State Immunization Information System (ASIIS) or Immunization Registry for the State of Arizona. Under state statute (ARS 36-135 and 32-1974), health care providers are required to report all immunizations administered to individuals 18 years and younger and pharmacists are required to report all immunizations administered into ASIIS.

Pediatric practices most commonly utilize ASIIS, but other practice types report into the system as well including family practice and general physician practices, obstetrician offices, pharmacies, public health departments, community health clinics, IHS facilities, hospitals, military facilities, fire departments, and urgent care centers.

Current Public Health Reporting Environment

Immunization Update -

The Arizona Department of Health Services is currently accepting electronic immunization submissions to the Arizona State Immunization Information System (ASIIS) for Meaningful Use

from all providers who administer adult or childhood vaccines. As of January 1, 2017 ASIIS was able to be ready for Meaningful Use Stage 3. ASIIS will meet the requirements included in the CDC Implementation Guide 1.5. Changes will include bidirectional capabilities allowing queries from EHRs. ASIIS will be able to receive NDC codes as well as CVX codes.

ADHS is working with providers to test an EHR upgrade for MU Stage 3. As of January 2018, Health Current, the HIE, and ASIIS were connected and providers that are connected to the HIE were able to go thru the HIE to report their immunization status.

The long term vision for ADHS and the ASIIS Registry is to be able to have bi-directional and query response functionality as shown in Figure 18 below. There is work ongoing to complete the bidirectional query capability of the registry and the HIE and the goal is to be completed by the end of December, 2019.

Figure 18: Long Term Vision for Bidirectional Immunization Registry
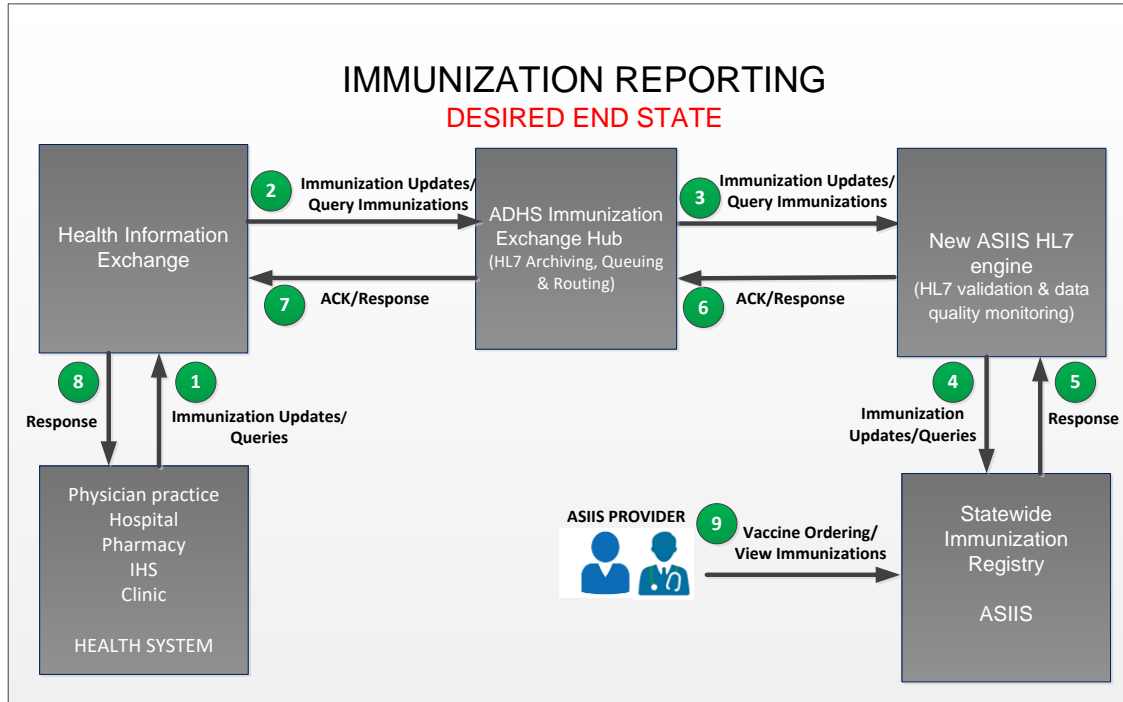
Data Source: Arizona Department of Health Services April, 2019

Immunization Background

ASIIS is the statewide immunization registry for documenting immunization administration. ASIIS is accepting HL7 2.5.1 Immunization messages from any organization that is administering vaccinations to children or adults. Immunizations must be reported for patients aged 18 and under.

If your practice or hospital utilizes an Electronic Health Record (EHR) to document your vaccine administration ASIIS can receive your HL7 2.5.1 messages electronically increasing the accuracy and efficiency of reporting. ASIIS requires HL7 Version 2.5.1 messages. For Meaningful Use the EHR must be certified under ONC requirements.

Immunization Steps for Providers

1. Please complete the registration in the Meaningful Use Portal.
2. Upon registering, specifications and instructions for the next steps will be emailed.
3. You will be required to send a test message proving that your EHR is HL7 2.5.1 capable.
4. After we receive your test message, credentials to the ASIIS Test system will be provided.

We require validation on our Test system prior to moving you to the ASIIS Production system. Approximately 200 production quality messages must be received by the ASIIS Test system.

5. After the ASIIS Interoperability team is satisfied that you have submitted enough quality messages to the Test environment your interface can be transitioned to the ASIIS Production Environment.

If the provider is already registered with ASIIS and would like to begin the process for Meaningful Use Stage 3 please email ASIIS_GROUP1@azdhs.gov.

AHCCCS does not anticipate requesting HITECH IAPD funds at this time to facilitate additional development and design and implementation of the Immunization Public Health Reporting Gateway.

Syndromic Surveillance Update

Syndromic surveillance is a public health measure available for eligible hospitals (EH) and Critical Access Hospitals (CAH) through the Arizona Department of Health Services. There are no plans to accept syndromic surveillance submissions from eligible professionals or eligible clinicians as of January 2016. As of April, 2019, this has not changed. At this time, ADHS believes that one focus for FFY 2019 could be comparing information currently available in Biosense (Syndromic Surveillance and Electronic Laboratory Reporting) to data in the HIE to determine how the HIE can improve reporting efficiency and accuracy**.**

Arizona's Syndromic Surveillance program consists of receiving inpatient and emergency department data in a timely manner so that public health can use pre-diagnostic clinical data to understand what is happening in the community. Arizona uses the national BioSense Platform to receive data and conduct Syndromic Surveillance activities. Syndromic Surveillance data is used to support event detection, increase situational awareness, and focus public health actions. Specifically, Arizona has used the data to monitor health during large public events, understand the severity of influenza and look for patients with emerging diseases such as dengue, chikungunya and Zika. ADHS will continue to onboard hospitals and work with public health users to incorporate syndromic surveillance where the data can be useful.

Electronic Labs Update

Electronic Laboratory Reporting (ELR) is the electronic transmission of laboratory reports which identify reportable conditions from laboratories to public health. ADHS has implemented an Electronic Laboratory Reporting (ELR) system to receive reportable disease results from EH/CAH laboratories and reference laboratories and place them into the epidemiology program surveillance databases, including the Medical Electronic Disease Surveillance Intelligence System (MEDSIS).

The ELR system receives standardized HL7 messages containing results from reference laboratories and hospitals. These reportable lab results are parsed to the appropriate state disease surveillance program based on LOINC and SNOMED codes. ADHS continues to onboard hospitals and commercial labs, thereby improving timeliness and accuracy of lab reporting in Arizona. At this time ADHS believes that one focus for FFY 2019 could be comparing information currently available in Biosense (Syndromic Surveillance and Electronic Laboratory Reporting) to data in the HIE to determine how the HIE can improve reporting efficiency and accuracy.

Cancer Registry Update

The Arizona Department of Health Services is currently accepting electronic submissions to the Arizona Cancer Registry (ACR) for Meaningful Use from providers who meet ALL of the following criteria:
•Are eligible professionals (EP), Hospital-based EPs do not qualify for Medicare or Medicaid EHR incentive payments.
- Diagnose or directly treat reportable cancers, and
- Must have certified software that is specific for cancer reporting under Meaningful Use (MU).

In addition to the above criteria, starting July 1, 2016 the ACR will only accept Meaningful Use registrations for Cancer Reporting from providers who meet the additional criteria:
- Submit "100 or more case reports to the Department in the previous calendar year or expects to submit 100 or more case reports in the current calendar year"

Cancer Reporting Registrations of Intent are only accepted for Eligible Provider specialties with 100 or more case reports: Dermatologists, Gastroenterologists, Hematologists, Medical Oncologists, Radiation Oncologists, Surgeons, and Urologists.

Other Public Health Care Coordination Activities

Connecting Other Medicaid Providers through AZ-PIERS To Health Current

Within the Arizona Department of Health Services (ADHS), there is a Bureau of Emergency Medical Services (EMS) and Trauma System. It is a part of the Department's Public Health Emergency Preparedness Framework. This past year, EMS providers partnered with Arizona Health Care Cost Containment System (AHCCCS) and ADHS to create a Treat and Refer (T&R) program to address situations where patients are assessed but not transported to a hospital emergency department. EMS providers became registered AHCCCS Medicaid providers under this program.

In addition to the community paramedicine T&R program, EMS operates AZ-PIERS, which is Arizona's Pre-Hospital Registry dedicated to supporting EMS providers in optimizing the care they provide to patients. EMS agencies are able to submit data to AZ-PIERS using their own electronic Patient Care Reporting System (ePCR) or EHRs.

EMS has used HITECH 90/10 funds this past year to   connect the AZ-PIERS system to Health Current for the purpose of being able to share information about Medicaid patients they see out in the field with Hospitals that participate in the PI Program, and to receive outcome results for EMS agencies' performance monitoring and improvement activities. This bi-directional flow of information addresses the meaningful use criteria for both provider types.

The figure below shows EMS personnel in the field recording patient care and documenting it to their Electronic Patient Care Reporting System (ePCR). EPCR feeds information to AZ PIERS (Arizona Prehospital Information and EMS Registry System) which is available to be sent to Health Current/HIE and from there, the data is available for Hospitals participating in the Medicaid PI Program.

Over time, EMS expects to receive hospital discharge data back from the HIE and will populate their AZ-PIERS data base with that information so that they have a more complete patient record when they respond to calls. As of now, the project has been able to send test messages between the HIE and the ePCR registry and ADHS expects to move to production by August 2019.

Figure 19: AZ-PIERS – Health Current Connectivity
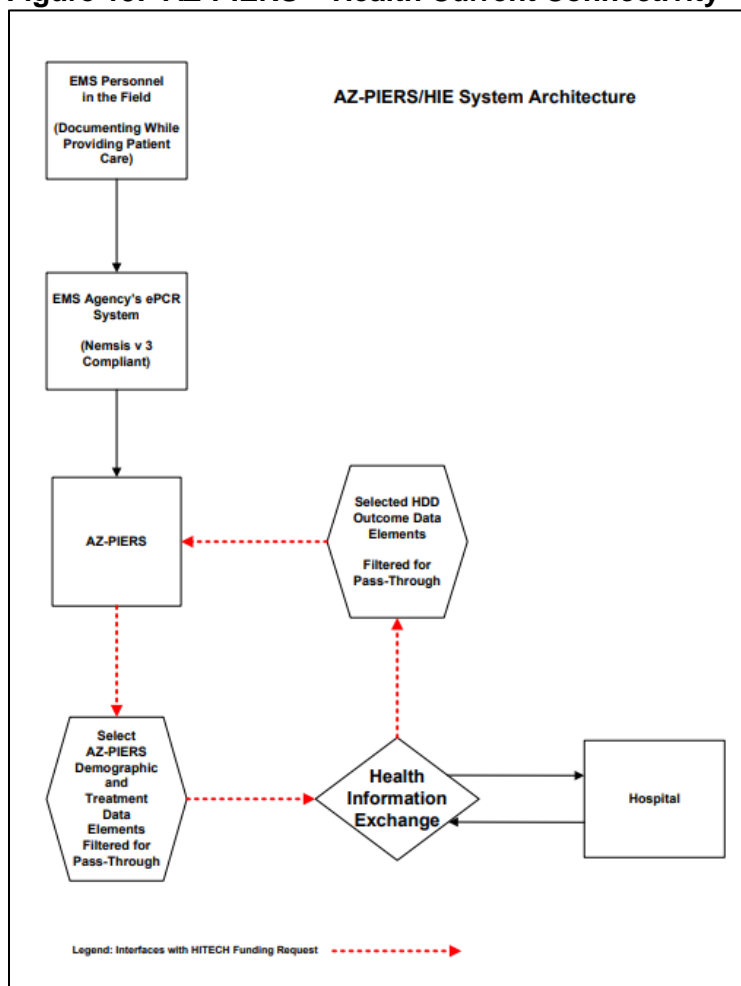
Data Source: ADHS EMS and Trauma System June, 2018

A.15 HIT Related Grant Awards to the State Update Request
(SMHP Companion Guide Question A #15)

Grants in Progress in the Agency

Targeted Investments Program

The agency received CMS approval as part of its 1115 Waiver renewal to spend up to $300 million in Targeted Investment payments to providers focused on:
- Increasing integration of physical and behavioral health (BH) care and
- Increasing care coordination for individuals with Behavioral Health needs

While this is not a grant, the agency is anticipating that several hundred providers will apply for the program. AHCCCS launched the TI Program in June, 2017 where it shared information about the eligible provider organizations and providers and overall program requirements and reporting expectations. In addition to being an eligible provider organization and provider type, applicants had to be an AHCCCS Registered Provider, Utilize an Electronic Health Record, consistent with AHCCCS standards, and to exchange electronic health information with other systems without special effort on their part of the user. The applicant also had to meet a minimum member attribution threshold which would be determined by AHCCCS.

Award letters were sent in December, 2017 to primary care providers, behavioral health providers, hospitals and Regional Behavioral Health Authorities that are working with Justice System providers. More information on this project can be found at the Agency's website: https://www.azahcccs.gov/PlansProviders/TargetedInvestments/

Health Information exchange activities are included in many aspects of the programs milestones and core components. We are working closely with Health Current to ensure there is adequate capacity to support these providers and the existing Medicaid providers that are in the onboarding queue.

Year 2 TI Payments have gone out to providers in May, 2019 to over 500 practice sites made up of providers from across the state working in justice systems, hospitals, primary care, and behavioral health practices.

Grants That Have Closed

TEFT – Testing Experience and Functional Tools Grant-was awarded to AHCCCS in April of 2014. The purpose of the grant is to further adult quality measurement activities under Section 2701 of the ACA (PPACA). The CMS strategy for implementing the Section is to support the SMA in collecting and reporting on the Adult Core Measures. This tool is primarily intended to test the collection of adult quality measures for use in Medicaid community based long term

services and support (CB- LTSS). Arizona has elected to participate in 2 of the 4 components of the TEFT grant which include:

1. Field Test a beneficiary survey,

2. Field Test a modified set of continuity assessment record and evaluation of functional assessment measures

At this time the grant is being managed by the Quality Improvement Unit in the Division of Health Care Management. The HIT Coordinator and HIT Project Manager are a part of the grant steering committee. HIT continues to be a focus of the grant as plans are being considered for long-term sustainability of the grant components being tested.

State Innovation Model (SIM) Planning Grant - The agency received a SIM Model Design planning grant which identified gaps or challenges providers have when trying to share or provide real time clinical quality data. The grant was meant to be a transformational plan that assessed different payment and care delivery models that improve the patient experience (including quality and satisfaction), improve the population health and reduce per capita costs of healthcare in the strategic focus areas below:

1. Enhance coordination and integration between Physical Health and Behavioral Health Providers for adults and children.

2. Improve justice system transitions through development of HIT/HIE infrastructure and health plan interfaces to coordinate coverage and care with Arizona Department of Corrections (ADOC), county jails and probation systems.

3. Enhance and develop regionally based care coordination models for the American Indian Health Plan (AIHP) members, including data sharing capacity, collaboration with Indian Health Services, 638 Tribally operated, and non-tribal providers to support provider infrastructure development and reduced delivery system fragmentation.

One of the deliverables of the SIM transformation plan was a Health IT plan that identifies at a high level how the agency could support communications and real time data exchange among the EPs that make up the care network for each of the 3 target populations. Health Current hosted and coordinated stakeholder engagement activities needed to develop the Health IT components of the SIM grant.

Section B: The State's " To Be" HIT Landscape

B1. Over the next five years what specific HIT/HIE Goals does the SMA want to Achieve

AHCCCS Strategic goals for 2017 through 2022 are identified in the figure below:

Figure 20: AHCCCS Strategic Plan

Data Source: AHCCCS Complete Care PowerPoint, January, 2018

In order to meet its own strategic goals of improving care and reducing costs, AHCCCS has developed health information technology and health information exchange goals and strategies it is using to reduce fragmentation in healthcare delivery to develop an integrated system of healthcare.

The three HIT/HIE Program Goals are:

Goal 1: Oversee and Administer the PI Program

    a. Ensure Providers Migrate Through the MU Continuum

    b. Support ADHS Public Health Onboarding for MU Measures

    c. Achieve Program Integrity Plan Goals

Goal 2: Increase Agency Use and Support for HIT/HIE

    a. Support Care Coordination and Integration Between Physical and Behavioral Health Providers

    b. Support AHCCCS Payment Modernization Initiatives (ie DAP) and Administrative Efficiency Projects

    c. Implement HIE requirements in American Indian Medical Home Waiver (AIHP)

    d. Improve Justice System Transitions by connecting justice sites with plans

    e. Improve Care for Children with Behavioral Health Needs including Those at Risk and Engaged in the Child Welfare System

    f. Continue Agency Participation in Qualified HIE for Governance, Policy Making and IT Service Offerings

Goal 3: Accelerate Statewide HIE Participation by All Medicaid by Providers and Plans

    a. Expand the HIE Onboarding Program for Medicaid Hospitals, FQHCs, RHCs Groups and All Other Medicaid Providers as allowed under SMD 16-0083

    b. Support Increased Health Plan Use of HIE to Improve Health Outcomes and e-Prescribing Rates

    c. Coordinate other State and Federal Agencies Participation in HIE Based on the Governor's Opioid Action Plan implement Health IT solutions to ensure timely clinical data sharing among Opioid Treatment Providers and Office Based Treatment Providers.

See the figure below for a snapshot of the Agency wide HIT Goals and the three HIT/HIE Goals and Strategies supporting them.

Figure 21: HIT/HIE Goals and Strategies

Reaching Across Arizona to Provide Comprehensive Quality Healthcare for Those in Need

- Bend the Cost Curve While Improving the Member's Health Outcomes
- Pursue Continuous Quality Improvement
- Reduce Fragmentation in Healthcare Delivery to Develop an Integrated System of Healthcare
- Maintain Core Organizational Capacity, Infrastructure and Workforce

Leverage HIT Investments to Reduce Fragmentation and Improve Care Coordination

Goal 1
Oversee and Administer the EHR Incentive Program

- 1A - Ensure Providers Migrate Through the MU Continuum
- 1B - Support ADHS Public Health Onboarding for Meaningful Use Measures
- 1C - Achieve Program Integrity Plan Goals

Goal 2
Increase Agency Use and Support for HIT/HIE

- 2A - Support Care Coordination and Integration Between Physical and Behavioral Health Providers
- 2B Support AHCCCS Payment Modernization Initiatives and Administrative Efficiency Projects
- 2C Implement American Indian Medical Home Waiver (AIHP)
- 2D – Improve Justice System Transitions
- 2E – Improve Care for Children with Behavioral Health Needs including Those at Risk and Engaged in the Child Welfare System

Goal 3
Accelerate Statewide HIE Participation by All Medicaid Providers and Plans

- 3A – Expand the HIE Onboarding Program for Medicaid Hospitals, FQHCs, RHCs, Groups and All Other Medicaid Providers
- 3B - Support Increased Health Plan Use of HIE to Improve Health Outcomes and e-Prescribing Rates
- 3C - Coordinate Other State and Federal Agencies' Participation in HIE

Data Source: AHCCCS HIT April, 2019

Under each goal, the SMA has created strategies it is using to accomplish each goal. The strategies are listed below. A list of benchmarks for each goal is in Section E.

Goal 1: Oversee and Administer the PI Program

Strategy 1A - Ensure Providers Migrate Through the MU Continuum
1. Implement and maintain the electronic Provider Incentive Payment System (ePIP) for providers attesting to the EHRS Program, including automation and maintenance
2. Implement education and training communications, materials and tools for providers to help them reach MU Milestones
3. Process provider registrations, attestations and payments
4. Conduct pre and post payment audits and submit Annual Audit Strategy to CMS
5. Participate in CMS led trainings including Communities of Practice (CoPs), All-States CMS Calls, and HIT-related conferences and events
6. Develop and update State Medicaid HIT Plan (SMHP) and HIT funding documents

Strategy 1B - Support ADHS Public Health Connectivity to HIE
1. Support onboarding of providers to the HIE in order to access and send information through the electronic Public Health Gateway.
2. As appropriate, request HITECH IAPD funds for establishment of ADHS infrastructure for Gateways
3. Collaborate with ADHS to develop a long term plan for using the HIE to enhance public health reporting for Medicaid providers
4. Based on the Governor's Opioid Action Plan implement Health IT solutions to ensure timely clinical data sharing among Opioid Treatment Providers and Office Based Treatment Providers.

Strategy 1C - Achieve Program Integrity Plan Goals
1. Ensure Agency has engaged Audit Subject Matter Experts (SMEs) to support the implementation of the Agency EHR Audit strategy
2. Complete the HHS –OIG PI Program Audit and complete recoupments and underpayments for all hospitals by Q4, 2019.
3. Update and submit to CMS a new AHCCCS EHR Audit Strategy annually

Goal 2: Increase Agency Use and Support for HIT/HIE

Strategy 2A- Support Care Coordination and Integration Between Physical and Behavioral Health Providers
1. Recruit BH and high volume Medicaid providers to the HIE to encourage data sharing. .
2. Support the implementation of the AHCCCS Complete Care contracts starting in October 1, 2018 which requires health IT adoption to facilitate communication and care coordination. This includes expectations of clinical data sharing, development of high risk registries, population health monitoring, and data analytic reporting capabilities by the contractors. .

Strategy 2B – Support AHCCCS Payment Modernization Initiatives   and Administrative Efficiency Projects
1. Participate in the CMS led Healthcare Payment Learning & Action Network (LAN) to identify opportunities to link alternate payment reform efforts with Health IT/HIE milestones and measures
2. Working with the Value based team create language that encourages provider use of the HIE
3. Provide input into the development of the Agency's strategic plan that identifies opportunities for administrative efficiency using the HIE across divisions.

Strategy 2C –Support the Implementation of American Indian Medical Home State Plan Amendment
1. Support Indian Health Service (IHS), Tribal and 638 facilities primary care site transformation into the American Indian Medical Home Program (AIMH) a voluntary program for members enrolled in the Fee

for Service (FFS) American Indian Health Program (AIHP)
2. Develop a data infrastructure that can support data analytics using both clinical data and claims data for providers serving AIHP members.
3. Reduce fragmentation of care among IHS/Tribal 638 and non-IHS/Tribal 638 providers serving AIHP members through regional Care Management Collaboratives that improve outcomes for AIHP members
4. Monitor the participation of Tribes and Indian Health Services Facilities to deliver a Medical Home, including the sites participating in the HIE.

Strategy 2D –Improve Justice System Transitions

1. Develop the data sharing agreements between the integrated health care settings within county probation offices or Department of Corrections parole offices to address beneficiary health care needs upon release and throughout the term of probation/parole for individuals transitioning out of incarceration.
2. Support the county and state correctional entities have signed a Participation Agreement with the HIE and are actively using real time clinical information to inform their clinical decision making processes.
3. Participate in planning to ensure that Medication History becomes more readily available through the HIE to appropriate providers
4. Through the Targeted Investments program support justice sites use of e clinical information to improve care coordination between justice and health plans

Strategy 2E- Improve Care for Children with Behavioral Health Needs including Those at Risk and Engaged in the Child Welfare System

1. Support the integration of behavioral health and primary care services for children in both primary care sites and community behavioral health sites.
2. Improve treatment for the care of children with and at risk for Autism Spectrum Disorder (ASD)
3. Improve treatment for the care of children engaged in the child welfare system and ensure continuity in care across providers over the continuum of the child's involvement in the child welfare system, by developing electronic connectivity between providers at the HIE.

Goal 3: Accelerate Statewide HIE Participation by All Medicaid Providers and Plans

Strategy 3A – Expand the HIE Onboarding Program for Medicaid Hospitals, FQHCS, Groups and All Other Medicaid Providers

1. Using federally approved 90/10 HITECH funds, work with the HIE to recruit all other PI Program ineligible Medicaid providers as long as they support an eligible provider demonstrate MU – (SMD#16-003).
2. Track and monitor HIE onboarding milestones and payments

Strategy 3B- Support Increased Health Plan Use of HIE to Improve Health Outcomes and Clinical Quality Measures

1. Identify opportunities to improve administrative efficiencies with the agency and the plans related to HIE functionality and services.
2. Work with Health Current to expand the permitted use policy of the HIE to include some agency and health plan operations and reporting in order to improve administrative efficiency.

Strategy 3C- Coordinate Other State and Federal Agencies' Participation in HIE

1. Through the State HIT Coordinator, initiate discussions with other state agencies to educate them about health information exchange and health information technology initiatives
2. Work with Health Current and AZ Secretary of State Office to secure the Advanced Directives Registry for use by HIE participants
3. Work with the Arizona Department of Health Services to coordinate implementation of public health meaningful use measures and other registries such as EMS that can improve and inform long term population health management.
4. Monitor the integration of the Board of Pharmacy's Controlled Substance Prescription Drug Monitoring Program (CSPMP) with the HIE to ensure providers can seamlessly access drug information
5. Work with Health Current to recruit the participation of federal health partners such as the Veterans Administration, Indian Health Services and Social Security Administration by 2021.

Description of Program Metrics for Goal 1: Oversee and Administer the PI Program

EHR Registration and Payment Goals for Eligible Professionals and Eligible Hospitals

According to the projections in the table below, by 2020, AHCCCS projects it will have 5,980 EPs registered in the EHR Program with 69% of them receiving an AIU Payment. 1,644 EPs will receive an MU 1 Payment and 1,759 EPs will receive an MU Stage 2 Payment. It is projected that by CY 2020, 600 providers will have received a Stage 3 payment.

Table 27: AHCCCS PI Goals for Eligible Professionals

AHCCCS Goals for Eligible Professionals							
	CY 2015	*CY 2016*	*CY 2017*	*CY 2018*	*CY 2019 Estimates*	*CY 2020 Estimates*	*CY 2021 Estimates*
EP Registered in ePIP	*4,893*	*5,493*	*5,743*	*5,967*	*5,980*	*5,980*	*5,980*
EP Receive AIU payment	*3,109*	*3,448*	*3,732*	*4,072*	*4,142*	*4,142*	*4,142*
Registered EP Received AIU Payment	*63.54%*	*62.77%*	*64.98%*	*68.24%*	*69.26%*	*69.26%*	*69.26%*
EP Receive MU Stage 1 Payment	*1,127*	*1,615*	*1,629*	*1,629*	*1,644*	*1,644*	*1,644*
Successful AIU EP Received MU Stage 1 Payment	*36.25%*	*46.84%*	*43.65%*	*40.00%*	*39.69%*	*39.69%*	*39.69%*
EP Receive MU Stage 2/2^M Payment	*7*	*219*	*664*	*1,068*	*1,259*	*1,759*	*1,759*
Successful MU Stage 1 EP Received MU Stage 2/2^M Payment*	*0.62%*	*13.56%*	*40.76%*	*65.56%*	*76.58%*	*107.00%*	*107.00%*
EP Receive MU Stage 3 Payment	*0*	*0*	*0*	*0*	*0*	*600*	*725*
Successful MU Stage 2 EP Received MU Stage 3 Payment	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*34.11%*	*41.22%*

Data Source: AHCCCS PI Team May, 2019

*Note: Percentage greater than 100% because providers were required to meet Stage 2 on or after Program Year 2015 regardless of if they met Stage 1.

The table below reflects PI Program goals for Eligible Hospitals until CY 2021. Projections include 76 EHs will be registered in ePIP, 97% of the EHs will receive an AIU payment, 65 EHs will receive an MU Stage 1 and Stage 2 Payment and 2 hospitals are expected to attained Stage 3 MU.

Table 28: AHCCCS Program Registration and Payments to Hospitals

AHCCCS Goals for Eligible Hospitals							
	FFY 2015	*FFY 2016*	*FFY 2017*	*FFY 2018*	*FFY 2019 Estimates*	*FFY 2020 Estimates*	*FFY 2021 Estimates*
EH Registered in ePIP	*75*	*76*	*76*	*76*	*76*	*76*	*76*
EH Receive AIU payment	*72*	*73*	*74*	*74*	*74*	*74*	*74*
Registered EH Received AIU Payment	*96.00%*	*96.05%*	*97.37%*	*97.37%*	*97.37%*	*97.37%*	*97.37%*
EH Receive MU Stage 1 Payment	*61*	*61*	*65*	*65*	*65*	*65*	*65*
Successful AIU EH Received MU1 Payment	*84.72%*	*83.56%*	*87.84%*	*87.84%*	*87.84%*	*87.84%*	*87.84%*
EH Receive MU Stage 2/2^M Payment	*3*	*15*	*15*	*21*	*41*	*70*	*76*
Successful MU Stage 1 EH Received MU Stage 2/2^M Payment*	*4.92%*	*24.59%*	*23.08%*	*32.31%*	*63.08%*	*107.69%*	*116.92%*
EH Receive MU Stage 3 Payment	*0*	*0*	*0*	*0*	*0*	*0*	*2*
Successful MU Stage 2/2^M EH Received MU Stage 3 Payment	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*2.63%*

Data Source: AHCCCS PI Team May, 2019

*Note: Percentage greater than 100% triggered as a result of mandatory requirement to meet Stage 2^M on or after Program Year 2015 regardless of if the provider met Stage 1.

For Goal 2: Increasing Agency Use and Support for Health IT/HIE

The strategies identified under Goal 2 are all priorities under the Agency's Strategic Plan and it's recently released AHCCCS Complete Care (ACC) RFP. The RFP was released and was awarded in March of 2018. The ACC Program is designed to further integrate care delivery systems and align incentives to transition the structure of the Medicaid program to improve health outcomes and better manage limited resources. It is the largest procurement in State of Arizona history.

For AHCCCS members, this means that as of October, 2018, the health care plan you choose will manage the provider network for all your health care services, including your medical care (physical) as well as any behavioral health services you may need. So, instead of navigating two separate networks for medical and behavioral services, all your providers will be under one network, managed and paid for by a single health care plan. It is for all adults on AHCCCS (excluding adults with Serious Mental Illness (SMI) and All Children on AHCCCS (excluding Foster Care Children covered under CMDP)

Figure 23: AHCCCS Integration Planning – AHCCCS Complete Care
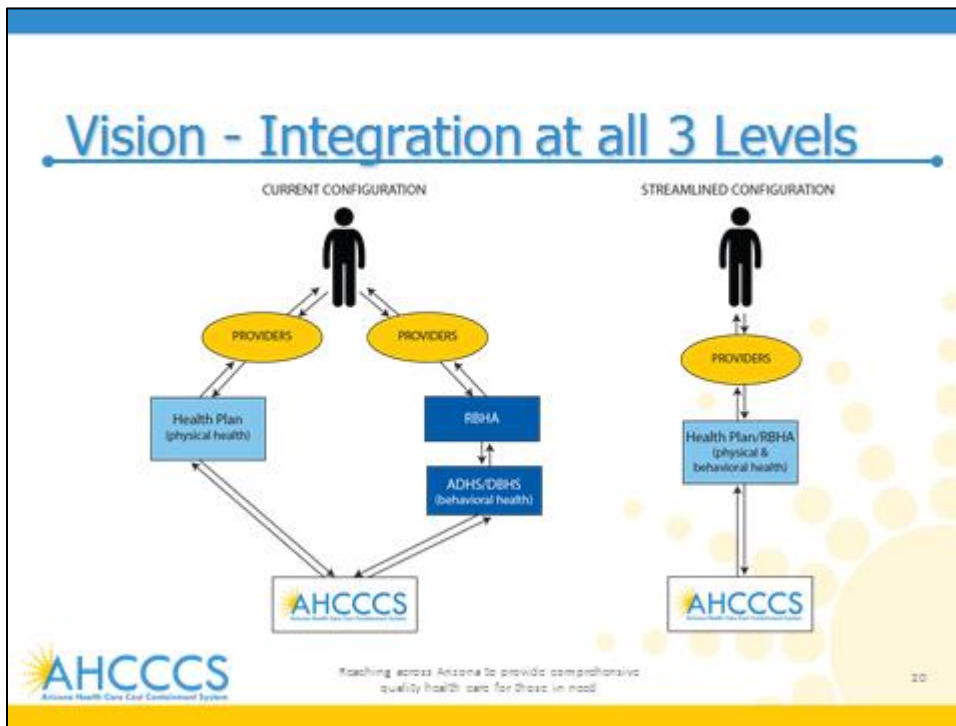
The design of the AHCCCS Complete Care (ACC) Program provides for:

- Comprehensive and coordinated delivery of integrated services including administrative and clinical integration

- The delivery of physical and behavioral health services to meet the whole health needs of members and

- Improving member care experiences

ACC Program Values are: (partial list)

- Prompt and easy access to culturally competent care

- Comprehensive care coordination for physical and behavioral health services

- Continuous quality improvement

- Improved health outcomes

- Education and guidance to providers on service integration and care coordination

- Collaboration with community

- Cost containment and efficiencies

- Implementation of HIT to facilitate communication and care coordination.

ACC Program AHCCCS Initiatives

- Arizona Opioid State Targeted Response

- Children at Risk of Removal by the Department of Child Safety

- Services for Children with Autism Spectrum Disorder

- Justice System Transitions

- Payment Modernization

- Electronic Health Records and

- Targeted Investments (formerly DSRP/SIM)

All of these efforts will require a range of health IT adoption and information exchange in order to be successful. ACC Contractor performance accountability will be based on:

- Self-monitoring of operations and clinical performance, using available data
- Develop and implement interventions designed to improve operational or clinical performance
- Evaluate effectiveness of interventions and adjust as necessary to achieve excellence
- Staff to meet Performance Expectations

In addition to these efforts, work is going to continue on things like e-prescribing. The table below is an updated summary of how the AHCCCS Plans are performing related to raising their e-prescribing rates. For the Acute Plans the goals are 60% of Providers will e-prescribe.

For the Maricopa County RBHA 70%; CMDP, CRS and DDD 65%; ALTCS/EPD 40%

- (Goal – Prior Year Baseline) * 20% = Requirement
- Prior Year Baseline + Requirement = Target
- Peak Quarter results >= Target

In the table below,for the three organizations showing decline, a change in contractual relationship resulted in data not being required and submitted since they were removed as a contractor.

Table 29: E-prescribing and Health Plans

Health Plan	2014 Baseline	2015 Baseline	2016 Baseline	2017 Baseline	2018 Baseline	5 Year Trend
Acute	42.22%	45.20%	49.10%	54.20%	62.20%	
CARE 1ST ARIZONA	40.57%	45.20%	49.10%	53.30%	59.10%	
HEALTH CHOICE AZ	43.34%	43.80%	45.20%	50.00%	62.00%	
HEALTH NET ACCESS	34.58%	42.30%	48.30%	53.90%	62.40%	
MARICOPA HEALTH PLAN	39.67%	43.70%	47.40%	52.90%	25.00%	
MERCY CARE PLAN	40.06%	42.80%	45.60%	49.10%	55.40%	
PHOENIX HEALTH PLAN	40.16%	45.10%	49.40%	53.40%	11.80%	
UNITED HEALTHCARE	43.70%	48.00%	52.80%	58.90%	65.90%	
UNIVERSITY FAMILY CARE	47.28%	49.80%	55.40%	62.30%	68.50%	
DCS/CMDP	46.57%	50.20%	55.10%	59.40%	63.90%	
CRS	41.82%	49.00%	57.00%	63.90%	63.70%	
LTC	23.76%	25.00%	28.30%	31.30%	35.50%	
BRIDGEWAY - LTC	20.70%	21.20%	22.90%	26.50%	15.90%	
MERCY CARE PLAN - LTC	23.49%	24.30%	27.80%	32.80%	39.30%	
UNITED HEALTHCARE LTC	25.98%	28.30%	31.50%	34.60%	38.80%	
Banner University LTC				0.00%	28.50%	
RBHA			54.90%	62.80%	70.20%	
MERCY/MARICOPA INTEGRATED	31.97%	38.26%	51.50%	57.40%	63.80%	
HEALTH CHOICE INTEGRATED			54.50%	64.30%	71.80%	
CENPATICO INTEGRATED CARE			58.80%	66.70%	75.00%	

Data Source: AHCCCS DHCM, March, 2019

For Goal 3: Accelerate Statewide HIE Participation for all Medicaid Providers and Plans, the agency will be tracking the HIE Annual Benchmarks which are displayed in Section E including:

- Identifying all other payers and contributions to Health Current (Behavioral Health Providers (81), Community Providers (289), Hospitals and Health Systems (55), ACO's (16), Health Plans and Payers (18), FQHC's and CHC's, (21)State and Local Government (19), Reference lab's and imaging Center's (6), Emergency Medical Services (18) and Long Term and Post Acute Care (104). As of May, 2019)
- Providing the Cumulative Number and % of total providers successfully connected annually
- The number and % of total Medicaid Covered lives with clinical data in the HIE
- Status of HIE onboarding Program for Eligible Hospitals, broken down by milestones
- Status for HIE onboarding Program for FQHCS/Rural Health Centers broken down by milestones
- And new status of HIE Onboarding program for other Eligible Groups of Providers, broken down by milestone (below):

Table 30: HIE Participant Milestone Status

Health Information Exchange – Paid Providers By Milestone				
Milestone	**Milestone Description**	**Count**	**HITECH Funding Total**	**Notes**
Milestone 1	Provider has signed a Participation Agreement.	365	$6,801,668	Health Systems count as one participant. There are 59 hospitals in 9 Arizona Health Systems.
Milestone 2	One way interface (either way).	76	$2,310,668	
Milestone 3	Bi-directional Interface (send and receive).	216	$4,738,501	
Milestone 4	Administrative offset back to provider.	65	$880,000	
Milestone 5	Optional add-on services off of menu	1	$15,000	

Data Source: AHCCCS Onboarding Master File – May, 2019

B.2 Future of AHCCCS IT System Architecture

(SMHP Companion Guide Question B #2)

SMA System Architecture 2020

Long term, we expect AHCCCS and the contracted MCOs and RBHAs to utilize the HIE for care coordination of their Medicaid members and for clinical quality analysis. We expect Medicaid providers to utilize the HIE to better understand/assess their patients' medical health and to coordinate and share patients' health information with the patients and their other providers in an effort to improve patient health outcomes.

In the future, we expect AHCCCS to utilize the HIE to assist with the eligibility and enrollment for the Children's Rehabilitative Services Program (CRS).and in supporting member eligibility for the AHCCCS Long Term Care Program (ALTCS). In September 2016, the American Indian Health Program (AIHP) established connectivity with the HIE to support the sharing of clinical data for care coordination. The AIHP is for members enrolled in the American Indian Health Plan which is operated by the AHCCCS Division of Fee for Service Management. Eventually, the agency would like to be able to use the HIE to assist with the determination of eligibility process for those members that rely on federal agency information coordination such as Social Security Administration (SSA) or Veterans Administration or Indian Health Services and Long Term Care.

The following diagram, in the figure below, highlights how the SMA IT system will support the AHCCCS long term goals and objectives of reducing costs, improving care coordination and improving health care outcomes. There are no plans at this time to combine the internet portals, enterprise service bus, master patient index or record locator services that are operated by Health Current (HIE) with the agency's member eligibility process, Health-e-Arizona Plus, which uses similar technology.

Our vision shows that the Public Health Registries are connected to the HIE enabling providers to view and update their patient's registry data using their HIE connection. It also shows that the HIE is connected to AHCCCS using the web portal infrastructure with our MMIS which allows the Agency to more fully utilize the member health data available through the HIE. Lastly, it shows HEAplus connected with the HIE to access applicant healthcare information needed to support medical eligibility determination. All of these are beginning steps towards improving healthcare outcomes.

Figure 23: Integrated Medicaid IT Environment – Future Plans (2023 Vision)

Medicaid IT – Vision 2023

Transactions

1 Register for EHR Incentive Program at CMS	6 Receive ADT Alerts, Read Patient Data
2 Register for EHR Incentive Program in Arizona	7 Patient Volume and other EHR Program reports
3 Receive EHR Incentive Payment	8 Submit Application, Update Data for Health & Human Services
4 Verify Eligibility, Update Provide Data, Submit Claims	9 Submit Application for Health Insurance at CMS
5 Read, Add, Update Public Health Registry Data	10 Submit to SSA for SSI MAO

Key:
Solid Black lines – as is 2019
Dotted Blue lines – to be 2023

Data Source: AHCCCS ISD March, 2019

Plans to leverage the State Level Repository (SLR) Beyond the Promoting Interoperability Program

Future plans are being developed and evaluated between the agency and Health Current and could include using the SLR (e-PIP) to pull MU-related data from the HIE for the PI Program. During our MITA HITECH SS-A in 2016, the agency identified the need to coordinate agency planning closer with the MMIS and E & E initiatives already underway.

