State of West Virginia
Bureau for Medical Services

State Health Information Technology (HIT) Plan (SMHP)

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Revision History:

Version	Delivered Date	Update Reason
0.1	12/10/10	Initial draft for internal review and discussion only
1.0	12/16/10	Final draft submitted for approval
1.1	1/26/11	Final draft revised with the most recent changes to the Final Rule for the PIP relative to the Net Average

		Allowable Costs, provider responsibility for contribution to those costs, and verification of those costs.
2.0	5/18/11	Final version revised per CMS comments.
3.0	6/14/2011	Final version incorporating all of CMS comments

Executive Summary

In September 2009, the State of West Virginia issued the West Virginia Health Information Technology Statewide Strategic Plan (Statewide HIT Plan). As the entity within the West Virginia Department of Health and Human Resources (DHHR) responsible for establishing the overall strategic direction and priorities for the West Virginia Medicaid Program, the Bureau for Medical Services has developed the State Medicaid HIT Plan (SMHP) as the "Medicaid Volume" of the Statewide HIT Plan "book series". It describes how the vision set forth in the Statewide HIT Plan will be made a reality for citizens who are or may be covered by Medicaid.

The West Virginia State Medicaid HIT Plan presents an assessment of the State's HIT landscape, a vision of the HIT future in the year 2014, specific actions the State believes will be necessary to implement the provisions of section 4201, and a roadmap that serves as a strategic pathway to move from the "as-is" HIT landscape to the "to be" HIT vision.

Three groups have been involved in the development of the WV State Medicaid HIT Plan: the Bureau's WV Medicaid HIT Planning Core Team, the WV HIT Collaborative, and the WV Medicaid HIT Planning Workgroup (Workgroup). Additionally, the Bureau sponsors the WV HIT Collaborative to provide a forum for the discussion of common HIT issues state-wide.

As part of the SMHP development effort, the Bureau identified health information technologies that could complement the functionality within the traditional MMIS, increase the use of evidence-based clinical services, and enhance the quality of care provided to members.

The Bureau will conduct the BMS Health Information Exchange Initiative to evaluate opportunities and implement necessary technology to achieve desired health information exchange capabilities to benefit the West Virginia Medicaid population. Additional health information technology initiatives have been identified as necessary to support strategic goals and objectives are described in section 4.0 of the SMHP.

The implementation and meaningful use of certified Electronic Health Records (EHR) by the provider community in WV is central to achieving Medicaid's HIT vision. Section 5.0 details the EHR Provider Incentive Program Design that will be implemented to achieve adoption and meaningful use of certified EHR throughout the State.

Provider outreach and communication will be critical to the success of the EHR Provider Incentive Program. Outreach and communication efforts conducted to date have not produced desired results. The West Virginia Regional HIT Extension Center (WVRHITEC) will be engaged to implement a multi-faceted, robust outreach and communication plan and to provide technical support to providers as they strive to adopt and achieve meaningful use of certified EHR technology.

1.0 Background

The West Virginia State Medicaid Health Information Technology (HIT) Plan (SMHP) is a vision document that includes a current assessment of West Virginia's current HIT landscape, a vision of the HIT future in the year 2014, actions that may be necessary to implement the provisions of section 4201, and a roadmap that serves as a strategic pathway to move from the State's "as-is" HIT landscape to the "to be" HIT vision. It also outlines the actions necessary to implement the EHR Provider Incentive Program (PIP). The West Virginia State Medicaid HIT Plan has been developed in accordance with guidance provided in 42 CFR Parts 495.332 as modified by the Centers for Medicare and Medicaid Services (CMS).

The West Virginia Medicaid program is managed by BMS, a bureau within the Department of Health and Human Resources (DHHR). The total Medicaid expenditures for SFY2010 were approximately $2.5 billion. The Medicaid program provides health care benefits to just over 411,000 people annually in 55 counties, using a network of approximately 24,000 active providers. The MMIS processes about 17.7 million claims per year: 9.5 million medical/dental claims and 8.2 million pharmacy claims. About 93% of claims are received electronically, of which about 53% are pharmacy claims.

Approximately 165,000 Medicaid members (families with dependent children, low-income children, and pregnant woman) are enrolled in three managed care organizations (MCOs). The Medicaid program has historically paid for certain carved-out services for these MCO members, such as pharmacy, children's dental services, long-term care, non-emergency transportation, and behavioral health services. In the current fiscal year, Supplemental Security Income (SSI) members, behavioral health services, and children's dental services are expected to transition to the MCOs.

The Medicaid program also manages a Primary Care Case Management (PCCM) program—the Physician Assured Access System (PAAS). The Bureau's MMIS processes claims for two Home and Community Based Services (HCBS) waiver programs and several State funded eligibility programs. It also functions as a third party administrator (TPA) for other state agencies.

1.1 *Program Environment*

West Virginia is focused on offering health care coverage to its citizens and improving their health care outcomes, through both Medicaid and non-Medicaid programs. This section describes the State's multi-faceted and dynamic program environment.

1.1.1 *Medicaid Program.* West Virginia Medicaid operates under a combined managed care and fee-for service environment.

1.1.1.1 *Mountain Health Trust (Managed Care Organization (MCO) and Physician Assured Access System (PAAS))*
Mountain Health Trust is a managed care program. Eligible members are asked to choose either a PAAS primary care provider (PCP) or an MCO based on their county of residence. If a member does not make a choice, they are automatically assigned by the enrollment broker. MCO-enrolled members are also asked to select a PCP to provide or approve most of their health care needs. Pharmacy, children's dental services, long-term care, non-emergency transportation, and behavioral health services are carved out of the MCO and PAAS programs. .

1.1.1.2 *Mountain Health Choices (aka Medicaid Redesign)*
West Virginia's "Mountain Health Choices" was implemented in 2007 through a State Plan Amendment and is active in all 55 counties. Its purpose is to ensure that members receive the right care, at the right time, by the right provider. The hallmarks of the program are:

- Prevention,
- Personal Responsibility,
- Care Management, and
- Establishment of a Medical Home.

Members who are eligible for Mountain Health Choices have the opportunity to choose a Basic or Enhanced benefit plan. At this time, only certain members are eligible to participate in Mountain Health Choices.

1.1.1.3 *Medicaid Fee-For-Service*
Services for Medicaid members not eligible for participation in Mountain Health Trust or Mountain Health Choices, such as waiver clients, long-term care and foster care children, continue to be paid according to a fee-for-service schedule. Medicaid dual-eligibles (individuals eligible for both Medicaid and Medicare) remain in fee-for-service. Children in foster care have their medical, pharmaceutical, and dental expenses covered by Medicaid.

1.1.1.4 *Medicaid Pharmacy Program*
The outpatient pharmacy program is an optional service provided to eligible Medicaid beneficiaries. It is the Bureau's most utilized service with 42% of all clients receiving services monthly. Pharmacy coverage policies are governed by Federal statutes and regulations. The majority of pharmacy claims (99%) are submitted electronically using the pharmacy point-of-sale (POS) system. Claims are adjudicated on-line and are considered either paid or denied at the time of service. In State Fiscal Year 2010, 8.2 million claims were processed by the current POS, with expenditures of $331,666,990 paid to pharmacy providers.

The POS system edits each prescription for appropriateness using prospective drug utilization review, limitations, and prior authorization edits. BMS incorporates a Preferred Drug List developed with the assistance of a vendor and a Pharmaceutical and Therapeutics Committee. Criteria for coverage of non-preferred drugs and other drugs necessitating prior authorization are

developed with the assistance of the Drug Utilization Review Board. An automated prior authorization system operates in conjunction with the current POS system. The Rational Drug Therapy Program (RDTP), affiliated with the West Virginia University School of Pharmacy, is the prior authorization vendor. The pharmacy lock-in program is managed by a vendor to address over utilization. Medicaid members are required to pay a co-payment at the time of service with some exceptions. Currently, all Medicaid members have pharmacy benefits in the fee-for-service program, regardless of their enrollment in Medicaid managed care plans.

1.1.1.5 *Waiver Programs*
The West Virginia Medicaid Program currently operates two Home and Community Based Services (HCBS) waiver programs:

- Aged Disabled Waiver (AD): This waiver provides a number of services, such as case management, homemaker, transportation, RN assessment and review, for eligible members. Participants may chose to receive these services through a traditional agency model or they may select the personal option, which allows AD members to recruit, hire, and supervise their own workers. For SFY2011 there are 8,165 approved AD Waiver positions.
- Mental Retardation/Developmental Disability Waiver (MR/DD): This program serves approximately 4,400 individuals across the state. Services include service coordination, respite care, residential and community habilitation, nursing services, supported employment, and transportation. Participants in the MR/DD also may select self-directed options.

1.1.1.6 *Medicaid Work Incentive Network (M-WIN)*
M-WIN is a Medicaid-funded work incentive program that allows working West Virginians with disabilities or chronic health conditions to pay a monthly premium to keep or obtain Medicaid health care coverage. M-WIN eliminates a major barrier to employment—losing current healthcare benefits when you return to work. This program offers Personal Care Employment Support, hands-on assistance with daily activities related to personal hygiene, dressing, eating, environmental support functions, as well as health-related tasks during job-seeking activities and employment.

1.1.2 Other *Programs Offering Health Care Coverage*. BMS supports claims processing for a number of other programs which provide a level of coverage for health care services. All programs listed below have their claims processed through the MMIS.

1.1.2.1 *Limited Pharmacy Program (aka Ryan White)*
The West Virginia AIDS Drug Assistance Program (ADAP) provides HIV-related prescription drugs to underinsured and uninsured individuals living with HIV/AIDS.

1.1.2.2 *Tiger Morton Commission*
The James “Tiger” Morton Catastrophic Illness Commission was created during the 1999 regular session of the West Virginia Legislature. The Commission

acts as a last resort for those in dire need of medical assistance once all other resources are exhausted.

1.1.2.3 *Children with Special Health Care Needs (CSHCN) Program*
The Office of Maternal, Child and Family Health of the Bureau for Public Health CSHCN Program advances the health and well-being of children and youth with certain chronic, debilitating conditions. It provides specialized medical care and care coordination services to children under 21 years of age who meet eligibility criteria.

1.1.2.4 *Juvenile Justice Services*
Services are provided to youth involved or at risk of being further involved in the Juvenile Justice System. Services include comprehensive psychosocial history assessments and reports, medical, pharmacy, and dental services, treatment recommendations, initial service plan, case management, referrals and linkage to community service providers and transportation to necessary appointments, such as probation or mental health.

1.1.2.5 *Adult Protective Services*
Medicaid pays for some services provided to adults who are abused or neglected when a case is handled through the Bureau for Children and Families (BCF) Adult Protective Services Program.

1.1 Current HIT Landscape in West Virginia

The Department of Health and Human Services, Bureau for Medical Services worked in collaboration with West Virginia Health Information Network (WVHIN) Chief Operating Officer (COO), Raul Recarey and WVHIN Chief Information Officer (CIO), Dennis Belter to review existing documentation and conduct research and information-gathering activities to develop a baseline assessment of the current HIT environment in the State of West Virginia.

The survey conducted during the development of the Planning-Advanced Planning Document (P-APD) served as the foundation for more in-depth interviews with members of the WV HIT community to assess potential alignment of Medicaid HIT efforts with existing HIT/HIE efforts throughout the State.

The output of this effort is the WV Medicaid HIT Landscape Assessment found in section 2.0. It describes in detail current HIT activities and their impact on Medicaid beneficiaries.

1.2 Vision of HIT Future

The Bureau for Medical Services utilized Medicaid Information Technology Architecture (MITA) concepts, tools and processes in working with project participants to develop a vision for HIT in WV Medicaid. BMS Business Area Owners engaged in a series of strategic planning sessions to update the Bureau's strategic plan. Participants discussed and reached consensus on how current and emerging health information technology will be used in support of the Bureau's

strategic goals and objectives. The output of the Bureau's most recent strategic planning sessions, conducted during the Fall 2010, are provided in Appendix B. The HIT vision derived from the Bureau's overarching Strategic Plan is described in section 3.0 of the WV State Medicaid HIT Plan.

1.3 HIT Roadmap

The "WV Medicaid HIT Roadmap" is one of the outputs of the strategic planning sessions conducted during the Fall of 2010. It describes the HIT initiatives necessary to achieve the Bureau's strategic goals and objectives.

- Funding sources for projects and ongoing operations
- Governance structure that will be used to align responsibility, authority and accountability for the execution of the component initiatives and projects
- Program and portfolio management processes and methods that will be used to provide integrated management and objective oversight of component initiatives and projects
- Plan for ongoing HIT education, training, communication and outreach for State staff

1.4 Provider Incentive Program Implementation

The Bureau for Medical Services has developed an EHR Provider Incentive Program (PIP) Design comprised of two components:

- EHR PIP: Communication, Outreach and Education (COE) Plan
- EHR PIP: Administration and Oversight Processes

<u>EHR PIP: Communication, Outreach and Education (COE) Plan</u>

The Bureau conducted a survey of providers (Provider Scan) to gain an understanding of several factors that may influence use of EHR, including but not limited to the following:

- Provider access to the internet
- Current use of HIT and EHR
- Provider preferences for education, training, outreach and communication
- Provider preferences and statistics for support of providers implementing and adopting EHR
- Historical barriers to adoption and meaningful use of EHR
- State-specific funding barriers
- Integration of EHR and HIT with provider practice workflow and practice management systems
- Potential HIE functionality that would incentivize adoption and meaningful use
- Negative as well as positive incentives and messages that would be effective in promoting implementation and adoption of EHR
- Provider education, training, communication and outreach needs related to Medicaid HIT
- Define EHR adoption levels for success
- Strategies to enhance connectivity and expand broadband access to underserved areas

The information gathered in the Provider Scan was used to develop the EHR PIP: Communication, Outreach and Education (COE) Plan.

EHR PIP: Administration and Oversight Processes

The Bureau has designed an EHR Provider Incentive Program that will reimburse authorized providers for the adoption and meaningful use of certified EHR technology. This program design will define an organizational function and structure and include the ability to:

- Identify audit control objectives for the incentive program
- Identify the prospective authorized provider
- Document criteria that will be used to validate the adoption of certified EHR systems by the provider for authorized technology and services
- Identify and document criteria for the "meaningful use" of the technology by the provider as defined at the federal level and supplemented by state requirements
- Effect an auditable financial transaction that documents payments to the provider at the authorized monetary levels defined in the final rules established by the federal government and state payment policies and procedures
- Provide subject matter support, technical support, education, training, communication and outreach to providers as they:
    - Evaluate benefits and costs of EHR
    - Assess impacts of delaying implementation
    - Select and implement a certified EHR
    - Work to comply with incentive program criteria and reporting requirements

The EHR Provider Incentive Program Design serves as the input to the systems analysis and requirements definition for automation of the incentive payment processes to be performed by the Medicaid Fiscal Agent. The Bureau will conduct systems analyses and requirements definition for payment delivery, tracking and auditing of payments, interfaces, data exchanges and data agreements as part of the program design effort.

2.0 Current "As-Is" HIT Landscape

2.1 Introduction

The Bureau for Medical Services (BMS) partnered with Shepherd University and KRM Associates, Inc. to develop and disseminate a series of surveys to help assess the HIT landscape and to develop a baseline assessment of EHR use and readiness within the state of West Virginia. Results from the surveys provided the "starting point" for understanding West Virginia's HIT landscape.

The subsequent West Virginia Health Information Technology (HIT) Statewide Strategic Plan, updated in September of 2009, contained the following information about the use of HIT within the State:

- Penetration and use of electronic clinical information by physicians' practices is less than 10% statewide. There are providers who do not have any technology in their clinical practice.
- Approximately 60% of practices have an electronic practice management system.
- Approximately 80% of hospital-based physicians have access to an electronic health record information system.
- West Virginia has been an early adopter of the open source clinical information systems (e.g. Vista/RPMS).

In an effort to capture recent HIT advancements and initiatives, the Bureau for Medical Services (BMS) conducted a survey in March 2010 to identify the Health Information Technology (HIT) initiatives that were currently in operation or being planned in the State of West Virginia. Results from this survey were used to develop a baseline assessment of the current HIT environment in the State and were included in the Medicaid Planning-Advanced Planning Document (P-APD).

The Bureau for Medical Services has and continues to collaborate with stakeholders representing HIT initiatives and workgroups throughout the State in the development of the WV Medicaid HIT Plan.

Key stakeholders and stakeholder groups include, but are not limited to, the following:

- Governor's Office of Health Enhancement and Lifestyle Planning (GOHELP)
- West Virginia Health Information Network (WVHIN)
- Bureau for Public Health
- Bureau for Behavioral Health and Health Facilities
- Governor's Office of Technology
- Department of Commerce
- WV Health Care Authority
- Tele-Health Alliance
- WV Department of Military Affairs and Public Safety
- WV Insurance Commission
- DHHR Office of Secretary
- Bureau for Children and Families
- Public Employees Insurance Agency

- State Children's Health Insurance Program
- WV Health Improvement Institute
- Community Health Network of WV
- WVRHITEC
- Primary Care Association
- Hospital Association
- WV State Medical Association

Workgroup members act as advisors and are asked to share their expertise, experience and lessons learned to benefit the Medicaid HIT effort. Opportunities for economy and efficiency will be explored. Topics to be discussed in this Workgroup include, but are not limited to:

- Medicaid's alignment with internal/external HIT/HIE efforts.
- Initiatives related to interoperability, data exchanges and system interfaces.
- Planning for provider education, outreach, training and conferences including provider surveys.
- Provider support and call center needs.
- Planning for the development of data agreements.
- Metrics to demonstrate meaningful use of electronic health records.
- Reporting requirements for clinical quality outcomes.
- Governance for HIT initiatives, including oversight and monitoring activities.
- Web site development and maintenance.
- Quality assurance activities, including independent verification and validation.

The costs associated with landscape assessment activities were allocated appropriately in accordance with the Bureau's established processes and procedures.

2.2 Landscape Assessment Survey and Responses

As part of the information gathering process for the Landscape Assessment within the State Medicaid HIT Plan, an additional survey (Appendix A) was conducted to provide added detail on HIT initiatives and systems, how these initiatives and systems impact Medicaid beneficiaries, and how these initiatives and systems may align with Medicaid HIT efforts.

Survey questions were developed by the members of the West Virginia Medicaid HIT Workgroup based on official CMS guidance regarding specific items that should be included as part of the Landscape Assessment. Twenty survey participants were identified by BMS due to their extensive involvement in statewide HIT efforts. The twenty organizations that were asked by BMS to complete the Landscape Assessment survey are included in the Table 1 below.

Table 1: Organizations Surveyed

Organizations Surveyed for Landscape Assessment

Department of Commerce	Department of Health and Human Resources Office of the Secretary
West Virginia Regional HIT Extension Center (WVRHITEC)	Bureau for Medical Services (BMS)
Bureau for Children & Families	Governor's Office of Health Enhancement & Lifestyle Planning (GOHELP)
West Virginia Healthcare Authority (WVHCA)	West Virginia Office of Technology
Community Health Network (CHN)	West Virginia Telehealth Alliance (WVTA)
West Virginia Health Information Network (WVHIN)	West Virginia School of Osteopathic Medicine (WVSOM)
Children's Health Insurance Program (CHIP)	West Virginia University
Insurance Commission	Department of Military Affairs & Public Safety
Bureau for Public Health (BPH)	Marshall University School of Medicine
Public Employees Insurance Association (PEIA)	Division of Homeland Security and Emergency Management

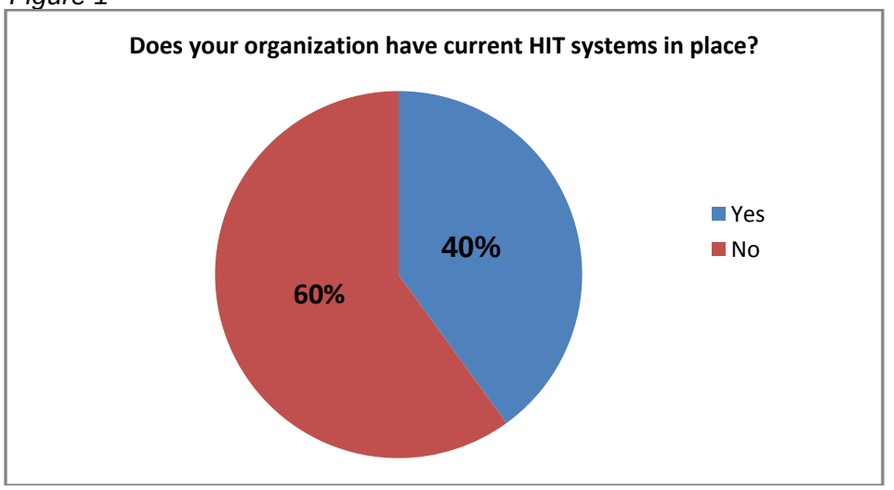
Surveys were distributed by the Medicaid Commissioner on October 12, 2010 and were asked to be returned to BMS by October 19, 2010. Sixteen surveys were completed and returned by survey participants, at a response rate of 80%. BMS did not receive survey responses from the Children's Health Insurance Program, Office of Technology, West Virginia University, or Marshall University School of Medicine.