The SMA and Health Current will be doing extensive program planning over the next year in preparation for the agency's 1115 Waiver submission to CMS by 9/30/2020 and having the appropriate health IT infrastructure will be a critical element for inclusion and work.

Medicaid Provider Interfaces with SMA IT System

AHCCCS hosts an on-line portal for providers where they can query eligibility and enrollment information about their patients. They may also enter and submit claims via the portal and check on their claims status. Provider demographics may also be updated via the portal.

AHCCCS also hosts an EDI VPN connection for providers to submit batch HIPAA transactions for claims submission, claims status, and eligibility verification, and to receive the corresponding responses.

As discussed previously, AHCCCS also hosts the SLR portal, named ePIP, for the provider interface to the PI Program.

Most Medicaid providers verify patient Medicaid eligibility and update their own provider demographics using one or more of these interfaces. To a lesser extent, Medicaid providers participate in the Promoting Interoperability Incentive Program. Medicaid providers with Fee for Service Medicaid members utilize one of the claim submission interfaces for electronic submission or they submit claims via paper.

State and Local Program Interfaces with SMA IT System

The following programs interface with the AHCCCS IT system many of which are part of the Medicaid eligibility determination process for both and acute and long term care members. Together these agencies and programs administer the following programs which interface with the SMA IT System:

- SNAP – Supplemental Nutrition Assistance Program
- TANF – Temporary Assistance for Needy Families
- BH - Behavioral Health
- SSI Cash – Supplemental Security Income
- SSI MAO – Supplemental Security Income Medical Assistance Only
- ALTCS - Arizona Long Term Care System
- FTW - Freedom to Work
- Children Program
- QMB - Qualified Medicare Beneficiary (Medicare Savings Program)
- SLMB - Specified Low-Income Medicare Beneficiary (Medicare Savings Program)

- QI - Qualified Individual (Medicare Savings Program)
- YATI - Young Adult Transitional Insurance (leaving foster care)
- Pregnant Woman Program
- BCCTP - Breast and Cervical Cancer Treatment Program
- Adult Program
- Parent and Caretaker Relative Program
- DDD – Division of Developmental Disabilities
- AHCCCS Medical Assistance

At this time, the AHCCCS IT system and its partners and functions are operated by State government and are separate from the state level health information exchange. Health Current is housed outside of state government in a non-profit organization and state government collaborates with Health Current, but does not manage or control its operations. Discussions are starting between AHCCCS programs and Health Current to identify if any areas exist for streamlining operations, but as of now, the HIE has some more narrow uses vs all of the activities included under HIPAA, but work continues to develop and evaluate use cases on a case by case basis.

B.3 Medicaid Providers Interface With the SMA Related to the PI Program

(SMHP Companion Guide Question B #3)

Medicaid Provider Interface With The EHR Management System

All Medicaid Providers registered in the Medicaid Promoting Interoperability Incentive program have done so through the electronic Provider Incentive Payment System (ePIP). This system was developed and is maintained by SMA programmers. All eligible professionals and Medicaid-only hospitals report their MU data through ePIP; dually eligible hospitals report their MU data to CMS using the National Level Repository (NLR) which is shared with the States via the NLR – SLR (ePIP) interface.

As discussed previously, AHCCCS also hosts the SLR portal, named ePIP, for the provider interface to the PI Program.

Plans to Leverage the State Level Repository

The agency completed its agency wide MITA state self-assessment and completed the HITECH portion of the engagement. One of the findings called for greater collaboration between the MMIS and E & E systems at the agency with the HITECH program. Discussions are starting to ensure the agency develops a plan and strategy for leveraging the IT system as it relates to the PI Program to see if it can be more integrated into the agency's overall business operations.

Part of the strategy discussion will include how to evaluate the quality and the robustness of the data elements that are captured through the electronic Provider Incentive Payment System (ePIP) and the Registration of EPs that want to participate in the Promoting Interoperability Incentive Program. Discussions are expected to occur across the agency to review how if possible any of the current standalone and possibly redundant systems can be integrated or closed in order to keep administration and upkeep of information to a minimum.

Another aspect of the MITA Assessment and the services and data that are available at the HIE will help inform the SMA about how it can leverage any clinical data for provider and or health plan performance. At this time, none of the information being captured by an EHR is being used by the agency other than what is needed to qualify a provider for an incentive payment.

Medicaid Providers Accessing ePIP

Currently there are more than 5,980 Medicaid providers registered in ePIP. They are from the following Medical specialties:

- MD's – 3,508
- DO's - 433
- Nurse Practitioners – 1,351
- Certified Nurse Mid-wives - 145
- Dentist's - 466
- Physician Assistants - 77

Local and State Programs Interfacing with ePIP

There are currently no local or state programs interfacing with ePIP other than the Medicaid Promoting Interoperability Incentive Program.

B.4 HIE Governance Planning and SMA HIT/HIE Goals and Objectives
(SMHP Companion Guide Question B #4)

HIE Governance Structure

In Arizona, the HIE governance structure is currently in place at Health Current, which serves as a public/private non-profit organization.   The Health Current board is comprised of 27 organizational representatives which includes the Director of the SMA. Health Current serves as our statewide governance entity for HIT/HIE. The full board is comprised of multiple organizations including employers, universities, reference labs, a health care quality organization, Long Term Care providers, Behavioral Health providers, hospitals, providers, health plans and a Federally Qualified Health Center members among others. The SMA believes this is the appropriate HIE governance structure that needs to be in place now and in the future to achieve the SMA HIT/HIE goals and objectives.

The current Health Current Board is detailed in the following table:

Table 31: Health Current Board of Directors 2019

Health Current Board of Directors - 2019

Abrazo/Carondelet William Ellert, MD Chief Medical Officer	**Collaborative Ventures Network (CVN)** Ginny Roberts COO
Arizona Care Network (ACN) David Hanekom, MD, FACP, CMPE CEO	**Dignity Health** Sean Turner Sr. Director, Interoperability & Population Health IT
Arizona Complete Health Paul Barnes CEO	**District Medical Group** Jeff Weil CIO
Arizona Department of Health Services (ADHS) Paula Mattingly Assistant Director & CIO	**El Rio Health** Nancy Johnson, RN, PhD CEO
Arizona Health Care Association (AHCA) David Voepel CEO	**Innovative Care Partners** David Baker Chief Technology Officer
Arizona Health Care Cost Containment System (AHCCCS) Jami Snyder Director	**Maricopa Integrated Health System (MIHS)** Kelly Summers SVP & CIO
Arizona Hospital & Healthcare Association (AzHHA) Ann-Marie Alameddin President & CEO	**Mercy Care** Lorry Bottrill CEO
Arizona Medical Association (ArMA) Libby McDannell, CAE Executive Vice President	**Partners in Recovery** Christy Dye, MPH President & CEO
Arizona Osteopathic Medical Association (AOMA) Pete Wertheim, MS Executive Director	**Sonora Quest Laboratories** Dave Dexter President & CEO
Banner Health Deanna Wise CIO	**Tucson Medical Center** Frank Marini SVP & CIO
Banner University Health Plans Kathleen Oestreich VP & CEO	**UnitedHealthcare** Karen Saelens COO, UHC Community Plan
BlueCross BlueShield of Arizona Sheri Jackson Chief Nursing Officer, VP Operations Engineering	**Yuma Regional Medical Center** Fred Peet CIO
Care1st Health Plan Arizona, A WellCare Company Scott Cummings State President, Arizona	

Data Source: Health Current 2019

Current HIT/HIE Initiatives Supporting SMA Program Management, Population Health Management and Potential Funding Requirements

Within the next 3 – 5 years the agency anticipates it will be facilitating access to infrastructure to support projects that ensure state level data access and analysis. The infrastructure will be implemented incrementally over five years with information technology that focuses on improving health information sharing, protocol development and analytics. The agency is considering a variety of funding mechanisms to ensure this can be created. The agency is participating in discussions and review of population health and data analytic tools and services that Health Current is engaged in with all of its stakeholders. The agency is evaluating HITECH funds, MMIS and E & E funding to see which funds would be most appropriate for request.

The Promoting Interoperability Incentive Program is setting the stage for more complete and complex clinical data sharing by increasing the number of Providers that are adopting and using EHRs. Once the providers are using them, they will be more likely to participate in Health Information Exchange. When EHRs are more widespread the agency will be able to ask its health plans to evaluate and measure provider's quality of care and experiment with paying for Episodes of Care vs in a Fee for Service model. AHCCCS and the Division of Behavioral Health Services were integrated as of July, 2016 and will support our goal of reducing fragmentation between physical health providers and behavioral health providers.

As the clinical data becomes more available through Health Current, it is expected that each Managed Care Organization will develop a population health management approach by being able to receive and analyze more timely clinical data from its membership. The improved quality of the data is allowing the SMA and its plans to more closely monitor the quality of the care that is being delivered and tying the outcomes of the care to its payment reform strategies.

Over time the Arizona Department of Health Services will continue to lead efforts for creating state population health analytics with Health Current.

The figure below is a visual of Health Current's participants and how they will access the Public Health Reporting Gateway and how all community providers can connect to Health Current.

AHCCS will be submitting a complete HITECH IAPD shortly but expects to request funding for administrative expenses, Health Information Technology Education, and Health Information Exchange funds for onboarding of Medicaid providers

Figure 24: HIE Current and Future Support of Population Management
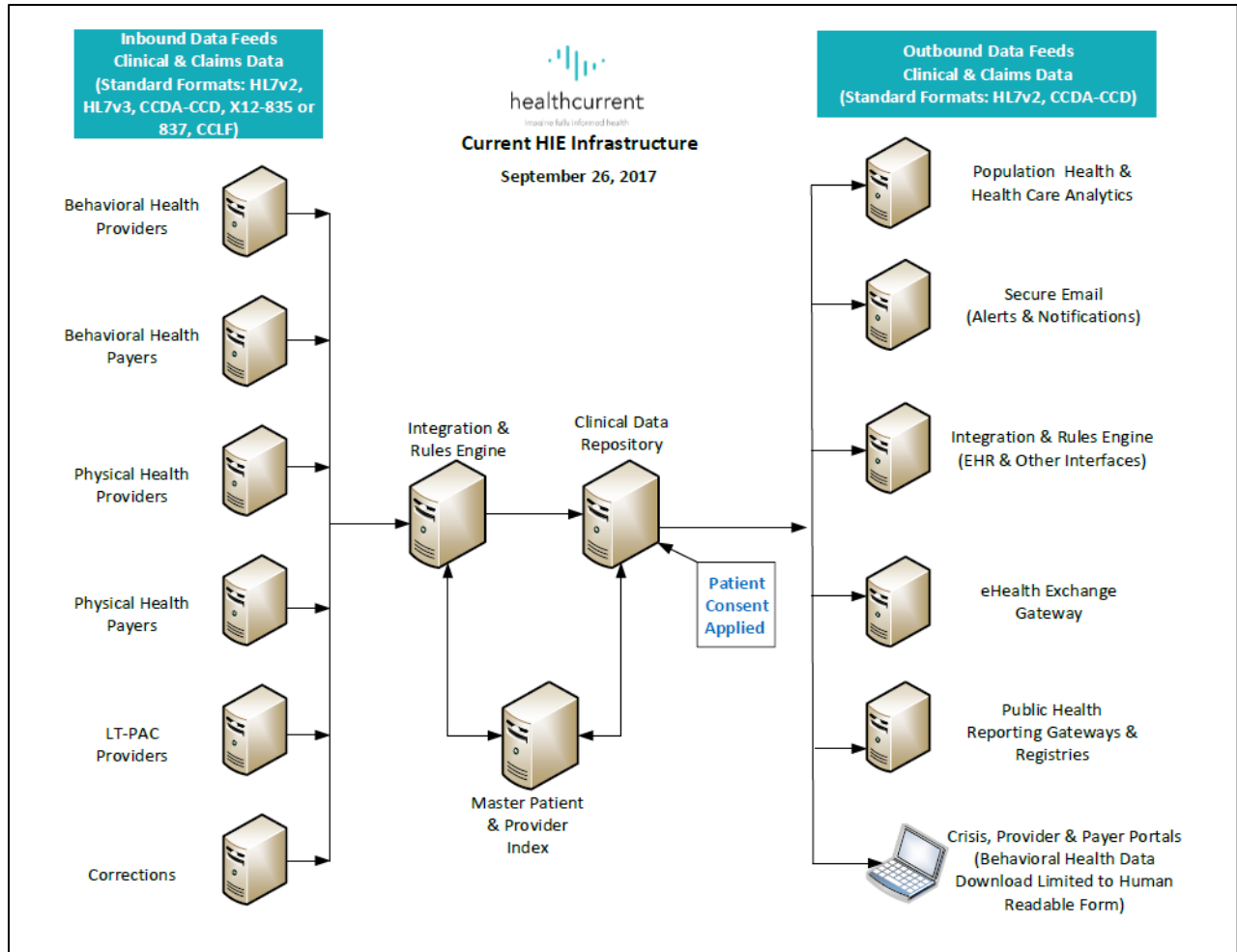
Data Source: Health Current April, 2019

B.5 Steps SMA will take in next 12 months to Encourage Provider Adoption of Certified EHRS technology?

(SMHP Companion Guide Question B #5)

According to the SMAs Network Operations area, while there has been member growth in the Medicaid program and there has been some provider growth associated with the General Mental Health/Substance Abuse dual integration. There has not been a very significant increase in the number of providers in the MCO Networks. The MCOS are focused on moving members into Value Based Payment and Accountable Care arrangements. The focus of the SMA PI Program has moved to promoting progress in advancing through stages of MU and HIE participation.

Encourage Adoption of Certified EHR

AHCCCS is continuing to pursue several internal initiatives to encourage provider adoption of certified EHR:

- In 2018, through its Business Intelligence Unit, AHCCCS identified Eligible Professionals who had not registered for the PI Program and may be eligible based on patient volumes. Those lists were sent to Health Current for Outreach.

- AHCCCS has contracted with Health Current to perform education and outreach webinars, phone contacts and emails to enrolled or eligible providers to increase the number of EPs that participate in the EHR program and to provide support for providers registered in the PI Program that are not progressing to the next stage of Meaningful Use. The Education and Outreach contract includes:

    - A monthly review of status reports received from Health Current.

    - A scope of work for education and recruitment to include dentists.

    - A scope of work for Health Current to include education and outreach to improve baseline e-prescribing rates.

    - Provision for both on-site and remote (phone/WebEx/e-mail) provider consults for those providers attempting to obtain AIU or progress through various stages of meaningful use.

- AHCCCS expanded the HIE onboarding program to include physician practices, facilitating the completion of MU objective 5, health information exchange and ability to share a summary of care record for each transition of care or referral.

- AHCCCS communicated with the SMAs program contractors (Managed Care Organizations) to also reach out to its high volume providers that are not participating and encouraged them to contact Health Current and get enrolled in the PI Program.

- AHCCCS is in the process of updating all of its educational materials for EPs and posting them to the web. Attestation guides and Patient Volume Estimation tools have been updated. An AIU Quick Reference Guide has been created and posted to the website along with an updated full guide.

- The agency is working to automate some parts of the ePIP administrative portal in order to decrease the amount of manual analysis and processes to speed attestation processing.

- AHCCCS has hired an additional IT programmer to help with the ePIP portal updates and to keep it HIPAA compliant.

- AHCCCS is working to have Health Current and the Arizona Department of Health Services complete their HIE discussions to allow providers to use the Next Gen public health reporting gateways as a way to automate MU submissions. A pilot for provider submissions of immunization data to Public Health through the HIE is currently underway to ensure data can be shared.

HIE Participation and Adoption of EHR by Non-Eligible Provider Types

Integrating health care delivery between behavioral health and physical health providers is an agency priority. Starting in July, 2016, through the Regional Behavioral Health Plans, funds were made available for behavioral health providers to onboard to the Health Current HIE. That work was completed and connected 58 high priority, behavioral health providers that were targeted to be connected. These funds are NON- HITECH funds.

Through the release of the new State Medicaid Directors letter (SMD # 16-003) AHCCCS encouraged HIE onboarding to Health Current for other non-eligible provider types. AHCCCS received approval from CMS in March 2017 to request permission to encourage health information exchange (HIE) interoperability by "…developing connectivity between Eligible Providers (whether eligible professionals or eligible hospitals) and other Medicaid providers if this will help the Eligible Providers demonstrate Meaningful Use." AHCCCS uses this funding authority to onboard long term care providers, additional behavioral health providers or any other Medicaid provider.

The agency completed the Health IT Plan that was one of the components of the State Innovation Model or SIM Design Grant. The Health IT plan recommended establishing HIE connectivity among the key participants that are focused on coordinating care for three unique populations: (1) for the American Indian Health Program, (2) for the individuals that are involved with the county and state justice system, and (3) for the organizations that are implementing integrated behavioral health and physical health delivery.

As of mid-April, 2019, Health Current has 594 different organizations participating with it.   The table and figure below through mid-March, illustrate the growth of Health Current. A full listing of participants is included in Appendix F: 6.

Table 32: The Success of Health Current HIE Growth YTD March, 2019

Major HIE Participant Groups	2011 YE	2012 YE	2013 YE	2014 YE	2015 YE	2016 YE	2017 YE	2018 YE	2019 YTD
Total Participants	11	21	27	27	74	244	399	565	586
Hospitals & Health Systems	5	7	10	10	14	22	30	53	53
Accountable Care Organizations	-	-	-	-	2	8	14	15	16
Health Plans & Payers	2	5	5	5	11	12	14	16	17
FQHCs & RHCs	1	2	2	2	14	21	21	21	21
Lab, Imaging Center & Pharmacy	-	1	1	1	1	1	3	5	5
Community Providers	1	4	5	5	18	78	149	269	277
Integrated Clinics	-	-	-	-	7	27	28	30	30
Behavioral Health Providers	-	-	-	-	2	42	47	49	49
Post Acute Care & Home Care	-	-	1	1	-	17	74	83	93
State & Local Government Agencies	2	2	3	3	4	6	7	7	7
EMS Paramedicine Programs	-	-	-	-	1	10	12	17	18
HIEs	-	-	-	1	1	2	2	16	16

Data Source: Health Current March, 2019

Figure 25: Health Information Exchange Participant Growth
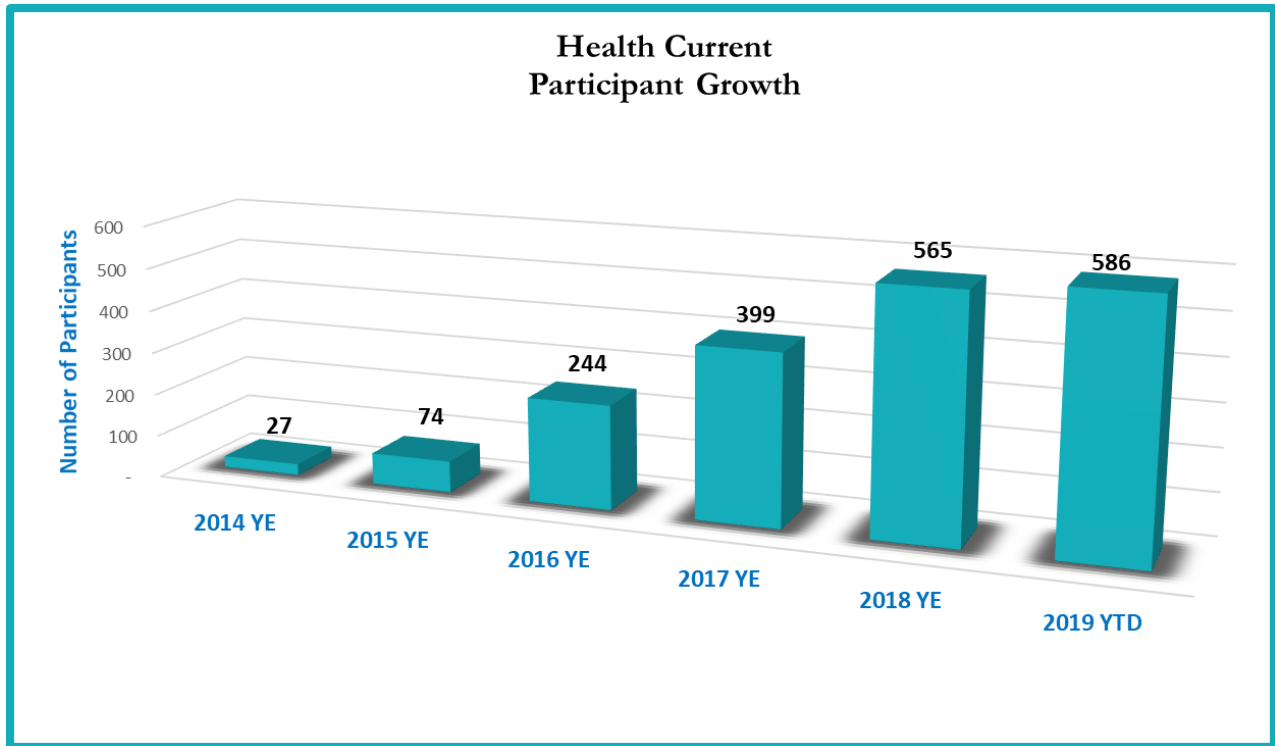
Data Source: Health Current YTD April, 2019

Describe changes that have been implemented for the Medicaid Expansion

According to the SMAs Network Operations area, while there has been member growth in the Medicaid program and there has been some provider growth associated with the General Mental Health/Substance Abuse dual integration, there has not been a very significant increase in the number of providers in the MCO Networks. The MCOS are focused on moving members into Value Based Payment and Accountable Care arrangements, which has actually driven down the number of providers as health outcomes and provider performance are heavily reviewed.

B.6 SMA Encouragement of FQHC PI Program HIE Participation
(SMHP Companion Guide Question B #6)

FQHC's and HRSA Funding

As reported in section A.3, there has been some funding from HRSA for "Electronic Health Record Reports".

AHCCCS does have an HIE onboarding program that encourages Eligible Hospitals, FQHCs and Rural Health Centers (RHCs) to join Health Current. At this time, of the 19 FQHCs/RHCs that are participants in the Health Information Exchange, 17 have Milestone 2 interfaces (Data to the HIE from the participant) and 10 Have Milestone 3 interfaces (data from the HIE to the participant).

Table 33: FQHC HIE Onboarding

FQHS and Rural Health Centers		Milestones				
		#1	#2	#3	#4	#5
Adelante Healthcare, Inc.	FQHC	✓	✓	✓	✓	
Canyonlands Community Health Care	FQHC	✓	✓			
Chiricahua Community Health Centers	FQHC	✓	✓			
Desert Senita Community Health Center	FQHC	✓	✓	✓	✓	
El Rio Health Center	FQHC	✓	✓	✓	✓	
Marana Health Center, Inc.	FQHC	✓	✓	✓	✓	
Maricopa County Health Care for the Homeless	FQHC	✓				
Maricopa Integrated Health Systems Clinics	FQHC	✓	✓	✓	✓	
Mariposa Community Health Center, Inc.	FQHC	✓	✓	✓	✓	
Mountain Park Health Center	FQHC	✓	✓	✓	✓	
Native Health	FQHC	✓		✓		
Neighborhood Outreach Access for Health	FQHC	✓				
North Country HealthCare	FQHC	✓	✓	✓	✓	
St. Elizabeth's Health Center	FQHC	✓	✓	✓	✓	
Sun Life Family Health Center	FQHC	✓	✓			
Sunset Community Health Center	FQHC	✓	✓	✓	✓	
United Community Health Center, Inc.	FQHC	✓	✓			
Wesley Community Center	FQHC	✓	✓			
San Luis Walk-In Clinic	RHC	✓	✓			

Data Source: AHCCCS Invoice Tracking, March, 2019

B.7 How will the SMA assess or provide Technical Assistance for Medicaid Providers

(SMHP Companion Guide Question B #7)

Eligible Providers Technical Assistance

The agency provides ongoing help to providers through phone calls and webinars to educate them about the Promoting Interoperability Incentive Program, how to attest and current MU requirements. The EHR team has created attestation guides for providers for walking them, step by step, through the attestation process. These are maintained on the agency website in downloadable PDF format.

The agency also maintains a contract with Health Current to produce alerts, newsletters, webinars and one on one consultation from a subject matter expert who was the former Director of the Regional Extension Center. This support is provided for the purpose of moving Medicaid providers through the stages of Meaningful Use and Attestation.

Challenges to Overcome and Lessons Learned

According to summaries gathered from providers that were awarded grant funds under the ONC State HIE Cooperative Agreement Program (SHIECAP) several barriers and common problems were encountered as they worked to adopt CEHRT and implemented transport and exchange options. Several of these "lessons learned" are listed below and are included in the agency's strategy to improve adoption of Health IT:

- Sometimes there may not be an immediate Return on Investment (ROI) for the participant for EHR adoption and HIE participation.

- Currently there is a lack of readily available, affordable technology support for some providers throughout the technology adoption and implementation cycle.

- The time involved in planning and implementing the HIT/HIE technology and strategy took longer and was more complex than many providers originally had expected.

- Implementation of both HIT and HIE took a very focused and ongoing commitment from providers and staff with many providers needing to supplement staff doing the work with subject matter experts.

- The EHR vendor community has been challenged to deliver the required software changes to make all of the MU Program changes in a timely fashion.

- Because each provider workflow is unique, it can be challenging to make large scale replicable implementations work – each implementation was unique making the rate of adoption slower than in other types of implementation projects.

- The SMA believes that in order to move towards care improvement and cost reduction, clinical information needs to flow freely across networks and between providers. For this reason, ensuring that certified EHR systems can be interoperable with the state level HIE, is an important priority.

Expanding CEHRT Adoption to Behavioral Health, LTC for adoption of CEHRT and movement by EPs/ EHs through the MU stages and Participation in HIE by all.

The State of Arizona does not have any state dollars funded or non-HITECH dollars to purchase EHRs for EPs or EHs. A limited number of state dollars have been made available to certain behavioral health providers to connect to the HIE, not to buy EHRs. However, due to such a competitive business environment in our state many EPs and Long Term Care facilities and BH providers are using their own resources or the resources of an ACO or Health Plan to implement CEHRT. These purchase and implementations of CEHRT are not being performed by the SMA.

The focus of the SMA is now supporting the movement of Medicaid providers through advanced stages of Meaningful use and funding their participation in the Health Information Exchange. The HIE is actively recruiting a variety of health care participants to ensure the HIE and the data it provides is robust and of high value to all of its participants.

As noted in Table 32 in Section B.5, the HIE is experiencing significant and continuous growth. The HIE has adopted a new platform (Mirth) and has expanded both its service offerings, use cases and the volume and type of providers served.

Beyond acute care hospitals, Critical Access Hospitals and FQHC's, RHC's, HIE participant types have expanded to include:

- Community Providers
- Behavioral Health Providers
- EMS Services
- Health Plans and Payers
- LTC/Post Acute Care/Rehabilitation
- Hospitals and Health Systems
- Reference Lab and Imaging
- State and Local Government

Year to date, active participants have grown to 586 with over 8.5 million unique patients representing 95% of Arizona beds.

B.8 SMA Management of Populations with Unique Needs

(SMHP Companion Guide Question B #8)

Serving Populations with Unique Needs

Internally, AHCCCS will be monitoring the number and type of providers (including FQHC, IHS and VA providers and pediatricians and dentists) that are successful in receiving a payment

through the Incentive Program as well as hearing about any barriers or challenges EPs may be having through monthly teleconferences with Health Current.

Through the Agency's Executive Health IT Team, each of the AHCCCS-covered populations is represented. The Assistant Directors from the Division of Health Care Management and Fee for Service Management are taking the leads in care coordination for behavioral health, dual eligibles and Children's Rehabilitative Services (CRS).

In future years, the Meaningful Use criteria may address children's issues and include more of a focus on improving the quality of preventive healthcare for children. AHCCCS will work with ADHS and AHRQ to ensure that data and reporting efforts are targeted on improved clinical outcomes. AHCCCS continues to monitor member coverage via the providers participating in the Promoting Interoperability Incentive Program to determine how comprehensive the Meaningful Use data is for measuring quality of care and where more information is needed. At this time, AHCCCS does not believe that the data would accurately reflect the population served; however, ongoing efforts continue to ensure the Meaningful Use of EHRs in order to increase the accuracy and availability of electronic clinical quality data.

The agency is consider hiring a consultant for clinical quality reporting in its Division of Health Care Management and this person helps staff a clinical reporting workgroup made up of representatives from AHCCCS health plans.

B.9 Grant Leverage of the PI Program

(SMHP Companion Guide Question B #9)

HIT Related Grant Management-

The agency had multiple grant projects running with Health Current and each of them will help inform the SMA about how to ensure that its stakeholders are participating and maximizing the value of the health IT tools, like EHRs and Health Current/HIE.

Project 1: State Innovation Model (SIM) Planning Grant - The agency received a SIM Model Design planning grant which identified gaps or challenges providers have when trying to share or provide real time clinical quality data in a transformational plan that assessed different payment and care delivery models that improve the patient experience (including quality and satisfaction), improve the population health and reduce per capita costs of healthcare in the strategic focus areas below:

1. Enhance coordination and integration between Physical Health and Behavioral Health Providers for adults and children.

2. Improve justice system transitions through development of HIT/HIE infrastructure and health plan interfaces to coordinate coverage and care with Arizona Department of Corrections (ADOC), county jails and probation systems.

3. Enhance and develop regionally based care coordination models for the American Indian Health Plan (AIHP) members, including data sharing capacity, collaboration with Indian Health Services, 638 Tribally operated, and non-tribal providers to support provider infrastructure development and reduced delivery system fragmentation.

One of the deliverables of the SIM transformation plan was a Health IT plan that will support communications and real time data exchange among the EPs that make up the care network for each of the 3 target populations. Health Current hosted and coordinated stakeholder engagement activities needed to develop the Health IT components of the SIM grant.

Project 2: Statewide BH-PH Integration (SHIP Plan) – Health Current was tasked by the State of Arizona to produce an integrated Physical and Behavioral Health Plan for HIE. Health Current developed a statewide plan to integrate physical and behavioral health information exchange under one infrastructure. The goal was to improve quality and outcomes for Arizona patients who receive physical and behavioral health care. The state level HIE model needs to support providers in developing integrated service delivery models and must contain these essential elements:

- A single HIE infrastructure managed by Health Current
- One marketing and communication and messaging strategy for the Integrated HIE for all physical and behavioral services; and
- One financial model that encompasses a single fee for physical and behavioral health care stakeholders to sustain the integrated physical and behavioral health network

Project 3: Health Current was awarded a Transforming Clinical Practice Initiative Grant (TCPI) - The grant was awarded September 29, 2015. It is a collaboration of Health Current, Mercy Care Health Plan and Mercy Maricopa Integrated Care Organization. It is expected that AHCCCS providers will be able to receive coaching and technology tools and workflow redesign to transform the way they provide care and to prepare them for Value Based Purchasing (VBP). Many of the EPs that have just gotten an AIU payment are interested in learning more about how they will need to make practice work flow changes to enable them to get the maximum value out of the new tools they have implemented.

Project 4: Testing Experience and Functional Tools Grant (TEFT) - TEFT – Testing Experience and Functional Tools Grant-was awarded April of 2014. The purpose of the grant is to further adult quality measurement activities under Section 2701 of the ACA (PPACA). The CMS strategy for implementing the section is to support the SMA in collecting and reporting on the Adult Core Measures. This tool is primarily intended to test the collection of adult quality measures for use in Medicaid community based long term services and support (CB- LTSS)

This grant also gives states the opportunity to use web based personal health records (PHR) systems, subject to beneficiaries permission, as a vehicle for capturing testing and reporting on state quality measures and other related quality information. Arizona has elected to participate in 2 of the 4 components of the TEFT grant which include:

1. Field Test a beneficiary survey,

2. Field Test a modified set of continuity assessment record and evaluation of functional assessment measures.   At this time the grant is being managed by the Office of the Medical Director. The HIT Coordinator and HIT Project Manager are a part of the grant steering committee. At this time the HIT pieces are being identified with the grant consultants.

B.10 SMA Need for New or Changed State Laws

(SMHP Companion Guide Question B #10)

Anticipate the Need for New or Changed State Legislation

In the last two legislative sessions there has been activity that has addressed substance abuse by requiring AHCCCS contractors to intervene if someone receives more than 10 prescriptions in a 3 month period (SB 1032) and requires the Board of Pharmacy to provide access to the Controlled Substance Prescription Monitoring Program (CSPMP) to prescribers licensed under the Controlled Substances Act. (SB 1370) In 2016, Senate Bill 1283 passed which requires all prescribers to access the CSPMP before prescribing opioids.

AHCCCS is working with the Board of Pharmacy to identify it's interest in joining Health Current and having its data be a part of the HIE and/or through participation as a specialized registry as part of the MU Program.

B.11 SMA Need for Issue Management and Other Institution Involvement for Five Year Goal realization

(SMHP Companion Guide Question B #11)

Other Issue Management and Interoperability Arrangements

The agency is committed to pursuing different payment reforms over the course of the next five years and has updated its new 1115 Waiver application to CMS to include cost sharing and expects its Medicaid Health Plans to be embracing technology for themselves and their members in order to reduce costs and improve health outcomes. Getting value out of the current care delivery system is a high priority.

AHCCCS joined the CMS sponsored Health Care Payment Learning & Action Network (LAN) in 2016, which was created to drive alignment in payment approaches across the public and private sectors of the US Health Care system. This group has created the Alternative Payment Models Framework which is represented below.

The APM Framework rests on seven principles:

1. Changing providers' financial incentives is not sufficient to achieve person centered care so must also empower patients to be partners in health care transformation.
2. The goal for payment reform is to shift US healthcare spending significantly towards population based (and more person focused) payments.
3. Value based incentives should ideally reach the providers that deliver care.
4. Payment models that do not take quality into account are not considered APMs and do not count toward payment reform.
5. Value based incentives should be intense enough to motivate providers to invest in and adopt new approaches to care delivery.
6. APMs (Alternative Payment Models) will be classified according to the dominant form of payment when more than one type of payment is used.
7. Centers of Excellence, Accountable Care Organizations, and Patient Centered Medical Homes are examples, rather than Categories in the APM Framework because they are delivery systems that can be applied to and supported by a variety of payment models.

The figure below gives a visual summary of the four pillars of the alternative payment model framework:

Figure 26: Alternative Payment Model Framework, AHCCCS Complete Care LAN
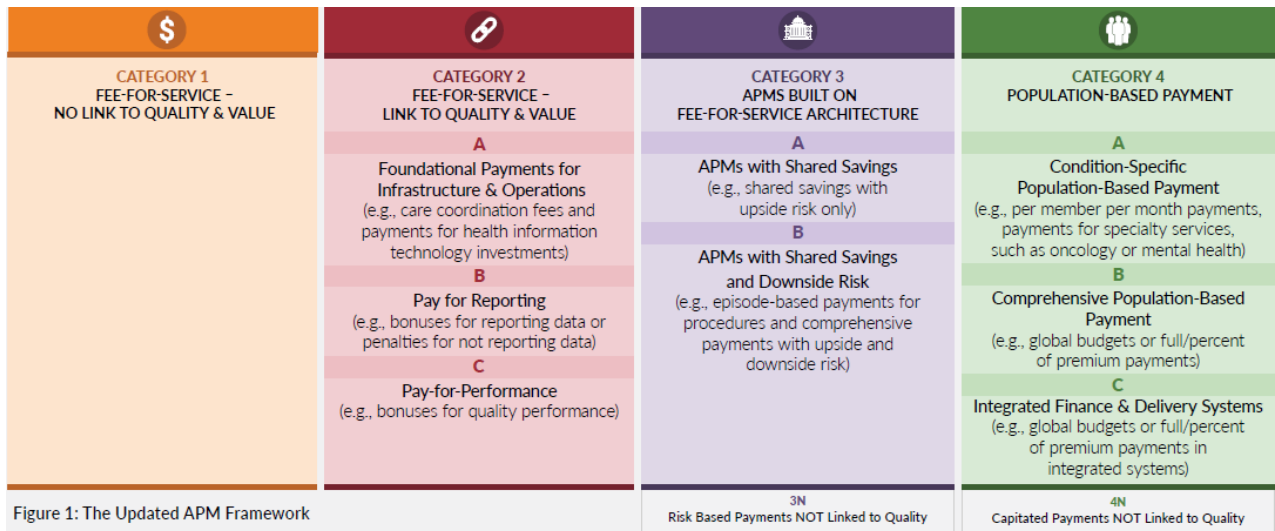
Data Source: ACC RFP, Prospective Offers Conference PDF, November 28, 3017

Section C Activities Necessary to Administer and Oversee the PI Program

C.1 SMA Verification of Provider Sanction, License, Qualification Status

(SMHP Companion Guide Question C #1)

Verification of Provider Eligibility Status

The SMA will employ both automated and manual processes when performing the pre-payment audit for sanctions, licenses and qualification status for EPs and EHs to ensure statutory and regulatory requirements are met for the PI Program.

Level 1: ePIP performs the 1st level verification during the attestation.

The provider's attestation is checked via a daily cyclic synchronization process against PMMIS. The provider's status and the payee are checked in the PMMIS provider database to determine if both are registered as a Medicaid provider, active and in good standing. PMMIS receives and updates provider additions, changes, and deletions from the State's regulatory boards. Unlicensed providers are not qualified or approved to be Medicaid providers and are reflected in PMMIS as inactive and/or not in good standing. Therefore, such providers can be easily identified as ineligible.

Level 2: The EHR staff performs the 2nd level verification during pre-payment audit process.

Before the PI Program payment is authorized by the State, the EHR staff reviews license, Medicaid enrollment, and sanctions for the Program year (YYYY) in which the provider is attesting.

- *License:* Provider license is checked against the State's regulatory board.

- *Medicaid Participant:* Provider Medicaid enrollment is checked against PMMIS.

- *Sanctions:* Provider sanctions are checked against the State's regulatory board, HHS-OIG Exclusions Database and PMMIS.

C.2 SMA Verification of EP "Hospital-Based" Status
(SMHP Companion Guide Question C #2)

Verification of EP "Hospital-based" Status

The SMA will employ both automated and manual processes when performing the pre-payment audit for the Medicaid hospital-based determination for EPs using Medicaid patient volume to ensure statutory and regulatory requirements are met for the PI Program.

Medicaid hospital-based EPs have 90 percent or more of their Medicaid patient encounters in an inpatient hospital [POS 21] and emergency room [POS 23] setting in a 12-month period in the prior calendar year. EPs must upload their detail report and enter the total number of Medicaid title XIX inpatient hospital, emergency department and total patient encounters paid during the prior calendar year.

Because Program Year 2016 was the last year a provider can begin participation in the program, the State will give some level of consideration to circumstances where the provider does not have patient encounters in 2015 calendar year to demonstrate they are not hospital-based. For Program Year 2016 EPs, EHR staff will make the determination that the provider is not hospital-based for a 12-month period from January 1, 2016 – December 31, 2016 (instead of a 12-month period from January 1, 2015 – December 31, 2015).

Level 1: ePIP performs the 1st level verification during the attestation process.

EPs that attest to being 90 percent or more Medicaid hospital-based are automatically denied in ePIP and do not require a level 2 review by the EHR staff.

Level 2: The EHR staff performs the 2nd level verification during pre-payment audit process.

The EHR staff reviews the detail provider report to ensure the data entered in the attestation is correct. Next, the EHR staff queries Medicaid title XIX business intelligence data in the Data Warehouse to validate the reported Medicaid hospital-based percentage. If the result shows that the provider is 90 percent or more Medicaid hospital-based, then the provider is not eligible.

If applicable, the EHR staff confirm service delivery location via internal business intelligence reports that are specific to each individual EP. If a large number of the EP's encounters are hospital or emergency department based, the EHR staff confirms the EP's primary practice location. If the EP practices primarily in a hospital and uses his own CEHRT system *(not the hospital's CEHRT system)*, an exclusion is granted for the hospital-based criteria. Additionally, EPs practicing predominantly in a FQHC or RHC location are exempt from the hospital-based criteria.

C.3 SMA Verification of Provider Attestations
(SMHP Companion Guide Question C #3)

The SMA will employ both automated and manual processes when determining program eligibility during the pre-payment audit to ensure statutory and regulatory requirements are met for the PI Program. Pre-payment validations for all MU stages are completed in alignment with the state's SMHP and the Final Rule, through both system-automated and manual validation processes.

EHR Payments System Workflow – Front End (Provider Workflow) and Backend (Support Staff Workflow After Attestation)

Front End Provider Workflow

Level 1: ePIP performs the 1st level verification during the attestation. The provider's attestation is checked via a daily cyclic synchronization process against PMMIS.