Information from the Landscape Assessment survey responses can be used to: identify redundant HIT efforts and identify areas of collaboration to maximize resources and funding in West Virginia; identify how HIT systems may impact Medicaid beneficiaries; avoid multiple sets of potentially inconsistent requirements for providers, payers, and Medicaid beneficiaries, etc.

The following information provides an overview of the responses obtained from the surveys. Please note that BMS received completed surveys from sixteen of the twenty organizations that were asked to complete a survey.

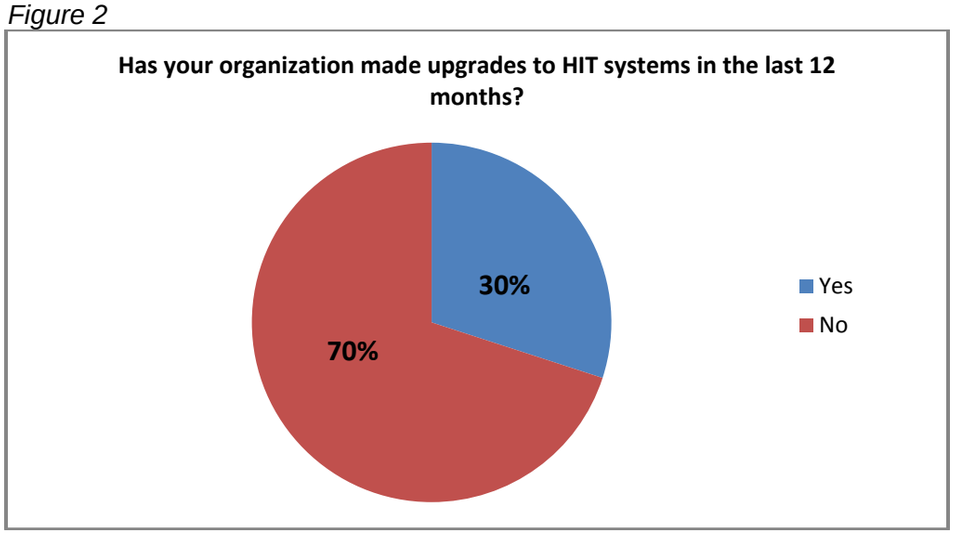
1. Figure 1 shows approximately 40% (7 respondents) of the survey respondents indicated that they have current HIT systems in place. These seven respondents include: BPH, WVSOM, WVRHITEC, CHN, BMS, WVTA, and WVHCA. These systems are discussed in *section 2.3*.

Figure 1



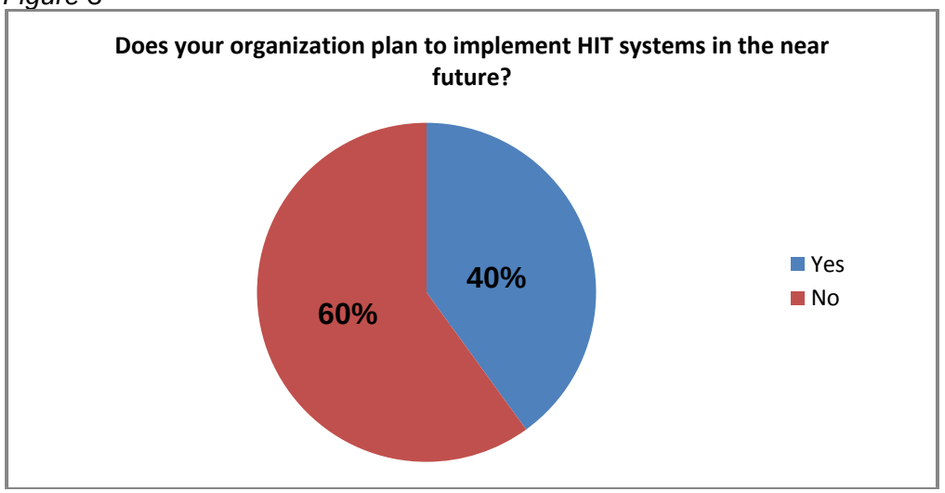
2. Figure 2 shows approximately 30% (5 respondents) of the survey respondents have made upgrades to current HIT systems in the last 12 months. These five respondents include: WVSOM, Insurance Commission, CHN, WVTA, and WVHCA. These upgrades are discussed in *section 2.3*.

Figure 2



3. Figure 3 shows approximately 40% (7 respondents) of the survey respondents plan to implement HIT systems in the near future. These seven respondents include: BPH, WVSOM, CHN, WVRHITEC, Insurance Commission, WVTA, and WVHIN. These HIT systems are discussed in *section 2.3*.

Figure 3



As identified in the survey responses, Table 2 below provides an overview of the current HIT systems in place, upgrades to current systems and plans to implement systems in the near future.

Table 2: Current and Planned HIT Systems

Respondent	Current HIT Systems in Place	Upgrades to Current HIT Systems in the last 12 months	Plans to Implement Systems in the Future
BPH	1. Patient Registries - WV Statewide Immunization Information System (SIIS); Electronic Disease Surveillance System (EDSS)	None	Yes - In the process of replacing EDSS with the National Electronic Disease Surveillance System (NEDSS)
WVSOM	1. Patient Registry and E-Prescribing - SAGE Intergy Practice Management System 2. Telehealth - Mountaineer Doctor Television	Yes - Upgraded Intergy to latest version	Yes - Recently released an RFP for an integrated Practice Management EHR application
WVRHITEC	1. Outcome Reporting System - SQL based system utilized to collect clinical measures and Meaningful Use measures from providers 2. Patient Registry - Chronic disease electronic management	None	Yes - In the process of assisting providers throughout West Virginia with adoption, implementation and use of electronic health records

Respondent	Current HIT Systems in Place	Upgrades to Current HIT Systems in the last 12 months	Plans to Implement Systems in the Future
	system registry 3. Patient Portal - Supported MyHealtheMountaineer PHR in several pilots		
CHN	1. Secure Patient E-mail 2. Health Information Exchange - Exchanges data with LabCorp 3. Outcome Reporting System 4. Patient Registry - included in RPMS 5. Telehealth 6. Electronic Health Record - RPMS 7. Personal Health Record 8. Patient Portal	Yes - Continual upgrades are made to all systems, including new servers, features and modules	Yes - Planning to upgrade systems to meet Meaningful Use criteria
BMS	1. E-Prescribing - WVeScript	None	Yes - Planning to upgrade MMIS
WVTA	1. Telehealth - Expanding broadband to facilitate telehealth interlinkages	Yes - Continual expansion of broadband as part of the Metro Fiber Build project	Yes - Continual service enhancement updates
WVHCA	1. Outcome Reporting System - Used to collect provider financial, administrative and claims data as well as state payer claims data; data is used to assess healthcare utilizations, access, costs, etc. to inform health policy and planning	Yes - Using COGNOS software to enhance data analysis and reporting	No plans
WVHIN	None	None	Yes - Planning to implement West Virginia's statewide HIE
Insurance Commission	The Insurance Commission did not have any HIT systems as identified in Question #1 of the survey. However, the Commission currently uses the System for Electronic Rate and Form Filing (SERFF) to	Yes - Updates made to SERFF system	Yes - Planning further updates to SERFF system; planning to develop and implement a Health Insurance Exchange; planning to implement the NAIC SBS in 2011; assessing the

Respondent	Current HIT Systems in Place	Upgrades to Current HIT Systems in the last 12 months	Plans to Implement Systems in the Future
	manage rate filing forms from insurance carriers.		possibility of developing an all-payer claims database

4. Approximately 75% (12 respondents) of the survey respondents said they were involved with other health-related initiatives/agencies. Examples of collaboration and coordination among health-related initiatives are described below.

   - The WVSOM has collaborated with multiple HIT initiates throughout the State of West Virginia. For example, the WVSOM is represented on the WVHIN Board of Directors and has also participated in West Virginia Health Improvement Institute's patient centered medical home initiative. WVSOM is also working with the WVRHITEC to promote certified EHR adoption among its physicians.

   - GOHELP is the State organization which coordinates health-related activities and policies, including HIT programs, among state agencies and some private sector entities. GOHELP coordinates and collaborates with all twenty survey respondents identified in this report. More detail is discussed in *section 2.3*.

   - The WVHIN is coordinating with BMS, PEIA, BPH, WVRHITEC, WVHCA, broadband initiatives, and the Insurance Commission to ensure HIE interoperability with state-based HIT systems including MMIS, BPH registries, etc. WVHIN also coordinates with the aforementioned initiatives to ensure broad stakeholder representation in its HIE efforts.

   - WVRHITEC and WVHIN coordinate EHR/HIE messaging to the provider community.

   - The West Virginia Health Improvement Institute (HII), which is leading the WVRHITEC project, was established to coordinate with all health related state-based agencies. For example, the HII has collaborated with BMS on its patient-centered medical home pilot program by including Medicaid members as direct targets for the pilot.

   - The WVTA works collaboratively with many of the twenty identified survey respondents. The Alliance's Board includes representatives from the WVHCA, WVSOM, WV DHHR, Office of Technology, and CHN.

   - The Insurance Commission is collaborating with the WVHCA and BMS to potentially develop an all-payer claims database.

   - BMS, in collaboration with WVRHITEC, is investigating the potential for integrating the WVeScript e-prescribing application (which is now offered to Medicaid enrolled providers) into EHRs which do not currently have e-prescribing functionality.

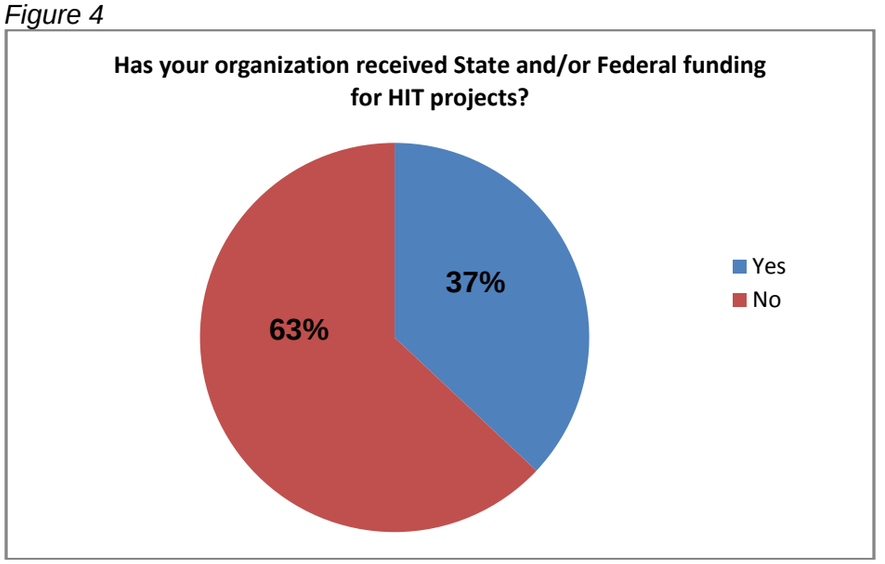
   - BPH is collaborating with the Insurance Commission on the State Health Access Plan (SHAP) grant.

- CHN is a partner in the WVRHITEC project.

- DHHR works with most of the identified survey respondents through multiple committees related to HIT. For example, the Secretary of DHHR is a member of the WVHIN Board of Directors. DHHR is also collaborating with the Insurance Commission to explore the use of the Information Network for Resident Online Access and Delivery of Services (InRoads) for the Insurance Commission's Health Insurance Exchange. InRoads is currently used by DHHR to allow West Virginia residents to search for and evaluate possible eligibility for benefits offered by the State of West Virginia.

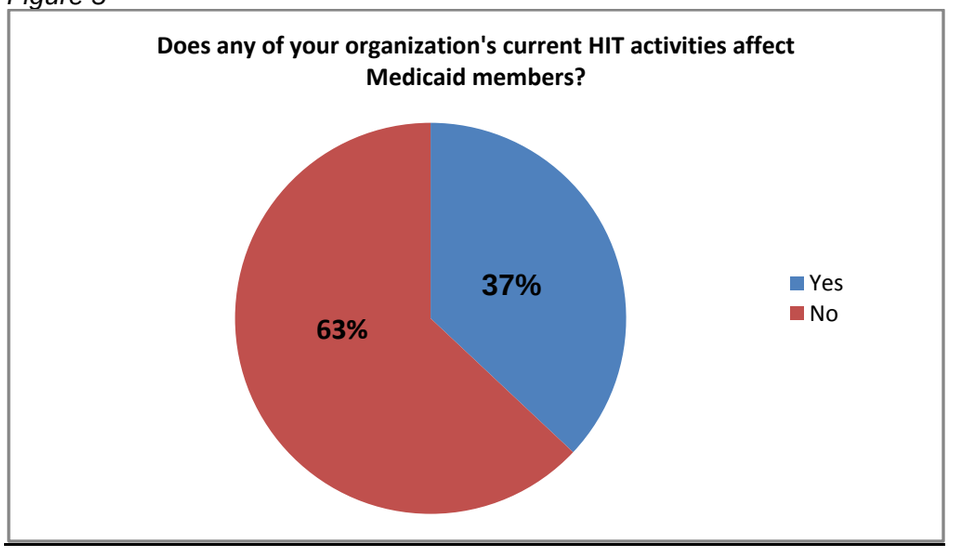
5. Figure 4 shows approximately 37% (6 respondents) of the survey respondents indicated that they have received State and/or Federal funding for HIT related projects. These six respondents include: BPH, WVRHITEC, Insurance Commission, CHN, WVHIN, and WVTA. This funding will be discussed in *section 2.3*.

Figure 4



6. Figure 5 shows approximately 37% (6 respondents) of the survey respondents indicated that their current HIT activities impact Medicaid members. These six respondents include: WVSOM, WVRHITEC, WVTA, CHN, WVHCA, and WVHIN. HIT impacts on Medicaid members are discussed more fully in *section 2.3*.

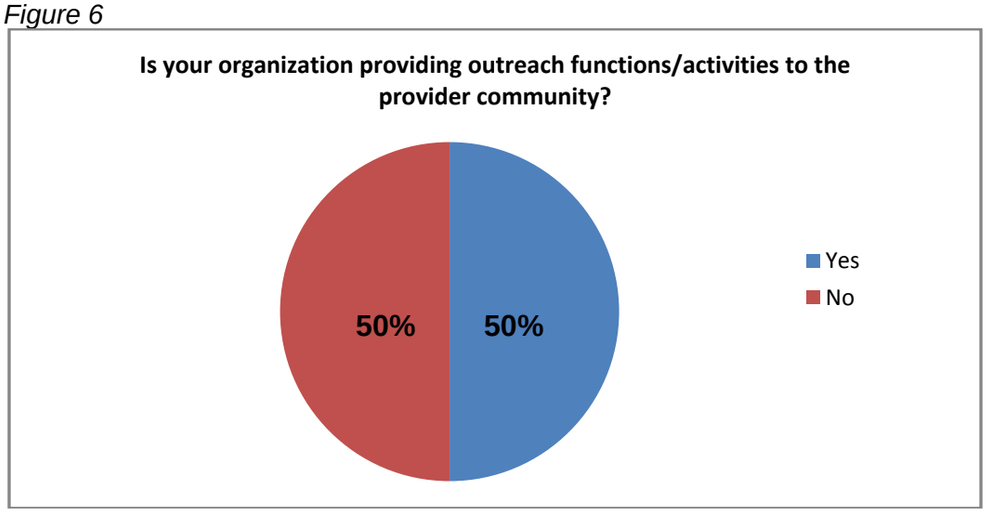
Figure 5



7. No survey respondents indicated that their HIT activities cross state borders. However, BMS enrolls prescribers and pharmacy providers within 30 miles of our state borders.

8. Figure 6 shows approximately half (8 respondents) of the survey respondents indicated that they are providing outreach to the provider community. These seven respondents include: BPH, PEIA, CHN, GOHELP, Insurance Commission, WVTA, WVHCA, and WVHIN.

Figure 6



Examples of current provider outreach functions and activities include:

- BPH provides direct training to physician office staff concerning reporting immunizations to the BPH's state-level immunization registry, Statewide Immunization Information System (SIIS).

- PEIA provides continual education to providers regarding ongoing issues surrounding services and payment. This education mainly takes place in the form of newsletters and PEIA-sponsored conferences.

- GOHELP has some interaction with the provider community through its GOHELP Advisory Council meetings, which are an open forum, and allow stakeholders to learn about HIT projects in West Virginia. Other channels for reaching the provider community that GOHELP uses includes communication through a GOHELP listserv, attending provider community meetings and conferences, etc.

- CHN provides direct education to their participating providers on the Meaningful Use requirements and how to enhance the use of RPMS as a health improvement tool.

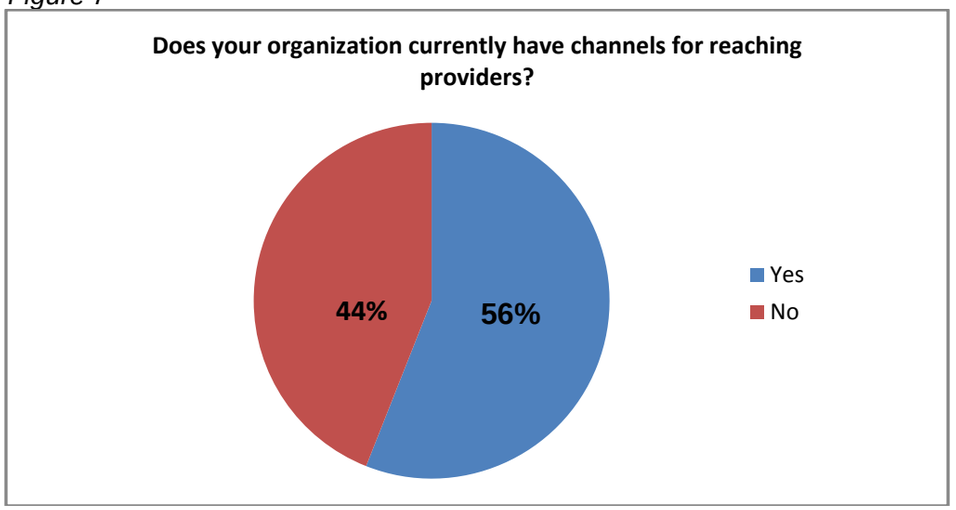
- The WVTA recently received a $200,000 Claude Worthington Benedum Foundation that will be used to fund a two-year telehealth outreach and education project. The project will facilitate the use of telehealth outreach coordinators to educate and engage users and potential users of telehealth applications throughout West Virginia. The plan calls for engaging experienced outreach trainers to provide support to telehealth sites, particularly those that have obtained enhanced telecommunication resources through the WVTA's Rural Health Care Pilot Program. The outreach coordinators/trainers will be assigned to site locations to assess each organization's telehealth IQ, infrastructure support technology and human resources capabilities and evaluate development needs and priorities. Sites will receive educational and consultation support to establish telehealth enhancement and applications relevant to their needs and goals; such support may include clinical staff training, technical staff support/education or linkages to external resources that can achieve/support their telehealth goals.

- WVHCA has actively engaged hospitals in a quality improvement collaborative to reduce elective pre-term deliveries.

- WVHIN is in constant contact and communication with hospitals, physicians, laboratories, health plans, and other stakeholders throughout the state to promote HIE services. WVHIN and WVRHITEC share a Physician Advisory Council which consists of a unique group of over 20 primary care and specialty physicians across the state. The Council helps mobilize the physician community to adopt electronic health records (EHRs) and participate in the WVHIN.

9. Approximately 56% (9 respondents) of the survey respondents indicated that they have channels for reaching providers. These nine respondents include: BPH, WVSOM, PEIA, GOHELP, WVRHITEC, WVTA, CHN, WVHCA, and WVHIN. The most commonly cited communication channels include newsletters, websites, committee meetings, and attendance at statewide healthcare conferences and meetings. BPH also reported using the West Virginia Health Alert Network to reach providers. The Network is used to disseminate secure alerts to providers regarding unusual outbreaks of illnesses that may be the result of terrorism involving biological or chemical agents.

Figure 7



10. Approximately 13% (2 respondents) of the survey respondents indicated that their organization is providing financial support to help providers in adopting EHRs and achieving Meaningful Use. WVSOM indicated that it will provide financial and operational assistance to its affiliated clinic, the Robert C. Byrd Clinic, as it prepares for certified EHR adoption and achievement of Meaningful Use. Additionally, the WVRHITEC's grant provides technical assistance for its members.

2.3 Overview of Survey Respondents

2.3.1 Governor's Office of Health Enhancement & Lifestyle Planning (GOHELP)

GOHELP is the State organization which coordinates health related activities and policies, including HIT programs, among state agencies and some private sector entities. GOHELP coordinates and collaborates with all twenty survey respondents identified in this report. This coordination and collaboration occurs through regular meetings with HIT project leaders and principals and sharing of program plans and activities. GOHELP also collaborates with HIT stakeholders to resolve key issues, such as e-prescribing electronic signature issues; HIT workforce supply; financial models relevant to HIT implementations; and other HIT-related policy or operational issues.

GOHELP promotes and supports HIT-related grant opportunities through the maintenance of a database of grant opportunities available to organizations. GOHELP identifies likely applicants and shares information with them in support of application development. GOHELP also gathers application materials to catalog reusable content and identify and share relevant information and best practices. GOHELP is also working with HIT programs to redraft the State's HIT Plan. This new plan will be reflective of federal and state health care reform triggered by the Affordable Care Act, ARRA, EHR incentive programs, guidance from CMS regarding grant funding for HIT, and West Virginia's MITA architectural plans.