- The provider must register in ePIP to create an account in order to participate in the Medicaid PI Program.

- The payee and the provider's active status and provider type are checked via a daily cyclic synchronization process against PMMIS.

- For EPs, the Pediatrician indicator is determined based on the provider's specialty in PMMIS. If the Pediatrician's attestation has a minimum 20% but less than 30% patient volume, the payment amount is reduced by one-third of the standard payment amount.

- The provider's Electronic Funds Transfer (EFT) status is checked via a daily cyclic synchronization process against AFIS system (new Accounting & Finance Information System in the Division of Business & Finance database).

- The provider's reporting periods are checked to ensure the attestation reporting periods meet the requirements. The attestation is not accepted with invalid reporting periods.

- The provider's patient volume calculation is checked to ensure the provider meets the minimum thresholds. If the provider's attestation does not meet the requirements, the attestation is automatically denied.

- The provider's meaningful use measures are checked to ensure the provider meets the minimum thresholds and that the appropriate number of measures are reported. If the provider's attestation does not meet the requirements, the attestation is automatically denied.

- The provider's attestation documentation must be uploaded in order to complete the attestation.

- The provider's CMS EHR Certification ID is checked to ensure it is valid and appropriate for the program year.

- "Unique patient" measures are checked to ensure the denominators are equal to one another

- The payment amount is determined as soon as the provider submits the attestation.

Back End Provider Workflow

The EHR staff performs the following functions to assist the provider:
- Provider education
- Problem resolution impacting registration, attestation and payment
- Help desk assistance
- Respond to voicemail inquiries
- Respond to email inquiries
- Partner with Health Current Education and Outreach assistors –(formerly Regional Extension Center)
- Coordinate with internal units *(DFSM, ISD, OALS, OBI, OIG, etc.)*
- Perform system testing
- Perform pre-payment audit
- Update workflow management tools
- Perform white paper analysis
- Identify fraud, waste & abuse

Perform Pre-Payment Audit Validation

Arizona has developed a robust pre-payment validation process that assures provider eligibility and appropriate participation and payment.

Level 2: The EHR staff performs the second level verification during the pre-payment audit process which verifies the following criteria:

- *Provider type* - Payee and the provider types are checked against PMMIS.
- *License:* Provider license is checked against the State's regulatory board.
- Medicaid Participant: Provider Medicaid enrollment is checked against PMMIS.Sanctions:
- Provider sanctions are checked against the State's regulatory board, HHS OIG Exclusions Database and PMMIS.

- *PA-led Practice* - EHR staff confirms the EP practices at a FQHC or RHC that is led by a PA. The practice is determined to be PA-led when one of the following is met:

  (1) A PA is the primary provider in a clinic;
  (2) A PA is a clinical or medical director at a clinical site of practice; or
  (3) A PA is an owner of an RHC.

  The EHR staff confirms the EP's practice and compares it against the FQHC/RHC listing on the State's website. To verify PA-led definition #1, EHR staff run business intelligence data to determine if a PA is the primary provider in the clinic. To verify PA-led definitions #2-3, EHR staff request and verify documentation to support a PA is the clinical/medical director or owner of the practice. If there are multiple PAs at a practice, all PAs will be eligible provider types if the practice is led by a PA.

- *FQHC /RHC Practice Location (needy)* - EHR staff confirms the EP's practice and compares it against the FHQC/RHC listing on the State's website. EHR staff verifies the EP has more than 50% of their total patient encounters at FQHC/RHC/tribal facilities in a 6-month period in the prior calendar year as described in section C7.

- *EP Practice Location (hospital-based)* - EHR staff confirms the EP's practice location with the hospital if the EP practices primarily in a hospital and uses his own CEHRT system *(not the hospital's CEHRT system)*. EHR staff performs verification steps described in step C2 to determine whether the EP is not hospital-based.

- *Group Proxy Patient Volume* - If the EPs at the practice collectively elect to use the group proxy patient volume for the program year to meet the eligibility criteria, EHR staff will review the Practice Request Form containing the practice roster and data supporting the calculation. EHR staff will verify all data used in the group proxy patient volume calculation occurred at the relevant practice as described in section C5.

- *Individual Patient Volume* - EHR staff reviews the EP's patient volume for the program year as described in section C5.

- *EH Patient Volume (Acute Care Hospitals)* - EHR Staff reviews the EH's patient volume for the program year as described in section C5.

- *EH Average Length of Patient Stay (Acute Care Hospitals)* - The average number of days a patient is confined in the hospital facility is measured by the ratio of inpatient bed-days to discharges using statistical fiscal year data reported on the prior CMS Hospital Medicare Cost Report that precedes the program year. The EHR staff review the ratio to ensure it is less than 25 days.

- *EH Payment Components* - The EH payment calculations are programmed in the ePIP system (SLR).

- *During the Pre-Payment Audit*, the EHR staff validates the reported payment calculation components against the hospital's documentation *(Medicare Cost Reports and Charity Report)* to ensure accuracy of the payment calculation.

- *During the Post-payment Audit, the EHR post-payment auditors review detailed patient data and financial documents submitted to support the reported payment calculation components. Adjustments to the payment calculation are made when discrepancies are identified.*

- Out-of-State patient Encounters – *The EHR staff verifies the reported Medicaid Title XIX & CHIP Title XXI encounters with each state if they are necessary to meet the required threshold.*

- *Certified EHR Technology (CEHRT) Documentation* – The EHR staff verifies utilization of CEHRT and CEHRT Edition certification requirements are met via review of vendor contract, vendor letters, CMS EHR certification ID verification against ONC HITECH and CHPL websites.

- *Meaningful Use* – EHR staff reviews the provider's MU reports compared to the provider's attestation to ensure there are no discrepancies.

- *Meaningful Use* – "Segment of patient population" measures are checked to ensure the denominators are less than or equal to the "unique patient" denominators.

- *Meaningful Use* – The provider must have 80% (50% in Modified Stage 2) of the provider's total unique patients had data in the CEHRT during the MU period. "Total unique patients" measures are checked to ensure the denominators equal one another. If there are discrepancies that result in the provider no longer meeting the minimum threshold for one or more measures, the attestation is rejected. Provider can re-attest within 30 days and must provide additional information regarding discrepancies with revised attestation.

- *Meaningful Use* – EHR staff reviews that at least 50% of the provider's total encounters occurred at a clinical location with CEHRT. If the provider only worked on one location, the staff can stop there. If the provider worked at more than one location the staff will need to request a listing of all locations, names of CEHRT at each location, and total number of encounters at each location. The staff will need to calculate percentage of the encounters occurring at locations with CEHRT. If there are discrepancies or concerns, additional documentation can be requested and must be submitted within 7 days.

- *Meaningful Use* – Providers must complete or update a security risk analysis (SRA) in accordance with 45 CFR 164.308 (a)(1) and, as of 2014 stage 2 and beyond, address the security (to include encryption) of ePHI created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3). The EHR staff must confirm that the SRA is dated appropriately and contains all necessary elements.

Conduct Program Analysis and Measurement

Ongoing analytics are an integral part of the PI Program. Data is reviewed at least weekly to ensure that workload is on track. There are various subsets of data that the team relies on, ranging from registration data to attestation trends. Program analytics support everything from attestation payment determinations and audit selections to provider outreach efforts and future planning. Program analytics are provided monthly to the managers, quarterly to the Executive Health IT Team and CMS, and also annually to stakeholders and CMS.

EH Participation Verification

The following hospitals are eligible to participate in the Medicaid PI Program: acute care hospitals (including CAHs and cancer hospitals) with at least 10 percent Medicaid patient volume; and children's hospitals (excluded from Medicaid patient volume requirements). Children's hospitals must demonstrate meaningful use with the SMA. As of Program Year 2015 and going forward, all hospitals must demonstrate meaningful use with the SMA.

Under the Medicaid EHR (PI) Incentive Program, EHs can qualify for incentive payments if they adopt, implement, upgrade (AIU) or demonstrate meaningful use (MU) of certified EHR technology during the first participation year or successfully demonstrate meaningful use of certified EHR technology in subsequent participation years. Data from CMS sent to the SMA via a C5 file transition was used as the primary determination for meaningful use. Beginning in Program Year 2015, EHs will complete a meaningful use workbook and submit the workbook to the SMA. The SMA completes the eligibility determination for all other components.

C.4 SMA Communication with Providers Regarding Eligibility, Payment Etc.

(SMHP Companion Guide Question C #4)

Communication with Providers Regarding Eligibility and Payment

The EHR staff communicates with providers via the EHR Email box at:

EHRIncentivePayments@azahcccs.gov or EHR Help Desk at 602.417.3333.

A provider can also check the status of their attestation and payment by logging onto their ePIP accounts.

If the provider's attestation data does not meet the program requirements, a message is displayed on the Attestation Status page. If the provider does not meet the MU requirements, the measures results are displayed on the MU Report Summary page.

Plans for Stakeholder Engagement about MU Stage and Other Changes

AHCCCS operates a website for all providers participating in the EHR program which contains a provider attestation portal called ePIP and houses reference and resource information including

news and alerts which are put out routinely by the agency. The SMA and Health Current maintain two different listservs that providers can sign up for to receive timely notices and alertsabout changes in the program or upcoming deadlines. Health Current publishes a newsletter which contains important program changes and updates and is sent to their listserv of over 3,200 participants.

Based on results of the AHCCCS online survey project, more providers wanted faster communication and resolution to their attestation questions or problems. Based on these findings, the agency is looking to automate some functions so that providers can be notified more quickly if there are issues with their attestation. The agency is planning to hire temporary workers to assist with customer service responses.

For the purposes of recruiting providers to the PI Program and assisting participating providers in progressing through the stages of meaningful use, AHCCCS has contracted with Health Current to perform education and outreach to eligible professionals. Through their website, webinars, phone calls and newsletters, providers are being educated about the MU program changes.

C.5 SMA Methodology for Patient Volume Calculation

(SMHP Companion Guide Question C #5)

Patient Volume Calculation Methodology

EPs and EHs *(excluding Children's Hospitals)* are required to meet a specific patient encounter volume percentage each program year in which they are applying to be eligible for a PI Program payment. Arizona has chosen to adopt the Patient <u>Encounter</u> methodology.

The qualifying patient encounter volume percentages for the Medicaid PI Program are given in the following table:

Table 34: EHR Patient Encounter Volume Percentage Criteria

Entity	Minimum 90-day Medicaid* Patient Encounter Volume Percentage
Physicians	30%
Pediatricians	30% or optional 20%**
Dentists	30%
Certified Nurse Midwives	30%
Physician Assistants when practicing at an FQRC/RHC led by a physician assistant	30%
Nurse Practitioner	30%
Acute care hospital	10%
Children's hospital	N/A

*If the Medicaid EP practices predominantly in an FQHC or RHC – 30% needy individual patient encounter volume percentage.
** Attesting to 20% Medicaid patient volume results in a reduced payment.

Eligible Professionals

Although EPs may not collect Medicaid PI Program payments from more than one state, if an EP practices in two locations, one with certified EHR technology and one without, the EP should include the patient volume at least at the site that includes the certified EHR technology.

When calculating individual patient volume (i.e., not using the group/clinic proxy option), an EP may calculate across all practice sites, or just at the one site.

EPs are permitted to aggregate their patients across State borders; however, the EHR Staff must have a means of verifying out-of-state encounters.

If a PA provides services, but they are billed through the supervising physician or group practice, the patients seen by the PA can be included as part of the patient volume for both the PA and the supervising physician or group practice if services were rendered by both providers. The providers must apply this policy consistently for both providers.

Medicaid Encounter

Program Years 2011 and 2012

A Medicaid patient encounter is defined as a service rendered on any one day where Medicaid Title XIX paid for all or part of the service or Medicaid paid the co-pays, cost-sharing, or premiums for the service.

Program Years 2013 and Beyond

As of Program Year 2013, the definition of a Medicaid encounter was updated to include services rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability. This includes zero-pay claims and encounters with patients in Title XXI-funded Medicaid expansions, but not separate CHIP programs.

Needy Individual Patient Encounters

Program Years 2011 and 2012

Needy individual encounters are defined as encounters in which:

- Medicaid or CHIP paid for part or all of the service;

- Medicaid or CHIP paid all or part of the individual's premiums, copayments, or cost-sharing;

- The services were furnished at no cost; and calculated consistent with §495.310(h) of the final rule; or The services were paid for at a reduced cost based on a sliding scale determined by the individual's ability to pay

<u>Program Years 2013 and Beyond</u>

- Medicaid patient encounters include services rendered on any one day to a Medicaid Title XIX enrolled individual, regardless of payment;

- CHIP patient encounters include services rendered to an individual on any one day where CHIP paid for part or all of the service, individual's premiums, co-payments, and/or cost sharing; or

- Patient encounters for services rendered to an individual on any one day on a sliding scale or that were uncompensated.

Counting Patient Encounters

Patient encounters are measured by counting unique visits based on date of service per provider per patient. Multiple claims for the same patient on the same day are counted as one visit for each rendering provider.

Patient Volume Calculation for EPs

The patient encounter volume percentage is defined as the total Medicaid (or Needy) patient encounters in any representative continuous 90-day period in the preceding year, divided by the total of all patient encounters in the same 90-day period multiplied by 100. The option to allow the selection of a reporting period that is 12 months prior to attestation is not available in Arizona.

Patient Volume Types

EP measurements are based on the Medicaid patient volume or needy patient volume type.

- Medicaid Patient Encounters (numerator) - Medicaid Title XIX patient encounters only.

- Needy Patient Encounters (numerator) - Medicaid Title XIX, CHIP Title XXI & sliding scale/uncompensated patient encounters. Only EPs practicing predominantly in FQHCs/RHCs have the option of qualifying using either the Medicaid patient volume or needy patient volume type.

Pediatricians

A pediatrician is defined as a physician who is board certified in pediatrics. Pediatricians may demonstrate a patient encounter volume percentage greater than 20% and less than 30% during a 90-day period. The payment amount is reduced by one-third of the standard payment amount.

Group Practice Definition

For the purposes of determining the practice's aggregate patient volume (group proxy) for the Arizona Medicaid PI Program, a group is defined as:

The lawful or legally standing business entity with legal capacity to operate as a group practice and with accountability for all business activity. The administration of the Arizona Medicaid PI Program captures a single business entity linked by any or all of the following criteria:

- Single and/or multiple Employer Identification Number (TIN)
- Single and/or multiple National Provider Identifier (NPI)
- Single and/or multiple Group AHCCCS Provider Numbers (defined by AHCCCS Provider Registration)

All sources of information are used to verify all providers associated to the group practice single business entity.

Clinic-Entity Proxy for Correctional Facilities

For the purposes of the Medicaid PI Program, a correctional health facility (prison or jail) may submit a request for consideration to the State to be considered as a clinic-entity for the purposes of meeting the patient encounter volume percentage. The correctional health facility must be able to report data for services rendered at the correctional health place of services only *(not combined with non-correctional health services for State, County, etc.)*. If approved, the correctional health facility is permitted to utilize the facility's Medicaid patient encounter volume and apply it to all of their EPs in the facility under the following conditions referenced in the Final Rule (i.e. same conditions as any other provider in a non-correctional facility such as a group practice or clinic):

1) The correctional health facility's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
2) There is an auditable data source to support the correctional health facility's patient volume determination; and
3) So long as the correctional health facility and EPs decide to use one methodology in each year (in other words, the correctional health facility could not have some of the EPs using their individual patient volume for patients seen at the correctional health facility, while others use the clinic-level data). The correctional health facility must use the entire clinic-level patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the clinic-level proxy in any participation year.

Furthermore, if the EP works in both the correctional health facility and outside the correctional health facility (or with and outside a correctional health facility), then the clinic- level determination includes only those encounters associated with the correctional health facility.

State Review Process: The State will review all NPIs & TIN associated with the correctional health facility and the submitted patient volume report to determine the appropriateness of use of the clinic-level data. If not approved, the EPs may continue participation in the program by using their individual patient volume data.

Note: Correctional facilities are subject to the same Federal & State Specific Rules as noted under the Clinics and Group Practice provision.

Determining Eligible Services for County Public Health Departments

The SMA could process applications for the PI Program from county public health departments. In order to consistently and fairly evaluate the application, the SMA will exclude non-clinical services from the numerator and denominator when the county public health department delivers non-clinical services. Arizona is going to exclude from the numerator and denominator any services that are non-clinical, which may include the following:

a. Farmers Market
b. Community Nutrition Program Food Assistance
c. Nutrition & Physical
d. Senior Food Assistance
e.   WIC and Food Plus
f. Child Car/Booster Seats
g. Child Care Consultants
h. First Things First
i. Hand Washing
j. Worksite Health
k. Animal Care & Enforcement
l. Child Care Health Consultants
m. Childcare Inspection
n. Consumer Product Safety
o. Health Inspection
p. Public Health Emergency
q. Public Pool Inspection
r. Restaurant Inspection & Ratings
s. Smoke Free Arizona
t. Mosquitos, Bed bugs, etc.
u. Birth Certificates
v. Child Care certificates
w. Health Inspection
x. Public Pool Inspection
y. Restaurant Inspection & Ratings
z. Complaints and Enforcement
aa. Found Pets
bb. Licensing
cc. Pet Adoptions
dd. Pet Vaccines
ee. Rabies
ff. Sheltering

gg.Spay/Neuter Clinics

gg. Vaccine Clinics

hh. Veterinary Clinics

ii. Or any other service or services that the County Public Health Department could document and attest to that are non-clinical.

Eligible Hospitals

Medicaid Encounter

Program Years 2011 and 2012

A Medicaid patient encounter is defined as any service rendered to a Medicaid patient where Medicaid paid for part or all of the services for services delivered in an inpatient or emergency department (ED) setting; POS 21 and 23 respectively. An emergency department must be part of the hospital under the qualifying CCN.

Program Years 2013 and Beyond

A Medicaid patient encounter is defined as any service rendered to a Medicaid-enrolled patient in an inpatient or emergency department (ED) setting; POS 21 and 23 respectively. An emergency department must be part of the hospital under the qualifying CCN.

Counting Patient Encounters

EH patient encounters are measured by counting unique hospital facility patient discharges for the same patient on the same day from the inpatient hospital or emergency department.

Patient Encounter Volume Calculation for Acute Care Hospitals

The patient encounter volume percentage is defined as the total Medicaid patient encounters in any representative continuous 90-day period in the preceding year Federal Fiscal Year (FFY), divided by the total of all patient encounters in the same 90-day period multiplied by 100.

C.6 SMA Verification of EP and Acute EH Patient Volumes
(SMHP Companion Guide Question C #6)

The SMA will employ both automated and manual processes when performing the pre-payment audit for the patient volume determination to ensure statutory and regulatory requirements are met for the PI Program.

Level 1: ePIP performs the 1st level verification during the attestation process.

Provider attestations with results that are below the patient volume requirements are automatically denied in ePIP and do not require a level 2 review by the EHR staff. Additionally, the attestation is not accepted with invalid reporting periods.

Level 2: The EHR staff performs the 2nd level verification during pre-payment audit process.

Eligibility Numerator Validation for Eligible Professionals

Medicaid and CHIP*: PMMIS data is used to verify the Medicaid Title XIX and CHIP Title XXI for portions of the numerator.

Uncompensated/Sliding Scale* (FQHC/RHC/IHS only): EPs may be asked to submit supporting documentation, in the form of billing data and Health Resources and Services Administration reports, as part of a pre-qualification process. EPs can upload supporting documents via ePIP. See below for an illustration of the needy patient volume calculation as it relates to the data available to the State.

*NOTE: Used in the numerator when determining the needy patient encounter volume.

**Figure 27: Needy Patient Volume Calculation**
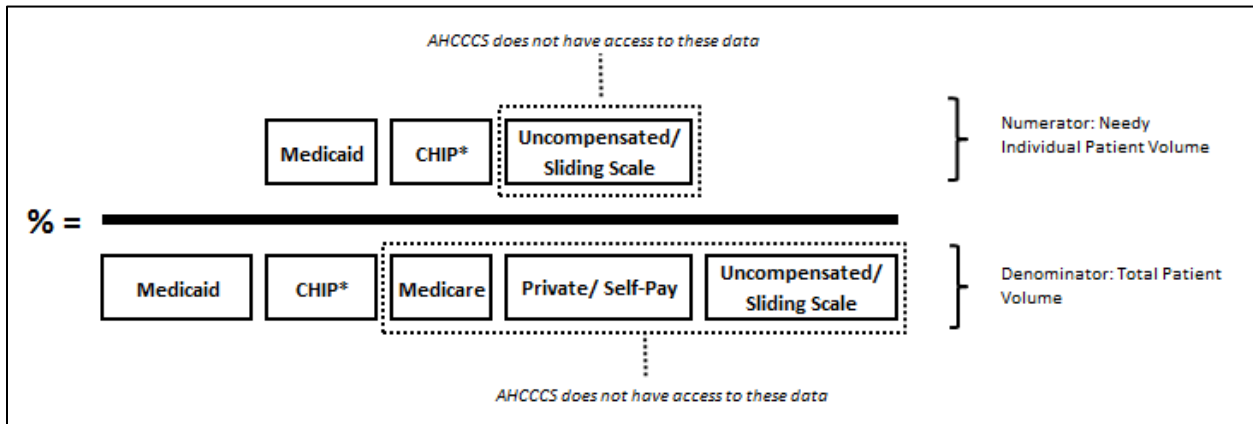
Eligibility Denominator Validation for Eligible Professionals

Medicaid and CHIP: PMMIS data is used to verify the Medicaid Title XIX and CHIP Title XXI for portions of the denominator.

Medicare: Arizona does not have access to pre-existing Medicare data and systems to verify the Medicare portion of the denominator. EPs are asked to submit data to support their attestation.

Private/Self Pay: Arizona does not have access to an all-payor claims database (APCD) system to validate patients who are privately insured or have paid out of pocket for services. EPs are asked to submit data to support their attestation.

(Section C6 Continued – Patient Volume Verification)

Uncompensated/Sliding Scale (FQHC/RHC/Tribal Clinics): EPs are asked to submit supporting documentation, in the form of billing data and Health Resources and Services Administration reports, as part of a pre-qualification process. EPs can upload supporting documents via ePIP.

Eligibility Numerator Validation for Acute Care Hospitals

The EHR analyst validates the Medicaid patient encounters in an inpatient hospital (POS 21) and an emergency department (POS 23) setting in a continuous 90-day period in the preceding Federal Fiscal Year from the PMMIS system. This includes running a data comparison in the data warehouse that contains data from PMMIS for claims and/or encounter data.

Eligibility Denominator Validation for Acute Care Hospitals

Arizona does not have access to an APCD; therefore a reasonableness test will be performed on the total encounters (denominator). EHs are asked to submit documentation, such as billing/claims data, to support their patient volume attestation.

C.7 SMA Verification that EPs at FQHCs/RHCs meet the "Practice Predominantly" Requirement
(SMHP Companion Guide Question C #7)

Verification of "Practices Predominantly" Status

The SMA will employ both automated and manual processes when performing the pre-payment audit for the practice predominantly determination for EPs using needy patient volume to ensure statutory and regulatory requirements are met for the PI Program.

EPs practicing predominantly at a FQHC or RHC have over 50 percent of his/her patient encounters over a period of six (6) months in the prior calendar year occur at FQHC/RHC facilities.

Because Program Year 2016 is the last year a provider can begin participation in the program, the State will give some level of consideration to circumstances where providers using needy patient volume do not have patient encounters in 2015 calendar year to demonstrate they practice predominantly in a FQHC or RHC. For Program Year 2016 EPs, EHR staff will make the determination that the provider is practicing predominantly at a FQHC/RHC/tribal clinic for any 6-month period January 1, 2016 – December 31, 2016 (*instead of a period selected from January 1, 2015 – December 31, 2015*).

Level 1: ePIP performs the 1st level verification during the attestation process. Provider attestations with practice predominantly results that are less than 50 percent are automatically denied in ePIP and do not require a level 2 review by the EHR staff. Additionally, the attestation is not accepted with invalid reporting periods.

Level 2: The EHR staff performs the 2nd level verification during pre-payment audit process.

The EHR staff reviews the detail provider report to ensure the data entered in the attestation is correct. Next, the EHR staff queries Medicaid Title XIX (and if applicable CHIP Title XXI) business intelligence data in the Data Warehouse to validate reasonability of the practice predominantly percentage. If the result shows that the provider has less than 50 percent FQHC/RHC encounters the provider is not eligible.

The EHR Staff confirms service delivery location via internal business intelligence reports that are specific to each individual EP. Only patient encounters for FQHC/RHC/tribal clinic can be used in the numerator.

C.8 SMA Verification of Adopt, Implement, Upgrade of CEHRT
(SMHP Companion Guide Question C #8)

Starting in 2011, providers in the state of Arizona were able to attest to adopting, implementing, or upgrading (AIU) to a certified EHR. Certified EHRs are identified through the Office of the National Coordinator (ONC) Certified HIT Product List (CHPL) and obtain a certification ID to identify the complete EHR system or combination of modular systems. AIU is defined as:

- **Adoption:** acquisition, purchase, or secured access to certified EHR technology (This definition does not include activities that may not result in installation such as researching EHRs or interviewing EHR vendors.)

- **Implementation:** installed or commenced utilization of certified EHR technology, e.g. staff training in the certified EHR technology, data entry of patients' demographic and administrative data into the EHR, establishing data exchange agreements and relationships between the provider's certified EHR technology and other providers, such as laboratories, pharmacies, or HIEs

- **Upgrade:** moving from non-certified EHR to certified EHR technology

Verification of AIU of CEHRT

The SMA will employ both automated and manual processes when performing the pre-payment audit of certified EHR technology (CEHRT) documentation for providers attesting to adopting,

implementing, or upgrading (AIU) the CEHRT to ensure statutory and regulatory requirements are met for the PI Program.

Level 1: ePIP performs the 1st level verification during the attestation process.

Provider attestations with an invalid CMS EHR certification ID are automatically denied in ePIP. ePIP links to the ONC CHPL site to ensure that the CMS EHR certification ID being reported by the provider is for a valid, certified system.

Level 2: The EHR staff performs the 2nd level verification during pre-payment audit process.

The EHR staff:

- Reviews the EHR vendor documentation including, but not limited to, vendor contracts, purchase orders and billing invoices.

- Verifies the provider is using the correct CEHRT edition based on the program year.

- Validates the vendor name for the CMS EHR certification ID.

- Verifies certified system was obtained during or before December 31st of the applicable year.

If the result shows that the provider's EHR system did not meet the program requirements (*executed contract, appropriate CEHRT Edition certification requirements, etc.*) by December 31st of the program year in which the provider is applying, the provider is not eligible.

Additionally, verification steps outlined in sections C1, C2, C3, C5, C6, and C7 will be performed when applicable for AIU attestations.

C.9 SMA Verification of Meaningful Use of CEHRT

(SMHP Companion Guide Question C #9)

At the opening of the Arizona Incentive Program in 2011, providers could only attest to AIU with 2012 being the first year for meaningful use (MU) attestations. The following reporting periods for MU objectives and clinical quality measures (CQM) are required for each stage and program year.

Table 35: MU and CQM Reporting Periods

Program Year	Stage	1st Time MU Provider		Returning MU Provider	
		MU Reporting Period	CQM Reporting Period	MU Reporting Period	CQM Reporting Period
2011	N/A	N/A	N/A	N/A	N/A
2012	Stage 1	90-days	90-days	N/A	N/A
2013	Stage 1	90-days	90-days	365-days	365-days
2014	Stage 1	90-days	90-days	90-days	90-days
2014	Stage 2	90-days	90-days	90-days	90-days
2015	Stage 2^M	90-days	90-days	90-days	90-days
2016	Stage 2^M	90-days	90-days	90-days	90-days
2017	Stage 2^M	90-days	90-days	90-days	90-days
2017	Stage 3	90-days	90-days	90-days	90-days
2018	Stage 2^M	90-days	90-days	90-days	90-days or 365-days*
2018	Stage 3	90-days	90-days	90-days	90-days or 365-days*
2019	Stage 3	90-days	90-days	90-days	90-days or 365-days*

* CQM reporting period will be 90-days for all EPs, EHs attesting to their first year of MU, and EHs reporting CQMs electronically. CQM reporting period will be 365-days for returning EPs and EHs that have already attested to MU in a prior year and EHs reporting CQMs via attestation.

In September 2014, CMS published the 2014 Edition Certified Electronic Health Record Technology (CEHRT) Flexibility Rule.

Process for Verifying Attestations via the Flexibility Rule

The SMA submitted to CMS on October 30, 2014 Arizona's 2014 Flexibility Rule Changes for the SMHP. Arizona received CMS approval on January 20, 2015 for flexibility and requested and received an extension to its tail period until August 31, 2015.

The SMA revised the SLR to meet the requirements outlined in the Flexibility Rule. The SMA provided onsite training to the REC and Health Current staff to test the Flexibility programming. The SMA and the REC/Health Current collaborated on developing a one page brief discussing how flexibility would be administered and developed an updated attestation guide that included the Flexibility option for EPs.

Table 36: Web Based Provider Support Document

Flexibility Rule
The Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) released a final rule in August 2014 that grants flexibility for providers who are unable to fully implement 2014 Edition certified electronic health record (EHR) technology (CEHRT) for the 2014 reporting year. Providers may use EHRs that have been certified under the 2011 Edition, 2014 Edition, or a combination of the 2011 and 2014 Editions to submit meaningful data for an EHR reporting period in 2014.

Only providers who have been unable to fully implement 2014 CEHRT can take advantage of the rule's flexibility options.

Providers will be required to report using 2014 Edition CEHRT beginning in 2015.

CEHRT Flexibility Resources

To help you understand the final rule's changes to 2014 participation, CMS has developed the following resources. Click the link to learn more.

Educational Resources: CMS has a number of resources to help you participate in the programs.

Final Rule: Regulation that grants flexibility to providers who are unable to fully implement 2014 Edition CEHRT for an EHR reporting period in 2014 due to delays in 2014 Edition CEHRT availability.

CEHRT Flexibility Decision Tool: Providers answer a few questions about their 2014 stage of meaningful use and Edition of EHR certification, and the tool displays the corresponding 2014 options.

2014 CEHRT Flexibility Chart: Chart provides a visual overview of CEHRT participation options for 2014.

2014 CEHRT Rule Quick Guide: Explains the participation options for 2014 based on the Edition of EHR certification providers used during 2014.

Medicaid Promoting Interoperability Program Flexibility Resources: Arizona has developed the following companion resources. Click the links to learn more.

The CMS 2014 Flexibility Rule is an option available to providers attesting to meaningful use. Vendor documentation is required to support use of the Flexibility Rule.

The CMS 2014 Flexibility Rule does not apply to providers attesting to Adopt, Implement or Upgrade (AIU). Providers attesting to AIU are required to meet the 2014 Edition certification criteria.

Flexibility Chart for Medicaid EPs: High-level overview of the CEHRT options available to providers due to the 2014 CHERT Flexibility Rule. Use in conjunction with the CMS CEHRT Flexibility Decision Tool.

Flexibility EHR Certification Number Guide for Medicaid EPs: High-level overview of the system's EHR Certification Number for the corresponding CEHRT option selected by the provider due to the 2014 CEHRT Flexibility Rule. Use in conjunction with the CMS CEHRT Flexibility Decision Tool.

Click here to link to the CMS CEHRT Flexibility Decision Tool.

Disclaimer: The above tools were created as a service to the public and are not intended to grant rights or impose obligations. The information provided is only intended to be a general summary of the rule's flexibility options. It is not intended to take the place of the regulation.

Figure 28: Flexibility Rule Attestation Workflow
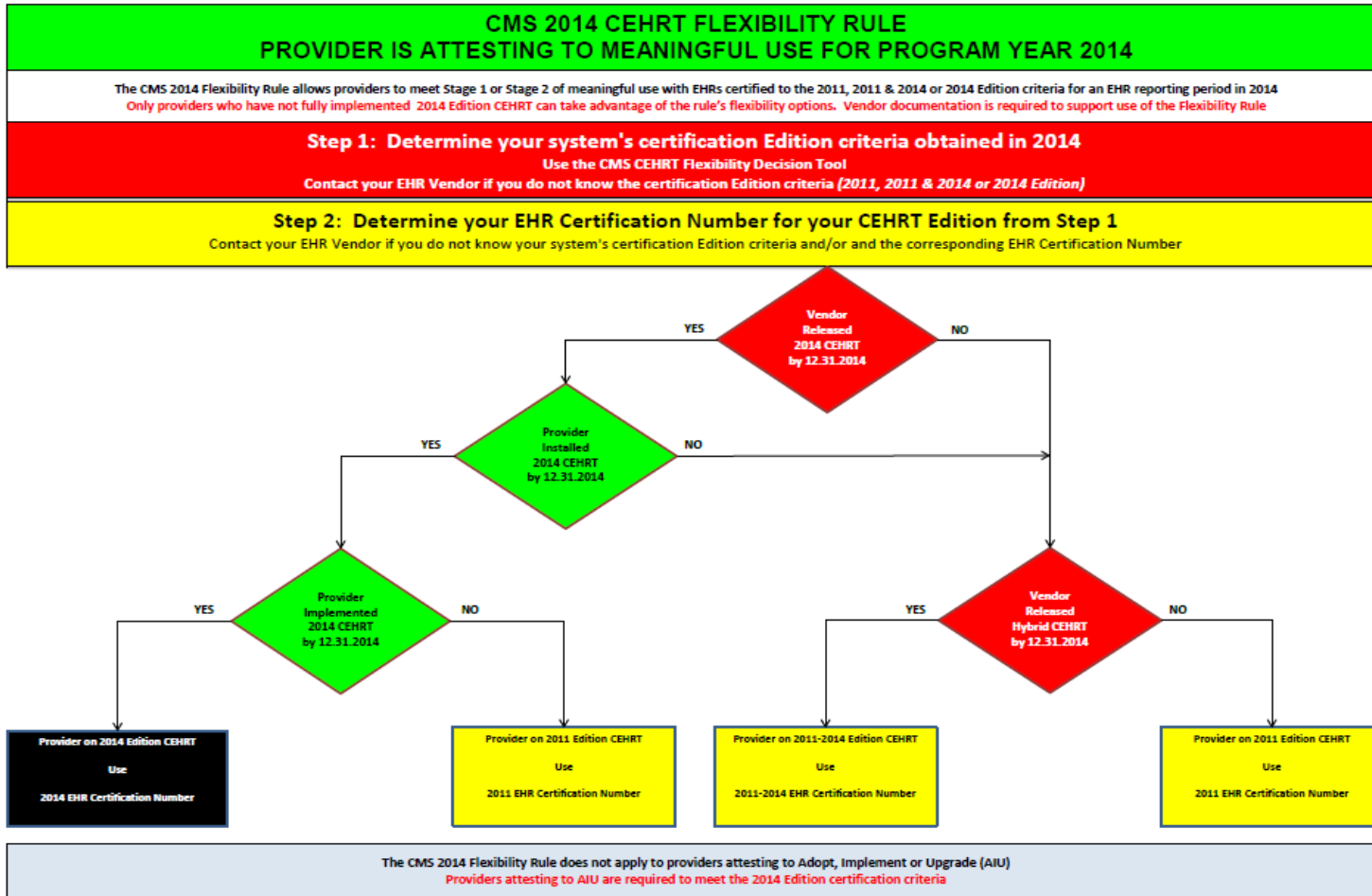
Table 37: Flexibility Workflow Policy

AHCCCS
Arizona Health Care Cost Containment System

Arizona Medicaid EHR Incentive Program
Flexibility Chart for Medicaid EPs
Applies to Attestations for Calendar Year 2014 ONLY

CMS 2014 CEHRT FLEXIBILITY RULE
### PROVIDER IS ATTESTING TO MEANINGFUL USE FOR PROGRAM YEAR 2014

The CMS 2014 Flexibility Rule allows providers to meet Stage 1 or Stage 2 of meaningful use with EHRs certified to the 2011, 2011 & 2014 or 2014 Edition criteria for an EHR reporting period in 2014
Only providers who have not fully implemented 2014 Edition CEHRT can take advantage of the rule's flexibility options. Vendor documentation is required to support use of the Flexibility Rule

Step 1: Determine your system's certification Edition criteria obtained in 2014
Use the CMS CEHRT Flexibility Decision Tool
Contact your EHR Vendor if you do not know the certification Edition criteria *(2011, 2011 & 2014 or 2014 Edition)*

Pre Flexibility Rule Schedule MU Progression	Pre Flexibility Rule Schedule MU Progression	Provider's Certified EHR Technology		
		2011 CEHRT	**2011 & 2014 CEHRT**	**2014 CEHRT**
Not Participating in the Program	AIU	Not Eligible Flexibility Rule Not An Option	Not Eligible Flexibility Rule Not An Option	2014 CEHRT Required Flexibility Rule Not An Option
Stage 1 2014 Definition of MU Measures	Stage 1 2013 Definition MU Measures	Flexibility Rule Option Vendor documentation required	Flexibility Rule Option Vendor documentation required	2014 CEHRT Required Flexibility Rule Not An Option
	Stage 1 2014 Definition MU Measures	Not Eligible Flexibility Rule Not An Option	Flexibility Rule Option Vendor documentation required	2014 CEHRT Required Flexibility Rule Not An Option
Stage 2 2014 Definition of MU Measures	Stage 1 2013 Definition MU Measures	Flexibility Rule Option* Vendor documentation required	Flexibility Rule Option* Vendor documentation required	2014 CEHRT Required Flexibility Rule Not An Option
	Stage 2 2014 Definition MU Measures	Not Eligible Flexibility Rule Not An Option	Flexibility Rule Option Vendor documentation required	2014 CEHRT Required Flexibility Rule Not An Option
	Stage 1 2014 Definition MU Measures	Not Eligible Flexibility Rule Not An Option	Flexibility Rule Option* Vendor documentation required	Flexibility Rule Option* Vendor documentation required

* Note that if provider is attesting Stage1 2013 Definition Mu Measures but is in Stage 2, this still counts as Stage 2 for the MU progression.

The CMS 2014 Flexibility Rule does not apply to providers attesting to Adopt, Implement or Upgrade (AIU)
Providers attesting to AIU are required to meet the 2014 Edition certification criteria

Step 2: Determine your EHR Certification Number for your CEHRT Edition from Step 1
Use the Flexibility Rule EHR Certification Number Guide for Medicaid EPs
Contact your EHR Vendor if you do not know your system's certification Edition criteria and/or and the corresponding EHR Certification Number

This reference was created as a service to the public and is not intended to grant rights or impose obligations. The information provided is only intended to be a general summary of the rule's flexibility options. It is not intended to take the place of the regulation.

Flexibility Rule Chart - EP
June 2015

Table 38: Flexibility System Implementation

Below is a chart that summarizes the Flexibility System implementation process.

PRE-SI1– System Implementation						
Review Criteria	**Source**	**System Change**	**Operational Change**	**No Change Necessary**	**Effective Date of Change**	**Comments**
Effective PY 2014: Enable an EP/EH to attest under the Flexibility Rule (using a 2011 or 2011/2014 Combination CEHRT in PY 2014)	495.6	X	X		June 2015	By following our state specific business objective outlined above, all phases of the SDLC were followed and the flexibility rule was implemented.
Effective PY 2014: CMS would permit an extended attestation tail period for PY 2014 to accommodate the Flexibility Rule. Was a longer attestation tail period requested, and, if so, when did the requested tail period end?	495.332	X	X		June 2015	Yes, a longer attestation tail period was approved and the tail period will end on 08/31/2015.

The SMA has developed Flexibility Rule pre and post-audit processes in conjunction with Myers Stauffer for EHs and EPs that participate in the EHR Incentive Program. An updated Audit Strategy was sent to CMS December 26, 2017 with CMS approval received February 5, 2018. Additionally, the SMA utilizes the back-end administrative components of ePIP to easily track which attestation type the EP completed as well as his/her qualifying rationale for needing to attest via Flexibility.

Table 39: Flexibility System Details

PRE-SM2 – SMHP STATE FLEXIBILITY Y/N QUESTIONS				
Ref #	**State Flexibility**	**Yes**	**No**	**Comments (Required)**
PreSM2.1	Did you implement any state policies, laws or regulations for the Medicaid Promoting Interoperability Program?		No	
PreSM2.2	Subject to §495.332, the state may propose a revised definition of MU of CEHRT, subject to CMS prior approval. Was your state approved by CMS to revise the definition?	Yes		For MU Program Years 2012 and 2013, AHCCCS requested to change the definition of Meaningful Use to exclude Syndromic Surveillance for EPs. As of Program Year 2014, there is not a revised definition in place for MU.
PreSM2.3	Do you have any plans to require providers to submit clinical quality measures (CQMs) electronically?	Yes		TBD pending functionality at The Network (now Health Current) and input from Health Plans
PreSM2.4	Will system changes be required to be implemented due to the IRS ruling on 1099s to providers?	Yes		Changed from payee to designee for 2013 – present
PreSM2.5	Do you have an approved HIE IAPD?	Yes		Approved March 12, 2015 HITECH v 5.1
PreSM2.6	Does your state have a statewide HIE?	Yes		Yes, Arizona Health-e Connection (now Health Current) operates and manages the network (HINAz)
PreSM2.7	Does your state have a Medicaid-only HIE?		No	Medicaid Health Plans and Regional Behavioral health Authorities must join the network (now Health Current) per contract
PreSM2.8	Does your state utilize a Children's Health Insurance Program (CHIP) proxy? If so, please describe the methodology.		No	In rare situations, where providers are unable to distinguish CHIP encounter volume from Medicaid encounter volume, a CHIP decrement is applied to the provider's reported patient volume numerator to adjust the provider's reported numerator. The CHIP decrement is calculated based on the provider's Title XXI claims in AHCCCS Business Intelligence reports.