2.3.2 West Virginia Regional Health Information Technology Extension Center (WVRHITEC)

The Regional Extension Center serving West Virginia is the West Virginia Regional Health Information Technology Extension Center (WVRHITEC) and as such received a $6 million grant from Office of the National Coordinator for Health Information Technology (ONC). The WVRHITEC is a consortium of state-based organizations brought together by the West Virginia Health Improvement Institute (the grantee from the Office of the National Coordinator) and includes the West Virginia Medical Institute (a state based Quality Improvement Organization and lead grantee for RECs in Delaware and Pennsylvania); the Community Health Network of West Virginia (a HRSA supported Integrated Service Delivery Network of Federally Qualified Health Centers); and the IPA of the Upper Ohio Valley (a provider independent practice association serving the upper panhandle of West Virginia).

The West Virginia Health Improvement Institute which serves as the grantee on the WVRHITEC project has experience in working with healthcare providers in West Virginia and supporting HIT systems. The Institute supports multiple HIT systems including an outcome reporting system; patient registry; patient portal; a reporting system to collect clinical measures and Meaningful Use measures from providers that participate in the Institute's medical home pilots (this is a SQL based system); and, a chronic disease electronic management system (CDEMS) registry for physician practices that need an interim solution prior to an EHR. The Institute also supported the HealtheMountaineer Personal Health Record (PHR) in two pilots. This PHR solution is an adaption of the My HealtheVet solution and is currently being supported by KRM Associates.

In the role of the Regional Extension Center, the WVRHITEC will assist West Virginia providers in adopting, implementing, and using certified EHRs. As a result of this role, the WVRHITEC has coordinated closely with the WVHIN and Medicaid since its launch. WVRHITEC anticipates supporting at least six to nine commercial off-the-shelf (COTS) EHR vendor solutions.

The WVRHITEC has a target of enrolling 1000 priority providers (including many that serve the Medicaid population) and assisting them with reaching Meaningful Use. The priority provider target market includes all of the Federally Qualified Health Centers which serve a disproportionate share of the Medicaid population. As of November 1, 2010, the WVRHITEC has enrolled 402 providers. The WVRHIETC strives through its outreach efforts to identify providers who are high prospects for pursuing participation in the Medicaid portion of the Meaningful Use incentive program and target services to that cohort to ensure their readiness to participate in the incentive program. In addition, the WVRHITEC is in constant communication with Medicaid regarding HIT-related challenges that providers report to the WVRHITEC.

2.3.3 West Virginia Health Information Network (WVHIN)

The West Virginia Health Information Network (WVHIN) was established by W. Va. Code § 16-29G-1, *et seq*. in 2006 and was charged to design, implement and maintain a statewide health information exchange (HIE). The WVHIN is governed by a 17-member public/private board of directors which is comprised of the State's greatest champions for HIE. The board represents a cross-section of stakeholders and is a neutral party well positioned to harmonize the interests of varied stakeholders. WVHIN's board composition includes representatives from hospital and

physician associations, nursing homes, medical schools, the Health Care Authority, health plans, government and others.

WVHIN has established goals, objectives, and milestones to implement the HIE in a consensus-based approach that includes statewide coverage of all providers. This consensus-based approach is organized and supported through a variety of mechanisms, including the WVHIN board, the Executive Committee, the Finance Committee, WVHIN's task forces which developed requirements for WVHIN's RFP (i.e. Privacy and Security Task Force, Data Standards Task Force, Functionality Task Force, Technical Task Force), and WVHIN's/WVRHITEC's Physician Advisory Council. These organizational mechanisms have been fundamental to WVHIN's planning process and will continue to play an important role in WVHIN's implementation process.

The WVHIN has been designated as the State Designated Entity (SDE) for Health Information Exchange (HIE) by ONC. As part of the State HIE Cooperative Agreement Program, the WVHIN received $7.8 million to implement West Virginia's statewide HIE. WVHIN has also received $3.5 million from the West Virginia Legislature for operations. WVHIN will connect to certified EHRs to enable exchange of patient data including lab results, patient care summaries, medication lists, electronic prescriptions, etc.

In addition to connecting West Virginia's hospitals and provider organizations to the HIE, the WVHIN intends to enable the HIE to connect with Medicaid through its MMIS. WVHIN plans to "pre-populate" the HIE with the past six years of Medicaid claims data dating back to 2004. Medicaid claims data contains important clinical information on the Medicaid population and can help Medicaid providers using the HIE better understand a patient's medical history. The WVHIN will also enable eligible professionals (EP) and eligible hospitals (EH) to fulfill Meaningful Use reporting requirements through the WVHIN. WVHIN plans to implement its pilot for HIE in the Wheeling, West Virginia area in 1Q11. WVHIN will enable data exchange between Wheeling Hospital and approximately 150 physicians in the Upper Ohio Valley IPA (a provider independent practice association serving the Wheeling area).

2.3.4 Department of Commerce (DOC)

The DOC leads and oversees the Broadband Initiative to expand broadband into West Virginia's rural areas. The DOC, in concert with Governor's Executive Office, received a BTOP grant that was fully funded for over $126 million. Recognizing that broadband is imperative in serving its citizens and bringing economic development, former West Virginia Governor Joe Manchin III signed legislation creating the Broadband Deployment Council (BDC), an entity designed to facilitate innovative, quality, affordable broadband to all West Virginians; the BDC is working directly with the BTOP grant project.

West Virginia, located in the heart of Appalachia, is entirely mountainous and has challenging demographics. West Virginia's terrain is a major challenge for broadband deployment, and this is being reflected in the broadband build out rate. It is critical that West Virginia have a complete and robust middle mile in order to facilitate the efficient delivery of critical public services in healthcare, education, and public safety.

West Virginia's broadband deployment strategy begins with the build out of an open network middle mile solution that will provide fiber to critical community anchor tenants. Distribution of

the bandwidth to support private, public, and individual connectivity will then occur through switching, routing, and leadership. This high quality middle mile is essential to last mile completion of broadband deployment, and will provide a full range of interconnect possibilities to meet provider, carrier, and end user requirements. West Virginia's strategy is designed to foster competition generated by built-in multiple accesses, with the foreseeable reduction in costs for service for actual end users. To address demand and sustainability issues, the State, through the selection of the anchor tenants for the build out, designed the broadband deployment strategy to enhance critical services to citizens, which is paramount to building demand for robust broadband service.

Direct work on the BTOP grant began in November 2010. The grant work must be substantially complete in two years (Feb 2012) and fully completed in three years (Feb 2013). The middle mile portion of this open access grant provides a backbone facilitating any entity in West Virginia access to broadband. The anchor tenant portion fully connects 1064 entities to receive broadband services. Each county in the state will receive some level of connectivity from the grant.

2.3.5 West Virginia Telehealth Alliance (WVTA)

The WVTA received $8.4 million to expand broadband across the State of West Virginia as participants in the FCC's Rural Health Care Pilot Program. In addition, the Alliance received nearly $1 million in state funds. All of this funding is being used by the WVTA to: enhance broadband connections among healthcare providers; educate hospitals and rural clinics about telehealth applications; and help facilitate possible telehealth interlinkages.

As part of the FCC's Rural Health Care Pilot Program, the WVTA is working to enhance broadband connectivity to 96 distinctive locations (hospitals, rural clinics, free clinics, etc.) across the State of West Virginia. Most of the entities that will benefit from the WVTA's projects and activities provide services to the State's Medicaid population. This improved broadband connectivity will provide a number of benefits, including but not limited to: enabling greater use of telehealth services and connections that will enable improved diagnostic capabilities and specialty treatment options; enabling better group purchasing power and enhanced reliability and quality of service; fostering tele-training and educational opportunities; and establishing virtual private networks to ensure security, reliability and connectivity.

As part of the FCC's Rural Health Care Pilot Program, the WVTA is helping to spearhead a Metro Fiber Build project in the Huntington, WV area that will provide a metropolitan fiber connection environment (1 gig) to facilitate eligible health care services at and among the following institutions: Marshall University (for its health education programs, courses), Marshall University Joan C. Edwards School of Medicine (MUSOM), St. Mary's Medical Center, and Cabell-Huntington Hospital. The three medical facilities, MUSOM, St. Mary's and Cabell-Huntington Hospital, provide medical and health care services to rural populations living and working in a multi-county, tri-state geographic region. They also serve as specialty medical and treatment centers (cardiovascular, neuroscience/stroke, cancer treatment, etc.) for rural residents who are referred from rural health care clinics and physicians.

Finally, the fiber build project not only will provide advanced broadband interconnection among these institutions for the exchange of health information and health education purposes, but it also will allow rural health centers to access remotely (via telehealth) the physicians and specialists at these interconnected organizations. In addition, two rural health care centers will benefit as part of the Metro Fiber Build project; these include the Lincoln Primary Care (in Lincoln County, WV) and Tug River Health Association (in McDowell County, WV). The fiber build project is scheduled to be completed in January 2011. Another upgrade project is underway that will involve 96 health care locations across the state.

2.3.6 West Virginia Healthcare Authority (WVHCA)

The programs administered by the WVHCA generally have two primary purposes: to constrain the rising cost of health care and to assure reasonable access to necessary health services. To accomplish these purposes, WVHCA has implemented programs such as Rate Review and Certificate of Need (CON).

Current systems in use by the WVHCA include an outcome reporting system which is used to collect and maintain databases of provider (e.g. hospitals, nursing homes, home health agencies, hospice agencies, behavioral health centers, ambulatory surgical care centers, and renal dialysis centers) financial, administrative, and clinical data as well as state payer (i.e. Medicaid, PEIA, CHIP) claims data. Data is used to assess healthcare utilization, access, costs, quality and to inform regulatory, health policy/planning, and quality improvement initiatives. WVHCA is in the process of developing analytic reports and management portals using COGNOS software to enhance data analysis and reporting. The WVHCA plays an integrate role in shaping the strategic direction of West Virginia's HIT initiatives. For example, WVHCA is represented on the WVHIN Board of Directors, WVTA Board of Directors, as well as GOHELP's Advisory Council.

2.3.7 DHHR Office of Secretary (DHHR)

DHHR is the second largest state agency in West Virginia, and encompasses multiple bureaus and programs including the Bureau of Medical Services (BMS), Bureau for Public Health (BPH), and Bureau for Children and Families (BCF). The Office of the Secretary is primarily administrative and supports the various HIT related initiatives throughout DHHR in collaboration with GOHELP, Office of the Insurance Commissioner, HCA and the WVHIN. The department is lead by Secretary Michael Lewis. The Secretary serves on the Board of Directors of the West Virginia Health Information Network. The State HIT Coordinator is the Deputy Commissioner of the Bureau of Medical Services under WVDHHR. The DHHR Chief Technology Officer has been involved in the development of the DHHR strategic and operational plan that will align the HIT initiatives within the department.