PRE-SM2 – SMHP STATE FLEXIBILITY Y/N QUESTIONS				
Ref #	**State Flexibility**	**Yes**	**No**	**Comments (Required)**
PreSM2.9	Does your state utilize a proxy for anything else (Qualified Medicare Beneficiaries, Managed Care)? If so, please describe your methodology.		No	N/A
PreSM2.10	Does your state assist in providing numerator data for EPs or EHs? If so, please describe your methodology.		No	Providers are expected to produce their own data, which is reconciled against the agency encounter data under pre-payment review. Providers can request data from the Agency; however, they must go through a formal process (outside of the EHR realm) and pay for the data, charged by the development hour.

Table 40: Flexibility System Details

PRE-SM3– STATE FLEXIBILITY TIMEFRAME QUESTIONS		
Ref #	**Timeframe**	**Date**
PreSM3.1	What is your timeframe for having Stage 2 MU system changes implemented?	Stage 2 system changes (prior to flexibility) were implemented in October 2014. With the introduction of Flexibility, extensive system accommodations were needed to effectively implement and manage the Rule changes. Stage 2 Flexibility options were implemented in June 2015.
PreSM3.2	What is your attestation tail period?	The Flexibility tail period was through August 31, 2015.
PreSM3.3	What is your frequency for EHR Incentive payments?	EHR Incentive payments are made one time a month. Payments are issued within 45 days of approved attestation payment determinations.

Table 41: Flexibility System Details – Pre-SMA

PRE-SM4 – STATE FLEXIBILITY QUESTIONS CONTINUED		
Ref #	**Flexibility**	**Explanation**
PreSM4.1	How do you handle non-enrolled providers?	In order to participate in the program, providers must be an active Medicaid provider. Non-enrolled providers are required to register with the AHCCCS Administration under the management of the Office of Inspector General *(Provider Registration)*.
PreSM4.2	Will CMS be conducting your EH post-payment audits?	Yes, Arizona elected to have CMS conduct the MU post-payment audits and appeals for dually eligible and Medicaid-only hospitals participating in the EHR Incentive Program prior to Program Year 2015. Beginning with Program Year 2015, the SMA will conduct EH MU post-payment audits.

Ref #	Flexibility	Explanation
PreSM4.3	Describe your public health integration efforts (i.e., Immunization Registry, Other Registries, Syndromic Surveillance).	The Arizona Department of Health Services (ADHS) is currently accepting electronic immunization submissions to the Arizona State Immunization Information System (ASIIS) for meaningful use from all providers who administer adult or childhood vaccines. HIE and ASIIS are connected and providers that are connected to the HIE will be able to go thru HIE to report or query immunization status. ADHS is currently attempting to have bi-directional and query response functionality. Syndromic surveillance is currently only available for eligible hospitals (EH) and Critical Access Hospitals (CAH) through the Arizona Department of Health Services. ADHS during FFY 2019 will be focused on comparing information currently available in Biosense (Syndromic Surveillance and Electronic Laboratory Reporting) to data in the HIE to determine how the HIE can improve reporting efficiency and accuracy. Electronic Labs is currently accepting reportable disease results from EH/CAH laboratories and reference laboratories. ADHS during FFY 2019 will be focused on comparing information currently available in Biosense (Syndromic Surveillance and Electronic Laboratory Reporting) to data in the HIE to determine how the HIE can improve reporting efficiency and accuracy. Cancer Registry is currently accepting registrations from EPs that diagnose or directly treat 100 or more cancer cases in a year. There are no plans by ADHS to connect the Cancer Registry to the State Level HIE.
PreSM4.4	Describe any efforts in your state to ensure providers return for 2nd year and beyond payments.	Education and Outreach contract with Health Current to help move providers through the MU continuum. Focus year 1 = Registration & AIU, Year 2 MU1 – MU2 Arizona is working with Myers and Stauffer to improve and increase provider outreach and education.

	PRE-SM4 – STATE FLEXIBILITY QUESTIONS CONTINUED	
Ref #	**Flexibility**	**Explanation**
PreSM4.5	What is your state's definition of a group practice?	The lawful or legally standing business entity with legal capacity to operate as a Group Practice and with accountability for all business activity. The administration of the Arizona Medicaid Promoting Interoperability Program captures a single business entity linked by any or all of the following criteria: • Single and/or multiple Employer Identification Number(s) (TIN). • Single and/or multiple National Provider Identifier (NPI) • Single and/or multiple Group AHCCCS Provider Numbers *(defined by AHCCCS Administration under the management of the Office of Inspector General (Provider Registration).* All sources of information are used to verify all providers associated to the Group Practice's single business entity.
PreSM4.6	What is your state's definition of a Pediatrician?	A pediatrician is defined as a physician who is board certified in pediatrics.

Modifications to Meaningful Use in 2015 and Beyond

On October 16, 2015, CMS published the Medicare and Medicaid Program's Electronic Health Record (EHR) Incentive Program – Stage 3 and Modifications to Meaningful Use in 2015 through 2017 (Modified Stage 2) in the Federal Register. On August 2, 2017, CMS published the Fiscal Year (FY) 2018 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Final Rule. The final rules' provisions encompass PI Programs in 2015 and beyond and establish Modified Stage 2 and Stage 3 meaningful use requirements. On August 17, 2018, CMS published the Fiscal Year (FY) 2019 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Final Rule. The final rules' provisions encompass revisions to the PI Programs (now Promoting Interoperability Program) in 2019 and beyond for Stage 3 meaningful use requirements.

Table 42: Meaningful Use Stages by Program Year

First Year Demonstrating Meaningful Use	Stage of Meaningful Use				
	2015	**2016**	**2017**	**2018**	**2019 and Future Years**
2011	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2012	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2013	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2014	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2015	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2016	N/A	Modified Stage 2	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2017	N/A	N/A	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2018	N/A	N/A	N/A	Modified Stage 2 or Stage 3	Stage 3
2019 & Future Years	N/A	N/A	N/A	N/A	Stage 3

Changes to Meaningful Use Objectives and Measures

The following tables outline the changes to meaningful use starting with the 2015 program year for EPs, EHs and CAHs, respectively. (*Table 42: Eligible Professionals Modifications to Meaningful Use/Table 43: Eligible Hospitals Modifications to Meaningful Use*)

Table 43: Eligible Professionals Modifications to Meaningful Use

Eligible Professionals (EP) – 2015 and Beyond Modifications to meaningful use (MU)		
Change	**Explanation**	**Effective Program Year**
Remove the differentiation between meaningful use core and menu objectives	Starting in 2015, all meaningful use objectives will be required and will be considered "core" objectives.	2015 and beyond
Stage 1 specifications for EPs in 2015; lower thresholds and exclusions	EPs scheduled to demonstrate Stage 1 meaningful use in 2015 will be required to report on the Modified Stage 2 meaningful use objectives for all consolidated objectives. EPs will report on Stage 1 meaningful use specifications for objectives that have a lower threshold in Stage 1 meaningful use than Modified Stage 2 meaningful use. Exclusions for objectives that do not have an equivalent Modified Stage 2 meaningful use objective are available. If an EP is scheduled to demonstrate Stage 1 meaningful use in 2015 but can attest to the Modified Stage 2 meaningful use threshold on an objective, he/she may choose to do so.	2015
Modified Stage 2 meaningful use objectives in 2016	All MU EPs will attest to the modified, consolidated Stage 2 meaningful use objectives in 2016 regardless of stage in 2015.	2016
Modified Stage 2 meaningful use objectives/Stage 3 Objectives in 2017 and 2018	EPs may attest to Modified Stage 2 meaningful use or Stage 3 meaningful use in 2017-2018.	2017 - 2018
Meaningful use required objectives for 2015 and beyond	The meaningful use objectives for EPs in 2015 and beyond include: 1. Protect Patient Health Information* 2. Clinical Decision Support o Beginning in 2019 at least one of the eCQMs they select must be an outcome measure. (If no outcome measures are relevant, they must select at least one other high priority measure.)	2015 and beyond

Eligible Professionals (EP) – 2015 and Beyond Modifications to meaningful use (MU)		
Change	**Explanation**	**Effective Program Year**

	3. Computerized Physician Order Entry (CPOE)
	   o Measure 2 and 3 threshold increased to 60% in Stage 3.
	   o In Stage 3, modified radiology orders to diagnostic imaging orders.
	4. Electronic Prescribing
	   o In Stage 3, the threshold increased to 60%.
	5. Health Information Exchange
	   o In Modified Stage 2, the objective only had one measure.
	   o In Stage 3, the objective transitioned to three measures.
	6. Patient Specific Health Education
	   o For Stage 3 this objective was incorporated into the Patient Electronic Access objective.
	7. Medication Reconciliation
	   o No longer an objective in Stage 3.
	8. Patient Electronic Access
	   o Measure 2 – remove 5% threshold for 2015 and 2016 and require that at least one (1) patient (or authorized representative) seen by the EP views, downloads, or transmits their health information to a third party.
	   o Measure 2 – in 2017-2018, the threshold returns to 5% of all unique patients.
	   o Measure 1 – in Stage 3, the threshold increased to 80%.
	   o Measure 2 – in Stage 3, the threshold increased to 35%.
	9. Secure Electronic Messaging
	   o In 2015, Modified Stage 2 the capability for patients to send a secure electronic message with the EP is fully enabled in the CEHRT.
	   o In 2016, Modified Stage 2 at least one patient seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of the CEHRT.
	   o In 2017-2018, at least 5% of unique patients seen by the EP sent a secure message using the electronic messaging function of the CEHRT. This objective was renamed Coordination of Care in Stage 3.	

Eligible Professionals (EP) – 2015 and Beyond Modifications to meaningful use (MU)		
Change	**Explanation**	**Effective Program Year**

	10. Public Health Reporting
	    o In Stage 3 Electronic Case Reporting was changed to EP is in active engagement with a public health agency to submit case reporting of reportable conditions.
	    o In Stage 3, measures 4 and 5 were added. Measure 4 – Public Health Registry Reporting: The EP is in active engagement with a public health agency to submit data to public health registries. Measure 5 – Clinical Data Registry Reporting: The EP is in active engagement to submit data to a clinical data registry.	

Discontinued meaningful use objectives 2015 and beyond	The meaningful use measures discontinued starting in program year 2015 and moving forward through the program include:
	1. Record Demographics
	2. Record Vital Signs
	3. Record Smoking Status
	4. Clinical Summaries
	5. Structured Lab Results
	6. Patient Lists
	7. Patient Reminders
	8. Summary of Care
	    a. Measure 1 - Any method
	    b. Measure 3 - Test
	9. Electronic Notes
	10. Imaging Results
	11. Family Health History
		2015 and beyond

*Program Years 2011-2013: the SRA must be dated before the end of the MU reporting period, this allows the SRA to be dated prior to the calendar year of the program year. Program Years 2014-2016: the SRA must be dated between the beginning of the program year and the attestation date. Program Year 2017 and Beyond: The SRA must be completed after the end of the EHR reporting period and must be conducted within the calendar year of the program year. A unique assessment (or review and update) must be completed for each program year.

Table 44: Eligible Hospitals Modifications to Meaningful Use

Eligible Hospitals (EH) and Critical Access Hospitals (CAH) – 2015 and Beyond Modifications to meaningful use (MU)		
Change	**Explanation**	**Effective Program Year**
Remove the differentiation between meaningful use core and menu objectives	Starting in 2015, all meaningful use objectives will be required and will be considered "core" objectives.	2015 and beyond
Stage 1 specifications for EHs in 2015; lower thresholds and exclusions	EHs scheduled to demonstrate Stage 1 meaningful use in 2015 will be required to report to the Stage 2 meaningful use objectives for all consolidated objectives. EPs will report on Stage 1 meaningful use specifications for objectives that have a lower threshold in Stage 1 MU than Stage 2 meaningful use. Exclusions for objectives that do not have an equivalent Stage 2 meaningful use objective are available. If an EH is scheduled to demonstrate Stage 1 meaningful use in 2015 but can attest to the Stage 2 meaningful use threshold on an objective, the EH may choose to do so.	2015
Modified Stage 2 meaningful use objectives in 2016	All MU EHs will attest to the modified, consolidated Stage 2 meaningful use objectives in 2016 regardless of stage in 2015	2016
Modified Stage 2 meaningful use objectives/Stage 3 Objectives in 2017 and 2018	EHs may attest to Modified Stage 2 meaningful use or Stage 3 meaningful use in 2017-2018.	2017 - 2018

Meaningful use required measures for 2015 and beyond	The meaningful use objectives for EHs in 2015 and beyond include:
	
	1. Protect Patient Health Information*
	2. Clinical Decision Support
	3. Computerized Physician Order Entry (CPOE)
	    o Measure 2 and 3 threshold increased to 60% in Stage 3.
	    o In Stage 3, modified radiology orders to diagnostic imaging orders.
	4. Electronic Prescribing
	    o In Stage 3, the threshold increased to 25%.
		2015 and Beyond

Eligible Hospitals (EH) and Critical Access Hospitals (CAH) – 2015 and Beyond Modifications to meaningful use (MU)		
Change	**Explanation**	**Effective Program Year**

	5. Health Information Exchange
	    o In Modified Stage 2, the objective only had one measure.
	    o In Stage 3, the objective transitioned to three measures.
	6. Patient Specific Health Education
	    o For Stage 3 this objective was incorporated into the Patient Electronic Access objective.
	7. Medication Reconciliation
	    o For Stage 3 this objective was incorporated into the Health Information Exchange objective.
	8. Patient Electronic Access
	    o Measure 2 – remove 5% threshold for 2015 and 2016 and require that at least one (1) patient (or authorized representative) discharged from the EH's inpatient (POS21) or emergency department (POS23) views, downloads, or transmits their health information to a third party.
	    o Measure 2 – in 2017-2018, the threshold returns to 5%.
	    o Measure 1 – in Stage 3, the threshold increased to 80% (50% for dual eligible EHs).
	    o Measure 2 – in Stage 3, the threshold increased to 35%.
	9. Public Health Reporting
	    o In 2015 Stage 1, an EH or CAH would need to meet two of the total number of measures available.
	    o 2015 Stage 2, all 2016 and 2017: An EH or CAH would need to meet three of the total number of measures available, exclusions do not count towards one of the measures unless all measures are excluded from or met.
	    o In Stage 3, EHs and CAHS required to choose from measures 1 through 6, and is required to attest to any combination of 4 measures. EHs and CAHs may attest to measure 4 and measure 5 more than once, and an exclusion to a measure does not count toward the total, unless all measures are excluded from or met.
	    o In Stage 3, measures 3, 4 and 5 were added. Measure 3 – Electronic Case Reporting: The EH or CAH is in active engagement with a public health agency to submit case reporting of reportable conditions. Measure 4 – Public Health Registry Reporting: The EH or CAH is in active engagement with a public health agency to submit data to public	

Eligible Hospitals (EH) and Critical Access Hospitals (CAH) – 2015 and Beyond Modifications to meaningful use (MU)		
Change	**Explanation**	**Effective Program Year**
	health registries. Measure 5 – Clinical Data Registry Reporting: The EH or CAH is in active engagement to submit data to a clinical data registry.	

Discontinued meaningful use measures 2015 and beyond	The meaningful use measures discontinued starting in program year 2015 and moving forward through the program include:
	
	1. Record Vital Signs
	2. Record Smoking Status
	3. Structured Lab Results
	4. Patient Lists
	5. Summary of Care
	    a. Measure 1 - Any method
	    b. Measure 3 - Test
	6. Electronic Notes
	7. Imaging Results
	8. Family Health History
	9. eMAR
	10. Structured Labs to Ambulatory Providers
	11. Advanced Directives
		2015 and beyond

*Program Years 2011-2013: the SRA must be dated before the end of the MU reporting period, this allows the SRA to be dated prior to the calendar year of the program year. Program Years 2014-2016: the SRA must be dated between the beginning of the program year and the attestation date. Program Year 2017 and Beyond: The SRA must be completed after the end of the EHR reporting period and must be conducted within the calendar year of the program year. A unique assessment (or review and update) must be completed for each program year.

EH and CAH Payment in the Prior Year

EHs and CAHs will not be allowed to attest in program year 2017 or in subsequent program years if a payment was not received in 2016.

Beginning in 2017, ePIP will allow EPs, EHs and CAHs to choose to attest to Stage 3 objectives and measures, if ready to attest to Stage 3 with a 2014/2015 combination or 2015 Edition CEHRT.

In 2019, all EPs, EHs and CAHs are required to attest to Stage 3 objectives and measures only. Any changes made to the Stage 3 guidelines will be reflected in future addendums or updates. Arizona is in the process of building an electronic attestation system that meets all Program requirements.

Verification of CEHRT for MU (Stages 1-3)

The SMA will employ both automated and manual processes when performing the pre-payment audit of certified EHR technology (CEHRT) documentation for providers attesting to meaningful use of CEHRT to ensure statutory and regulatory requirements are met for the PI Program.

Level 1: ePIP performs the 1st level verification during the attestation process.

Provider attestations with an invalid CMS EHR certification ID are automatically denied in ePIP. EPIP links to the ONC CHPL site to ensure that the CMS EHR certification ID being reported by the provider is for a valid, certified system.

Level 2: The EHR staff performs the 2nd level verification during pre-payment audit process.

The EHR staff:
* Reviews the EHR vendor documentation including but not limited to vendor contracts, purchase orders, billing invoices, screen shots of system version, etc.
* Verify the provider is using the correct CEHRT edition based on the program year and stage of MU.
* Validates the vendor name for the CMS EHR certification ID.
* Verify certified system was obtained during or before December 31st of the applicable year.

If the result shows that the provider's EHR system did not meet the program requirements (*executed contract, appropriate CEHRT Edition certification requirements, etc.*) by December 31st of the program year in which the provider is applying, the provider is not eligible.

Perform Pre-Payment Audit Validation of MU (Stages 1-3)

Pre-payment validations for all stages are completed in alignment with the state's SMHP and the Final Rule, through both system-automated and manual validation processes.

Level 1: ePIP performs the 1st level verification during the attestation process for EP MU. Beginning in Program Year 2015, EHs will complete a MU attestation work book. The following automated steps are implemented in both ePIP and the EH MU attestation work books.

Automated pre-payment verifications include but are not limited to the following:
- Measures are checked to ensure the provider meets the minimum thresholds.
- Reporting period dates are verified.
- The appropriate number of measures are reported.
- "Unique patient" measures are checked to ensure the denominators are equal to one another.
- Ensure all percentage-based measures do not have a percentage of more than 100% (exceptions apply to certain EH CQMs).

Level 2: The EHR staff performs the 2nd level verification of MU attestations during pre-payment audit process.

Manual pre-payment verifications include but are not limited to the following:
- Ensure minimum MU documentation is uploaded and appropriately dated.
- Review the provider's MU reports compared to the provider's attestation to ensure there are no discrepancies.
- Verify that at least 80% (50% in Modified Stage 2) of the provider's total unique patients had data in the CEHRT during the MU period.
- Verify that at least 50% of the EP's total encounters occurred at a clinical location with CEHRT (does not apply to EHs).
- When applicable, *"*Total unique patients" measures are checked to ensure the denominators equal one another. If there are discrepancies that result in the provider no longer meeting the minimum threshold for one or more measures, the attestation is
- Rejected. Provider can reattest within 30 days and must provide additional information regarding discrepancies with revised attestation.
- When applicable, "Segment of patient population" measures are checked to ensure the denominators are less than or equal to the "unique patient" denominators.
- Review the security risk analysis to ensure it was completed or reviewed during the appropriate time frame and contains all required elements.

Additional documentation may be requested for all meaningful use objectives and measures during post-payment audit. AHCCCS will not impose any documentation requirement for providers to validate their "intent" when exercising the alternate exclusion based on "they did not plan to attest to a menu objective."

AHCCCS Changes as a Result Stage 3 Rule

EP Program Change: AHCCCS initially opened for Program Year 2017 Stage 3 in Q2, 2018. Subsequent fixes were released in Q4, 2018. AHCCCS plans to open for Program Year 2018 Stage 3 in Q2, 2019.

EP System Change: At this time, AHCCCS is in the developing and testing phase for Program Year 2018 Stage 3 with an anticipated live date of Q2 2019.

EP Introduce Stage 3 Measures: Program Year 2017 was the introduction of Stage 3 measures. Program Year 2018 will continue with the same measures, so minimal updates are necessary.

EP Flexibility: In PY 2017-2018 AHCCCS will re-implement flexibility as done in PY 2014. If an EP is eligible to attest to Stage 3 (based on CEHRT) they will be presented an option to follow that path to Stage 3 measures. If they are not eligible (based on CEHRT) or choose not to attest to Stage 3 they will be presented with the Modified Stage 2 series of measures.

EP CQM Review: CQMs will be reviewed to ensure AHCCCS is using the latest version definitions and criteria.

EP Registration Restrictions: The EP registration for the AZ program will be restricted. The only "new" registrations that are allowed will be transfers from other states that were enrolled in the program before PY 2017.

EP Policy Change: As of 2017, the PI Program is no longer accepting AIU attestations or new providers to the program. Only providers that were previously enrolled in the program, but transferring to AZ from another state will be added to ePIP. AHCCCS will add an acknowledgement or disclaimer page that clearly states the definition of MU based on the Final Rule and the QPP amendments to the Final Rule. The providers will need to acknowledge this before submitting the attestation for a given program year.

EP MU Measure Calculation Time Frame: Certain measure calculations were modified to require that actions included in the numerator must occur within the EHR reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the EHR reporting period occurs. There is nothing in ePIP that ensures the numerator/denominator data occurred during the appropriate time frame. We rely on the manual pre-payment audit process and the supporting documentation provided by the EP to ensure that this occurred during the appropriate time frame.

EP Audit Change:
    Pre-payment audit: No changes anticipated
    Post-payment audit: At this time no changes are expected

EH Program Change: Planned opening for Stage 3 in Q2, 2018.

EH System Change: None required. EHs will not attest to Stage 3 MU in ePIP. Instead, hospitals will complete an MU attestation workbook.

EH Flexibility: In PY 2017 AHCCCS will re-implement flexibility as done in PY 2014. If an EH is eligible to attest to Stage 3 (based on CEHRT) they will be presented an option to complete the Stage 3 attestation workbook. If they are not eligible (based on CEHRT) or choose not to attest to Stage 3 they will be presented with the Modified Stage 2 attestation workbook.

EH CQM Review: CQMs will be reviewed to ensure AHCCCS is using the latest version definitions and criteria.

EH Policy Change: As of 2017, the PI Program is no longer accepting AIU attestations or new providers to the program. AHCCCS will add an acknowledgement or disclaimer page that clearly states the definition of MU based on the Final Rule and the QPP amendments to the Final Rule. The providers will need to acknowledge this before submitting the attestation for a given program year.

The hospital MU attestation process is manual therefore; such changes must be added to the worksheets.
- EPIP Attestation Statements - Myers and Stauffer will be updating the 2017 MU Worksheet and the attached change must be included with the updates.
- EPIP Attestation Disclaimer – We will add the ePIP Attestation Disclaimer to the Eligibility & Payment Worksheet. Myers and Stauffer will be directed to add to the MU Worksheet.

EH MU Measure Calculation Time Frame: Certain measure calculations were modified to require that actions included in the numerator must occur within the EHR reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the EHR reporting period occurs. There is nothing in the MU attestation workbook that ensures the numerator/ denominator data occurred during the appropriate time frame. We rely on the manual pre-payment audit process and the supporting documentation provided by the EH to ensure that this occurred during the appropriate time frame.

EH Audit Change:
    Pre-payment audit: No changes anticipated
    Post-payment audit: At this time no changes are expected

C.10 SMA Proposal of Permissible Changes for Meaningful Use
(SMHP Companion Guide Question C #10)

Meaningful EHR User Definition: : (1) Subject to paragraph (3) of this definition, an EP, eligible hospital or CAH that, for an EHR reporting period for a payment year or payment adjustment year, demonstrates in accordance with 495.40 meaningful use of certified EHR technology by meeting the applicable objectives and associated measures under 495.20, 495.22, and 495.24, supporting information exchange and the prevention of health information blocking and engaging in activities related to supporting providers with the performance of CEHRT, and successfully reporting the

clinical quality measures selected by CMS to CMS or the States, as applicable, in the form and manner specified by CMS or the States, as applicable.

EP Tail Period Extension

Arizona has requested approval to extend EP tail period For Program Year 2018 attestations to August 31, 2019

Program Year 2018 system changes are expected to be deployed May 1, 2019 for Eligible Professionals.   Arizona is recommending and requesting from CMS an extension to the 2018 attestation deadline to August 31, 2019 to allow providers time to submit their applications because:
· Attestation activity for Program Year 2018 has been deployed
· Large practices need additional time to coordinate with providers
· Technical assistance required for existing MU providers
· Staffing attrition
· Training due to staffing changes
· Pending Temp position for additional staff (training required)

Eligible Hospital Tail Period Extension

Program Year 2015 Updated Request

AHCCCS requested additional time to process hospital payments in alignment with any changes that were anticipated to come out of the HHS-OIG Audit of the PI Program. On October 17, 2016, CMS granted approval extending the EH tail period for Program Year 2015 to March 31, 2017.

AHCCCS received approval of our updated Audit Strategy from CMS on October 4, 2017 and is currently in the process of applying the agreed upon audit recommendations to all other hospitals not audited by HHS-OIG. As a result of this delay, AHCCCS requested permission to allow the hospital to submit attestations impacted by the delay following the post-payment audit activities (*incudes time required to complete the system corrections*).

The work effort to incorporate the results of the HHS-OIG & State Medicaid Agency post-payment audits into the ePIP System was initiated to process payment adjustments for impacted attestation years. Temporary staff was hired to assist. There were 25 hospitals that were part of the HHS-OIG audit and have already been fully paid or are underway and an additional 47 hospitals have been fully paid or are currently being audited. Of the additional hospitals, only 6 audits are still in progress.

The Pre-Payment Audit team will prepare the hospital's account as follows:
· Determine impact to hospital's ePIP account (attestation & payment)
· Coordinate ePIP System changes with State's Information Services Division

· Retract prior payment(s) and replace with the audited payment calculation
· Initiate next attestation application (*as determined by the State if additional application years available*)
· Process or re-process attestation & transmit payment changes to CMS

Therefore AHCCCS requested the EH tail period be extended until December 31, 2018 subject to re-consideration if the system changes for the post-payment audit findings are not completed prior to this date.

Program Year 2016

The attestation deadline for 2016 must be evaluated at the conclusion of the 2015 Program Year applications. AHCCCS will need to discuss with CMS upon Program Year 2015 completion. At this time, the State must allow the hospital to submit the attestation following the post-payment audit activities (*incudes time required to complete the system corrections*).

Program Year 2017*

The attestation deadline for 2017 must be evaluated at the conclusion of the 2016 Program Year applications. AHCCCS will need to discuss with CMS upon Program Year 2016 completion. At this time, the State must allow the hospital to submit the attestation following the post-payment audit activities (*incudes time required to complete the system corrections*).

*AHCCCS is not able to establish a tail period extension date for PY 2016 and 2017 for EHs because we must first process corrections resulting from the audit findings that impacted previously paid program years. Only one open attestation is permitted in the ePIP Registration & Attestation System at a time.   Once the audit corrections are processed, we will work with the hospital to submit the next attestation if they were unable to do so due to audit. At this time, we expect to be back on track over the next 18 months.

C.11 SMA Verification of Providers' Use of CEHRT
(SMHP Companion Guide Question C #11)

SMA Process for Providers Use of CEHRT

See sections C.8 and C.9 above.

As part of the PI Program, as the functionality of the HIE increases, the SMA expects to require more information from the MCOs and their provider networks electronically versus through onsite or paper chart audits.

The SMA is planning to increase the number of measures and types of SMA reporting to be electronic versus through claims/encounters or through paper reporting. Currently, the SMA has

established an e-prescribing reporting requirement for the MCOs and the providers that are in their network. The agency is starting to work with the HIE to plan for the electronic clinical quality

measure submission and is working with Health Current to support MU Public Health reporting for immunizations, labs, syndromic surveillance, cancer registry and a specialized registry.

The agency completed its MITA Self-Assessment which has informed our Health IT Plan. The assessment found that most of the agency's processes were at a level two and over the course of the next five years as CMS establishes more standards; the agency expects to move higher in the MITA framework.

C.12 SMA Collection of MU and ECQM Data

(SMHP Companion Guide Question C #12)

CQM Initiatives Evolving from Meaningful Use

With regards to the clinical quality measures (CQMs) associated with meaningful use, AHCCCS is continually looking for opportunities to utilize specific fields in provider EHRs to collect data for CQMs and meaningful use objectives, as well as the Children, Adult and Maternity Core Measures, many of which align with meaningful use measures. It is anticipated that most, if not all, data necessary to conduct these and other outcomes measures will be available electronically from providers that have implemented EHRs.

In addition, AHCCCS continues to explore possible use of the state's HIE to collect more detailed information from EHRs in order to provide Medicaid data necessary for the Agency to calculate, report and/or develop QI initiatives related to meaningful use. AHCCCS anticipates storing necessary field data in the AHCCCS data warehouse for use in analyzing and reporting CQMs and developing interventions to improve care. The EHR data will also be used to supplement current HEDIS outcomes measures and mandatory Performance Improvement Projects as required by federal Medicaid Managed Care regulations (42 CFR 438.240). AHCCCS will have different approaches to clinical outcome measures for the short-term and the long-term.

Short Term Approach for Meeting Meaningful Use

In order to meet federal requirements and expectations for health care quality improvement, AHCCCS will capture timely, accurate and meaningful data that can be used to monitor quality among various types of providers and in a way that is consistent with national standards or core measures developed/adopted by CMS, so that health information is available and actionable from both the individual provider level and also from a system perspective. To move further down this path, AHCCCS has implemented sections of the American Recovery and Reinvestment Act (ARRA) to promote and provide Medicaid PI Program payments for the adoption and meaningful use of EHRs to EPs and EHs, as well as those related to the electronic use and exchange of health information for quality improvement and oversight purposes.

Agency staff has implemented meaningful use functionality and reporting of the related CQMs by EPs through the ePIP system. AHCCCS staff is also responsible for collecting, analyzing and reporting existing clinical quality measures and other quality and outcomes data utilized by the Agency has plans to develop processes for collection, storage, analysis and reporting of MU/CQM data from EPs.

In Program Years 2012-2014, EHs submitted their meaningful use attestations directly to CMS in the EHR Registration & Attestation (R&A) system and reported CQMs via the QualityNet portal if submitting electronically. In Program Years 2015 and beyond, EHs can still report CQMs electronically via the QualityNet portal. However, EH meaningful use objectives and CQMs reported via attestation will have to be submitted to the SMA in the EH MU attestation work book.

AHCCCS' EHR staff are evaluating existing processes for collection, analysis and reporting of clinical quality data, including Healthcare Effectiveness and Data Information Set (HEDIS) measures currently collected, to determine how the Agency may use existing processes/resources and what additional resources or tools are necessary to fulfill federal requirements. The Agency has identified staff that will be responsible for monitoring and evaluating quality measurement and improvement.

Processes under development include methods of data validation that are the most cost/resource efficient, and mechanisms for reporting aggregate data by provider to CMS. Existing HEDIS and other reports may be used to benchmark provider-reported data and identify any opportunities for quality improvement in the future. Data imported from public health registries such as the Arizona State Immunization and Information System (ASIIS) also may be used to benchmark and/or validate provider-reported data in the future.

Long Term Approach for Meeting Meaningful Use

Long-term, AHCCCS will expand capabilities to the next level of inter-operability as we head into a new generation of quality reporting. Through the wide-spread implementation of EHRs, AHCCCS anticipates improvements in monitoring of quality of care and outcomes at a variety of levels in the Medicaid system: provider, managed care organization, county/geographic service area, population (e.g., by race/ethnicity, diagnosis or special health care need), program/state and including national comparisons.

It is anticipated that Agency and MCO administrative burden will decrease as AHCCCS moves towards receiving data from the state HIE.

C.13 Data Collection Alignment with Other CQM Data
(SMHP Companion Guide Question C #13)

MU Data Alignment with Other CQM Data

To further expand the focus on clinical outcomes rather than processes or episodes of care, AHCCCS will focus on developing the mechanisms needed to incorporate electronic health information into quality performance measures, such as the HEDIS measures and meaningful use measures. EHRs offer a much richer data source than administrative data, providing information such as laboratory values indicating improvement in a members' health status or

condition, and whether comprehensive preventive and follow-up services were provided during a visit, such as those required under the federal Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) Program. Implementing a philosophical shift toward incorporating

EHR connectivity/data sources will add another layer of complexity to the clinical outcomes measure process.

AHCCCS anticipates the following objectives related to capturing and sharing data:

- Support reporting of CMS core measures and meaningful use and CQMs as they are approved and implemented by CMS, including reporting of HEDIS measures.

- Determine ways to improve quality oversight of contracted managed care organizations and their network providers, including ensuring complete, accurate, and timely reporting of data.

- Secure electronic health information from Medicaid providers including hospitals, physicians, FQHCs, RHCs, behavioral health providers, long- term care facilities, dental providers, etc., in order to test processes and applications for quality monitoring and oversight.

- Develop mechanisms to reduce process waste and maximize automation to increase administrative simplicity and efficiency in quality measurement/oversight.

- Share information for care coordination and quality measurement with other entities serving AHCCCS members (e.g., Arizona Department of Health Services, Tribal Entities, IHS) in a timely and seamless manner while ensuring the privacy of AHCCCS members and data security.

- Enhance existing processes to report quality measurement data through the AHCCCS website, as well as through stakeholder forums (State Medicaid Advisory Committee, Arizona Medical Association Maternal and Child Health Committee, The Arizona Partnership for Immunization, legislative caucuses, etc.).

Increase transparency in the Medicaid program by making available performance and quality data to a variety of stakeholders, including members/patients, other health care professionals, policy makers and the public at large.

AHCCCS also anticipates that activities implemented as a result of clinical outcomes and meaningful use measures may result in improved outcomes. The use of EHRs and the implementation of clinical outcomes measures may result in an increase in productive patient/provider interactions, improved clinical decision support, improved delivery system design including patient navigator, work up nurses, care manager/clinical outreach coordinator, health educator and support staff, and the establishment of EP and EH goals such as, better chronic disease control, reduced medication errors, improved discharge planning, improved patient cycle time, improved patient self- management, reduced tobacco use, improved immunization rates and reduced inappropriate ER utilization.

AHCCCS also expects the reporting of CQMs to result in changes to the organizational and payment structures surrounding the care experience to focus on outcomes and quality of life.

Current changes underway include payment reform methodologies based on performance of established measures as well as contractor promotion of patient-centered medical home and accountable care organization models of care. Ultimately, focusing efforts on clinical outcomes measures may result in cost savings/benefits for AHCCCS including:

- Increased chart data from EHRs will increase accuracy and completeness of data used to report clinical quality measures (including HEDIS) without the cost of data abstraction by nurses or other qualified individuals

- AHCCCS data will be more comparable to other states when submitted to CMS and NCQA

- Complements current data sources by including chart data, public health data, registry data into all applicable clinical quality measures without additional human resource requirements

- Reduced administrative burden on providers, health plans and AHCCCS as data can be collected, received and analyzed electronically

- Identification of opportunities for population health management and quality improvement initiatives

- Potential to reduce clinical and medication errors

- Potential to drive down emergency room and inpatient utilization

- Potential to improve discharge planning and thus reduce hospital re-admissions

AHCCCS will eventually use meaningful use-reported data as a comparison to other performance measures tracked by the Agency. As noted, many of the CHIPRA and Adult Core Measures, as well as existing clinical quality/performance measures utilized by AHCCCS to evaluate contractor performance and the program overall, align with meaningful use CQMs. Since AHCCCS already has the capability to analyze existing quality measures by Contractor, county/geographic service area (GSA), etc., data collected from providers will be compared to other measure data collected and reported by AHCCCS to check for reasonableness and to identify opportunities for improvement; e.g., by provider type or GSA. The EHR data will also be used to supplement current HEDIS outcomes measures and Performance Improvement

Projects as required by federal Medicaid Managed Care regulations (42 CFR 438.240), since EHRs have the capability to produce additional information for quality improvement that cannot be obtained from administrative (encounter) data alone.

In addition, AHCCCS continues to monitor the development of new clinical quality measure requirements under meaningful use to determine alignment of meaningful use measures to agency-selected performance measures. Examples of alignment efforts include the following:

Beginning in Program Year 2017, CMS adopted final policies to align specific CQMs available to EPs participating in the Medicaid PI

Incentive Program with those available to professionals participating in the Merit-based Incentive Payment System (MIPS). Changes include:

- The minimum amount of CQMs EPs must attest to has been reduced from 9 CQMs to 6 CQMs.

- EPs are no longer required to attest to CQMs that cover a minimum amount of NQS domains.
- 11 CQMS have been removed, leaving EPs the option to attest to 53 CQMs instead of 64 CQMs.

Beginning in Program Year 2019, the 2019 Physician Fee Schedule (PFS) established that of the six eCQMs reported on; at least one of the eCQMs reported on must be an outcome measure. If no outcome measures are relevant to that EP, they must report on at least one high priority measure. If there are no outcome or high priority measures relevant to an EP's scope of practice, they must report on any six relevant measures.

- There are 6 outcome measures and 27 high priority measures
- As established in the PFS rule, high priority measures for the Medicaid PI Program are determined via three methods:
  - High priority measures under MIPS
  - Measures included in the Adult and Child Core Sets
  - Any additional measures selected by individual states

Beginning in Program Year 2016, CMS adopted final policies to align specific CQMs available to EHs participating in the Medicaid PI Program with those available to hospitals participating in the hospital Inpatient Quality Reporting program (IQR). Changes include:

- The minimum amount of CQMs EHs must attest to has been reduced from 16 CQMs to 4 CQMs **if reported electronically** (16 are required if the hospital reports via attestation).
- EHs are no longer required to attest to CQMs that cover a minimum amount of NQS domains **if CQMs are reported electronically** (3 out of 6 NQS domains are required if the hospital reports via attestation).

C.14 IT, Fiscal and Communication Systems That Will Support Implementation of the PI Program

(SMHP Companion Guide Question C #14)

IT and Fiscal Systems Supporting the PI Program

Information Systems: The PI Program has long-established systems (such as the Electronic Provider Incentive Payment system, also known as ePIP, and all other systems such as PMMIS, Data Warehouse, Outlook, Oracle, and AFIS - described below) in place to support all aspects of attestation, review, payment, audit, and ongoing provider support. There are no planned changes to the systems beyond those that are needed to maintain operations of the Program or support Federal Rule changes.

In order to achieve the goals and objectives of the PI Program, AHCCCS adopted and established the appropriate technical infrastructure to support key initiatives and activities. The following systems were utilized:

- PMMIS subsystems, including:

    o Provider: To validate provider Medicaid status, type of service, NPI, TIN, and EFT status

    o Finance and Payments: To process the actual incentive payments

    o Data Warehouse: To capture the Medicaid PI Program data, report provider patient volume, and generate program reports

- Microsoft Outlook email for communication with providers as they register and progress through the process to payment

The ePIP was built for provider registration, attestation, and payment. The ePIP system interfaces with the R&A system at CMS and PMMIS. AHCCCS will use PMMIS as a source for current provider information. The website accesses PMMIS using a script to call provider information. No modifications to PMMIS have been needed given AHCCCS has modified the system to comply with the new HIPAA standards, 5010, and implemented ICD-10 in October 2015. APDs are already approved for these projects. However, the ePIP continues to be updated according to the new rules for Stage 1 meaningful use, Stage 2 meaningful use, Stage 3 meaningful use, and will continue to change as new rules are published in the future.

The process AHCCCS will use to assure that all Federal funding, both for the 100% incentive payments as well as the 90% Administrative match are accounted for separately and not commingled with the MMIS FFP is that at this time the agency has not requested any MMIS funds for the HITECH program. All EHR program activity is tracked separately from other agency activities and is reported on the CMS 64 on its own line items.

Fiscal - The process AHCCCS will use to assure that payments go to an entity promoting the adoption of certified EHR technology and are designated by the state if participation in the arrangement is voluntary and is no more than 5% of payments are retained for cost unrelated to EHR technology adoption. This is not applicable to AHCCCS. AHCCCS did not delegate the promotion to any entity for the adoption of the certified EHR technology or handling of any

incentive payments to an external entity.