2.3.7.1 Bureau for Children and Families (BCF)

The WV Bureau for Children and Families has several large statewide systems for processing and tracking services for qualifying families, children and individuals. BCF coordinates closely with the Bureau for Medical Services and the Children's Health Insurance Program.

2.3.7.2 Bureau for Public Health (BPH)

The BPH operates several statewide systems for disease surveillance and immunization tracking, and mandatory reporting to multiple registries. The West Virginia Title 64 Legislative Rule authorizes the Public Health Commissioner to establish and maintain a centralized registry for tracking compliance with nationally recommended immunization schedules and for monitoring vaccine use. Thus, BPH receives immunization data through West Virginia's state-level immunization registry called the WV Statewide Immunization Information System (WV SIIS). Approximately 50% or more of local health departments do direct data entry into the WV SIIS and about 700 of West Virginia's approximate 3,800 physicians enter data into the WV SIIS via direct data entry through a web portal that BPH provides. The majority of physicians send immunization data to the BPH via a flat file format. Approximately 3% of physicians send immunization data to the BPH via paper records.

The West Virginia Title 64 Legislative Rule establishes the procedures governing the reporting of certain diseases and conditions, unusual health events, and clusters or outbreaks of diseases to the BPH from laboratories, healthcare providers, and healthcare facilities. Such events are reported to the BPH through the Electronic Disease Surveillance System (EDSS). All local health departments direct data entry into the EDSS using an application called Health Stat 2000. The BPH will be able to electronically receive lab reports into the EDSS beginning in early 2011; the first labs that will send reports electronically include LabCorp and the state-based labs. In mid-2011, the BPH plans to enable at least five of the state hospitals to do direct data entry of notifiable lab results into the EDSS. With the five hospitals reporting into the EDSS as well as data coming in from LabCorp and state-based labs, the BPH will be able to electronically capture around 60-75 percent of the lab data within the state.

West Virginia utilized data collected by the WV Office of Health Licensure and Certification to determine there are approximately 2,765 laboratories operating in the state. The majority of the laboratories are concentrated in the following cities:

- Beckley
- Charleston
- Huntington
- Morgantown
- Parkersburg
- Wheeling

At this time, it is unknown how many labs have electronic submission capabilities. However, WV has engaged the lab partners through the participation in the HIT collaborative and it is the Bureau's goal to maintain and report more in depth metrics once the HIE is online.

Please refer to Appendix F for further demographics.

WVHIN leadership has been working closely with the BPH on how the WVHIN can integrate with BPH's existing systems (e.g. SIIS, EDSS, and its provider alerting system, the West Virginia Health Alert Network). BPH sees value in the WVHIN's ability to enable providers and laboratories to access a single portal in order to interact with the BPH's systems.

Furthermore, WVHIN users, such as hospitals, physicians, labs, etc. would have the convenience of accessing a single portal in order to report data to BPH and receive public

health alerts. As part of BPH's plans to establish syndromic surveillance in the near future, the BPH also sees information flowing through the WVHIN as a potential data source for syndromic surveillance.

2.3.7.3 Bureau for Medical Services (BMS)

West Virginia has a population of approximately 1.8 million. Medicaid is a $2.5 billion a year program with an enrollment of approximately 405,000 people, or 22.5% of the State's population. The state of West Virginia is one of the first in the nation to redesign its Medicaid program under the authority granted by the Deficit Reduction Act of 2005 to improve the health of enrolled members through enhanced access to preventive and disease management services and defined personal health management goals and responsibilities. As part of the Medicaid program redesign, BMS is leveraging HIT to improve health quality and outcomes for Medicaid beneficiaries.

Medicaid plans to leverage the integration, connectivity and networking services that the WVHIN can provide and as such planning is underway to ensure full interoperability between the WVHIN and the MMIS. Medicaid has committed to pre-populating the WVHIN with approximately six years of Medicaid claims data from which valuable clinical history can be gathered and exchanged. WVHIN and Medicaid leadership continue to collaborate to identify common business priorities. Several elements of the WVHIN that support Medicaid have been identified. These include:

- Provide data exchange with public health
- Use the WVHIN portal to support Medicaid applications and connectivity
- Utilization of common data standards to support collaboration and interoperability
- Compatibility and interoperability with the Nationwide Health Information Network
- Provide functionality and connectivity required in the new MMIS as defined in the HIT P-APD

West Virginia was the recipient of five Medicaid Transformation grants that focused on HIT and health quality/outcomes. These grants are entitled: Healthier Medicaid Members through Personal Responsibility, Healthier Medicaid Members through a Stronger Medicaid Program, Healthier Medicaid Members through Applied Technology, Healthier Medicaid Members Health Systems Improvements, and Healthier Medicaid Members through Enhanced Medication Management. Funding from the transformation grants were used for multiple projects, such as:

- Conducting a landscape assessment to determine percentage of EHRs in use within the State of West Virginia - To develop this baseline assessment of EHR use within the state of West Virginia, BMS partnered with Shepherd University and KRM Associates, Inc. to develop and disseminate of a series of surveys to help assess the HIT landscape and readiness across West Virginia. Results from the surveys are included in a 2008 report entitled *West Virginia Health Information Technology Readiness Final Report*. This report provided the "starting point" for understanding West Virginia's HIT landscape.

- Developing and deploying a Personal Health Record (PHR) system as a proof of concept - BMS partnered with KRM Associates, Inc. to develop the PHR, HealtheMountaineer. This PHR solution is an adaption of the My HealtheVet solution and is currently being supported by KRM Associates.

- Conducting a proof of concept demonstration of an EHR interacting with a PHR through a HIE - In March 2010, KRM Associates, Inc. partnered with Northrop Grumman to demonstrate how their PHR solution interacted with an EHR through HIE. The HIE was developed by Northrop Grumman and utilizes the NHIN CONNECT standards. In the demo, the PHR developed by KRM was capable of requesting EHRs from the Health Information Exchange. Upon this action, the HIE would request the appropriate records from test EHR installations of RPMS and OpenVistA, retrieve these records, and parse them into a secure personal health record repository. This data was then displayed and interpreted through the PHR web-interface.

- *Developing an e-prescribing system - The funds allocated for the Enhanced Medication Management grant have been used to develop an e-prescribing system that is certified with SureScripts. This new web-based application, WVeScript, is free for medical prescribers across West Virginia who are enrolled with West Virginia Medicaid. Medicaid-enrolled providers can use WVeScript for all their patients, not just Medicaid members. WVHIN is working with the West Virginia Department of Health and Human Resources (DHHR) to offer this e-prescribing application via the WVHIN and offer it to any physician in the State of West Virginia as a means of ensuring physicians in the State can meet Meaningful Use requirements for e-prescribing.*

2.3.8 Public Employees Insurance Association (PEIA)

PEIA provides major medical insurance to approximately 220,000 West Virginia government employees. PEIA does not currently have any HIT systems; however, the WVHIN is working with PEIA on possibly providing insurance eligibility information through the WVHIN portal.

2.3.9 West Virginia School of Osteopathic Medicine (WVSOM)

The WVSOM, located in Lewisburg, West Virginia, incorporates the latest technologically advanced medical teaching tools as part of its curriculum. For example, the WVSOM utilizes Mountaineer Doctor Television (MDTV) as a telehealth network which provides telemedicine and educational/administrative video conferencing services. The WVSOM has SAGE Intergy Practice Management System with some EHR capabilities; this SAGE product has been recently updated to its latest version. The WVSOM has also issued a Request for Offer (RFO) for an integrated Practice Management EHR application. WVSOM participated in the Health Improvement Institute's patient centered medical home pilots which included Medicaid members as direct targets of the pilot program. Representatives from the WVSOM are actively engaged in West Virginia's HIT initiatives through their participation on various Boards including the WVHIN and the WVTA.

2.3.10 Department of Military Affairs and Public Safety (DMAPS)

DMAPS is made up of many divisions. The *Military Affairs Divisions,* for example, consists of the National Guard and the Division of Veterans Affairs. The National Guard serves a dual federal-state mission unique to the U.S. military. The distribution of soldiers, equipment and facilities across the state allows the National Guard to respond quickly and efficiently to statewide emergencies. The Guard also serves a federal mission through deployment of personnel and resources in support of U.S. operations around the world. The Division of Veterans Affairs assists WV veterans and their dependents in obtaining all benefits to which they are entitled, both federal and state.

The Public Safety Divisions within DMAPS are responsible for providing a safe environment for West Virginia citizens; this includes the ability to respond to natural and man-made disasters. *The Public Safety Divisions* are the State Police, the Division of Homeland Security and Emergency Management, the Regional Jail and Correctional Facility Authority, the Division of Corrections, the Division of Juvenile Services, the Division of Protective Services, the Parole Board, the Office of the Fire Marshall and the Division of Criminal Justice Services.

DMAPS is involved with the DOC's broadband initiative which is going to increase broadband availability across West Virginia. DMAPS also coordinates disaster planning with the Bureau for Public Health; this includes coordinating statewide communication regarding emergencies, etc. via the Health Alert Network.

2.3.11 West Virginia Division of Homeland Security and Emergency Management (DHSEM)

DHSEM provides coordination to assist local emergency managers and first responders in the event of statewide emergencies. DHSEM coordinates with DHHR and BPH to facilitate advanced planning and preparation for health disasters; this includes utilizing the Wide Area Rapid Notification System (W.A.R.N.) in the event of public health emergencies and other statewide emergencies. W.A.R.N. is a web-based notification service that provides an organization with instant outbound messaging and allows the organization to track delivery of the notification. Messages can be sent by e-mail, fax, mobile phone, pager, land-line phone, and/or short message service; messages can be sent to one or all devices anywhere and anytime.

2.3.12 West Virginia Insurance Commission

The West Virginia Insurance Commission regulates the approximate 1,500 insurance entities that are licensed and registered to conduct business in the State of West Virginia. Some of the responsibilities of the Insurance Commission include issuing new and renewal licenses to insurance companies, examining insurance companies to monitor financial soundness, investigating the integrity of their marketplace practices, and monitoring insurance company compliance with West Virginia insurance laws.

The Insurance Commission currently uses the System for Electronic Rate and Form Filing (SERFF) which allows the Commission to manage rate filings from insurance carriers. The Commission recently received a state grant for $1 million to update its SERFF system. The Commission has also received a $1 million Exchange Planning Grant from the Department of

Health and Human Services. Funds will be used to: assess the State's health insurance consumer and business markets using demographic surveys; develop an economic assessment of West Virginia's health insurance market and determine who will participate in Health Insurance Exchange; develop an education and outreach strategy for the Exchange project which will result in education and outreach plan; and, assess the efficiency and effectiveness of current West Virginia IT systems which could potentially perform technical tasks for the Health Insurance Exchange. As a partner with DHHR on the State Health Access Program (SHAP) grant, the Insurance Commission will receive some of the SHAP grant monies for Exchange planning and development, primarily for full-time employees (FTEs). The Insurance Commission plans to implement the National Association of Insurance Commissioner's (NAIC) State Based System (SBS) in late February 2011. The SBS will be used for agent licensing purposes as well as providing the platform for the Commission's Consumer Services Division to compile and track consumer complaints regarding insurance carriers.

2.3.13 Community Health Network (CHN)

The CHN of West Virginia is a health center controlled network (HCCN) comprised of member health centers. The CHN is the first HCCN to successfully adapt and deploy the Resource and Patient Management System ("RPMS") clinical information system used by Indian Health Service (IHS) as a public domain HIT tool for use in community health centers outside of IHS. The Network has received HRSA grants to support the adoption and use of RPMS as a health improvement tool for participating member health centers. CHN staff has trained more than 800 clinicians and administrative support personnel in nine CHN member organizations operating 37 clinical locations; more than 195,000 patient files are included in the Network's RPMS database (over 10% of West Virginia's population).

The RPMS system includes a patient registry and future plans include full e-prescribing integration (in order to support Meaningful Use) with the next system upgrade. Healthcare facilities which currently use RPMS include Tri-County Health Clinic (Community Care of WV), Lincoln Primary Care (Southern WV Health Systems), E.A. Hawse, Tug River Medical, Pendleton Community Care and FamilyCare. Belington Health has been trained on the system but has not started using it yet. Ultimately, the CHN is continually upgrading the functionality of the system, including new servers and virtual operating environment.

The Network system also includes a telehealth network, integrated outcome reporting and the Network has piloted the integration of KRM Associates, Inc. PHR solution with patient portal and secure messaging. The PHR and patient portal features were integrated as part of a Medicaid pilot within the last year. The CHN also has a well-child and woman's health module in development as part of a beta-test project with IHS. The CHN also exchanges information electronically with LabCorp.

2.4 Conclusion

The Landscape Assessment effort captured information about planned as well as current health information technology deployed within the state. The "To Be" Medicaid HIT Vision described in the next section acknowledges and builds upon existing HIT efforts. Furthermore, when appropriate, the Bureau will integrate Medicaid HIT efforts with those planned by other entities within the State to avoid duplication of effort, redundant spending and proliferation of conflicting communication and standards.

3.0 Future "To-Be" HIT Environment

Section 2 illustrated the current HIT environment and provided some general background of future HIT plans among WV State agencies. Sections 3 and 4 provide a road map of West Virginia Medicaid's goals, objectives, initiatives and benchmarks as they relate to HIT. The future "To Be" Medicaid HIT environment envisioned by the Bureau for Medical Services builds upon and, when appropriate, integrates with other HIT efforts within the State. The Bureau considered several factors when evaluating candidate strategic goals, objectives and initiatives. They included:

- Compliance with law and regulation,
- Avoidance of duplicated effort and redundant spending,
- Financial sustainability, and
- Alignment with strategic goals and objectives

3.1 Medicaid Goals and Objectives

Strategic planning is not a one-time activity. The transformation of state Medicaid programs will be an ongoing, iterative process. Each successive effort is expected to be more inclusive and result in broader change than the last. To that end, BMS periodically revisits its strategic goals and objectives in light of changes in the program environment.

The strategic planning efforts conducted by the Department of Health and Human Resources, Bureau for Medical Services in the Fall of 2010 built upon the strategic foundation and direction provided by the following:

- Former Governor Manchin's Healthy West Virginia (HealthyWV) Strategic Plan completed and published in April 2007[1]
- CMS Medicaid Information Technology Architecture (MITA) State Self-Assessment (SS-A) requirements[2]
- West Virginia Health Information Technology Statewide Strategic Plan[3]
- Medicaid provision of the American Recovery and Reinvestment Act of 2009[4]
- Medicaid provisions of the Patient Protection and Affordable Care Act of 2010[5]

[1] Former Governor Manchin's Healthy West Virginia (HealthyWV) Strategic Plan completed and published in April 2007 (http://www.gohelp.wv.gov/AdvisoryCouncil/Meetings/Documents/West%20Virginia's%20Health%20Information%20Technology%20Initiative%207.pdf).

[2] CMS Medicaid Information Technology Architecture (MITA) State Self-Assessment (SS-A) requirements (https://www.cms.gov/MedicaidInfoTechArch/04_MITAFramework.asp).

[3] West Virginia Health Information Technology Statewide Strategic Plan (http://www.wvhealthimprovement.org/wvhii/Attachment443.aspx)

[4] Medicaid provision of the American Recovery and Reinvestment Act of 2009 (http://www.recovery.gov)

[5] Medicaid provisions of the Patient Protection and Affordable Care Act of 2010 http://ritterim.files.wordpress.com/2010/03/healthcarereformbill_final.pdf

A series of visioning meetings and work activities were conducted to update the Bureau's strategic plan. The goals and objectives developed in 2009 for the CMS Medicaid Information Technology Architecture (MITA) State Self-Assessment (SS-A) and updated in subsequent planning activities were used as a starting point for this effort.

BMS has made a commitment to utilize MITA principles wherever possible when conducting any business and information technology planning activities. This commitment has established an environment where MITA principles are embraced and understood within the Bureau and allows for more efficient and effective strategic and tactical planning activities.

In order to measure progress in achieving Medicaid goals and objectives, the Bureau will employ industry standard project management processes and controls to manage project activities. State staff, with the assistance of the project management contractor, will manage the project, provide policy and programmatic expertise, and review and approve all contractor deliverables and work products. Refer to Appendix H for the Medicaid goals and objectives timeline.

The BMS Project Manager will develop a Project Management Plan for Bureau review and approval. The Project Management Plan will summarize how the State will conduct project activities. It will describe the State's project organization and identify key staff by name and title. It will describe how and when the activities will be conducted with schedules and milestones for completion of key events. It will describe the project processes used for the ongoing management of scope, schedule, cost, resources, risk, and communication.

The following tables provide the BMS goals and objectives that were updated and adopted during the SMHP planning process. Several of the goals listed align with the CMS MITA model. The first six goals, referenced with a "Gen" ID prefix, are those that are considered to be overarching and not applicable to only one MITA business area.

Table 3: BMS Strategic Goals

ID	Goals & Objectives by Business Area
Gen	**High-Level Administrative and Management Goals and Objectives**
Gen 1.0	Goal: Improve BMS effectiveness and efficiency.
Gen 2.0	Goal: Minimize risk and maximize value from contracted services and products.
Gen 3.0	Goal: Leverage technology to enhance performance and decision making.
Gen 4.0	Goal: Assess, implement, and monitor compliance with all relevant federal laws and regulations (e.g. PPACA, State Medicaid Manual, HIPAA).
Gen 5.0	Goal: Ensure program quality.
Gen 6.0	Goal: Enhance and improve efficient, effective and meaningful outreach and communication.
OM	**Operations Management**
OM 1.0	Goal: Improve operational efficiency and reduce costs in the healthcare system.
OM 2.0	Goal: Improve access to information necessary for operations management.
OM 3.0	Goal: Improve provider access to real-time data.
ME	**Member Management**

ID	Goals & Objectives by Business Area
ME 1.0	Goal: Enhance ability for members to participate in and exercise responsibility for their personal health choices.
PG	**Program Management**
PG 1.0	Goal: Enhance the Bureau's ability to analyze the effectiveness of potential and existing benefits and policies.
PG 2.0	Goal: Improve consistency of Program management processes and effective communication of policy.
PM	**Provider Management**
PM 1.0	Goal: Simplify process for submission of provider information.
CM	**Care Management**
CM 1.0	Goal: Improve healthcare outcomes for members.
CM 2.0	Goal: Increase use of evidence based clinical and appropriate services.
CO	**Contractor Management**
CO 1.0	Goal: Enhance the Bureau's ability to monitor contractor performance against approved measures.
PI	**Program Integrity Management**
PI 1.0	Goal: Improve effectiveness and efficiency of Program Integrity Management function.
BR	**Business Relationship Management**
BR 1.0	Goal: Enhance the security, timeliness and accuracy of data exchanged with authorized and authenticated business partners.

After reviewing and the updating the goals, Bureau leadership updated the list of related objectives for each goal. The full list of goals and objectives are listed in the following table:

Table 4: BMS Strategic Goals and Objectives

ID	Goals & Objectives by Business Area
Gen	**High-Level Administrative and Management Goals and Objectives**
Gen 1.0	Goal: Improve BMS effectiveness and efficiency.
Gen 1.1	Align resources with core business functions.
Gen 1.2	Secure necessary resources.
Gen 1.3	Establish and provide necessary professional education and training to enhance staff performance.
Gen 1.4	Develop MMIS Roadmap to support future business needs.
Gen 1.5	Implement performance management and measurement principles within BMS.
Gen 2.0	Goal: Minimize risk and maximize value from contracted services and products.
Gen 2.1	Streamline and improve procurement business functions.
Gen 2.2	Continuously improve project management capabilities.
Gen 2.3	Implement performance management and measurement principles.
Gen 3.0	Goal: Leverage technology to enhance performance and decision making.
Gen 3.1	Enhance reporting capabilities to allow for more efficient and effective performance

ID	Goals & Objectives by Business Area
	monitoring.
Gen 3.2	Improve data access, analysis and reporting to support decision making.
Gen 4.0	Goal: Assess, implement, and monitor compliance with all relevant federal laws and regulations (e.g. PPACA, State Medicaid Manual, HIPAA).
Gen 4.1	Establish a team and process for assessing compliance with new laws and regulations. .
Gen 4.2	Establish a team and process for implementation of changes necessary to comply with new laws and regulations.
Gen 4.3	Establish a team and process for monitoring compliance with laws and regulations.
Gen 4.4	Verify and monitor MMIS and Fiscal Agent operations to ensure transactions are processed in accordance with all relevant federal laws and regulations.
Gen 5.0	Goal: Ensure program quality.
Gen 5.1	Develop and execute a Quality Management Plan.
Gen 5.2	Design and configure systems and processes to support the Quality Plan.
Gen 5.3	Enhance ability to measure compliance with quality indicators.
Gen 6.0	Goal: Enhance and improve efficient, effective and meaningful outreach and communication.
Gen 6.1	Improve communication with providers and members.
Gen 6.2	Rebrand Medicaid as another provider of healthcare coverage.
OM	**Operations Management**
OM 1.0	Goal: Improve operational efficiency and reduce costs in the healthcare system.
OM 1.1	Document operations management roles, responsibilities and business processes.
OM 1.2	Analyze operations management organization structure to align resources with core business functions.
OM 1.3	Enhance and automate reporting capabilities to measure compliance with operational performance measures.
OM 2.0	Goal: Improve access to information necessary for operations management.
OM 2.1	Enhance cost avoidance capability by improving access to accurate other third party payer information.
OM 2.2	Establish integration with other entities to further reduce the potential for redundancy of service and payment.
OM 3.0	Goal: Improve provider access to real-time data.
OM 3.1	Enhance provider portal to support clinical decisions and to provide real-time access to cost settlement and rebate data.
OM 3.2	Implement real time access to data based on claim adjudication results.
OM 3.3	Integrate automated prior authorization capability to provide real time approval or rejection of routine Pharmacy prior authorizations.
ME	**Member Management**
ME 1.0	Goal: Enhance ability for members to participate in and exercise responsibility for their personal health choices.