Additionally, AHCCCS ensures that no PI Program payments go through the MCO capitation process because the incentive payments are being paid by the agency to the individual eligible professional and eligible hospital or as assigned. No funds are paid by the agency to MCOs for the EHR program.

The table below shows the major milestones of the Arizona Medicaid PI Program.

Table 45: AHCCCS Major IT Milestones

AHCCCS IT Major Milestones	
Activity	**Completion Dates**
Implement AIU – Eligible Hospitals	8/12/2011
Implement AIU - Eligible Professionals	1/05/2012
Implement MU Stage 1 Phase 1	10/29/2012
Implement MU Stage 1 Phase 2	2/15/2013
Implement MU Stage 1 Phase 3	7/31/2014
Implement Stage 2	9/1/2014
Implement Flexibility	6/22/2015
Implement 2015 MU	5/19/2016
Implement 2016 MU (First Year MU Providers)	8/10/2016
Implement 2016 MU (All Remaining Providers)	1/03/2017
Implement 2017 Modified Stage 2 and Stage 3 MU	11/21/2018
Implement 2018 Modified Stage 2 and Stage 3 MU (Projected)	5/1/2019

Data Source: AHCCCS ISD, March 2019

Additionally, AHCCCS has implemented a process to account for all Federal funding. AHCCCS is required to follow the State Accounting Manual guidelines for recording accounting transactions. By policy, Federal Grants are recorded in the Federal Grants Fund. Separate tracking is maintained by unique grant and phase numbers in the State's accounting system (AFIS). The unique grant and phase numbers provide a separate account for each federal grant. By state statute, normal and APD/PAPD enhanced MMIS funds are accounted for in the AHCCCS Fund

that is separate from the Federal Grants Fund and that will prevent any commingling of the HIT grant funds.

In addition, to ensure that funding is being properly allocated by providers, the ePIP system that includes a statement that requires the provider to verify that they are voluntarily applying for this payment and that no more than five percent of such payment is retained for costs unrelated to EHR technology adoption. The provider signs an attestation to this fact. Additionally, AHCCCS ensures that no EHR reimbursement funds go through MCO capitation process given that the funds are being paid by the Agency and not through the MCO. Arizona PI Progrm payments are not payable to MCOs.

To prevent fraud from inappropriate access to the provider's ePIP account, the EHR staff also emails a payment verification/notification to the provider of intent to auto-assign the PI iProgrampayment.

For Communicating with Providers

The SMA has a dedicated email, phone, listserv and website for provider inquires and information. Providers can access the general program information at the Arizona website and contact the EHR staff at:

- Email EHRIncentivePayments@azahcccs.gov

- EHR Help Desk 602-417-4333

- Website: http://www.azahcccs.gov/EHR/default.aspx

- Listserv: http://listserv.azahcccs.gov/cgi-bin/wa.exe?HOME

The SLR (ePIP) also displays basic messages regarding attestation and payment.

The provider can check the status of their attestation and payment by logging onto their ePIP accounts. If the provider's attestation data does not meet the program requirements, a message is displayed on the Attestation Status page. If the provider does not meet the MU requirements, the measures results are displayed on the MU Summary page.

Updated Organizational Chart: As of October 1, 2016, the PI Program staff has different reporting relationships. The Pre- Payment team is currently still in the Division of Health Care Management but reporting up through the Reimbursement Administrator.

The Post-Payment team has been moved to the SMA Office of Inspector General in order to ensure there is a good firewall between the Pre- Payment team and the Post-Payment team. Please see the updated organizational chart below.

Figure 29: EHR Team Organizational Chart in the Division of Health Care Management and the Office of Inspector General
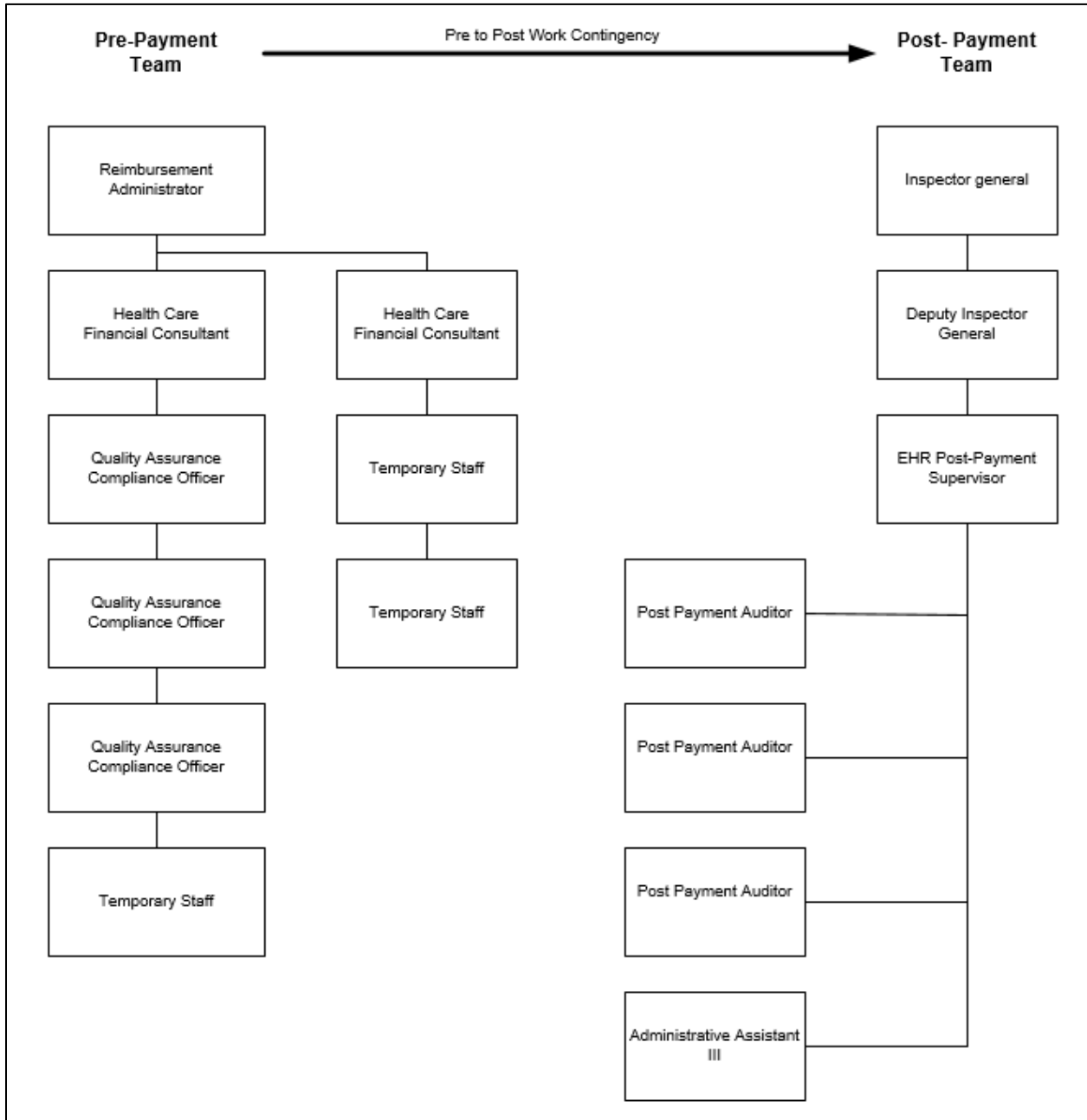
Data Source: DHCM and OIG Org Chart, March 2019

C.15 SMA IT System Changes Needed to Implement the PI Program
(SMHP Companion Guide Question C #15)

SMA IT System Changes Needed to Implement the PI Program

The SMA maintains an in-house developed system that addresses the needs of the PI Program. This system (ePIP) currently includes registration, attestation, and account management functionality for eligible professionals and eligible hospitals as well as an internal administrative portal for the EHR staff to utilize for payment decisions, group/provider management, and auditing purposes.

C.16 SMA Timeframe for Systems Modifications
(SMHP Companion Guide Question C #16)

SMA Timeframe for Pending System Changes

Stage 3 is optional in Program Years 2017-2018 and required in Program Year 2019. Stage 3 changes are complete. We plan to implement Program Year 2018 by May 1, 2019. In Program Year 2018, EPs and EHs will have the options of Stage 2 (Modified) or Stage 3, (Flexibility).

C.17 Interface Testing With CMS National Level Repository
(SMHP Companion Guide Question C #17)

AHCCCS began file exchange testing work with CMS for this program on October 1, 2010. Arizona was in the second group of states to test with the NLR which started in January 2011. AHCCCS has been capable of interfacing with the CMS National Level Repository (NLR) since July 2011.

The SMA has made a modification in 2017 that was NLR related that applies to the B6 process. CMS added some fields to the B6 specification. AHCCCS is expecting to implement Program Year 2018 at the beginning of May 2019. After that the SMA will begin requirements gathering for Program Year 2019. It is planned that Program Year 2019 will go live in January 2020.

C.18 SMA Acceptance of Medicaid Provider NLR Registration Data
(SMHP Companion Guide Question C #18)

The AHCCCS program's plan for accepting the registration data for its Medicaid providers from the CMS NLR is through a communication protocol called Cyber Fusion. Cyber Fusion is a computer software tool used to securely transfer files between entities. It accepts the registration data from Medicaid providers from the CMS NLR. At this time the agency is reviewing its business operations and MITA State Self-Assessment results to identify any opportunities for interoperability. No plan exists at this time to implement interoperability between the SMA's HITECH systems and the T-MSIS and MACPro.

Provider Engagement Regarding Enrollment, Program Detail, MU Stage Changes

AHCCCS staff are currently researching how other states engage providers related to MU Stage 3 changes and would like to add additional information about MU Stage Changes to the ePIP homepage in addition to updated provider reference guides.

Providers may sign on to the ePIP System at any time to get information about their attestation and payment status. The system will be used as a communication vehicle to provide updates and keep the provider informed. Once the provider completes the attestation process, ePIP will reflect messages indicating if an action is "In Progress" or "Completed". Both attestations and payments will be tracked in the ePIP.

The screenshot in the following figure is the first screen a provider would see after successfully registering with CMS and AHCCCS. This screen gives new providers the opportunity to register and registered providers the opportunity to log on and access to following options:

- Manage My Account – where they can review & edit their contact information

- Attest – Where the provider can create & maintain attestations for separate program years

- Payments – Where providers can track payments for separate program years

- Manage Documents – Where providers can submit documents to support their attestation

- Log Off – Providers log out of ePIP

- EHR Certification Tool – Providers can validate their system's CMS EHR Certification ID before applying

Figure 30: ePIP Home Page
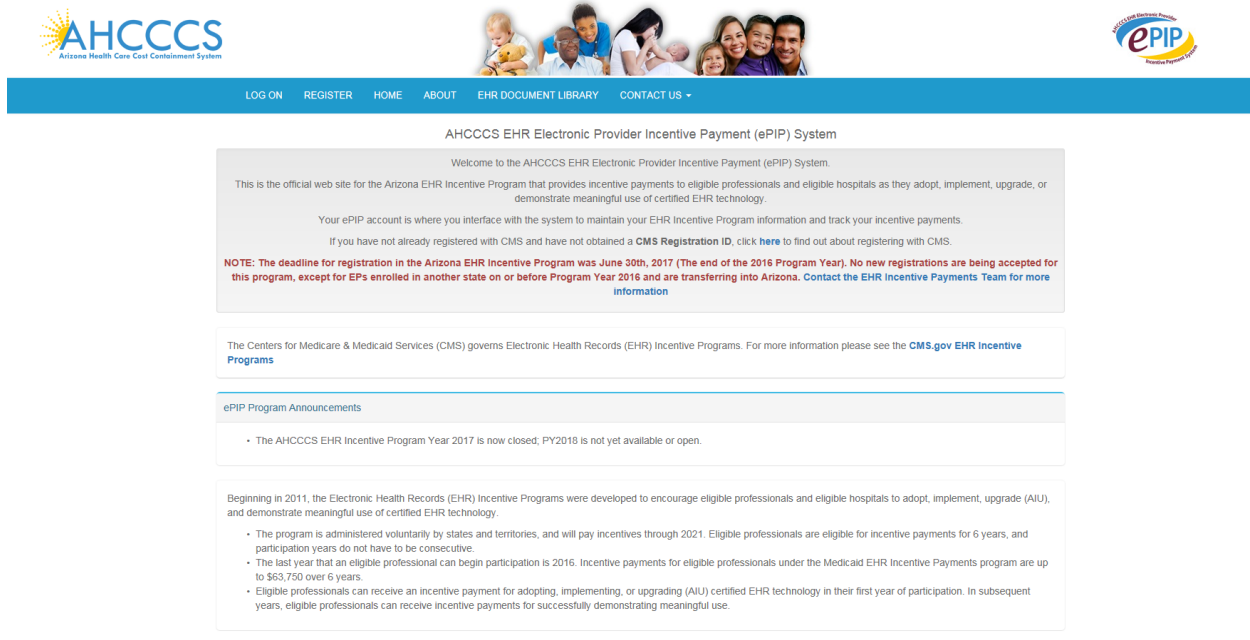
Data Source: e-PIP Home Page – AHCCCS Website 2019

C.20 SMA Anticipation of Modifications to MMIS
(SMHP Companion Guide Question C #20)

Anticipated SMA Changes to MMIS

At this time, the agency has not made any significant modifications to the MMIS environment so no MMIS IAPD has been requested for this program.

C.21 SMA Provision of a Help Desk

(SMHP Companion Guide Question C #21)

SMA Provision for Provider Questions Regarding the Incentive Program

The SMA has a dedicated email, phone, listserv and website for provider inquires and information. Providers can access the general program information at the Arizona website and contact the EHR Staff at:

- Email EHRIncentivePayments@azahcccs.gov

- EHR Help Desk 602-417-4333

- Website: http://www.azahcccs.gov/EHR/default.aspx

- Listserv: http://listserv.azahcccs.gov/cgi-bin/wa.exe?HOME

The SLR (ePIP) also displays basic messages regarding attestation and payment.

The provider can check the status of their attestation and payment by logging onto their ePIP accounts. If the provider's attestation data does not meet the program requirements, a message is displayed on the Attestation Status page. If the provider does not meet the MU requirements, the measures results are displayed on the MU Summary page.

AHCCCS has an approved contract with Health Current to perform education and outreach for eligible providers. Health Current recruits Medicaid providers, provides telephone and in person educational support for the PI Program, as well as attestation support.

AHCCCS has included help at Health Current that can assist providers who have questions about how to modify their workflow to be successful adopters of EHRs and for e-prescribing questions and support. These changes are in response to the findings from our online Provider Survey where providers expressed frustration with the current customer service limitations.

C.22 SMA Provision for Provider Appeal Regarding Eligibility, Payment, AIU

(SMHP Companion Guide Question C #22)

SMA Process for Provider Appeals

The SMA uses the existing provider grievance and appeal process, which was established in accordance with federal CMS requirements. The appeals process is managed by the AHCCCS Office of Administrative Legal Services (OALS) that coordinates with PI Program Staff on all cases related to the PI Program. Once an adverse decision is made by the EHR staff on an attestation, the provider is notified of the appeal process. Providers are able to work with EHR staff throughout the entire process to help resolve any questions or concerns. Providers that choose to appeal must submit a written request to AHCCCS OALS as outlined in their Notice of Decision. An appeal is a request from an EP and EH to reconsider or change a decision, also

known as an action. Providers may appeal all AHCCCS's adverse decisions if denied eligibility or a PI Program payment or has received an incorrect payment.

The provider may appeal any of the following decisions:

- Provider eligibility determinations (patient volume, hospital-based, practice predominantly)
- Demonstration of adoption, implementation or upgrade of certified EHR technology
- Meaningful use eligibility
- Denial of PI Program payment
- Level or amount of payment
- Recoupment of payment

An administrative re-determination/issue resolution process is followed before going to appeals to limit the number of cases that require a full appeals process. The appeals relating to payment amounts to providers should be separated from those that have to do with adopt, implement, upgrade and meaningful use and other eligibility problems.

Providers must contact OALS with a written appeal via mail or e-mail. AHCCCS will investigate the provider's request and respond with a written notice of a decision within 60 days.

AHCCCS's written Notice of Decision shall include the following information:
- The date of the decision
- The factual and legal basis for the decision
- The contractor's right to request a State Fair Hearing under A.R.S. § 41-1092, et seq.
- The manner in which a contractor is to file a State Fair Hearing request under A.R.S. § 41-1092 et seq.

<div align="center">

AHCCCS
Office Administrative Legal Services
701 E. Jefferson Street, MD 6200
Phoenix, AZ 85034

</div>

Request for Hearing

If the provider is not satisfied with the response from AHCCCS, that provider may request a State Fair Hearing.

- The provider may file a written request for a State Fair Hearing with AHCCCS no later than 30 days after the date the provider receives the above written Notice of Decision, or

- AHCCCS does not render a written Notice of Decision within 30 days after the grievance is filed. A written request for a State Fair Hearing within 30 days after the date that the Notice of Decision should have been mailed.

AHCCCS shall mail a Director's Decision to the provider no later than 30 days after the date the Administrative Law Judge sends the Office of Administrative Hearings (OAH) decision to AHCCCS. AHCCCS shall accept a written request for withdrawal if the written request for withdrawal is received from the provider before AHCCCS mails a Notice of Hearing under A.R.S. § 41-1092, et seq. If AHCCCS mailed a Notice of Hearing under A.R.S. § 41-1092, et seq., a provider shall send a written request for withdrawal to the Office of Administrative Hearings.

AHCCCS shall deny a request for hearing under A.R.S. § 41-1092, et seq., upon written determination that:

- The request for hearing is untimely
- The request for hearing is not for an action permitted under State law
- The provider waives the right to a hearing
- The request for hearing is moot, as determined by AHCCCS, based on the factual circumstances of the case

Appeal Changes in Hospital Payments

Once hospitals have been notified of the final aggregate incentive payment amount, AHCCCS shall report any over or under payments to CMS and begin the recoupment or disbursement process. The hospitals may appeal the findings as outlined above and will have the opportunity to submit additional documentation. If additional documentation is submitted during the appeals process that impacts the aggregate incentive payment calculation, AHCCCS shall report the revised over or under payment to CMS. The revised over or under payment amount will supersede any amount previously reported to CMS and the hospitals.

C.23 SMA Accounting for Separation of HITECH and FFS Funds
(SMHP Companion Guide Question C #23)

SMA Process for Separation of HITECH and MMIS FFS Funds

The process AHCCCS will use to assure that all Federal funding, both for the 100% incentive payments as well as the 90% Administrative match are accounted for separately and not commingled with the MMIS FFP is that at this time the agency has not requested any MMIS funds for the HITECH program. All EHR program activity is tracked separately from other agency activities and is reported on the CMS 64 on its own line items.

C.24 SMA Anticipated Frequency of PI Program Payments

(SMHP Companion Guide Question C #24)

Anticipated Frequency of EHR Incentive Payments by SMA

Batched payments to EPs and EHs are made monthly. These payments are made according to the statute and regulations of the Final Rule. The Medicare and Medicaid Extenders Act of 2010 (Public Law No: 111-309), enacted on December 15, 2010, amended the Health Information Technology for Economic and Clinical Health (HITECH) established by the American Recovery and Reinvestment Act of 2009.

C.25 SMA Verification of Payment to Provider without Deduction or Rebate

(SMHP Companion Guide Question C #25)

Incentive Payment without Deduction or Rebate

Providers that attest for the Medicaid PI Program must complete their Payee NPI & Payee's TIN information in the CMS Registration & Attestation System. Payments are disbursed directly through electronic funds transfers to the Payee providing they are set-up in PMMIS.

Please note that payments under the Medicare and Medicaid PI Programs will be treated like all other income. The incentive payment legal authorities do not supersede any State or Federal laws requiring wage garnishment or debt recoupment. Therefore, if there is a legal basis for the State or Federal government to net or recoup debts then such authority would apply to incentive payments, just as it applies to all other income.

C.26 SMA Verification Payments to Entities Supporting Adoption of CEHRT

(SMHP Companion Guide Question C #26)

Arizona does not have a State designated entity proving the adoption of CEHRT.

NOT RELEVANT FOR AN UPDATE PER COMPANION GUIDE

C.27 SMA Process of Fiscal Arrangements for Payment Disbursement
(SMHP Companion Guide Question C #27)

AHCCCS ensures that no PI Program payments go through the MCO capitation process because the incentive payments are being paid by the agency to the individual eligible professional and eligible hospital or as assigned. No funds are paid by the agency to MCOs for the EHR program.

NOT RELEVANT FOR AN UPDATE PER COMPANION GUIDE

C.28 SMA Verification of Calculation and Payment Incentives are Consistent with Statute and Regulation
(SMHP Companion Guide Question C #28)

Verification of Calculation of Payment Incentive

AHCCCS will employ an automated process when determining the payment calculation for EPs and EHs to ensure statutory and regulatory requirements are met for the PI Program. The payment determination for EPs and EHs are programmed in the State Level Repository (ePIP) system.

Level 1: ePIP performs the 1st level payment calculation during the attestation process.

Level 2: The EHR staff performs the 2nd level payment amount verification during pre-payment audit process.

Eligible Professionals

EP EHR incentive payments are predetermined based on a schedule of payments over six-years, as defined in the Final Rule.

The maximum payment amount over the six years is $63,750 for providers *(including Pediatricians)* who have a minimum 30% patient encounter volume and disbursed as follows:
- $21,250 for Year 1
- $8,500 for Years 2, 3, 4, 5, 6 *(each payment year)*

For pediatricians (only) with a minimum 20% but less than 30% patient encounter volume, the maximum payment is $42,502 and disbursed as follows:
- $14,167 for Year 1
- $5,667 for Years 2, 3, 4, 5, 6 *(each payment year)*

The provider can only receive an EHR payment from one State or Medicare/Medicaid program each payment year. The total amount paid cannot exceed the maximum payment amount.

<u>Eligible Hospitals</u>

EH EHR incentive payments are determined based on a formula and disbursed over four years, as defined in the Final Rule.

The Aggregate EHR Hospital Incentive Amount is calculated as the product of the Overall EHR Amount and the Medicaid Share. For each payment year, the PI Program payment is based on a percentage *(defined by the State 40%, 30%, 20% & 10%)* of this Aggregate EHR Hospital Incentive Amount.

Dually eligible hospitals can only receive a Medicaid EHR incentive payment from one State each payment year. The total amount paid between Medicaid States cannot exceed the Aggregate EHR Hospital Incentive amount. Amounts are verified each application year and applicable recalculations and adjustments are reconciled on all prior payments, as necessary.

The initial Medicaid payment calculation requires data from the hospital's CMS hospital Medicare cost reports (MCR) and the hospital's database. Hospitals must report using the most accurate MCR. Data from the audited MCR always supersedes the filed MCR. The final payment calculation is determined in the post-payment audit after the hospital submits detail documentation that supports the MCR. All hospitals participating in the Medicaid PI Program will be selected for a post-payment audit of the aggregate payment calculation. A comprehensive four-year audit is also conducted prior to issuance of the fourth EH payment.

Program Year 2016 is the last year that a hospital may begin participation in the Medicaid PI Program. Hospital events that resulted in the establishment of new hospitals or change of ownerships limited the hospital's ability to obtain a 12-month cost reporting period for use in the hospital's attestation for Program Year 2016. As a result, the State will allow *(including but not limited to)* the following auditable data sources during the pre-payment audit to assist the hospital in submitting the Payment Year 1 application in order to calculate the Medicaid aggregate EHR hospital incentive amount.

- Hospital Financial Statements
- Hospital Accounting Records
- Medicare Cost Report *(if available but not expected)*

The State will be required to perform annual payment reconciliations until all four of the Medicare Cost Reports (MCRs) are available to calculate a final payment. In order to finalize the payment; the hospital will be required to submit details to support the MCRs during the post-payment audit.

HHS-OIG Audit Findings and Lessons Learned

A sample of EHR (PI) Incentive Program payments disbursed to EHs by AHCCCS was audited by the U.S. Department of Health and Human Services, Office of the Inspector General (HHS-OIG). According to the report, AHCCCS was found to have made incorrect Medicaid EHR Incentive Payments to 24 of 25 hospitals reviewed, totaling $14,953,577. These incorrect payments included both overpayments and underpayments resulting in a net overpayment of

$14,830,859. Because the incentive payment is calculated once and then paid out over 4 years, payments made after January 31, 2016 will also be incorrect. The adjustments to these payments total $1,674,728. According to HHS-OIG, the errors occurred because hospitals did not always follow Federal and State requirements for calculating their incentive payments. In addition, the State agency did not review supporting documentation provided by the hospitals to help identify errors in their calculations.

AHCCCS did not agree with the HHS-OIG findings; therefore, the agency conducted its own audits of the payment calculations for the 25 hospitals included in HHS-OIG's audit. The agency identified a net overpayment of $11,649,377.70, which is a 21% decrease from the net overpayment calculated by HHS-OIG. CMS reviewed AHCCCS's findings and provided their approval to proceed with payments to the effected hospitals on August 18, 2017.

Lessons learned related to the HHS-OIG audit findings:

1) While the MCR is a good starting point for the EH payment calculations, detailed patient-level documentation should be reviewed in order to determine the accuracy of the payments. As a result, AHCCCS will perform detailed post-payment audits of the aggregate payment calculation for all hospitals participating in Arizona's Medicaid PI Program.

2) Labor and delivery bed-days and discharges were being incorrectly excluded when calculating the EHR incentive payment for EHs. This blanket exclusion of labor and delivery bed-days and discharges did not comport with the instructions given to hospitals when completing their Medicare cost reports. In an effort to bring Arizona's SMHP into alignment with CMS guidance, the instructions for Medicare cost reports, and other states' PI Programs, AHCCCS removed the blanket exclusion of labor and delivery bed-days and discharges from its SMHP effective July 18, 2011. CMS approved this retroactive change to Arizona's SMHP. This resulted in revised definitions for the following terms:

Average Length of Patient Stay
Average number of days a patient is confined in the hospital facility measured by the ratio of inpatient bed days to discharges using statistical fiscal year data reported on the most recent CMS Hospital Medicare Cost Report. Nursery (excluding NICU*) and observation hospital services are not included in the inpatient bed-day or discharge counts because they are not considered to be acute inpatient services based on the level of care provided.

Services attributed to the psychiatric or rehabilitation units that are a distinct part of the hospital are not included in the Average Length of Patient Stay calculation.

* AHCCCS has defined NICU as services billed under revenue code 174.

Average Annual Growth Rate
Hospital's growth rate measured by discharges averaged over the most recent 3 years using statistical Fiscal year data. Nursery (excluding NICU*) and observation services are not included in the inpatient bed-day or discharge counts because they are not considered to be acute inpatient services based on the level of care provided**.**

Services attributed to the psychiatric or rehabilitation units that are a distinct part of the hospital are not included in the Average Annual Growth Rate calculation.

* AHCCCS has defined NICU as services billed under revenue code 174.

Medicaid Share
Percentage of a hospital's inpatient, non-charity care days that are attributable to Medicaid inpatients measured using statistical fiscal year data.
   o   For discharges and inpatient bed-days data used in the Medicaid share calculation, nursery (excluding NICU*) and observation services are not included in the inpatient bed-day or discharge counts because they are not considered to be acute inpatient services based on the level of care provided.

   o   For hospital charges data used in the Medicaid share calculation, nursery (including NICU*) and observation services are included in the hospital charges or hospital cost counts because they reflect the total amount of the eligible hospital's charges.

Services attributed to the psychiatric or rehabilitation units that are a distinct part of the hospital are not included in the Medicaid share calculation.

* AHCCCS has defined NICU as services billed under revenue code 174.

3)   Arizona hospitals required education regarding Federal and State requirements for calculating their incentive payments. The following clarification regarding units that should be excluded when determining eligibility and payment has been provided.

Rehabilitation Hospitals are health care facilities such as free standing rehabilitation hospitals and rehabilitation units in acute care hospitals that have a CMS Certification Number (CCN) designation 033025 through 033099 (excluded from Inpatient Prospective Payment Systems).

Long Term Care Hospitals are health care facilities where the average length of patient stays is greater than 25 days that have a CMS Certification Number (CCN) designation as 032000 through 032299 (excluded from Inpatient Prospective Payment Systems).

Psychiatric Hospitals are institutions with a CMS Certification Number (CCN) designation 034000 through 034499 (excluded from Inpatient Prospective Payment Systems) that are (1) primarily engaged in providing, by or under the supervision of a Doctor of Medicine or Osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons; (2) Satisfies the requirements of §§1861(e)(3) through (e)(9) of the Social Security Act (general hospital requirements); (3) Maintains clinical and other records on all patients as the Secretary finds necessary to determine the degree and intensity of the treatment provided to individuals entitled to hospital insurance benefits under Part A; and (4) Meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals receiving services in the institution.

Nursery: The treatment of nursery and NICU days and discharges in regards to the Medicaid EHR incentive payment calculations is based on the section of the Arizona Administrative Code (AAC) related to reimbursement for inpatient hospital services. Per the AAC, only services billed to revenue code 174 should be included as intensive care unit stays (high-level nursery). All nursery days billed under revenue codes 170 - 173 are considered non-acute care (low-level nursery) and should be excluded from the calculation of the growth rate factor and the acute days portion of the Medicaid share. This policy does not apply to children's hospitals due to differences in the payment structure for newborns in a children's hospital setting. Children's hospitals may include nursery days billed under revenue codes 171 – 173 in the calculation of the growth rate factor and acute days portion of the Medicaid share.

Additionally, the agency updated the Audit Strategy for the PI Program as a result of the HHS-OIG audit. The updated Audit Strategy was approved on February 5, 2018.

Detailed Plan How State Will Work with Hospitals on Changes

The agency is actively reaching out to the hospitals that have already received an EHR Program Payment and presenting them with a preliminary findings letter. The letter describes the payment calculations and gives the hospital 30 days from the date of this letter to upload additional supporting documentation they would like AHCCCS to consider prior to finalizing their post-payment audit. Documentation should be uploaded into the Electronic Provider Incentive Payment system (ePIP). Upon receipt of all requested documentation, AHCCCS will complete the review as quickly as possible. **If the hospital fails to respond within 30 days AHCCCS will proceed with making the adjustment.**

C.29 Role of SMA Contractors in Implementing the PI Program
(SMHP Companion Guide Question C #29)

SMA Contractor Roles in the PI Program Implementation

AHCCCS is unusual in that much of the PI Program's infrastructure has been performed by in-house agency staff. AHCCCS does not have an MMIS contractor. That work is done in-house. Modifications of the ePIP (EP portal) are done in-house. This past year, AHCCCS has used temporary staffing contracts if any extra administrative or programming services were needed to support the PI Program. Going forward the agency may need to increase the number and skill of contractors in order to ensure it is managing the program.

AHCCCS MCOs are involved in communicating pre-established information to the provider networks with which they contract and to direct providers to the AHCCCS website for more detailed information. AHCCCS MCOs are asked to indicate support for the implementation of EHRs in provider practices to improve the efficiency of health care and to improve clinical outcomes measures.

If the agency has a specific need that it cannot perform on its own or needs a subject matter expert it would contract with an organization to perform that special piece of work.

The agency did contract with Myers and Stauffer to support our PI Program Audit updates and to train staff on new pre and post-payment auditing policies and procedures. The agency contracts with ASU/CHIR for a provider survey, Health Current for Education and Outreach and temporary firms for extra administrative or specialty help. The agency can initiate after receiving CMS approval amendments to state contracts for services that helps the EHR Program and can include RFP help, eCQM help and other specialty assistance.

C.30 Description of SMA Assumptions, Path, Timing and Planning Dependencies

(SMHP Companion Guide Question C #30)

SMA Planning Assumptions Regarding Path, Timing and Dependencies

CMS Dependency

AHCCCS depends significantly on getting adequate notice from CMS about program changes or rule changes as the Agency performs its own programming in house and does not participate with any of the large vendor sponsored communities like other SMAs.

State Assumption of Status/ Availability of EHR Technology

The SMA assumes that providers that want to participate in the Medicaid PI Program have been contacted multiple times through the SMA Education and Outreach contract with Health Current. This agreement is funded through the HITECH Program and is envisioned to be maintained through the end of 2021. The SMA assumes CMS will continue the certification of EHRs that most closely match the functionality of the MU criteria.

State Assumption of Regional Extension Centers and ONC HIE Cooperative Agreements

When the ONC grant programs ended, the SMA initiated a contract with Health Current to provide some resources for Medicaid provider education related to the MU Program. Through the SMA HIE Onboarding program, the agency is helping to increase the number of Medicaid Providers that are connected to the state wide HIE.

State Specific Readiness Factors

Current Public Health Environment and Projected Timing etc.

Arizona State Immunization Information System (ASIIS) is the statewide immunization registry for documenting immunization administration. ASIIS is accepting HL7 2.5.1 Immunization messages from any organization that is administering vaccinations to children or adults. Immunizations must be reported for patients aged 18 and under. As of January 2018, Health Current, the HIE, and ASIIS are connected and providers that are connected to the HIE are able to submit data to ASIIS through the HIE but are not able to query ASIIS data on a specific patient.

(Section C30 Continued – Dependencies)

There is currently no HIE connectivity work in the ADHS work plan for FFY 2019 for Syndromic Surveillance, Electronic Labs Reporting or Cancer Registry. There have been multiple competing staffing and funding priorities at Public Health related to these programs. At this time ADHS believes that one focus for FFY 2019 could be comparing information currently available in Biosense (Syndromic Surveillance and Electronic Laboratory Reporting) to data in the HIE to determine how the HIE can improve reporting efficiency and accuracy.

Delivery System Reform Incentive Payment (DSRIP) Program –Targeted Investments

Arizona applied for DSRIP funding but was denied. CMS did approve a Targeted Investment Program which is AHCCCS's strategy to provide financial incentives to eligible AHCCCS providers to develop systems for integrated care. In accordance with 42 CFR 438.6 (c) and the 1115 Waiver, managed care plans will provide financial incentives to eligible Medicaid providers who meet certain benchmarks for integrating and coordinating physical and behavioral care for Medicaid beneficiaries.

Launched in 2017, there are over TI sites that cover justice clinics, hospitals, PCP and BH providers and Year 2 payments were just made out to them totaling over $60 million dollars based on their achieving care milestones.

Figure 31: Targeted Investment Overview

Data Source: https://www.azahcccs.gov/PlansProviders/TargetedInvestments/

Here is the official agency web page for the project:

https://azahcccs.gov/PlansProviders/TargetedInvestments/

There are several key technology requirements as part of the TI program including all participants must join Health Current/HIE and receive Hospital Admissions, Discharges and Transfers (ADTs). In Year # of the TI Program, participants can receive a Milestone Payment if they achieve Bi directional information exchange with the HIE. AHCCCS has worked with Health Current to ensure there are adequate education and technical resources available to ensure each TI participant can be successful. Here is the Health Current TI home page that all participants are expected to use:

Non- HITECH Agency Use Cases with Health Current (HIE)

The agency has a signed participation agreement with Health Current that is funded using NON-HITECH dollars. Due to this participation, the agency is able to have electronic access to the clinical data at Health Current and several different divisions are now accessing the HIE in order to perform their work.

Division of Fee for Service Management
The DFSM unit is responsible for providing care coordination for the Fee for Service population in Az. The AHCCCS Division of Fee For Service Management was the first unit who wanted access to real time clinical data for 200 of its High Need/High Cost Members. The unit receives hospital alerts, discharges and transfers through the portal with Health Current and shares that information with its care teams. The Fee for Service Program includes American Indians who have enrolled in the American Indian Health Program.

Children's Rehabilitative Services (CRS)
Starting in April of 2017, AHCCCS sent a memo to Health Current requesting permission to assign existing Title XIX members to the appropriate Health Plan. Since 2013, the AHCCCS staff has had the role of establishing and approving health plan assignment if a member is determined to be eligible for the CRS. Medical records mostly from hospitals are needed for AHCCCS staff to determine if a child can be enrolled based on specific CRS program criteria. Clinical Information in the HIE is not used for medical underwriting as the child is already a Title XIX member, rather it is used to provide appropriate health plan placement. Often times, the children have multiple specialists and treatment locations, so being able to securely receive this information from providers that are located across the state is important. Each applicant must have one of the specific conditions that are identified as an eligibility criteria for the CRS program before they can be enrolled.

Currently there are 5 AHCCCS staff have been trained on the use of the HIE and currently connected and receiving medical records electronically since November, 2017. They have been able to reduce the number of days it takes to determine eligibility to within 1 or 2 now that they have access to the data in more real time ways.

Division of Health Care Management
AHCCCS received approval from Health Current earlier this year for staff in the Division of Health Care Management to respond to quality of care concerns. There are three units within the division that are able to access the clinical data on Medicaid members, in the event the unit is asked to investigate a member complaint or concern about the care they received or want to receive. Typically a member would contact this unit if they are having a bad experience with an existing provider or if the member is having trouble getting their AHCCCS health plan to address or resolve a care issue(s).

The Clinical Resolution Unit assists members with navigating the AHCCS system, facilitates member communication with the health plans and assesses the current care services members are receiving. The unit ensures the appropriate delivery of health care services for the member.

The Medical Management Unit assists the highest acuity members (e.g.transplant cases) with care coordination and coordination of complex member needs usually on an urgent basis and with the member's AHCCCS health plan needs to provide care and services immediately.

All 3 units completed training and went live.

Long Term Care – Program Assessment Screening (PAS)
The agency has been able to use the information in Health Current to help improve the administrative efficiency of the Long Term Care Plan or ALTC program. Since late 2018, a small pilot program was created in the Division of Member service so that a small number of PAS Assessors were given secure credentials to gain access to the Title XIX members clinical patient records are in the HIE. These documents are important to the process that PAS assessors need to follow to order to determine if the member is at risk of hospitalization and qualifies for the Long Term Care Program.

In December 208 thee were 11 Assessors, 1 Manager and 1 Trainer and 5 PAS Quality Reviewers. They were able to reduce the number of days it took to make a determination on th applicants they were seeing. Based on that they wanted to roll out the HIE access to all of their team and of now, there is a total of 94 Assessors, 15 Managers, 2 PAS Trainers, 5 PAS Quality Reviweres whti is a total of 116 staff who can now securely access patient information at Healht Current.

The one time connectivity fees and ongoing operational funding for Health Current for these purposes is paid out of non-HITECH funds. AHCCCS follows Health Current's "permitted use policy" for all of its agency activities.

Section D: The State's Audit Strategy

AHCCCS received approval on its most recent audit strategy from CMS on April 22, 2019 for Version 9.0. It reflected the changes that needed to be incorporated as part of the HHS OIG Audit response.

It is anticipated that Audit Strategy version 10.0 will be submitted in 2020.

D. SMA Methods to Avoid Improper Payments
(SMHP Companion Guide Question D)

SMA Methods to Avoid Improper Payments

The agency has invested significant resources in performing a comprehensive pre-payment audit to validate provider attestations. In early 2015, the agency contracted with Myers and Stauffer, LC to update its Audit Strategy and made comprehensive changes to its methods, timing, risk assessment, selection of audit elements in pre and post-pay, proxy data, how the SMA will focus on audit efforts.

Comprehensive audit strategy should be saved and submitted as a separate standalone document.

The pre-payment and post-payment audit processes and all of the data elements used to validate provider eligibility are outlined in the AHCCCS Audit Strategy toolkit that was sent to CMS on December 26, 2017 and approved by CMS February 5, 2018.

D.1 SMA Methods Employed to Identify Fraud and Abuse
(SMHP Companion Guide Question D #1)

SMA Description of Methods to Identify Suspected Fraud and Abuse

Suspected fraud, waste or abuse may be detected at any point during the audit process. The Arizona Medicaid PI Program policies and procedures include validation checks and audit controls throughout the entire process of the payment cycle, to identify potential fraud and abuse issues. At any time in the process, if fraud or abuse is suspected, The EHR staff submits all relevant details to the Office of Inspector General (OIG) Program Integrity Team pursuant to that office's guidelines.

The Division of Health Care Management (DHCM) Reimbursement Unit performs the pre-payment audit. The Office of Inspector General performs the post-payment audit. Debits and Credits for provider payments and recoupments will be made through the Division of Business and Finance and coordinated with the Information Services Division (ISD).

OIG is the office charged with the responsibility for conducting criminal investigations and investigative audits for all AHCCCS programs involving State and/or federal tax dollars. This

office is also responsible for overseeing provider registration functions in the Arizona Medicaid program. The OIG is designated as a criminal justice Agency and is authorized by the FBI and the Arizona Department of Public Safety to access criminal justice information relevant to official investigations.

The office has statutory authority to issue subpoenas and place persons under oath to obtain evidence for investigations. Additionally, the unit works closely with federal, State and local law enforcement agencies in the detection, investigation and prosecution of any provider, subcontractor, member or employee involved in fraudulent activity involving the program. In addition to criminal investigations, OIG also issues and collects civil monetary penalties in accordance with federal and State statutes, rules and regulations.

AHCCCS currently tracks all supplemental payments to providers. The PI Program payments will be tracked with standard payment tracking procedures that are used for all other supplemental payments. In the event that AHCCCS recoups EHR funds:

- The EHR staff (DHCM/OIG) issues a Notice of Recoupment demand letter to the provider and forwards a copy to the Payee and Division of Business and Finance (DBF), indicating the provider name, AHCCCS Provider Number, and any payments and/or amount to be recouped.

- ISD will process recoupments in ePIP and disburse payments to CMS and DBF.

- DBF will load recoupment amounts into Arizona Financial Information System (AFIS) via the Invoice Files.

- ISD will process recoupment amounts in the Invoice Files.

- If funds are not received within 60 days, the EHR staff sends a memo to OIG Investigative Unit that will include the following:

  o Provider attestation Details

  o Date of original payment

  o Reason for recoupment

  o Amount of recoupment

  o Correspondence regarding recoupment, communication with provider

Agency Use of Contractors

AHCCCS does not use contractors for identifying or reporting suspected fraud and abuse. Anytime the EHR staff have a finding that raises a concern during any part of the payment cycle, the issue is sent to the AHCCCS Office of Inspector General (OIG) for research and follow-up.

Agency plans to incorporate findings from Audits to Address Fraud and Abuse

If at any time AHCCCS receives findings from its reports from the AHCCCS OIG office or the HHS Office of the Inspector General, these findings would be reviewed to see if changes or updates would be needed to the agency's pre and post-payment activities.

Elements examined during the pre-payment audit include, but are not limited to:

- Provider type
- Licensure
- Sanctions (State (MMIS), Regulatory Board, HHS-OIG (exclusions database)
- State Medicaid provider
- Practice location (hospital-based, practice predominantly and physician assistant)
- Patient volume type (Medicaid or needy)
- Patient volume methodology (individual proxy)
- Patient volume methodology (group proxy)
- Patient volume out-of-state patient encounters
- Patient volume reports (including hospital-based and practice predominantly reports)
- MU & CQM Reports
- EHR vendor documentation (contract agreements, system certification requirements, etc.)
- Provider re-assignment of PI Program payment
- Hospital payment calculation (initial determination based on MCR)
- Hospital charity reports
- Hospital MCRs (details reviewed during post-payment audit)

Elements examined during the post-payment audit include, but are not limited to:

- Any elements not reviewed during the pre-payment audit
- Detailed patient volume report
- Targeted audits flagged during pre-payment audit
- MU/CQM discrepancies between provider documentation and attestation
- Security risk assessment
- Hospital charity reports
- Hospital financial reports (detail trial balance reports, etc.)
- Detailed patient reports to support hospitals' average annual growth rate calculations and the Medicaid share calculations

D.2 SMA Method of Tracking the Total Dollar Amount of Overpayments
(SMHP Companion Guide Question D #2)

SMA Tracking of Overpayments and Reporting to CMS

The process for payments are coordinated by ePIP (invoice process), Medicaid Management Information System, EHR Staff, EHR Technical SME, Information Service Division (ISD), Division of Business & Finance (DBF) and Department of Administration Computer Operations (DOA OPS).

All providers that receive a PI Program payment are subject to review for improper payments. There are no limitations on the look back period for payment adjustments. Payment adjustments are either additional payment disbursements (+) or payment recoveries/recoupments (-).

Additional Disbursements

If the payment received by the provider was determined to be improper and requires a disbursement of additional funds based on the results of this post-payment audit, the auditor must initiate a payment disbursement. The amount and the timeline to disburse the funds will be identified in the letter. All disbursement adjustments must be paid within one year of the discovery.
- Step 1 The State emails a Notice of Disbursement Letter to the provider.
- Step 2 The State disburses payment to the provider within 60 days of the Disbursement Notice.
- Step 3 The State must report payment to CMS as soon as possible but no later than one year from discovery.

Recoupment

If the payment received by the provider was determined to be improper and requires a recovery of funds based on the results of this post-payment audit, the provider must return the incentive payment. The amount and the deadline to return the funds will be identified in the letter. All recovery adjustments must be collected within one year of the discovery.

- Step 1 The State emails a Notice of Recoupment Letter to the provider.
- Step 2 The provider must remit payment to the State within 60 days of the Recoupment Notice.
- Step 3 The State must remit payment to CMS as soon as possible but no later than one year from discovery.

A payment cannot be retracted once the post-payment audit notification letter is issued. Furthermore, in response to the audit, the provider may not voluntarily return the PI program payment in order to retract a program year. Therefore, providers who have been notified of audit and received adverse audit findings will have their payments recouped rather than retracted.

In the event a provider has closed its practice, is unable to be located, or does not respond to a recoupment letter, the PI auditor will close the audit and let the AHCCCS OIG Collections process begin. The AHCCCS OIG Collections team will follow the Collection process in an attempt to locate the provider and collect the amount reflected in the recoupment letter. When it has been

determined that the debt is uncollectable by the Collections team, the amount will be submitted to the Arizona Attorney General's Office to be written off. CMS will be notified with details of the case and explanation why the audit findings were written off.

Reasons for Adjustments

A payment calculation can be adjusted for any of the following reasons:

- Appeal
- Audit
- Calculated payment amount updated
- Recoupment
- Retraction

Forfeiture of Payments/Participation Year

In the instance where AHCCCS determines that an EHR attestation was submitted using fraudulent data and/or with the intent to defraud the SMA, the offending provider (EP or EH) will lose a participation year from the PI Program. If a payment has not been made, a denial notice will be sent, explicitly outlining the loss of the participation year. If a payment has been made, a recoupment will be issued and the loss of the payment/participation year will be clearly delineated in the recoupment letter. If CMS is the entity auditing and/or issuing a recoupment of funds for a provider, the provider will lose a participation year in alignment with CMS protocol.

State Registration & Attestation System (SR&A)

EPIP is the Registration & Attestation System for the Arizona Medicaid PI Program. EPIP is used to coordinate the provider registration, attestation and payment process. A successful submission of a provider attestation triggers the PI Program payment calculation.

CMS File Transfer Coordination (ISD)

Arizona uses the CMS file exchange process to prevent duplicate and improper payments. Payments for the Medicaid PI Program must comply with the below *(included but not limited to)* requirements

Eligible Professionals:

- EP payments are on a calendar year (CY) basis from January 1 – December 31 *(program application year)*.

- EPs cannot receive payment for more than six program application years.

- EPs cannot receive more than $63,750 for six program application years.

- EPs may not begin participation in the PI Program after the 2016 (CY) application year.

- EPs may not receive payments for program application years after 2021 *(last year to apply)*.

- EPs may receive one PI Program payment from only one State in a program application year.

- EPs may be eligible for both Medicare PI Program and the Medicaid Incentive Program but may only participate and receive one PI Program payment from either program in a program application year.

- EPs may switch once between the Medicare PI Program and Medicaid PI Program but the switch must occur before the 2015 application year.

- EPs may elect to voluntarily re-assign their PI Program payment to their employer at point of attestation (payee) who is has an AHCCCS Provider Number in the Medicaid Management Information System (MMIS).

- EP or Payee must have an active Electronic Funds Transfer (EFT) record with AHCCCS in order to receive payments.

- EP payments may be recouped in cases of fraud, abuse or if the Arizona State Medicaid Agency audit determines the provider was ineligible for the PI Program payment.

- EPs suspected of fraud or abuse are reported to the Agency's Office of Inspector General (Medicaid Fraud Control Unit).

EPs must agree to the below attestation disclaimer each time an attestation is submitted.

> *I certify that the foregoing information is true, accurate and complete. I understand that the Arizona Medicaid PI Program payment will be paid from Federal funds, that by filing this attestation I am submitting a claim for Federal funds, and that the use of any false claims, statements, or documents, or the concealment of a material fact used to obtain an Arizona Medicaid PI I Program payment, may be prosecuted under applicable Federal or State criminal laws and may also be subject to civil penalties.*

EPs are subject to audit by the Agency anytime a PI Program payment is disbursed and must agree to the below attestation disclaimer each time an attestation is submitted.

> *I understand that AHCCCS reserves the right to perform an audit of this information. The audit may include an on-site visit by AHCCCS staff or designee to gather supporting data. I hereby agree to keep such records as are necessary, for six years, to demonstrate that I met all Arizona Medicaid PI Program requirements and to furnish those records to the Medicaid State Agency, Arizona Health Care Cost Containment System Administration (AHCCCS), or contractor acting on their behalf.*

Eligible Hospitals:

- EH payments are on a Federal Fiscal Year (FFY) basis from October 1 – September 30 *(program application year)*.

- EHs cannot receive payment for more than four program application years.

- EHs cannot receive more than the aggregate PI Program amount over four program application years.

- EHs may not begin participation in the PI Program after the 2016 FFY application year.

- EHs may not receive a PI Program payment after 2016 FFY unless the hospital received a PI Program payment in the prior FFY year.

- EHs may not receive payments for program application years after 2019 FFY *(last year to apply)* based on Arizona's 4-year incentive disbursement period.

- A multi-site hospital with one CMS Certification Number is considered one hospital for purposes of calculating the PI Program payment.

- EHs may receive one Medicaid PI Program payment from only one State in a program application year.

- EHs may be eligible for both the Medicare PI Program and the Medicaid PI Program. Hospitals that register for only one of the programs will not be able to manually change their registration (i.e., change to "Both Medicare and Medicaid PI Program" or from one program to the other) after a payment is initiated. The EH must select "Both Medicare and Medicaid" during the Federal Registration process even if planning to apply only for one of the programs.

- EHs must have an active Electronic Funds Transfer (EFT) record with AHCCCS in order to receive payments.

- EH payments may be recouped in cases of fraud, abuse or if the Arizona State Medicaid Agency audit determines the provider was ineligible for the PI Program payment.

- EHs suspected of fraud or abuse are reported to the Agency's Office of Inspector General (Medicaid Fraud Control Unit).

EH authorized contacts must agree to the below attestation disclaimer each time an attestation is submitted.

> *I certify that the foregoing information is true, accurate and complete. I understand that the Arizona Medicaid PI Program payment will be paid from Federal funds, that by filing this attestation I am submitting a claim for Federal funds, and that the use of any false claims, statements, or documents, or the concealment of a material fact used to obtain an Arizona Medicaid PI Program payment, may be prosecuted under applicable Federal or State criminal laws and may also be subject to civil penalties.*

EHs are subject to audit by the Agency anytime a PI Program payment is disbursed and must agree to the below attestation disclaimer each time an attestation is submitted.

> *I understand that AHCCCS reserves the right to perform an audit of this information. The audit may include an on-site visit by AHCCCS staff or designee to gather supporting data. I hereby agree to keep such records as are necessary, for six years, to demonstrate that I met all Arizona Medicaid PI Program requirements and to furnish those*

records to the Medicaid State Agency, Arizona Health Care Cost Containment System Administration (AHCCCS), or contractor acting on their behalf.

Provider Eligibility *(EHR Staff)*

The EHR staff in DHCM performs the pre-payment audit to determine the provider's eligibility. Payments for approved attestations are disbursed within 45 days after the approval date. If issues are encountered with the payment process, the payment request moves to a pend status until resolved. Attestations that are not approved remain on hold in ePIP until the provider is ready to re-submit a new attestation. A Notice of Decision is emailed to the provider.

Process for Recoupments

Pre-payment Audit
The EHR staff in the DHCM Reimbursement Unit performs the pre-payment audit to detect and prevent improper payments. At any time prior to the post-payment audit, if an improper payment is detected, a Notice of Recoupment demand letter is initiated to the provider with copies sent to the Payee (if applicable) and Division of Business and Finance (DBF).

Post-payment Audit
The EHR staff in the Office of Inspector General division performs post-payment audits to detect improper payments. At any time, if an improper payment is discovered, a Notice of

Recoupment demand letter is initiated to the provider, with copies sent to the Payee (if applicable), Division of Business and Finance (DBF), and Division of Health Care Management (DHCM).

Both Pre-Payment Audit & Post-payment Audit
The provider is directed to remit payment directly to DBF within 60 days from the date of notification or has the option to file appeal within 60 days. If the provider remits payment, DBF will record the payment in AFIS and notify DHCM & Information Services Division (ISD) that payment has been received. ISD will record the recoupment in ePIP, create an invoice adjustment on the ePIP invoicing file, and report the recoupment to CMS on the CMS D-16 interface file transfer.

If payment is not received or an appeal is not filed within the above time frame, the EHR staff will notify the OIG Program Integrity Team (PIT) of failure to repay the PI iProgram payment. OIG then follows standard operating procedures to collect the debt.

Payment Process

The Division of Business and Finance (DBF) processes payments through the Arizona Financial Information System (AFIS). Payments are made to the Payee's Taxpayer Identification Number (TIN) reflected in the CMS registration. Requests for payments are tracked by a supplier number in the Arizona Financial Information System and by a vendor number in PMMIS. The vendor number is composed of the payee's AHCCCS Provider Number and location code that is tied to the payee's NPI & TIN.

Arizona only issues electronic payments once per month for the Medicaid PI Program. Providers and/or payees are required to set-up an Electronic Funds Transfer (EFT) account in order to receive payment.

Payments cannot be made for negative amounts (recoupments), such amounts are saved in AFIS and offset by either future positive amounts (payment) or a remittance of the amount owed.

The EHR staff initiates the payment process by releasing the hold in ePIP. This triggers a payment request on the CMS D16 interface file transfer. CMS must respond with an approval to initiate a payment record in the monthly ePIP Invoice process. Payment records are batched and collected until the monthly cycle engages.

The monthly payment processing cycle engagement triggers the following tasks:

(1) EPIP automatically generates the Invoice Files & ePIP Invoice Interface Report to DBF.

    (a)   The Invoice Files are uploaded to an FTP site to be processed by the Arizona Financial Information System.

    (b)   A notification email is sent to DBF EPEP users indicating the Invoice Files are loaded at the FTP site for processing along with the ePIP Invoice Interface Report.

(2) The EHR Technical SME reconciles the expected payments against the CMS approved payments on the CMS D16 interface file and emails a payment certification statement to DBF.

(3) The ISD System Application Developer emails notification of the payment production run to the EHR Staff.

(4) The DBF Accountant performs the payment reconciliation between the ePIP Invoice Report and the payment certification statement. Differences found are escalated to ISD System Application Developer and the EHR Technical SME for resolution.

(5) The DBF Accountant completes and submits the AFIS PARM Form to the Department of Administration Computer Operations group (DOA OPS) to process the payments.

Please note that DBF has responsibility and oversight of the below tasks:

(1) Ensuring that the appropriate funding sources are used to make Medicaid PI Program payments.
(2) Following notification from DHCM and ISD, compliance with repaying CMS all Federal Financial Participation funds received by EPs or EHs identified as an overpayment, regardless of recoupment from such providers, within 60 days of discovery of the overpayment.

D.3 SMA Process for Managing Detection of Fraud and Abuse
(SMHP Companion Guide Question D #3)

Process for Managing Fraud and Abuse When Detected

Suspected fraud, waste or abuse may be detected at any point during the audit process. The Arizona Medicaid PI Program policies and procedures include validation checks and audit controls throughout the entire process of the payment cycle, to identify potential fraud and abuse issues. At any time in the process, if fraud or abuse is suspected, the EHR staff submits all relevant details to the Office of Inspector General (OIG) Program Integrity Team pursuant to that office's guidelines.

The Department of Health Care Management Reimbursement Unit performs the pre-payment audit. The Office of Inspector General performs the post-payment audit. Debits and Credits for provider payments and recoupments will be made through the Department of Business and Finance and coordinated with the Information Services Division (ISD).

OIG is the office charged with the responsibility for conducting criminal investigations and investigative audits for all AHCCCS programs involving State and/or federal tax dollars. This office is also responsible for overseeing provider registration functions in the Arizona Medicaid program. The OIG is designated as a criminal justice Agency and is authorized by the FBI and the Arizona Department of Public Safety to access criminal justice information relevant to official investigations.

The office has statutory authority to issue subpoenas and place persons under oath to obtain evidence for investigations. Additionally, the unit works closely with federal, State and local law enforcement agencies in the detection, investigation and prosecution of any provider, subcontractor, member or employee involved in fraudulent activity involving the program. In addition to criminal investigations, OIG also issues and collects civil monetary penalties in accordance with federal and State statutes, rules and regulations.

D.4 SMA Intent Regarding Leveraging Existing Data Sources for verification of Meaningful Use.
(SMHP Companion Guide Question D #4)

Verification of Meaningful Use and CEHRT

The SMA will employ both automated and manual processes when performing the pre-payment audit for EHR Technology documentation for providers attesting to meaningful use of certified EHR technology to ensure statutory and regulatory requirements are met for the PI Program. See section C9 for verification steps.

At this time, all providers who attest to Public Health measures to meet MU must keep paper copies and screen shots of their approvals they receive from the ADHS/Public Health agency. In the future, the agency would like to work with the HIE to ensure it can receive electronic confirmations/proof by each provider that they have met the required measures

In the future, the agency will be working with its Health Plans and the HIE to better understand the existing data sources that could be made available to verify MU.

D.5 SMA Use of Sampling as Part of Its Audit Strategy

(SMHP Companion Guide Question D #5)

Sampling Methodology of the Audit Strategy

A risk-based approach is used for the post-payment audits to target providers that may pose an elevated risk of improper payments and noncompliance with the requirements of the Medicaid PI Program. The EHR Audit Team gathers and analyzes data and conducts desk audits and/or on-site audits.

The audit selection process for EPs is based on the sampling methodology table below. The EHR Audit Team may audit additional providers based on capacity. Using defined risk categories and thresholds, EPs receiving a Medicaid incentive payment will be subject to a post-payment audit.

Audits will generally start as desk audits. However, if compliance cannot be determined and the desk audit is deemed insufficient, an on-site audit will be scheduled with the EP or EH. The goal of the on-site audit is to support EPs and EHs to be in a position to adequately participate in the PI Program.

Table 45: Risk Stratification Description

Risk Strata	High Risk Providers	Medium to High Risk Providers	Medium Risk Providers	Low to Medium Risk Providers	Low Risk Providers
Sampling (PY 2011 and 2012 MU)	100%	A random sample of the lower of 60% of the medium-high risk audit pool or 40 EPs.	A random sample of the lower of 40% of the medium risk audit pool or 30 EPs	A random sample of the lower of 20% of the low-medium risk audit pool or 30 EPs	A random sample of 10% of the low risk audit pool.
Sampling (PY 2012 AIU)	100%	A random sample of 50% of the medium-high risk audit pool	A random sample of the lower of 25% of the medium risk audit pool or 25 EPs	A random sample of the lower of 20% of the low-medium risk audit pool or 20 EPs	A random sample of the lower of 10% of the low risk audit pool or 10 EPs
Sampling (PY 2013 AIU)	100%	A random sample of the lesser of 50% of the medium-high risk audit pool or 20 EPs	A random sample of the lower of 20% of the medium risk audit pool or 15 EPs	A random sample of the lower of 15% of the low-medium risk audit pool or 15 EPs	A random sample of the lower of 10% of the low risk audit pool or 10 EPs
Sampling (PY 2013 MU)	100%	A random sample of 50% of the medium-high risk audit pool	A random sample of the lower of 20% of the medium risk audit pool or 10 EPs	A random sample of the lower of 15% of the low-medium risk audit pool or 10 EPs	A random sample of the lower of 10% of the low risk audit pool or 10 EPs
Sampling (PY 2014 AIU)	100%	A random sample of lesser of 30% of the medium-high risk audit pool or 15 EPs	A random sample of the lower of 20% of the medium risk audit pool or 10 EPs	A random sample of the lower of 15% of the low-medium risk audit pool or 5 EPs	A random sample of the lower of 10% of the low risk audit pool or 5 EPs
Sampling (PY 2014 MU)	100%	A random sample of lesser of 40% of the medium-high risk audit pool or 20 EPs	A random sample of the lower of 25% of the medium risk audit pool or 20 EPs	A random sample of the lower of 15% of the low-medium risk audit pool or 10 EPs	A random sample of the lower of 10% of the low risk audit pool or 10 EPs
Sampling (PY 2015 AIU)	100%	A random sample of lesser of 30% of the medium-high risk audit pool or 7 EPs	A random sample of the lower of 20% of the medium risk audit pool or 7 EPs	A random sample of the lower of 15% of the low-medium risk audit pool or 5 EPs	A random sample of the lower of 10% of the low risk audit pool or 5 EPs
Sampling	100%	A random sample of	A random sample of	A random sample of the	A random sample of

Risk Strata	High Risk Providers	Medium to High Risk Providers	Medium Risk Providers	Low to Medium Risk Providers	Low Risk Providers
(PY 2015 MU)		lesser of 40% of the medium-high risk audit pool or 15 EPs	the lower of 25% of the medium risk audit pool or 10 EPs	lower of 15% of the low-medium risk audit pool or 5 EPs	the lower of 10% of the low risk audit pool or 5 EPs

Data Source: AHCCCS EHR Program Audit Strategy Version 9.0

AHCCCS will audit the aggregate payment calculation for all EHs; therefore, conducting a risk assessment for the purpose of sample selection is unnecessary. Primarily the EH's payment calculation will be finalized during post-payment audit process to ensure the accuracy of the aggregate payment. The eligibility requirement for EHs is typically reviewed during pre-payment audit. In cases where the hospital's eligibility was not verified during the pre-payment audit, the post-payment team will analyze eligibility documentation for at least one participation year.

It is the Department's request that Program Year 2012 through 2014 meaningful use reviews for all dually-eligible and Medicaid only EHs be performed by CMS.

As related to EH meaningful use audits and appeals, the State of Arizona:
- Designates CMS to conduct all audits and appeals of EH meaningful use attestations;
- Will be bound by the CMS audit, and appeal, findings;
- Will perform any necessary recoupments arising from the CMS audits; and
- Will be liable for any federal financial participation granted to the state to pay EHs that, upon audit (and any subsequent appeal) are determined not to have been meaningful EHR users. Any adverse CMS audits would be subject to the CMS administrative appeals process and not the state appeals process.

Beginning in Program Year 2015, CMS will no longer conduct meaningful use audits for EHs. AHCCCS will randomly select a sample of EHs per program year to validate the MU payments.

D.6 SMA Methods to Relieve Provider Burden and Maintain Integrity and Efficacy of the Oversight Process
(SMHP Companion Guide Question D #6)

Plans to Reduce Provider Burden by Use of Existing Data and Leveraging SMA Audit Mechanisms

AHCCCS will rely on existing data to reduce provider burden and maintain integrity and efficacy of oversight processes. For instance, AHCCCS uses provider data in PMMIS to verify provider eligibility and to calculate projected patient encounter volume percentages during the pre-payment audit.

D.7 Program Integrity Operations Locations
(SMHP Companion Guide Question D #7)

Revision of Incentive Payment Oversight

The SMA's PI Program responsibility for program integrity is divided between two different divisions**.**

- Division of Health Care Management (*pre-payment audit)*

The Division of Health Care Management (DHCM) performs the pre-payment audit procedures on provider attestations and also refers any suspicious activity to the SMA Office of Inspector General (OIG) Program Integrity Team.

- *Office of Inspector General (post-payment audit)*

The Office of Inspector General (OIG) performs the post-payment audit procedures on provider attestations and also refers any suspicious activity to the SMA Office of Inspector General (OIG) Program Integrity Team.

The SMA Office of Inspector General (OIG) is responsible for program integrity by preventing, detecting and investigating fraud and abuse through the Provider Compliance Division Investigative Analysis Unit, Investigations Unit and Provider Registration Units. The OIG Provider Registration Unit are responsible for conducting OIG, state, and medical board sanctions and keeping provider information up to date in PMMIS so that excluded or suspended providers are flagged.

Both the pre-payment audit and the post-payment audit teams are responsible for implementing and updating the agency's PI Program Audit Strategy.

Section E. The State's HIT Roadmap

E.1 SMA Graphical/Narrative Pathway from "As Is" to "To Be"
(SMHP Companion Guide Question E #1)

"As Is" and "To Be" Pathway

Over the next five years, the agency is expecting almost 100% of all Medicaid providers to be using an EHR and participating in secure health information exchange. With this degree of Health IT deployment, the agency will be focused on leveraging all of the Health IT investments made through the HITECH Program with the goal of reducing care and coverage fragmentation for Medicaid members.

The agency has 3 goals it is using to improve care coordination and reduce care fragmentation:

Goal 1: Oversee and Administer the PI Program

Goal 2: Increase Agency Use and Support for HIT/HIE

Goal 3: Accelerate Statewide HIE Participation by all Medicaid Providers and Plans

Figure 32 below represents the graphical expectation that almost 100% of physicians in Arizona are expected to be using an Electronic Health Record by 2018. The immediate focus for the agency has been recruiting providers to the HIE onboarding program in order to ensure that data can be shared between Medicaid providers and to enable the "data capture" phase of the MU program.

By the end of 2018, it is expected that more providers would be positioned to focus on health information exchange (HIE) due to their EHR adoption and the continued maturity and robustness of Health Current and its stakeholders.

Through policy efforts at the agency like requiring health plans to have e-prescribing goals, having them join the HIE to access real time clinical data for care coordination, and additional discussions about payment reform opportunities, the agency expects that by 2020 each plan will be able to demonstrate care improvements and be able to bend the cost curve.

Figure 32: SMA Graphic "As Is" and "To Be"
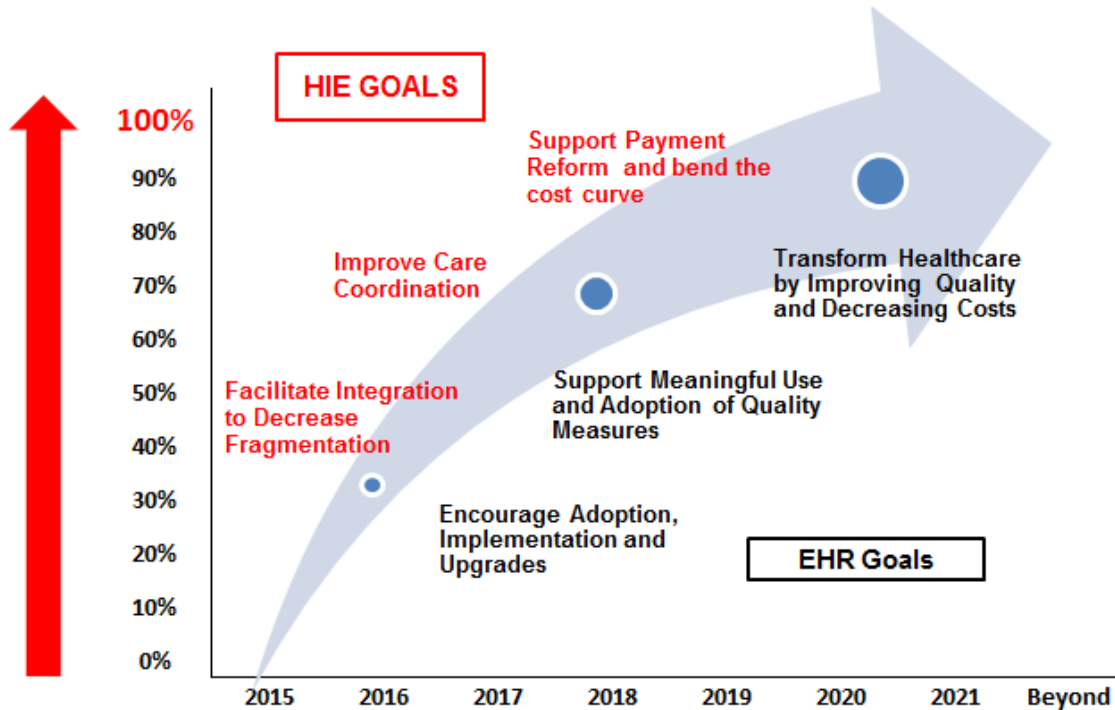
E.2 SMA Expectations Regarding Provider EHR Technology Adoption over Time

(SMHP Companion Guide Question E #2)

SMA Expectation of Provider EHR Adoption

Researchers at the Arizona State University/Center for Health Information Research (CHiR) have studied the adoption of EHRs in Arizona since 2007. Their most recent report shows the percentage of Arizona physicians using EHRs increased from approximately 45% in 2007-2009 to approximately 91% in 2016-2018. The use of paper files as the only type of medical record declined significantly over the same period; however, reliance on EHRs as the only medical record did not increase proportionately.

According to CHiR's forecast, 100% of physicians are expected to be using an electronic health record by the year 2020. The trend towards EMR adoption in Arizona is consistent with national trends. See the chart below for the adoption percentages and forecast.

Figure 33: Projected Arizona EP EHR Adoption Percentage By 2021
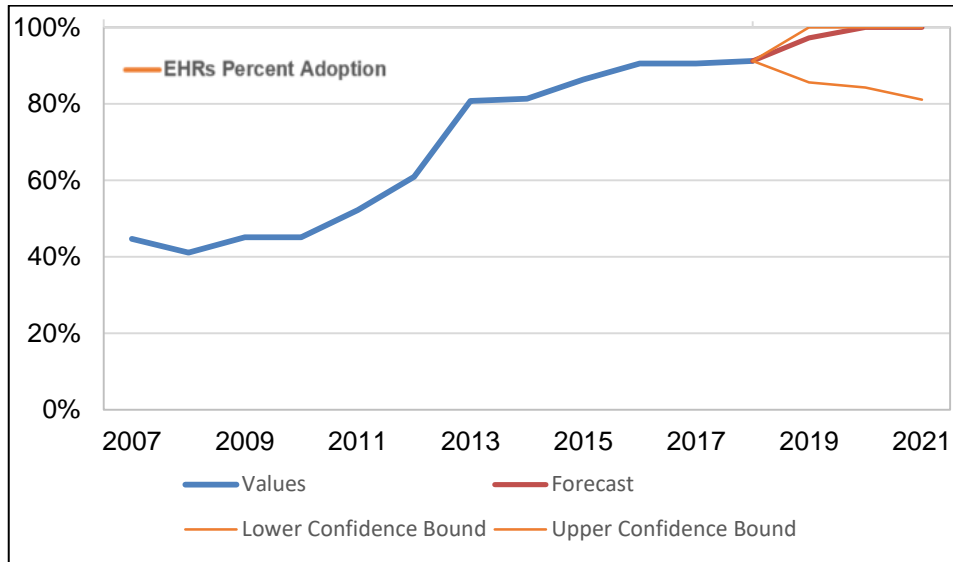
Source: ASU Center for Health Information & Research

Reference:
Johnson WG, Harootunian G, Sama TL, Kommareddy S. (August 2018). Physicians' Use, Exchange, and Evaluation of Electronic Medical Records 2016-2018. Phoenix (AZ): Arizona State University, Center for Health Information & Research.

Benchmarks for SMA Goals in Registration and Participation

Increase the Adoption of EHR by EPs and EHs

In addition to Agency long-term goals for their PI Program, AHCCCS is committed to encouraging EHR and HIT adoption for eligible providers in the next five years. The following table provides an overview of the projected number of EPs in Arizona expected to apply and qualify for the PI Program.

EHR Registration and Payment Goals for Eligible Professionals and Eligible Hospitals

According to the projections in the table below, by 2020, AHCCCS projects it will have 5,980 EPs registered in the EHR Program with 69% of them receiving an AIU Payment. 1,644 EPs will receive an MU 1 Payment and 1,759 EPs will receive an MU Stage 2 Payment. It is projected that by CY 2020, 600 providers will have received a Stage 3 payment.

Table 47: AHCCCS PI Goals for Eligible Professionals

AHCCCS Goals for Eligible Professionals							
	CY 2015	*CY 2016*	*CY 2017*	*CY 2018*	*CY 2019 Estimates*	*CY 2020 Estimates*	*CY 2021 Estimates*
EP Registered in ePIP	*4,893*	*5,493*	*5,743*	*5,967*	*5,980*	*5,980*	*5,980*
EP Receive AIU payment	*3,109*	*3,448*	*3,732*	*4,072*	*4,142*	*4,142*	*4,142*
Registered EP Received AIU Payment	*63.54%*	*62.77%*	*64.98%*	*68.24%*	*69.26%*	*69.26%*	*69.26%*
EP Receive MU Stage 1 Payment	*1,127*	*1,615*	*1,629*	*1,629*	*1,644*	*1,644*	*1,644*
Successful AIU EP Received MU Stage 1 Payment	*36.25%*	*46.84%*	*43.65%*	*40.00%*	*39.69%*	*39.69%*	*39.69%*
EP Receive MU Stage 2/2^M Payment	*7*	*219*	*664*	*1,068*	*1,259*	*1,759*	*1,759*
Successful MU Stage 1 EP Received MU Stage 2/2^M Payment*	*0.62%*	*13.56%*	*40.76%*	*65.56%*	*76.58%*	*107.00%*	*107.00%*
EP Receive MU Stage 3 Payment	*0*	*0*	*0*	*0*	*0*	*600*	*725*
Successful MU Stage 2 EP Received MU Stage 3 Payment	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*34.11%*	*41.22%*

Data Source: AHCCCS PI Team May, 2019

*Note: Percentage greater than 100% triggered as a result of mandatory requirement to meet Stage 2^M on or after Program Year 2015 regardless of if the provider met Stage 1.

PI Program Registration and Payments for Eligible Hospitals

The table below reflects PI Program goals for Eligible Hospitals until CY 2021. Projections include 76 EHs will be registered in ePIP, 97% of the EHs will receive an AIU payment, 65 EHs will receive an MU Stage 1 and Stage 2 Payment and 2 hospitals are expected to attained Stage 3 MU.

The table below reflects PI Program goals for Eligible Hospitals until CY 2021. Projections include 76 EHs will be registered in ePIP, 97% of the EHs will receive an AIU payment, 65 EHs will receive an MU Stage 1 and Stage 2 Payment and 2 hospitals are expected to attained Stage 3 MU.

Table 48: AHCCCS EHR Goals for Eligible Hospitals

AHCCCS Goals for Eligible Hospitals							
	FFY 2015	*FFY 2016*	*FFY 2017*	*FFY 2018*	*FFY 2019 Estimates*	*FFY 2020 Estimates*	*FFY 2021 Estimates*
EH Registered in ePIP	75	76	76	76	76	76	76
EH Receive AIU payment	72	73	74	74	74	74	74
Registered EH Received AIU Payment	96.00%	96.05%	97.37%	97.37%	97.37%	97.37%	97.37%
EH Receive MU Stage 1 Payment	61	61	65	65	65	65	65
Successful AIU EH Received MU1 Payment	84.72%	83.56%	87.84%	87.84%	87.84%	87.84%	87.84%
EH Receive MU Stage 2/2^M Payment	3	15	15	21	41	70	76
Successful MU Stage 1 EH Received MU Stage 2/2^M Payment*	4.92%	24.59%	23.08%	32.31%	63.08%	107.69%	116.92%
EH Receive MU Stage 3 Payment	0	0	0	0	0	0	2
Successful MU Stage 2/2^M EH Received MU Stage 3 Payment	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	2.63%

Data Source: AHCCCS PI Team May, 2019

*Note: Percentage greater than 100% triggered as a result of mandatory requirement to meet Stage 2^M on or after Program Year 2015 regardless of if the provider met Stage 1.

E.3 Annual Benchmarks for each of the SMA Goals

(SMHP Companion Guide Question E #3)

AHCCCS described its EHR Program Registration and Payment metrics in the previous question (E.2). Other benchmarks for each goal are identified below:

AHCCCS Goal 1: Oversee and Administer the PI Program

a. *Ensure Providers Migrate Through the MU Continuum (Refer back to Question E.2)*

b. *Support ADHS Public Health Onboarding for MU Measures*

   i. *Benchmark: Allow providers to submit immunizations electronically by July 1, 2017.* –**Completed***; working on query response now*

c. *Achieve Program Integrity Goals*
   i. *Update Agency Audit Strategy to comply with HHS OIG findings by June 1, 2017* – **Completed** *Agency Audit strategy approved April 2019*

AHCCCS Goal 2: Increase Agency Use and Support for HIT/HIE

a. *Care Coordination between Physical and Behavioral Health Providers*

   i. *Add 2 new integrated FQHCS/RHCS clinics to the PI Program* –**Completed**

   ii. *Pay 4 New FQHCS/RHCS a PI Payment by March 2017.* –**Completed**

   iii. *Increase the number of BH providers who get connected under the State Health Integration Plan (SHIP) from current 38 to 60 by December 2017.* **Completed**

b. *Support AHCCCS Payment Modernization Initiatives and Adminstrative Efficiency Projects*

   i. *Of the 42 hospitals that have qualified for an increase in their payments due to meeting MU 2 and having established connectivity with the HIE, track the amount of additional funding that is generated for hospital.* **Completed- since 2017, the DAP/Value based payment program has awarded $90 million to hospitals and other providers for HIE participation and connectivity**

c. *Implement the American Indian Health Home Waiver*

   i. *Have 3 care collaboratives established for AIHP members by July 2018* -**Completed-there are 4 AIMH**

d. *Improve Justice System Transitions-* **Completed- through the Targeted Investments program there are now 12 justice sites that operate as a one stop shop/clinics for people leaving jails and prison. AHCCCS health plans have to have a full time justice liaison to coordinate services for people transitioning out of jails and prison. .**

e. *Improve Care for Children with Behavioral Health Needs Including those at Risk and Engaged in the Child Welfare System*

    i. *Have 15 community providers that are experts in Autism Spectrum Disorder Connect to the HIE by July 2018 –***Completed- there are 289 Community providers including those 15 with ASD expertise participating with Health Current.**

AHCCCS Goal 3: Accelerate Statewide HIE Participation for All Medicaid Providers and Plans

Expand the HIE Onboarding Program for *Medicaid Hospitals, FQHC's, RHC's, Groups and All Other Medicaid Providers.*

a. *Onboard up to 70 different Medicaid provider organizations by end of FFY 2018 including PI eligible and other Medicaid non- eligible providers.***Completed – over 200 Medicaid community providers are participating at the HIE**

b. *Support Increased Health Plan Use of HIE for Improved Health Outcomes and CQM.-*

    a. **In process- the agency is updating its clinical quality and performance measure strategies – the HIT HIE portion is under review and discussion**

c. *Coordinate Other State and Federal Agencies' Participation in HIE.*

    a. **Outreach is continuing to the Board of Pharmacy, ADHS and to IHSS for new projects**

HIE Annual Benchmark Report

As required by CMS, AHCCCS is enclosing a summary of the Arizona State Leve HIE Annual Benchmark Report for Health Current. The HIE Annual Benchmark report covers the time period of January – December 2018.

HIE Annual Contributions

The pie chart on the next page displays the total contributions to Health Current from:

Hospitals Data Management Fee = 12%

Health Plans Data Management Fee = 12%

AHCCCS HIE Onboarding Funding = 37%

ACCCS Statewide HIE Integration Plan = 6%

AHCCCS Education and Outreach = 6%

CMS Transitioning Clinical Practice (TCPI) = 26%

Other Sources = 1%

The figure below graphically demonstrates the sources of funding for the for the state level health information exchange.

Figure 34: Payer Contributions to the HIE

Data for Health Current Funds was pulled to insure that a complete 12 month period could be represented.
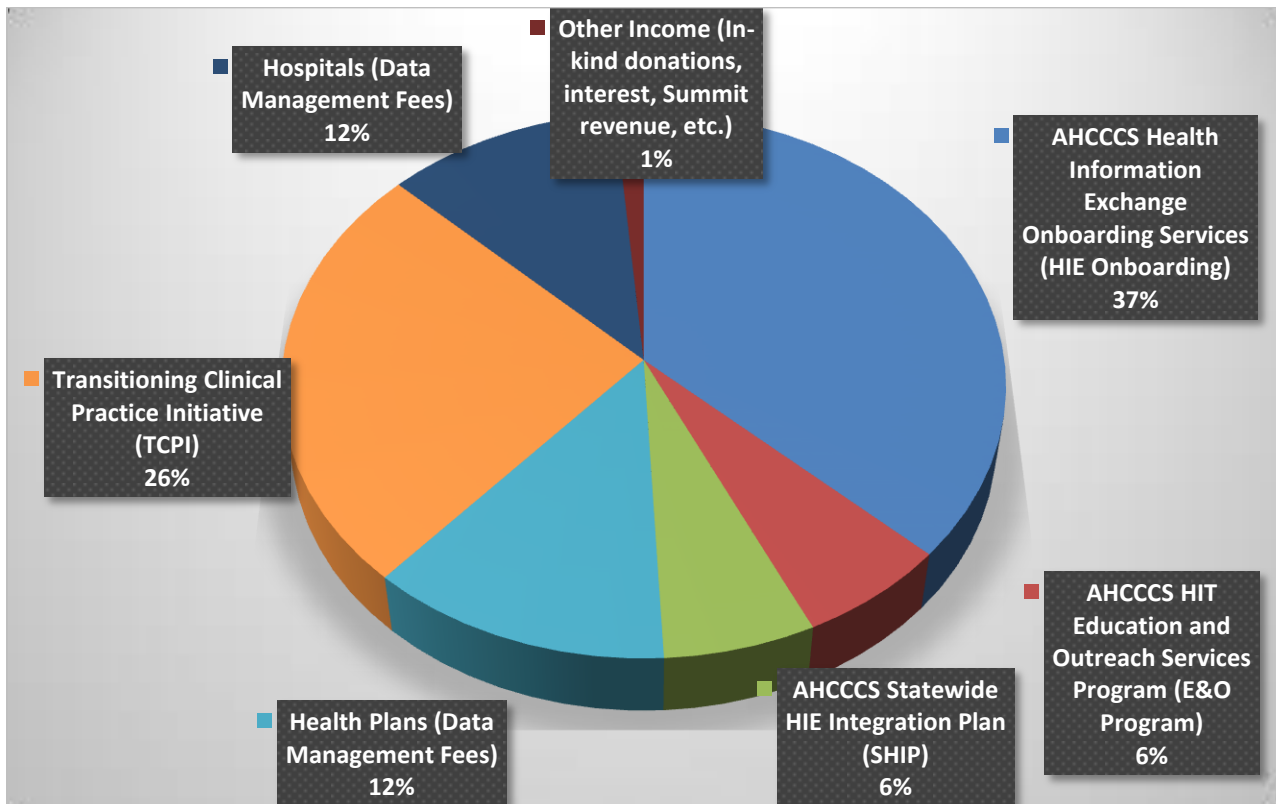
Data Source: Health Current April, 2019

HIE Annual Benchmark Successful Connections:

The following section details the number and type of organizations that have become participants in the state level Health Information Exchange (Health Current). A full listing of participants is included in Appendix F:6.

The following connections have been made as of May, 2019:

- Accountable Care Organizations (16)

- Behavioral Health Organizations (81)

- Community Provider Organizations (289)

- Emergency Medical Services (18)

- FQHC and Community Health Centers (21)

- Health Plans (18)

- Hospitals and Health Systems (55)

- Labs, Imaging Centers and Pharmacies (6)

- Long Term and Post-Acute Care (104)

- State and Local Government (7)

Total Number of Active Participants in Health Current as of May, 2019 was 615

Note that not all organizations that have become participants have yet connected to the HIE for data exchange.

HIE Annual Benchmark Covered Lives:

Total number of patients with clinical data =8.5 million.

The total number of lives in Arizona is 6. 8 million Residents in Arizona.

% of Arizonans with clinical data in the HIE = 91% of population

HIE Annual Benchmark and Medicaid Provider HIE Onboarding Goal Progress

The numbers below specify milestones of implementation achieved by organization type and subsidized through HITECH funds.

Note that not all participants in the in the HIE are eligible for the Onboarding Program.

The total number of Medicaid providers that are participating with Health Current is 484. Of those 344 have access to the HIE data or established an interface or portal connection to the HIE.

That means 71% of participating Medicaid providers are sending or receiving data with the HIE.

As of May,2019, the total number of Medicaid Hospitals/Health Systems participating with Health Current = 52

- *Milestone 1: 52*

- *Milestone 2: 38*

- *Milestone 3: 37*

- *Milestone 4: 34*

- *Milestone 5 : 1*

Total Number of Medicaid FQHCS/RHCS/Look A-likes Participating with Health Current = 18

- *Milestone 1: 18*

- *Milestone 2: 14*

- *Milestone 3: 15*

- *Milestone 4: 9*

- *Milestone 5: 0*

Total Number of Medicaid Community Providers Participating with Health Current = 199

- *Milestone 1:199*

- *Milestone 2: 8*

- *Milestone 3: 120*

- *Milestone 4: 7*

- *Milestone 5: 0*

Data Source: AHCCCS Onboarding Tracking Master May, 2019

Financial Status – See Appendix F.5 in Reference to the HIE Audited Financial Statement

Electronic Quality Measures

- *At this time, the agency has not established an eCQM registry for the MU measures and is in the process of evaluating and updating its Clinical Quality Strategy. As part of that process presentations have been done to educate our agency clinical quality experts about the eCQM components of the PI program. Discussion is ongoing about how these measures fit into our overall agency Clincal Quality Strategy. The agency expects to have a more complete strategy by September, 2019 and it will help inform the PI program about how to proceed with the eCQM use.*

Progress in Enabling MU Such as Public Health Facilities and Transmission of Summary of Care Records

ADHS has completed one way connectivity between the HIE and ASIIS, where records can either go directly into ASIIS or a provider can send their immunization record through the HIE and ASIIS can record it. They are in the process of completing a bi-directional interface between ASIIS and the HIE that will allow providers who are in the HIE to query the ASIIS registry and pull out an electronic record of member immunizations. This is expected to be completed by December, 2019.

The connectivity of the EMS AZ-PIERS registry with the HIE is expedted to be completed by August 2019.

For the next year, AHCCCS expects to work with ADHS and Health Current for the purpose of implementing an Advanced Directives Registry (Specialized Registry) and a Master Patient Index for the Immunizaiton Program. These will be explained in more detail in our upcoming HITECH IAPD submission.

Table 49: HIE Annual Benchmarks Through 2018 (Annual) and February, 2019

Health Current has provided the agency with financial information and annual benchmark measures that are below**.**

Financial Information

The pie chart below represents the breakdown of the funds that support Health Current in Calendar Year 2018. The AHCCCS HIE onboarding program for Medicaid providers represents 37% of their budget, the AHCCCS Education and Outreach contract equals 6% and the SHIP program equals 6%. The participating Health Plans and Hospitals make up 12% each or 24% of the total budget and the Federal Grant/TCPI and other revenues = 27% of the budget.

healthcurrent
HIE Annual Benchmark Data

ANNUAL		
4.2.1 - HIE Annual - Benchmark **Payer Contributions**		
Total Contribution January 1, 2018 through December 31, 2018		
Payers	**Amount of Funding**	**% of Total Funding**
AHCCCS Health Information Exchange Onboarding Services (HIE Onboarding)	$5,804,000	37%
AHCCCS HIT Education and Outreach Services Program (E&O Program)	$983,744	6%
AHCCCS Statewide HIE Integration Plan (SHIP)	$986,568	6%
Total AHCCCS Funding	**$7,774,312**	**49%**
Health Plans (Data Management Fees)	$1,963,510	12%
Transitioning Clinical Practice Initiative (TCPI)	$4,030,620	25%
Hospitals (Data Management Fees)	$1,818,380	12%
Other Income (In-kind donations, interest, Summit revenue, etc.)	$219,667	1%
Total Other Funding	**8,032,177**	**51%**
All Funding was Direct Total	**$15,806,489**	
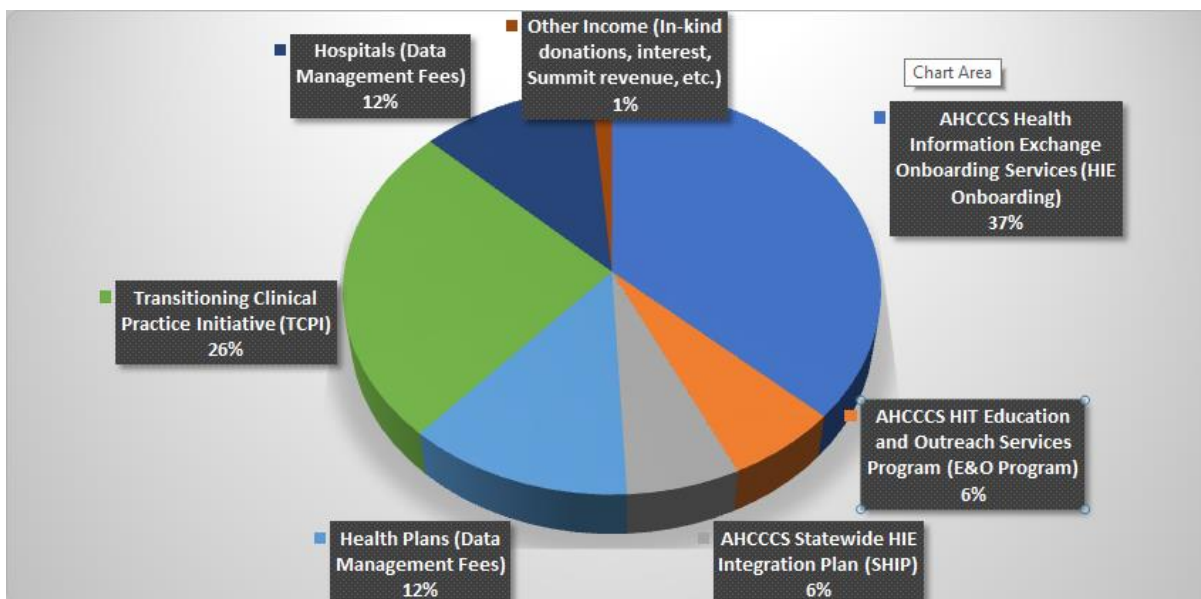
Other Benchmarks -
The chart below is a summary of the monthly report we get from Health Current which summarizes:

Section 4.2.8.1 - HIE Monthly Total Number of Signed Agreements

Section 4.2.8.2 - Medicaid HIE Onboarding Participants

Section 4.2.8.4 – Total Number of Active Portal Users

Section 4.2.8.5 - Total Number of Patients Access Via the Portal

Section 4.2.8.6 –Total Number of HL7 V2 Transactions Received by Type

Section 4.2.8.7 – Total Patients with Clinical Information in the HIE

Section 4.2.8.8 – The Number of People in the Master Patient Index

As of February 2019

MONTHLY

| 4.2.8.1 - HIE Monthly Total Number of Signed Participation Agreements
4.2.8.2 - HIE Monthly Total Signed Participation Agreements, Onboarding Amendments and SHIP Agreements by Organization Type | |

	All Time Participation Totals through February 28, 2019						
Organization Type	Total Signed Participation Agreements	HIE Onboarding Amendments Signed	SHIP Participants w/ Signed SHIP Subsidy	Total Medicaid Participants	Total Other Participants	% Medicaid Participants	% Other Participants
Accountable Care Organizations (ACOs) & Clinically Integrated Networks (CINs)	15	0	0	0	15	0%	100%
Behavioral Health Provider	79	11	58	79	0	100%	0%
Community Provider	274	142	0	264	10	96%	4%
Emergency Medical Services (EMS)	18	4	0	4	14	22%	78%
Federally Qualified Health Center (FQHC) & Rural Health Clinics	21	17	4	21	0	100%	0%
Health Plans	17	0	0	0	17	0%	100%
Hospitals and Health Systems	53	52	0	52	1	98%	2%
Laboratories, Imaging Centers and Pharmacies	5	3	0	3	2	60%	40%
Long-Term and Post-Acute Care	87	57	0	57	30	66%	34%
State and Local Government Agency (includes corrections)	7	1	2	3	4	43%	57%
Grand Total	576	287	64	483	93	84%	16%

| 4.2.8.3.1 - 4.2.8.3.6 - HIE Monthly

Rolling 12-month Operational Statistics by Milestone
(See Table A pages 26-28 of RFP for complete Milestone descriptions) | |

4.2.8.4 - HIE Monthly	A monthly total of the number of individual active Portal users.
Total Active Portal Users	

Section 4.2.8.4 – Active Portal Users

Each access of a patient record via the Portal is logged in the audit files, this entry includes date and time as well as the identity of the user accessing the records.

The audit files are the primary input for this total with the audit report providing an unduplicated count as to the number of users accessing at least 1 patient record.

February 2019 Total Individual Active Portal Users: 1,042

4.2.8.5 - HIE Monthly	A monthly total of the number of patients accessed via the Portal
Total Patients Accessed via Portal	

Section 4.2.8.5 – Patients accessed via the Portal

Each access of a patient record via the Portal is logged in the audit files, this entry includes date and time as well as the identity of the user accessing the records.

The audit files are the primary input for this total with the audit report providing a count as to the number of patients accessed; this count may include multiple accesses to the same patient at different dates and times or by different end users. Health Current is unable to report Medicaid only

transactions, therefore the statics reported includes all patients.

February 2019 Total Number of Patients Accessed via Portal: 105,455

4.2.8.6 - HIE Monthly **Total HL7 v2 Transactions Received by Type**	The monthly total of the number of HL7 V2 transactions received by the Contractor (Health Current) including Admissions, Discharges and Transfers, laboratories, Radiology, Transcription and CCDs received by the Contractor.

Section 4.2.8.6 – HL7 v2 transactions received

Each HL7 v2 transaction received by the HIE is captured and stored within transaction type (ADT, Lab, Rad & Transcription) specific tables in the system's primary database. Each transaction type is received at the HIE via a dedicated data channel containing only that transaction type from a specific provider. Each recorded transaction contains, among many elements, the identity of its source, the type of transaction, the date and time received and the patient's identity. These database tables are the primary input for these counts.

- o Each ADT Transaction received contains a message type code identifying the event (e.g. admission, discharge, transfer or registration). The report producing the monthly totals counts each transaction once.
- o Each Laboratory Result transaction received may contain multiple individual lab tests. The report producing the monthly totals counts each Lab Result transaction once even though it may have contained multiple individual test results.
- o Each Radiology Result transaction received may contain multiple individual radiology tests. The report producing the monthly totals counts each Radiology Result transaction once even though it may have contained multiple individual test results.
- o Each Transcription transaction received contains a code identifying the type of document contained in the transaction. The report producing the monthly totals counts each Transcription transaction once.

Section 4.2.8.6 – CCD transactions received

CCD transactions are received by the HIE in two (2) different standards-based formats, HL7 v3 and Consolidated Clinical Document Architecture (C-CDA). Each CCD transaction type is received at the HIE via a dedicated data channel containing only that CCD type from a specific provider and is recorded in a database table specific to that CCD type. Each recorded transaction contains, among many elements, the identity of its source, the type of transaction, the date and time received and the patient's identity. These database tables are the primary input for this count and report producing this total counts each CCD transaction once.

February 2019 Total HL7 V2 and CCD Transactions Received: 19,205,705
(February 2019 HL7 V2 transactions received: 17,450,043 - February 2019 CCD transactions received: 592,394)

4.2.8.7 - HIE Monthly	The total number of patients with clinical information in the HIE.
Total Patients with Clinical Information Residing in HIE	

Section 4.2.8.7. - Total Number of patients with clinical data This count represents the number of unique patients in the Master Patient Index (MPI) who have some level of clinical data in their longitudinal patient record. This count is generated from reading the MPI and counting each unique patient identity where some level of clinical data (e.g. lab result, radiology results, transcribed document, medication list, problem list, allergies, immunizations) has been received for that patient from at least one provider organization.

Total Number of Patients with Clinical Information in the HIE: 9,022,510

4.2.8.8 - HIE Monthly	The total number of people in the Master Patient Index.
Total People in Master Patient Index	

Section 4.2.8.8 – Total number of patients in the Master Patient Index (MPI) This count represents the number of unique patients in the Master Patient Index (MPI) regardless of the presence of clinical data for that patient. This count is generated from reading the MPI and counting each unique patient identity. (Health Current is unable to report Medicaid only transactions, therefore the statics reported incudes all patients).

Total Number of People in the Master Patient Index: 10,430,164

(Section E3 Continued – Annual Benchmarks for SMA Goals)

HIE Onboarding Program for Medicaid Providers for FFY 2019, FFY 2020 and FFY 2021

As the HIE matures, we needed to expand the type of interfaces that are available to participants, so the table below is an updated summary from Health Current of their available interfaces and grouped under Milestones of the HIE Onboarding Program. Due to an increase in the number of Medicaid providers that have joined Health Current, the agency will be submitting an updated HITECH IAPD in June, 2019 to address its need for increased HIE funding, as well as for additional contracts and services for FFY 2019 – FFY 2021**.**

The Milestones of the HIE Onboarding program remain almost exactly the same but the options and types of interface work has been expanded :

Milestone 1: Recruitment
It includes all recruitment activities, fully executed agreements, patient consent guidance and individual organization's assessment and options for bi directional HIE connectivity with workflow review and redesign support.

Milestone 2: Participant Data to the HIE (One-Way Interface Development)
A Milestone 2 payment (options A-H below) will be made to the Contractor when one-way connectivity between a Medicaid Provider (Participant) and the Contractor has been established, resulting in the submission of data from the Participant to the HIE. If the Medicaid Provider is an entity that operates more than one electronic health record ("EHR") system or one or more instance of the same EHR, resulting in the implementation of multiple interfaces, then multiple Milestone 2 payments (options A-H below) may be made. A Milestone 2 payment (options I-O below) will be made to the Contractor when the Medicaid Provider that already has an established interface needs adjustments to the interface to be completed to send more comprehensive and complete data to the HIE, or to make other adjustments to be in compliance with Medicaid HIE requirements. If multiple adjustments need to be made to multiple interfaces within a single entity, then multiple Milestone 2 payments (options I-O below) may be made.

For Milestone 3: **Health Current Data to Participant** (One-Way Interface Development or Service Implementation) A Milestone 3 payment (options A-G below) will be made when an interface is developed to allow HIE data to flow to the Participant's EHR or when the Alerts & Notifications service is implemented. If the Medicaid Provider is an entity that operates more than one EHR system or more than one instance of the same EHR system, then multiple Milestone 3 payments may be made. A Milestone 3 payment (options H-I below) will be made to the Contractor when a Medicaid Provider that already has an established interface needs adjustments to the interface to be completed to receive more comprehensive and complete data from the HIE, or to make other adjustments to be in compliance with Medicaid HIE requirements, or if the Participant desires an interface to receive HIE data in addition to having established Alerts & Notifications.

Milestone 4: Participant Administrative Offset Payments - The Contractor will receive administrative offset payments to be passed through directly to the Medicaid Providers upon achievement of Milestones 1, 2 and 3.

AHCCCS will pay the Contractor, based upon the payment schedule below, and the Contractor shall pay this entire amount in a one-time administrative offset payment directly to the Medicaid Provider. The Contractor shall retain NO PORTION OF THIS PAYMENT.

For the purpose of the HIE Onboarding Program for Medicaid, Milestone 4 payments are dependent on the number of providers within an Eligible Participant organization. A "provider" is defined as a doctor of allopathy (MD), doctor of osteopathy (DO), nurse practitoner (NP) or physician assistant (PA). Other types of Medicaid Providers may be considered in these calculations, upon written approval by AHCCCS. AHCCCS can adjust these payments as it deems necessary. Offeror does not need to provide pricing for this Milestone.

Milestone 5: Optional Meaningful Use Support Services
The optional Milestone 5 payment will be made when an Eligible Medicaid Provider establishes one or more of the optional connectivity services listed under "Milestone 5: Optional Meaningful Use Support Services". Multiple Milestone 5 payments may be made for each Eligible Medicaid Provider, as long as the Eligible Medicaid Provider requires multiple connection options under Milestone 5 to meet Meaningful Use requirements

A Milestone 5 payment (options A-G below) will be made if documented by the Contractor based on the need of the Medicaid Provider. A Milestone 5 payment (option H below) will be made if documented by the Contractor based on the need of the Medicaid Provider and approved by AHCCCS in writing.

Table 49: Proposed HIE Onboarding Program Milestones

healthcurrent

HIE Onboarding Program	
FFY 2019 through FFY 2021	
Milestones & Options	

Milestone 1: Recruitment

Recruitment of Medicaid Provider

Includes all recruitment activities, fully executed agreements, patient consent guidance, and individual organization's assessment and options for bi-directional HIE connectivity with workflow review and redesign support.

A Milestone 1 payment will be made to the Contractor once a Medicaid Provider signs a Participation agreement with the Contractor.

Milestone 2: Participant Data to the HIE (One-Way Interface Development)

A Milestone 2 payment (options A-H below) will be made to the Contractor when one-way connectivity between a Medicaid Provider (Participant) and the Contractor has been established, resulting in the submission of data from the Participant to the HIE. If the Medicaid Provider is an entity that operates more than one electronic health record ("EHR") system or one or more instance of the same EHR, resulting in the implementation of multiple interfaces, then multiple Milestone 2 payments (options A-H below) may be made. A Milestone 2 payment (options I-O below) will be made to the Contractor when the Medicaid Provider that already has an established interface needs adjustments to the interface to be completed to send more comprehensive and complete data to the HIE, or to make other adjustments to be in compliance with Medicaid HIE requirements. If multiple adjustments need to be made to multiple interfaces within a single entity, then multiple Milestone 2 payments (options I-O below) may be made.

A.	Interface Development: HL7 v2 Data Feed for all transactions types
B.	Interface Development: HL7 v3 or CCDA Data Feed for all transactions types
C.	Interface Development: HL7 v2 Data Feed for ADT transactions only plus Interface Development of Query Response (non-eHealth Exchange) to supply the remaining laboratory, radiology and transcription transactions
D.	Interface Development: HL7 v3 or CCDA Data Feed for ADT transactions only plus Interface Development of Query Response (non-eHealth Exchange) to supply the remaining laboratory, radiology and transcription transactions
E.	Interface Development: HL7 v2 Data Feed for ADT, laboratory and radiology transactions plus Interface Development of Inbound using XDS.b protocol for all transcribed documents
F.	Interface Development: HL7 v3 or CCDA Data Feed for ADT, laboratory and radiology transactions plus Interface Development of Inbound using XDS.b protocol for all transcribed documents
G.	Interface Development: Direct Secure Email with CCDA/CCD encounter summary
I.	Conversion from A to B: (A) HL7 v2 Data Feed for all transaction types → (B) HL7 v3 or CCDA Data Feed for all transaction types

J.	Conversion from A to C: (A) HL7 v2 Data Feed for all transaction types → (C) HL7 v2 ADT transactions only plus Interface Development of Query-Response (non-eHealth Exchange) to supply the remaining laboratory, radiology and transcription transactions
K.	Conversion from A to D: (A) HL7 v2 Data Feed for all transaction types → (D) HL7 v3 or CCDA - ADT transactions only plus Interface Development of Query-Response (non-eHealth Exchange) to supply the remaining laboratory, radiology and transcription transactions
L.	Conversion from A to E: (A) HL7 v2 Data Feed for all transaction types → (E) HL7 v2 for ADT, laboratory and radiology transactions plus Interface Development of Inbound using XDS.b protocol for all transcribed documents
M.	Conversion from A to F: (A) HL7 v2 Data Feed for all transaction types → (F) HL7 v3 or CCDA for ADT, laboratory and radiology transactions plus Interface Development Inbound using XDS.b protocol for all transcribed documents
N.	Conversion from C to E: (C) HL7 v2 for ADT transactions only plus Interface Development of Query-Response (non-eHealth Exchange) to supply the remaining laboratory, radiology and transcription transactions → (E) HL7 v2 for ADT, laboratory and radiology transactions plus Interface Development of Inbound using XDS.b protocol for all transcribed documents
O.	Conversion from C to F: (C) HL7 v2 for ADT transactions only plus Interface Development of Query-Response (non-eHealth Exchange) to supply the remaining laboratory, radiology and transcription transactions → (F) HL7 v3 or CCDA for ADT, laboratory and radiology transactions plus Interface Development of Inbound using XDS.b protocol for all transcribed documents

Milestone 3: **HIE Data to the Participant (One-Way Interface Development or Service Implementation)**

A Milestone 3 payment (options A-G below) will be made when an interface is developed to allow HIE data to flow to the Participant's EHR or when the Alerts & Notifications service is implemented. If the Medicaid Provider is an entity that operates more than one EHR system or more than one instance of the same EHR system, then multiple Milestone 3 payments may be made. A Milestone 3 payment (options H-I below) will be made to the Contractor when a Medicaid Provider that already has an established interface needs adjustments to the interface to be completed to receive more comprehensive and complete data from the HIE, or to make other adjustments to be in compliance with Medicaid HIE requirements, or if the Participant desires an interface to receive HIE data in addition to having established Alerts & Notifications.

A.	Interface Development: HL7 v2 Data Feed (all transaction types)
B.	Interface Development: HL7 v3 or CCDA Data Feed (all transaction types)
C.	Interface Development: eHealth Exchange Query-Response
D.	Interface Development: Non-eHealth Exchange Query-Response
E.	Alerts & Notifications: Direct Secure Email & HIE Portal included, but not required
F.	Interface Development: Direct Secure Email with CCDA/CCD encounter summary
G.	Interface Development: Vendor hosted cloud-based service receiving a CCDA/CCD encounter summary via a single interface
H.	Conversion from E to C: (E) Alerts & Notifications (may include Direct Secure email & HIE Portal) → (C) eHealth Exchange Query-Response
I.	Conversion from E to D: (E) Alerts & Notifications (may include Direct Secure Email & HIE Portal) → (D) Non-eHealth Exchange Query-Response

Milestone 4: Participant Administrative Offset Payments

The Contractor will receive administrative offset payments to be passed through directly to the Medicaid Providers upon achievement of Milestones 1, 2 and 3.

AHCCCS will pay the Contractor, based upon the payment schedule below, and the Contractor shall pay this entire amount in a one-time administrative offset payment directly to the Medicaid Provider. The Contractor shall retain NO PORTION OF THIS PAYMENT.

For the purpose of the HIE Onboarding Program for Medicaid, Milestone 4 payments are dependent on the number of providers within an Eligible Participant organization. A "provider" is defined as a doctor of allopathy (MD), doctor of osteopathy (DO), nurse practitioner (NP) or physician assistant (PA). Other types of Medicaid Providers may be considered in these calculations, upon written approval by AHCCCS. AHCCCS can adjust these payments as it deems necessary. Offeror does not need to provide pricing for this Milestone. The Participant Administrative Offset Payments are as follows:

A.	Hospital Administrative Offset Payment
B.	FQHC, FQHC Look-Alike & Rural Health Clinic Administrative Offset Payment
C.	Community Provider Administrative Offset Payment (practices of 1 to 10 providers)
D.	Community Provider Administrative Offset Payment (practices of 11 to 25 providers)
E.	Community Provider Administrative Offset Payment (practices of 26+ providers)

Milestone 5: Optional Meaningful Use Support Services

The optional Milestone 5 payment will be made when an Eligible Medicaid Provider establishes one or more of the optional connectivity services listed under "Milestone 5: Optional Meaningful Use Support Services". Multiple Milestone 5 payments may be made for each Eligible Medicaid Provider, as long as the Eligible Medicaid Provider requires multiple connection options under Milestone 5 to meet Meaningful Use requirements.

A Milestone 5 payment (pptions A-G below) will be made if documented by the Contractor based on the need of the Medicaid Provider. A Milestone 5 payment (option H below) will be made if documented by the Contractor based on the need of the Medicaid Provider and approved by AHCCCS in writing.

A.	Direct Accounts Only (for transport between providers)
B.	Public Health: Immunizations
C.	Public Health: Reportable Labs
D.	Public Health: Syndromic Surveillance
E.	Public Health: Disease Registries (per registry)
F.	Specialized Registries (ie. Controlled Substances Prescription Drug Monitoring, Advanced Directives, etc)
G.	Miscellaneous Service - TBD

Data Source: Health Current May, 2019

E.4 Annual Benchmarks for Audit and Oversight Activities

(SMHP Companion Guide Question E #4)

AHCCCS is committed to ensuring program integrity and conducting comprehensive audit and oversight activities. AHCCCS updated its PI Program Audit Strategy and received CMS approval on the new Audit Strategy in April, 2019. This ensures the SMA is overseeing the EHR Program.

The PI Program includes a significant number of requirements, many of which are evaluated prior to payment by the Arizona Electronic Health Record (EHR) Incentive Program staff. Pre-payment evaluations by EHR Program staff include review of provider compliance with requirements for:

- Hospital -based status, Medical license status, and Provider type

- Valid payee information and Medicaid patient volume or needy individual patient volume

- Valid CMS Certification ID for the certified EHR technology (CEHRT);

- Limit of one payment per provider per year (completed in conjunction with CMS); and

- Licensure exclusion status both in Arizona and other states, if applicable.

In addition to pre-payment checks, the SMA performs post-pay audits on random samples by program year according to our risk stratification strategy contained in our approved Audit Strategy. The table below is a summary of our post-pay audit benchmarks.

Table 50: Predicted Audit and Oversight (under existing Audit Strategy, Version 9)

Predictive Audit and Oversight Cumulative Annual Benchmarks					
	Program Year 2011 (PY11)	Program Year 2012 (PY12)	Program Year 2013 (PY13)	Program Year 2014 (PY14)	Program Year 2015 (PY15)
Eligible Professionals (EP)	128	138	136	120	79
Eligible Hospitals (EH)	75 total year 1 hospitals in various program years. MU EH selection TBD.				

Data Source: Post-payment Audit Team – OIG AHCCCS, January, 2019

EPs - PY 2011 (AIU) total = 128

EPs – PY 2012 (AIU) total = 104

EPs – PY 2013 (AIU) total = 68

EPs – PY 2014 (AIU) total = 39

EPs – PY 2015 (AIU) total = 27

EPs – PY 2012 (MU) total = 34

EPs – PY 2013 (MU) total= 68

EPs – PY 2014 (MU) total= 81

EPs – PY 2015 (MU) total= 52

Section:F Appendices

Appendix	Item
F.1	Acronyms
F.2	Description of AHCCCS Executive Offices and Divisions
F.3	Flexibility Amendment Planning and Approval
F.4	Section F.4 Health Current Audited Financial Statement (Separate Attachment) Please note that the following appendix is not included in this document due to size and can be viewed separately.
F.5	Section F.5 Identifies the priority Arizona behavioral health community providers who have been designated by the Statewide HIE Integration Plan (SHIP) to be integrated into the statewide health information exchange. Arizona's three Regional Behavioral Health Authorities have funded this integration.
F.6	Section F.6 Provides a listing of contracted participants, by count and type, that are members of Health Current, the state level health information exchange.
F.7	Section F. 7 Health Current Strategic Plan

Appendix F.1: Acronyms

Acronym	Definition
ACC	AHCCCS Complete Care
ACE	AHCCCS Customer Eligibility
ADHS	Arizona Department of Health Services
AHCCCS	Arizona Health Care Cost Containment System
AHRQ	Agency for Healthcare Research and Quality
AI / AN	American Indian / Alaska Native
AIU / AIU1	Adoption, Implementation or Upgrade; AIU for first year
API	Application Programming Interface
ARRA	American Recovery and Reinvestment Act
ASIIS	Arizona Statewide Immunization Information System
ASET	Arizona Strategic Enterprise Technology
ASU-BMI	Arizona State University's Department of Biomedical Informatics
CAH	Critical Access Hospital
CDA	Clinical Document Architecture
C-CDA	Consolidated Clinical Document Architecture
CCDS	Common Clinical Data Set
CCN	CMS Certification Number
CDS	Clinical Decision Support
CEHRT	Certified Electronic Health Record Technology (current version 2015 Edition)
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program (also known as KidsCare in Arizona)
CIO	Chief Information Office
CMS	Centers for Medicare and Medicaid Services
CSPMP	Controlled Substance Prescription Monitoring Program
CQM	Clinical Quality Measure
CY	Calendar Year (used by Eligible Professionals)
DBF	Division of Business & Finance
DEA	Drug Enforcement Agency
DFSM	Division of Fee for Service Management
DHCM	Division of Health Care Management
DSH	Disproportionate Share Hospital Report
eCR	Electronic Case Reporting
eICR	Electronic Initial Case Report
EFT	Electronic Funds Transfer
EIN	Employer Identification Number
EH	Eligible Hospital
EHI	Electronic Health Information
EHR	Electronic Health Record
EHR IP	Electronic Health Record Incentive Program
EP	Eligible Professional
EPCS	Electronic Prescribing of Controlled Substances
ePIP	Electronic Provider Incentive Payment System
FDASIA	Food and Drug Administration Safety and Innovation Act
eRx	Electronic Prescribing

Acronym	Definition
FFY	Federal Fiscal Year (used by Eligible Hospitals in the PI Program)
FHIR	Fast Healthcare Interoperability Resources (standard for electronic health record exchange)
FQHC	Federally Qualified Health Center
FTP	File Transfer Protocol
FY	Fiscal Year (used by Hospitals)
HIE	Health Information Exchange
HIN	Health Information Network
HIPAA	Health Insurance Portability and Accountability Act of 1996 (version 2.0 pending)
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health Act
HIX	Health Insurance Exchange
HL7	Health Level 7 (Interface Programming Language in Health Care)
HSAG	Health Services Advisory Group
HRSA	Health Resources Services Administration
I&A	CMS Identity & Access Management
IAPD	Implementation Advanced Planning Document
ICD-9/10	International Classification of Diseases
IHS	Indian Health Services
ISA	Interoperability Standards Advisory
ITU	IHS, Tribal & Urban Indian Health Facilities (also referred to as IHS and 638 tribally Operated Facilities)
LEIE	List of Excluded Individuals/Entities
MCO	Managed Care Organization
MCR	Medicare Cost Report
MED	Medicare Exclusion Database
MU/MU1	Meaningful Use; Meaningful Use for first year
MMIS	Medicaid Management Information Systems
NIHB	National Indian Health Board
NLR	National Level Repository; also known as CMS Registration & Attestation System
NIST	National Institute of Standards and Technology
NPI	National Provider Identifier
NPPES	National Plan & Provider Enumeration System
NPRM	Notice of Proposed Rule Making
OALS	Office of Administrative legal Services
OAH	Office of Administrative Hearings
OIG	Office of Inspector General
ONC	Office of the National Coordinator for Health Information Technology
ONC-AA	ONC Approved Accreditor
ONC-ACB	Office of the National Coordinator Authorized Certification Body
ONC-ATL	Office of the National Coordinator Authorized Testing Laboratory
OTP	Opioid Treatment Provider
PA	Physician Assistant
PHSA	Public Health and Service Act
PI	Promoting Interoperability
PMMIS	Prepaid Medicaid Management Information System

Acronym	Definition
R&A	CMS Registration and Attestation System
REC	Regional Extension Center
RHBA	Regional Behavioral Health Authority
RHC	Rural Health Clinic
RPMS	Resource and Patient Management System
SHIP	Statewide HIE Integration Plan
SMA	State Medicaid Agency
SME	Subject Matter Expert
SMHP	State Medicaid Health Information Technology Plan
SSI	Supplemental Security Income
TEFCA	Trusted Exchange Framework and Common Agreement
TIN	Taxpayer Identification Number; (Also see Payee TIN)
USCDI	United States Core Data for Interoperability

Appendix F.2: Description of AHCCCS Executive Offices and Divisions

	Executives - Office of the Director
Director	The Director has overall responsibility for ensuring that the Agency meets the goals established in the Agency strategic plan and insures that the organization has the administrative infrastructure to meet the needs of the Agency. The Director provides strategic direction and manages high level, critical issues for the Agency at the local, state and federal levels. Through the Executive Staff, the Director manages all aspects of the Agency's business processes and is responsible for implementing and developing administrative policies and procedures to support the delivery of health care services for over one million AHCCCS members.
Deputy Director – Business Operations	Under the general direction of the Agency Director, the Deputy Director of Business Operations acts as full authority as AHCCCS Director in the Director's absence or at her/his designation and represents the Agency among a wide range of Agency stakeholders. The Deputy Director of Business Operations is responsible for providing counsel and recommendations to the Director on Agency issues and programs.
Deputy Director – Health Plan Operations	Under the general direction of the Agency Director, the Deputy Director of Health Plan Operations acts as full authority as AHCCCS Director in the Director's absence or at her/his designation and represents the Agency among a wide range of Agency stakeholders. The Deputy Director of Health Plan Operations is responsible for providing counsel and recommendations to the Director on Agency issues and programs.
Chief Medical Officer	The Chief Medical Officer (CMO) oversees the quality and delivery of healthcare services provided by AHCCCS health plans and contractors. The Chief Medical Officer approves AHCCCS medical policies and assures the appropriate evaluation of the health plan's and contractor's compliance. The CMO can serve as an expert witness on behalf of AHCCCS and the state on legal and regulatory matters involving the provision of medical care services and assists in evaluating and resolving member and provider grievances if they were not resolved at lower levels.
	Divisions Reporting to the Director of AHCCCS
	Office of Inspector General Deputy Director Business Operations Deputy Director Health Plan Operations Chief Medical Officer Administrative Legal Services Community Advocacy and Intergovernmental Relations Human Resources and Development Continuous Improvement Project Manager

Divisions Reporting to the Deputy Director of Business Operations of AHCCCS

Business and Finance
Member Services
Information Services
Health Information Technology
Project Manager

Divisions Reporting to the Deputy Director of Health Plan Operations of AHCCCS

Health Care Management – Finance, Rate Development and Data
Health Care Management – Clinical and Operation
Fee for Service Management
Chief Legislative Liason
Project Manager

Divisions Reporting to the Chief Medical Officer of AHCCCS

Clinical Services
Clinical Initiatives Project Managers

Flexibility Application Page 1of 5

AHCCCS
Arizona Health Care Cost Containment System

Janice K. Brewer, Governor
Thomas J. Betlach, Director

October 30, 2014

Hye Sun Lee
Acting Regional Administrator
Centers for Medicare and Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, California 94103-6706
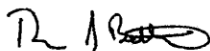
RE: Arizona 2014 Flexibility Rule Changes for SMHP

Dear Ms Lee:

ONC released a final rule that allows providers participating in the EHR Incentive Programs to use the 2011 Edition of certified electronic health record technology (CEHRT) for calendar and fiscal year 2014. The rule grants flexibility to providers who are unable to fully implement 2014 Edition CEHRT for an EHR reporting period in 2014 due to delays in 2014 CEHRT availability. Providers may now use EHRs that have been certified under the 2011 Edition, a combination of the 2011 and 2014 Editions, or the 2014 Edition for 2014 participation.

State Medicaid Agencies were required to submit by November 1st 2014 a description of how it will accommodate providers who choose this option when attesting for the EHRS Incentive Program. Attached please find the state of Arizona's 2014 State Medicaid HIT Plan amendment as required. Please contact Lorie Mayer at Lorie.Mayer@azahcccs.gov or (602) 417-4420 should you have any questions or need any additional information.

Sincerely,

Thomas J. Betlach
Director

cc: Stephen Chang, Region 9 HITECH Rep
        Robert McCarthy, HITECH Contact

801 East Jefferson, Phoenix, AZ 85034 • PO Box 25520, Phoenix, AZ 85002 • 602-417-4000 • www.azahcccs.gov

AHCCCS
Arizona Health Care Cost Containment System

Janice K. Brewer, Governor
Thomas J. Betlach, Director

SMHP Addendum for Implementation of the 2014 Flexibility Rule:
Arizona EHR Incentive Program

On October 1, 2014 a new Flexibility Rule went into effect for Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. The Rule outlines changes to Program Year 2014 attestation submissions, centering on increased flexibility around 2014-certified EHR technology and how providers can demonstrate Meaningful Use (MU). The Arizona EHR Incentive Program is committed to offering eligible providers the flexibility provided to them in the Final Rule.

Arizona is not anticipating substantial changes to the attestation process; however, the changes that are needed are still considered a major system build and will therefore take time to implement. Arizona is anticipating that the Rule will be implemented in March 2015 so that providers who meet the Flexibility requirements can complete attestations at that time. Stage 1 and Stage 2 will be open for attestation prior to February; however, only the original 2014 requirements will be accessible.

System Changes

AHCCCS is planning the following system changes in order to accommodate the Flexibility Rule:
- Creation of a Certified EHR Technology (CEHRT) selection screen for providers to supply relevant CEHRT number(s)
- Creation of a Flexibility "pathway" screen that builds upon the CEHRT screen entry – providers will be presented with all possible attestation options based on the CEHRT number(s) submitted
- Creation of a Flexibility statement that clearly outlines the reasons that an EP may choose to meet Meaningful Use using the Flexibility option
- Reintroduction of Program Year 2013 Stage 1 Meaningful Use attestation that is linked from the pathway screen described above
- Logic changes around CEHRT requirements and Participation exceptions (e.g. more than two years of Stage 1 = ok)
- Linking the 2014 system to the pathway screen

AHCCCS does not use a vendor for EHR attestations. The AHCCCS Information Services Division (ISD) built and maintains the Electronic Provider Incentive Payment (ePIP) system where providers can electronically submit their EHR attestation. ePIP is one of many high-level priorities for ISD; while maintenance and system changes are scheduled as quickly as possible, the ISD resources must remain balanced for all AHCCCS systems and programs. AHCCCS considered processing manual (paper) attestations prior to system implementation; however, there were two concerns that ultimately led to the decision to wait for the automated system: 1) paper-based processing is counter-intuitive the underlying purpose of the EHR Incentive Program and 2) systematic checks to ensure compliance as well as long-term tracking/documentation would be limited, increasing Agency risk for improper payments and incomplete audit trails.

Planning meetings regarding needed system changes have been under way since the Notice of Proposed Rule was released. All requirements have been outlined and system changes are underway. The programming is expected to take two months, followed by both internal and external testing before the new attestation system is moved to production.

Attestation Process

AHCCCS is not anticipating much change to the attestation process. Once system changes are in place, providers will be able to access ePIP as they normally would in order to complete an attestation. AHCCCS is concerned about provider's knowledge of the Flexibility changes and what each option entails. Extensive education will be made available on the AHCCCS website and via the Arizona EHR Program Hotline and Email Inbox. Arizona is also

considering other methods of outreach to provide education on the Flexibility requirements and attestation process; however, final decisions have not yet been made.

Extended Tail Period

Due to the programming complexities of the Flexibility Rule and the associated timeline for ISD staff to complete the work, AHCCCS would like permission to extend the Program Year 2014 Attestation Tail Period through June 2015 for Eligible Professionals (EPs). If approved, it would allow providers three months to complete their attestations and also provide enough time to offer technical assistance if providers are uncertain about the Flexibility Rule and related attestation process.

AHCCCS is also seeking approval to extend the Eligible Hospital (EH) attestation tail period. While the vast majority of attestation data comes directly from CMS via attestations that EHs complete with them, there is still a need to EHs to upload proof of Medicaid eligibility. At this time, ePIP cannot accept EH data due to system enhancements that are under way. With such in mind, the requested tail period for EHs is through March 2015.

Pre-Payment Review Process

AHCCCS is not anticipating major change to the pre-payment review process. All attestations will go through a thorough review to ensure that providers meet the qualifications and requirements outlined in the Final Rule. Review staff will be trained on all attestation scenarios outlined in the Final Rule to ensure efficient review of each attestation, regardless of which option the provider selected. Attestations will be compared against federal requirements related to the chosen attestation type along with Agency Business Intelligence data to assure attestation reasonableness.

Additionally, for those EPs who opt to meet Meaningful Use via the Flexibility pathway, AHCCCS will develop a policy that describes validation of provider eligibility/options related to CMS Flexibility guidance.

Post-Payment Audit Process

AHCCCS is not anticipating major changes to the post-payment audit process. AHCCCS aligns its EHR audit protocols with issued CMS guidance. Risk assessment will be conducted during the pre-payment review process; EHR auditors will review those assessments along with other elements that AHCCCS considers when selecting audits. Providers that do not fall into a high-level risk category will be randomly selected for a desk-level audit. If a provider audit cannot be completed at the desk-level or the concerns are great enough to warrant such, onsite audits will be conducted.

Protocols specific to the attestation type will be applied for the audit process as is standard practice currently. AHCCCS will review its current Audit Strategy and revise as needed to incorporate risk factors and audit elements related to Flexibility. AHCCCS will review all guidance issued from CMS, including any updates to the Audit Strategy Toolkit and Community of Practice discussions.

Appeal Process

There will be no change to the Appeal Process. If AHCCCS issues a rejection or denial for any reason (including not meeting Flexibility requirements), the provider will be given the standard 30-day timeframe to request a hearing.

Summary

AHCCCS will fully implement Flexibility Rule requirements over the next four months; it is anticipated that the Final Rule will be fully implemented in March 2015. The majority of changes will be to the attestation system (ePIP), with limited impact to ongoing administrative processes. All staff will be fully trained on each attestation type as well as what is considered acceptable supporting documentation for each. Additionally, the system will allow for a selection of attestation options that either currently exist or have existed in previous years for the Program; review protocols will not deviate from pre-established processes. If an unforeseen barrier does arise,

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AHCCCS will seek technical assistance from the appropriate CMS contact if the issue cannot be resolved by the Agency.

It was noted in a recent CMS All States call that additional guidance will be made available to states as they implement the Flexibility Rule. AHCCCS will review all issued guidance and incorporate any changes that do not aligned with the planned implementation strategy outlined above. AHCCCS looks forward to ongoing coordination related to Flexibility and appreciates any additional information that CMS may provide.

October 31, 2014

Arizona Checklist for 2014 CEHRT Flexibility Rule:

Flexibility Rule Changes Effective October 1, 2014		State Checklist - Implementation Status				
Subject	**Change**	**Target Date**	**Not Started**	**In Process**	**Complete**	**Notes**
SMHP/IAPD	Submit SMHP Addendum to CMS	Nov.1, 2014				HITECH mailbox; RO Director; RO Rep; Letter from Director to accompany addendum.
	Submit IAPD-U to CMS, if additional FFP needed	Nov. 2014				Additional funding for system build and changes in ePIP.
General Policy Changes	Review/update policies as it may relate to the Flexibility Rule	Jan. 2015		X		
	Determine parameters defining acceptable reasons that providers were unable to fully implement 2014 Edition CEHRT	Feb. 2015		X		Discuss – Review CMS Hardship Exemption criteria.
	Determine CEHRT verification process providers will use				X	Same as other.
	Review/update pre-payment verification documentation requirements	Jan. 2015		X		
Systems/ Infrastructure	Design system changes and develop system requirements	Nov. 2014		X		
	Develop system changes	Feb. 2015		X		
	Test system changes	Mar. 2015	X			
	Determine if attestation tail period needs extended	June 2015		X		
Outreach	Implement outreach strategy for stakeholders	March 2015		X		
	Provide training for SMA staff/vendors that field phone/email questions from providers	Ongoing		X		
Auditing	Update post-payment audit procedures to incorporate Flexibility Rule	April 2015	X			
	Review/update audit risk profile(s) to reflect Flexibility Rule	March 2015	X			

CMS Flexibility Approval

Subject: CMS Approval Arizona SMHP Addendum 1-20-15
Importance: High

Thank you for your letter, dated October 30, 2014, requesting that the Centers for Medicare & Medicaid Services (CMS) review and approve an addendum to the CNMI State Medicaid Health Information Technology Plan (SMHP). This SMHP addendum was submitted in response to our recent final rule at 79 FR 52910 (September 4, 2014), which grants flexibility to eligible providers who are unable to fully implement 2014 Edition certified electronic health record technology (CEHRT) for an EHR reporting period in 2014 due to delays in 2014 CEHRT availability.

CMS approves the addendum to Arizona's SMHP effective as of the date of this email transmission. Our approval of Arizona's addendum is subject to the provisions in regulations at 42 CFR Part 495 Subpart D.

Additionally, in the next SMHP submission, CMS requests Arizona:
1. Provide updates on when changes to policies will be completed as they relate to the Flexibility Rule.
2. Provide a description of any outreach efforts as they relate to the flexibility rule.
3. Provide updates on when system design changes and system requirements will be completed.
4. Provide updates on when additional information will be added as they relate to the risk profiles established in the Audit Strategy, in regards to the provider flexibility option.

Please note: the information included in this addendum must be incorporated into the next official SMHP submission and noted in a change control document specifying where in the SMHP the Addendum has been added.

If you have any questions or concerns regarding this information, please let me know.

Flexibility Rule

The Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) released a final rule in August 2014 that grants flexibility for providers who are unable to fully implement 2014 Edition certified electronic health record (EHR) technology (CEHRT) for the 2014 reporting year. Providers may use EHRs that have been certified under the 2011 Edition, 2014 Edition, or a combination of the 2011 and 2014 Editions to submit meaningful data for an EHR reporting period in 2014.

Only providers who have been unable to fully implement 2014 CEHRT can take advantage of the rule's flexibility options.

Providers will be required to report using 2014 Edition CEHRT beginning in 2015.

CEHRT Flexibility Resources

To help you understand the final rule's changes to 2014 participation, CMS has developed the following resources. Click the link to learn more.

Educational Resources: CMS has a number of resources to help you participate in the programs.

Final Rule: Regulation that grants flexibility to providers who are unable to fully implement 2014 Edition CEHRT for an EHR reporting period in 2014 due to delays in 2014 Edition CEHRT availability.

CEHRT Flexibility Decision Tool: Providers answer a few questions about their 2014 stage of meaningful use and Edition of EHR certification, and the tool displays the corresponding 2014 options.

2014 CEHRT Flexibility Chart: Chart provides a visual overview of CEHRT participation options for 2014.

2014 CEHRT Rule Quick Guide: Explains the participation options for 2014 based on the Edition of EHR certification providers used during 2014.

Medicaid EHR Incentive Program Flexibility Resources: Arizona has developed the following companion resources. Click the links to learn more.

The CMS 2014 Flexibility Rule is an option available to providers attesting to meaningful use. Vendor documentation is required to support use of the Flexibility Rule.

The CMS 2014 Flexibility Rule does not apply to providers attesting to Adopt, Implement or Upgrade (AIU). Providers attesting to AIU are required to meet the 2014 Edition certification criteria.

Flexibility Chart for Medicaid EPs: High-level overview of the CEHRT options available to providers due to the 2014 CHERT Flexibility Rule. Use in conjunction with the CMS CEHRT Flexibility Decision Tool.

Flexibility EHR Certification Number Guide for Medicaid EPs: High-level overview of the system's EHR Certification Number for the corresponding CEHRT option selected by the provider due to the 2014 CHERT Flexibility Rule. Use in conjunction with the CMS CEHRT Flexibility Decision Tool.

Click here to link to the CMS CEHRT Flexibility Decision Tool.

Disclaimer: The above tools were created as a service to the public and are not intended to grant rights or impose obligations. The information provided is only intended to be a general summary of the rule's flexibility options. It is not intended to take the place of the regulation.

Flexibility Rule

AHCCCS
Arizona Health Care Cost Containment System

Arizona Medicaid EHR Incentive Program
Flexibility Chart for Medicaid EPs
Applies to Attestations for Calendar Year 2014 ONLY

CMS 2014 CEHRT FLEXIBILITY RULE
PROVIDER IS ATTESTING TO MEANINGFUL USE FOR PROGRAM YEAR 2014

The CMS 2014 Flexibility Rule allows providers to meet Stage 1 or Stage 2 of meaningful use with EHRs certified to the 2011, 2011 & 2014 or 2014 Edition criteria for an EHR reporting period in 2014
Only providers who have not fully implemented 2014 Edition CEHRT can take advantage of the rule's flexibility options. Vendor documentation is required to support use of the Flexibility Rule

Step 1: Determine your system's certification Edition criteria obtained in 2014
Use the CMS CEHRT Flexibility Decision Tool
Contact your EHR Vendor if you do not know the certification Edition criteria *(2011, 2011 & 2014 or 2014 Edition)*

Pre Flexibility Rule Schedule MU Progression	Post Flexibility Rule Schedule MU Progression	Provider's Certified EHR Technology		
		2011 CEHRT	**2011 & 2014 CEHRT**	**2014 CEHRT**
Not Participating in the Program	AIU	Not Eligible Flexibility Rule Not An Option	Not Eligible Flexibility Rule Not An Option	2014 CEHRT Required Flexibility Rule Not An Option
Stage 1 2014 Definition of MU Measures	Stage 1 2013 Definition MU Measures	Flexibility Rule Option Vendor documentation required	Flexibility Rule Option Vendor documentation required	2014 CEHRT Required Flexibility Rule Not An Option
	Stage 1 2014 Definition MU Measures	Not Eligible Flexibility Rule Not An Option	Flexibility Rule Option Vendor documentation required	2014 CEHRT Required Flexibility Rule Not An Option
Stage 2 2014 Definition of MU Measures	Stage 1 2013 Definition MU Measures	Flexibility Rule Option* Vendor documentation required	Flexibility Rule Option* Vendor documentation required	2014 CEHRT Required Flexibility Rule Not An Option
	Stage 2 2014 Definition MU Measures	Not Eligible Flexibility Rule Not An Option	Flexibility Rule Option Vendor documentation required	2014 CEHRT Required Flexibility Rule Not An Option
	Stage 1 2014 Definition MU Measures	Not Eligible Flexibility Rule Not An Option	Flexibility Rule Option* Vendor documentation required	Flexibility Rule Option* Vendor documentation required

*Note that if provider is attesting Stage1 2013 Definition Mu Measures but is in Stage 2, this still counts as Stage 2 for the MU progression.

The CMS 2014 Flexibility Rule does not apply to providers attesting to Adopt, Implement or Upgrade (AIU)
Providers attesting to AIU are required to meet the 2014 Edition certification criteria

Step 2: Determine your EHR Certification Number for your CEHRT Edition from Step 1
Use the Flexibility Rule EHR Certification Number Guide for Medicaid EPs
Contact your EHR Vendor if you do not know your system's certification Edition criteria and/or and the corresponding EHR Certification Number

This reference was created as a service to the public and is not intended to grant rights or impose obligations. The information provided is only intended to be a general summary of the rule's flexibility options. It is not intended to take the place of the regulation.

EHR Certification Number Guide

Arizona Medicaid EHR Incentive Program
Flexibility EHR Certification Number Guide for Medicaid EPs
Applies to Attestations for Calendar Year 2014 ONLY

CMS 2014 CEHRT FLEXIBILITY RULE
PROVIDER IS ATTESTING TO MEANINGFUL USE FOR PROGRAM YEAR 2014

The CMS 2014 Flexibility Rule allows providers to meet Stage 1 or Stage 2 of meaningful use with EHRs certified to the 2011, 2011 & 2014 Edition criteria or 2014 Edition criteria for an EHR reporting period in 2014
Only providers who have not fully implemented 2014 Edition CEHRT can take advantage of the rule's flexibility options. Vendor documentation is required to support use of the Flexibility Rule

Step 1: Determine your system's certification Edition criteria obtained in 2014
Use the CMS CEHRT Flexibility Decision Tool
Contact your EHR Vendor if you do not know the certification Edition criteria (2011, 2011 & 2014 or 2014 Edition)

Step 2: Determine your EHR Certification Number for your CEHRT Edition from Step 1
Contact your EHR Vendor if you do not know your system's certification Edition criteria and/or and the corresponding EHR Certification Number

Vendor Released 2014 CEHRT by 12.31.2014 — YES / NO

Provider Installed 2014 CEHRT by 12.31.2014 — YES / NO

Provider Implemented 2014 CEHRT by 12.31.2014 — YES / NO

Vendor Released Hybrid CEHRT by 12.31.2014 — YES / NO

Provider on 2014 Edition CEHRT
Use
2014 EHR Certification Number

Provider on 2011 Edition CEHRT
Use
2011 EHR Certification Number

Provider on 2011-2014 Edition CEHRT
Use
2011-2014 EHR Certification Number

Provider on 2011 Edition CEHRT
Use
2011 EHR Certification Number
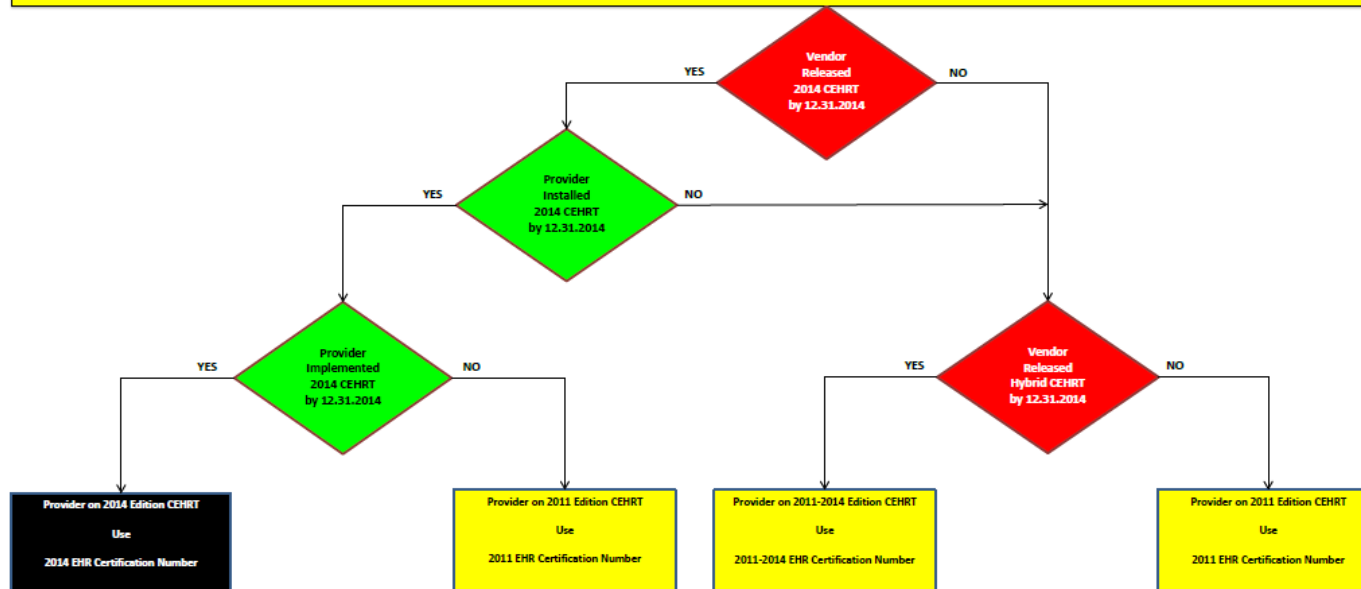
The CMS 2014 Flexibility Rule does not apply to providers attesting to Adopt, Implement or Upgrade (AIU)
Providers attesting to AIU are required to meet the 2014 Edition certification criteria

This reference was created as a service to the public and is not intended to grant rights or impose obligations. The information provided is only intended to be a general summary of the rule's flexibility options. It is not intended to take the place of the regulation.

Appendix F.4: HIE Financial Statements (Submitted Under Separate Cover)

healthcurrent

Statewide HIE Integration Plan (SHIP)

High Priority Providers for Connectivity

Health Current, formerly Arizona Health-e Connection (AzHeC), is *the* health information exchange (HIE) that helps partners transform care by bringing together communities and information across Arizona.

The Statewide HIE Integration Plan (SHIP) calls for integration of behavioral health information into the HIE. The three Arizona Regional Behavioral Health Authorities (RHBAs) have funded Health Current to connect the top 100 behavioral health providers listed below to the HIE by May 2018.

Behavioral Health – Community Providers (62)

A New Leaf
Arizona's Children Association
Arizona Counseling & Treatment Services
Assurance Health & Wellness (dba Sinfonia)
Banner University Whole Health Clinic, Epicenter & CRC
Bayless Healthcare Group
Casa De Los Ninos
ChangePoint Integrated Health
CHEEERS, Inc
Chicanos Por La Causa (CPLC)
Child & Family Support Services
CODAC Health Recovery Wellness, Inc.
Community Bridges, Inc.
Community Health Associates
Community Provider of Enrichment Services, Inc. (CPES)
ConnectionsAZ
Cope Community Services
Corazon Integrated Healthcare Services
Crisis Preparation & Recovery (CPR)
Crisis Response Network (CRN)
Crossroads Mission
Devereux Arizona
Easter Seals Blake Foundation
Ebony House, Inc.
Encompass Health Services
Family Involvement Center
Grace Behavioral Health
Helping Associates, Inc.
Hope Incorporated
Hope Lives
Intermountain Center for Human Development

Jewish Family & Children's Services (Phoenix)
Jewish Family & Children Services of Southern Arizona
La Frontera Center, Inc
La Frontera – Empact
LifeShare Management Group
Lifewell Behavioral Health and Wellness
Little Colorado Behavioral Health Center
Marc Community Resources Inc (Marc Center)
Mentally Ill Kids in Distress (Mikid)
Mohave Mental Health Clinics, Inc.
Native American Connections
NAZCARE, Inc.
New Hope of Arizona
NurseWise
Old Pueblo Community Services
Partners in Recovery
Pathways of Arizona, Inc. (formerly Providence)
PSA Behavioral Health Agency
Recovery Innovations
S.E.E.K. Arizona
Sojourner Center
Southeastern Arizona Behavioral Health Services
Southwest Behavioral & Health Services
Southwest Human Development
Southwest Network
Spectrum Healthcare Group, Inc.
The Crossroads
The Guidance Center
Touchstone Behavioral Health
Wellness Connections
West Yavapai Guidance Clinic, Inc.

C-SHIPHighPriorities 04-17-17

healthcurrent

Statewide HIE Integration Plan (SHIP)
High Priority Providers for Connectivity

Behavioral Health Hospitals (12)

Arizona State Hospital
Aurora Behavioral Health System LLC (Glendale)
Aurora Behavioral Health System - Tempe
Banner Behavioral Health Hospital
Banner – University Medicine Behavioral Health Clinic
ChangePoint
Maricopa Integrated Health System –Desert Vista & Annex
Mohave Mental Health
St Luke's Behavioral Health LP (BH Hospital/Gero/Psych Unit) – Phoenix (IASIS)
The Guidance Center
Valley Hospital
Windhaven Psychiatric Hospital

Correctional Health Services (5)

Coconino County
Maricopa County
Pima County
Yavapai County
Yuma County

FQHCs & Community Health Centers (11)

Canyonlands Community Health Center
Circle the City
Desert Senita Community Health Center
El Rio Community Health Center
Horizon Health and Wellness
Marana Health Center
Maricopa Integrated Health System Clinics
Native American Community Health Center Inc (dba Native Health)
North Country HealthCare
Terros Health
Valle del Sol

Appendix F.6: Current Count and Type of HIE Participants

The following provides a detailed list of participants in Arizona's state level health information exchange by the following sub-groups:

- Accountable Care Organizations and Clinically Integrated Networks

- Behavioral Health Providers

- Community Providers

- Emergency Medical Services

- FQHC's and Rural Health Clinics

- Health Plans

- Hospitals and Health Systems

- Labs, Imaging Centers and Pharmacies

- Long Term and Post-Acute Care

- State and Local Government

HIE Participant Counts by Provider Type

HIE Participants
594 and growing as of 04/11/2019

Health Current is *the* health information exchange (HIE) that helps partners transform care by bringing together communities and information across Arizona.

ACOs & Clinically Integrated Networks (16)

ACO Partner, LLC	Innovation Care Partners
Arizona Care Network	Lifeprint Accountable Care Organization, LLC
Arizona Connected Care	Nobility Healthcare
Arizona Priority Care	Northeast Arizona Regional Care Team
ASPA Connected Community, LLC	Optum Medical Network
Collaborative Ventures Network	PathfinderHealth, LLC
CommonWealth Primary Care ACO	Steward Health Care Network
Equality Health	Yavapai Accountable Care

Behavioral Health Providers (79)

A New Leaf	ConnectionsAZ
Arizona Autism United, Inc.	Cope Community Services
Arizona Youth & Family Services, Inc.	Corazon Integrated Healthcare Services
Arizona's Children Association	Crisis Preparation & Recovery, Inc.
Assurance Assertive Community Treatment, LLC	Crisis Response Network
Bayless Healthcare Group	Crossroads Mission
Black Family & Child Services, Inc.	Cultivate Counseling, PLLC
Casa De Los Ninos	Devereux Advanced Behavioral Health Arizona
ChangePoint Integrated Health	Easter Seals Blake Foundation
Chicanos Por La Causa	Ebony House, Inc.
Child & Family Support Services	Encompass Health Services
CODAC Health Recovery Wellness, Inc.	Escalera Heath and Wellness
Community Bridges, Inc.	Family Involvement Center
Community Health Associates, Inc.	Family Service Agency
Community Medical Services	Helping Associates, Inc.
Community Partners Integrated Healthcare	Hope Inc.
Community Partners, Inc.	Human Services Consultants
Community Provider of Enrichment Services, Inc.	IMHR Epicenter
Connections Southern AZ	Intermountain Centers for Human Development

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Behavioral Health Providers (79)

Jewish Family & Children's Services	PSA Behavioral Health Agency
Jewish Family Children's Services of Southern Arizona	Recovery Innovations
La Frontera Center, Inc.	Rio Salado Behavioral Health Services
La Frontera EMPACT	S.E.E.K. Arizona
LifeShare Management Group	San Tan Behavioral Health Services, LLC
Lifewell Behavioral Wellness	Sojourner Center
Little Colorado Behavioral Health Centers	Southeastern Arizona Behavioral Health Services
Marc Community Resources	Southwest Behavioral Health Services
Mentally Ill Kids in Distress	Southwest Human Development
Mohave Mental Health Clinics, Inc.	Southwest Network
National Council on Alcoholism Greater Phoenix Area (NCADD)	Spectrum Healthcare Group
Native American Connections	The Crossroads, Inc.
Native Americans for Community Action, Inc.	The Guidance Center, Inc.
NAZCARE, Inc.	The Haven
New Hope of Arizona	The Phoenix Shanti Group
NurseWise	Touchstone Health Services
Old Pueblo Community Services	Wellness Connections
Open Hearts Arizona	West Yavapai Guidance Clinic
Partners in Recovery	Youth Advocate Progams, Inc.
Pathways of Arizona, Inc.	Zarephath
Pinal Hispanic Council	

Community Providers (279)

1st Care Medical Clinic	Arizona Community Physicians
56th Medical Group Family Practice	Arizona Community Surgeons
A. T. Still University	Arizona Family Care
Abrazo Heart Institute	Arizona Independent Medical Associates
Abrazo Medical Group	Arizona Institute of Urology
Accu Care Urgent Care	Arizona Kidney Disease & Hypertension Centers
Adobe Care and Wellness, LLC	Arizona Kids Pediatrics
Advanced Ankle and Foot	Arizona Medical & Injury
Agave Pediatrics	Arizona Medical Clinic
Ahwatukee Pediatrics	Arizona Medical Services
All About Health and Wellness	Arizona OB/GYN Affiliates
All About Kids Pediatrics	Arizona Oncology
All Family Care	Arizona Otolaryngology Consultants
Allen Family Medicine	Arizona Pain Institute
Angela Wyatt Dermatology, PC	Arizona Pain Specialists
Arbor Medical Partners	Arizona Pediatric Clinics
Arizona Center for Hand Surgery	Arizona Procedural Center

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Community Providers (279)

Arizona Women's Specialist	Deseret Family Medicine
Arrowhead Internal Medicine	Desert Bloom Family Medicine
Arrowhead Pediatrics	Desert Grove Family Medical
ASAP Health Solutions	Desert Kidney Associates, PLC
Associated Rehabilitation Medicine Doctors	Desert Shores Pediatrics
Atembis, LLC	Desert Spine Institute
Barnett Dulaney Perkins Eye Center	Desert Sun Pediatrics
Bart J. Carter, MD	Desert Valley Pediatrics
Beech Medical Group, Inc.	Desert West Obstetrics & Gynecology, LTD
Bella Vita Healthcare	DispatchHealth Arizona, PC
Bestcare Internal Medicine	District Medical Group
Bethesda Pediatrics	Doc2U
Brain Solutions, PLLC	Donor Network of Arizona
Callie Pediatrics	Dorothy L. Wong Medical Offices
Canton Pediatrics, PC	Dr B's Children's Office
Canyon Pediatrics	Dr. Howard M. Robinson, D.O.
Catalina Pointe Arthritis & Rheumatology Specialists, P.C	East Flagstaff Family Medicine
Catalytic Health Partners	East Valley Access Centers
Central Phoenix Family Medicine	East Valley Family Medical
Chandler Pediatrics	Embry Riddle Wellness Center
Chandler Primary Care	EMS Advisors, LLC
Charles Welly, DO	Enticare
Children's Medical Center of Tucson	Estrella Internal Medicine & Geriatrics
Children's Oasis Pediatrics	Estrella Pediatrics
CHIROFIT	Excel Primary Care
Choice Medical Walk-In	Family First Convenient Care
Christopher Moor, MD	Family Medical Center, PLLC
Cigna Medical Group	First Care Healthcare
Clear Path Family Care	Flagstaff Bone & Joint
Clinica Hispana of West Valley	Flagstaff Emergency Physicians
Clinica La Familia	Flagstaff Family Care Clinic
Colorado River Pediatrics	Flagstaff Family Physicians
CoreBalance Therapy, LLC	Flagstaff Neurosurgery, PLLC
Corizon Health	Flagstaff OB/GYN
Cornerstone Family Medicine	Flagstaff Surgical Associates
Cornerstone Pediatrics	Flagstaff Urgent Care
Cottonwood Medical Center, Inc.	Fornara Eye Center
Crossroads Pediatrics	Forty-Third Medical Associates
Crystal Canyon ENT & Facial Plastic Surgery	Fresenius Medical Care North America
DaVita	G & K Medical Associates, PC

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Community Providers (279)

Garnet Pain Relief Services, LLC

GB Family Care

George Roso, MD, PLLC

Geriatric Solutions

Gila Health Resources

Gila Internal Medicine & Geriatrics, PC

Gila Valley Clinic

Global Retina Institute

Glover Family Medical

Hall Foot & Ankle, PLLC

Happy Kids Pediatrics

Hatfield Medical Group

Healing Hearts Pediatrics

Healthfinity

Healthy Kidz Pediatrics

Healthy Life Family Medicine

Healthy Outlook Family Medicine

Heart and Vascular Center of Arizona

Heavens Medical, PLC

Highland Medical Center, PC

Homan Hajbandeh, MD, PLLC

Homewood Family Medicine

Hyadoc Medical

I Care Internal Medicine

Innovative Healthcare Management

Innovative Primary Care

Integrated Medical Services

Internal Medicine of Yuma

Iora Health, Inc.

Joel S. Sellers, DO, PLLC

Karen Watts, NP, LLC

Kidshealth Pediatrics, PLLC

Kyrene Internal Medicine, PLLC

Life Health and Wellness Health Care

M.B. Best Medical Group

Marvin L Colvin, DO

MD24 House Call

Med-Cure Internal Medicine

Mercy Grace Private Practice

Mesa Pediatrics

Michael A Amadei, MD, PC

Midwestern Multispecialty University Clinic - Glendale

Mission of Mercy

Mobile Valley Physicians

MomDoc

More MD

Mountain Heart Medical Practice, PLLC

Mountain View Pediatrics

Multi Specialty Physicians, Inc.

MVP Kids Care

MY DR NOW

Natalie Camras, FNP-BC

Neil Singer, MD, PLLC

Neuromuscular Research Center

New Era Family Practice

New Pueblo Medicine, PC

North Phoenix Internal Medicine, PC

North Valley Pediatrics

Northern Arizona Dermatology Center

Northern Arizona Ear Nose And Throat

Northern Arizona Gastroenterology

Northern Arizona Orthopaedics, Ltd.

Northern Arizona Pain Services

Northern Arizona Podiatry Group, LLC

Northwest NeuroSpecialists

Northwoods Medical Associates

OnPointe Medical

Options Medical

OptumCare AZ Complex Care Management

OptumCare Medical Group

Page Family Practice

Pain Management and Rehab Medical Center

Palo Verde Family Care, Inc.

Pascua Yaqui Tribe Health Services Division

Pediatric Cardiac Care of Arizona

Pediatrics of Queen Creek

Pendleton Pediatrics

Peoria Foot and Ankle Specialists, PLLC

Phoenix Allies for Community Health

Phoenix Family Medical Care, PLLC

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Community Providers (279)

Phoenix Medical Group	Southwest Medical Associates
Phoenix-Tucson Integrated Kidney Care, LLC	Spectrum Internal Medicine Prescott
Piller Child Development	Steven B Wallach DO - Family Medical Center
Pima Heart	Sunrise Medical Associates, LLC
Pima Lung & Sleep Center, PC	Sunshine Pediatrics
Pinnacle Care Internal Medicine	SunValley Arthritis Center
Pinnacle Family Medicine	Surprise Health Center
Plastic Surgeons of Northern Arizona	Switzer Medical, Inc.
Pleasant Pediatrics	Tempe Family Practice
PopHealthcare	The Doctor Is In
Premier Medical Group, LLC	The Family Practice of Arizona
PremiseHealth	The Neighborhood Christian Clinic
Prescott Family Practice and Wellness	The Pediatric Endocrine & Diabetes Clinic, PC
Prescott General Surgery	The University of Arizona College of Medicine
Primary Care Associates	The Wellness and Prevention Center
Priority Family Medical Clinic	Thumb Butte Medical Center
Providence General Medicine	Thunderbird Internal Medicine
Providers Direct, PLLC	Total Medical Care
Pulmonary Consultants of Mesa	TriageLogic
Pulmonary Institute of Arizona	Trinity Adult Medicine
Pynch Medical	True Care, MD
Rajiv Parikh, MD	Tucson Central Pediatrics, PC
Richard Covey, MD, PC	Tucson Children's Clinics
Richard Shindell, MD	Tucson Endocrine Associates
Robert Bloomberg, MD	Tucson Pulmonology, PC
Ryan Internal Medicine	UA RISE Health & Wellness Center
Saguaro Surgical	Valley Anesthesiology & Pain Consultants
San Pedro Family Care	Valley of the Sun Institute for Pain Management, PLLC
Scottsdale Family and Urgent Care	Valley Perinatal Services
Scottsdale Physicians Group	Velda Rose Medical Center
Sedona Integrative Medical Clinic, LLC	Vijay S Gill, MD
Skyline Pediatrics	Virginia G. Piper St. Vincent DePaul Clinics
Sonoran Medical Centers	Walker Family Medicine, PLC
Sonoran Pediatric Endocrinology & Diabetes Institute	Wee Care Pediatrics
Sonoran Sky Pediatrics	West Sedona Family Practice
Sound Physicians of Arizona	West Valley Internal Medicine Associates, LLC
Southern Arizona Infectious Disease Specialists, PLC	West Valley Pediatrics
Southwest Internal Medicine Group	Westview Family Medicine, PC
Southwest Internal Medicine, LLC	Whitney James, MD, PC
Southwest Kidney Institute, PLC	Winslow Indian Health Care Center

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Community Providers (279)

Women's Clinic of Northern Arizona

Yuma Gastroenterology, PC

Wyatt Woodard Family Practice

Yuma Nephrology, PC

Your Family Practice Team, PC

Emergency Medical Services (18)

Arizona Fire & Medical Authority

Healthcare Innovations

Chandler Fire, Health & Medical

Lakeside Fire District

City of Avondale - EMS

Rincon Valley Fire District

City of Buckeye - EMS

Rio Rico Medical & Fire District

City of Goodyear - EMS

Show Low EMS

City of Mesa - Mesa Fire and Medical Department

Sierra Vista - Fry Fire District

City of Peoria - EMS

Sun City Fire District

City of Surprise Fire-Medical

Tempe Fire Medical Rescue Department

Fort Mojave Mesa Fire Department

Tucson Fire Department

FQHCs & Rural Health Clinics (21)

Adelante Healthcare

Native Health

Canyonlands Healthcare

North Country Healthcare

Chiricahua Community Health Center

Regional Center for Border Health/San Luis Walk In Clinic

Circle the City

St. Elizabeth's Health Center, Inc.

Desert Senita Community Health Center

Sun Life Family Health Center

El Rio Health Center

Sunset Community Health Center

Horizon Health and Wellness

Terros

Marana Health Center

United Community Health Center - Maria Auxilliadora, Inc

Mariposa Community Health Center

Valle del Sol

Mountain Park Health Center

Wesley Community Health Center

N.O.A.H.

Health Plans (17)

Blue Cross Blue Shield of Arizona

HealthNet

Bridgeway Health Solutions

Magellan Healthcare

Bright Health Plan

Maricopa Health Plan

Care1st Health Plan of Arizona

Mercy Care Plan

Cenpatico Integrated Care

Mercy Maricopa Integrated Care

CIGNA Healthcare of Arizona, Inc.

Phoenix Health Plan

Division of Developmental Disabilities - AZ DES

The University of Arizona Health Plan

Health Choice Arizona

UnitedHealthcare

Health Choice Integrated Care

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Hospitals & Health Systems (53)

Abrazo Community Health Network	Little Colorado Medical Center
Aurora Behavioral Health - Tempe, LLC	Maricopa Integrated Health System
Aurora Behavioral Health Systems, LLC	Mount Graham Regional Medical Center
Banner Health	Mountain Valley Regional Rehabilitation Hospital
Benson Hospital	Northern Arizona Healthcare
Canyon Vista Medical Center	Northern Cochise Community Hospital
Carondelet Health Network	Northwest Medical Center
Chinle Comprehensive Health Care Facility	Palo Verde Behavioral Health Hospital
Cobalt Rehabilitation Hospital	Phoenix Children's Hospital
Cobre Valley Regional Medical Center	Promise Hospital of Phoenix, Inc.
Copper Queen Community Hospital	Quail Run Behavioral Health Hospital
Copper Springs Hospital	Rehabilitation Hospital of Northern Arizona
Cornerstone Behavioral Health El Dorado	Santa Cruz Valley Regional Hospital
Dignity Health	Select Specialty Hospital - Phoenix
Encompass Health Rehabilitation Hospital of East Valley	Select Specialty Hospital - Phoenix Downtown
Encompass Health Rehabilitation Hospital of Northwest Tucson	Summit Healthcare
Encompass Health Rehabilitation Hospital of Scottsdale	TMC Healthcare
Encompass Health Rehabilitation Institute of Tucson	Tuba City Medical Center
Encompass Health Valley of the Sun Rehabilitation Hospital	Valley Hospital
Fort Defiance Indian Hospital - Tse'hootsooi' Hospital	Valley View Medical Center
Gila River Health Care	Western Arizona Regional Medical Center
Hacienda Healthcare	White Mountain Regional Medical Center
Havasu Regional Medical Center	Wickenburg Community Hospital
HonorHealth	Yavapai Regional Medical Center
IASIS Healthcare	Yuma Regional Medical Center
Kingman Regional Medical Center	Yuma Rehabilitation Hospital
La Paz Regional Hospital	

Labs, Imaging Centers & Pharmacies (6)

Integrated Pathology Services	Sonora Quest Laboratories
Lab Corp	Sun Radiology
Patient Care Infusion	Topical Solutions Pharmacy

Long-Term & Post-Acute Care (97)

A Servant's Heart Palliative and Nursing, LLC	Aviant Hospice Phoenix
Advanced Clinical Associates	Aviant Hospice Yavapai
Arizona Home Care	BAYADA Home Healthcare, Inc.
Arizona Palliative Home Care	Beatitudes Campus
Aviant Hospice Gila	Bella Vita Health & Rehab Center

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Long-Term & Post-Acute Care (97)

Bethany Gardens Assisted Living	Immanuel Care Center
Bethany Haven Assisted Living	Intrepid USA
Brookdale Santa Catalina - LaRosa	KC's Home Healthcare
Camelback Post Acute Care and Rehabilitation	Kindred Healthcare
Casas Adobes Post Acute Rehabilitation Center	La Canada Care Center
Catalina Post Acute and Rehabilitation	Lake Pleasant Post Acute Rehabilitation Center
Catalina Village Assisted Living	LifeStream at Cook Health Care
Chandler Post Acute & Rehabilitation	Lifestream Complete Senior Living at Northeast Phoenix
Christian Care Assisted Living	LifeStream Complete Senior Living at Sun Ridge, Inc.
Christian Care Assisted Living Cottonwood	Lifestream Complete Senior Living at Thunderbird
Christian Care Health Center	Lifestream Complete Senior Living at Youngtown
Christian Care Home Health	Montecito Post Acute Care & Rehabilitation
Christian Care Manor II	Mountain View Care Center
Citadel Post Acute	Nightingale Homecare
Complete Hospice Care of Phoenix	North Mountain Medical & Rehab Center
Copper Health Oro Valley	Oakmont Assisted Living
Copper Village Assisted Living	Osborn Health & Rehabilitation
CopperSands, Inc.	Park Avenue Healthcare & Rehab Center
Coronado Healthcare Center	Plaza Healthcare
Covenant Home Health	Prescott Nursing and Rehabilitation Center
Dependable Home Health	Pueblo Springs Rehabilitation Center
Desert Blossom Health and Rehabilitation Center	Rehab Arizona
Desert Sky Assisted Living	River Gardens, Ltd.
Desert Terrace Healthcare Center	Rose Court Senior Living
Devon Gables Rehabilitation Center	Sabino Canyon Rehab & Care Center
Emblem Home Health	Sacred Heart Home Health Care
Emblem Hospice	Sage Hospice and Palliative Care
Emblem Hospice - Tucson	Santa Rosa Care Center
Foundation for Senior Living	Sante' Operations, LLC
Glencroft Senior Living	Shea Parc Post Acute Rehabilitation Center
Grand Court of Mesa	Sherwood Village Assisted Living and Memory Care
Granite Creek Health & Rehabilitation Center	South Mountain Post Acute
Helping Hearts Residential Facilities, LLC	Springdale Village
Heritage Court Post Acute of Scottsdale	Summit Hospice
Home Health Insights, Inc.	Sunview Health & Rehabilation Center
Hope Hospice Care	Team Select Home Care
Horizon Home Health of Arizona	The Gardens Rehab & Care Center
Horizon Post Acute and Rehabilitation Center	The Legacy Rehab and Care Center
Hospice Family Care	The Lingenfelter Center, Ltd.
Hospice of the Valley	The Terraces of Phoenix

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Long-Term & Post-Acute Care (97)

Unhooked Recovery

Victory Home Care Agency

View Point of Paseo Village, LLC

View Point of Sunshine Village, LLC

Villa Maria Care Center

Welcome Home House Calls, LLC

Zion's Way Home Health & Hospice

State & Local Government (7)

Arizona Department of Health Services

Arizona Health Care Cost Containment System (AHCCCS)

Maricopa County

Pima County - Corrections

Pinal County

Yavapai County

Yuma County Jail District

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Data Source: Health Current April, 2019

Appendix F.7: Health Current Strategic Plan 2017 to 2020

https://healthcurrent.org/wp-content/uploads/2017/04/Health-Current-Webinar-Three-Year-Strategic-Plan-and-Governance-FINAL.pdf