ID	Goals & Objectives by Business Area
ME 1.1	Explore capabilities to establish and allow member access to a personal health record.
ME 1.2	Provide automated administration of a member incentive program as designed by BMS and approved by CMS.
ME 1.3	Provide for automated administration of personal Health Improvement Plans.
ME 1.4	Empower members by providing access to information and tools that can be used to improve their health.
ME 1.5	Simplify and streamline eligibility determination to enhance access to care.
PG	**Program Management**
PG 1.0	Goal: Enhance the Bureau's ability to analyze the effectiveness of potential and existing benefits and policies.
PG 1.1	Integrate reconciled claims data with clinical data.
PG 1.2	Improve tools and provide training for data analysis to help improve healthcare decision making.
PG 2.0	Goal: Improve consistency of Program management processes and effective communication of policy.
PG 2.1	Document Program management roles, responsibilities and business processes.
PG 2.2	Establish reporting capabilities to measure compliance with performance measures.
PG 2.3	Design policy management workflow to ensure alignment of law/regulation, policy, system processing and provider communication.
PM	**Provider Management**
PM 1.0	Goal: Simplify process for submission of provider information.
PM 1.1	Improve provider enrollment and administration processes.
PM 1.2	Provide capability for online submission of standard forms and reports by providers.
PM 1.3	Integrate automated prior authorization capability to provide real time approval or rejection of routine prior authorizations. Both the pilot and planned integration of this functionality will apply to pharmacy, not medical/dental.
CM	**Care Management**
CM 1.0	Goal: Improve healthcare outcomes for members.
CM 1.1	Establish access to data from sister-agencies and programs within the Department of Health and Human Resources.
CM 1.2	Improve access to clinical and encounter data.
CM 1.3	Enhance ability to measure quality of healthcare outcomes for members.
CM 1.4	Evaluate alternatives to enhance care management capabilities.
CM 1.5	Establish Health Home for members with chronic conditions.
CM 2.0	Goal: Increase use of evidence based clinical and appropriate services.
CM 2.1	Increase the use of evidence based clinical and appropriate services, including preventive services.
CM 2.2	Provide technical capability for Pay-for-Performance reimbursement model.
CM 2.3	Increase meaningful use of Electronic Health Records among Medicaid providers.

ID	Goals & Objectives by Business Area
CO	**Contractor Management**
CO 1.0	Goal: Enhance the Bureau's ability to monitor contractor performance against approved measures.
CO 1.1	Establish reporting capabilities to measure contractor compliance with performance measures.
CO 1.2	Create automated functions to establish and monitor corrective action plans for contractors not meeting approved performance measures.
CO 1.3	Include deliverable expectations and quality indicators as part of solicitations and resulting contracts in alignment with the Bureau's Quality Management Plan.
PI	**Program Integrity Management**
PI 1.0	Goal: Improve effectiveness and efficiency of Program Integrity Management function.
PI 1.1	Analyze Program Integrity Management business area structure to align roles, responsibilities, identify necessary skill sets and appropriately assign resources.
PI 1.2	Improve tools and provide training to automate and streamline investigations and case management.
PI 1.3	Monitor MMIS security and controls.
BR	**Business Relationship Management**
BR 1.0	Goal: Enhance the security, timeliness and accuracy of data exchanged with authorized and authenticated business partners.
BR 1.1	Document business relationship management roles and responsibilities.
BR 1.2	Standardize processes for data validation and reconciliation.
BR 1.3	Standardize process for capture of report and data exchange requirements.

The Roadmap presented in section 4.0 identifies those Medicaid goals and objectives that will be supported by the implementation of health information technology. It also describes the alignment of HIT initiatives with specific goals and objectives.

3.2 HIT Governance Structure

As part of HIT planning, the Department of Health and Human Resources initiated discussions with key stakeholders about the future of Medicaid HIT and how it will operate in conjunction with the larger health system and statewide HIT efforts. Key stakeholders and stakeholder groups include, but are not limited to, the following:

- Governor's Office of Health Enhancement and Lifestyle Planning (GOHELP)
- West Virginia Health Information Network (WV HIN)
- Bureau for Public Health
- Bureau for Behavioral Health and Health Facilities
- Governor's Office of Technology
- Department of Commerce
- WV Health Care Authority
- Tele-Health Alliance
- WV Department of Military Affairs and Public Safety
- WV Insurance Commission

- DHHR Office of Secretary
- Bureau for Children and Families
- Public Employees Insurance Agency
- State Children's Health Insurance Program
- Health Improvement Institute
- Community Health Network

The Deputy Commissioner for Processes, Applications and Methodologies in the Bureau for Medical Services serves as HIT Coordinator. The HIT Coordinator serves as the liaison between the WV Medicaid HIT initiative, Department management, and other State HIT initiatives. The HIT Coordinator works closely with the following three entities that share responsibility for the HIT planning, development and implementation in West Virginia:

- ***GOHELP:*** Pursuant to §16-29H-6, GOHELP's role in HIT is that of a coordinator. To that end, GOHELP facilitates discussion and assists constituent state agencies with HIT initiatives.

- ***WVRHITEC:*** Regional health information technology extension centers (RECs) were created out of the ARRA HITECH Action – Section 3012, and are under the U.S. DHHS Office of the National Coordinator for Health Information Technology (ONC). The WVRHITEC offers services/support (education, outreach, and guidance) to all health care providers in West Virginia — whether or not they have adopted electronic health record systems. Technical services also will be provided. Rural clinics and small practices may be eligible for subsidized services. WVRHITEC's objective is to help 1,000 eligible health care providers become meaningful users of health IT by 2011 so they can qualify for federal health IT incentive payments.

- ***WVHIN:*** The WVHIN was designated by former Governor Joe Manchin in 2006 to participate in a multi-state collaborative to address privacy and security concerns with EHR/HIT. The WVHIN is charged with building a secure electronic health information system for the exchange of patient data among physicians, hospitals, diagnostic laboratories, other care providers, and other stakeholders.

Additionally, the HIT coordinator is responsible for convening and facilitating the WV HIT Collaborative. The WV HIT Collaborative provides a forum for the discussion of common HIT issues statewide. Topics of common interest for discussion include but may not be limited to:

- Benefits and barriers to provider implementation and meaningful use of EHR
- Strategies to expand broadband to underserved areas of West Virginia
- Potential use of personal health care records to improve health outcomes

3.3 Provider Adoption of Certified EHR Technology

The implementation and meaningful use of certified Electronic Health Records (EHR) by the provider community in WV is central to achieving Medicaid's HIT vision. Section 4.0 describes the EHR Provider Incentive Program initiative defined in support of this goal. Section 5.0

describes the EHR Provider Incentive Program Design that will be implemented to achieve adoption and meaningful use of certified EHR throughout the State.

4.0 HIT Roadmap

This section describes the HIT initiatives and projects necessary to achieve the Bureau's strategic goals and objectives.

4.1 West Virginia Vision for Moving from "As-Is" to "To-Be" HIT Landscape

The Bureau for Medical Services leadership recently engaged in a series of facilitated work sessions to review and update strategic goals, objectives and supporting initiatives in response to significant changes in the program environment. These changes included both regulatory changes and the opportunities presented by new and enhanced funding. The Bureau for Medical Services Strategic Plan (updated December 2010) is provided as Appendix B.

The following health information technology initiatives were identified as necessary to support the Bureau's strategic goals and objectives.

Table 5: HIT Initiatives

Medicaid HIT Initiatives
MMIS Re-procurement Initiative - The MMIS Re-procurement Initiative includes the MITA State Self-Assessment, development of an Advance Planning Document (APD), and the execution of the Bureau's plan for re-procurement of the Fiscal Agent Contract.
Data Warehouse and Decision Support Initiative - The data warehouse developed under this initiative will contain reconciled claims, encounter, financial and clinical data. The decision support system will allow BMS to run standard management reports, ad hoc queries to analyze trends, and conduct what-if analyses.
Pharmacy Services: Automated Prior Authorization Project - The Automated Prior Authorization program allows BMS to use an Automated PA application to approve routine prior authorization of pharmacy services. This reduces the number of calls to the pharmacy clinical help desk, reduces administrative costs and allows for tighter management of the pharmacy program without adding additional administrative burden to healthcare providers. This project is presently funded through a Transformation Grant. The scope of this functionality applies to pharmacy only, not medical/dental processing.
Patient Care Web Portal Project - This pharmacy services initiative will give providers access to data that could enhance the quality of health care provided to Medicaid members and allow the program to avoid the cost of duplications of medical procedures, diagnostic testing and therapeutic duplications of medications. This project is presently funded through a Transformation Grant.
ePrescribing Pilot Project - The ePrescribing Pilot Project, presently funded through a Transformation Grant, will enhance the function of the patient care web portal by providing electronic prescribing software for prescribers (at no cost to them), while providing clinical decision support in the same application. ePrescribing has been proven to save money for pharmacy programs by preventing therapeutic duplications, reducing fraud, promoting preferred drug list compliance and coordinating TPL.
Outreach and Communication Initiative – The Bureau will undertake an effort to rebrand the program so that Medicaid is viewed as another healthcare coverage provider as opposed to a "welfare program". As part of this initiative, the Bureau will also evaluate and implement technologies to improve outreach and communication capabilities.

Medicaid HIT Initiatives
Medicaid Eligibility Initiative – The Bureau desires to avoid redundant spending and enhancing access to care. To this end, the Bureau intends to evaluate opportunities for collaboration and implement processes and technologies that simplify and streamline eligibility determination.
BMS Health Information Exchange Initiative – The Bureau will evaluate opportunities and implement necessary technology to achieve desired health information exchange capabilities to benefit the West Virginia Medicaid population.
EHR Provider Incentive Program – The Bureau will develop a program design and implement capabilities for the administration and oversight of incentive payments to providers who achieve meaningful use of certified EHR technology within a specified timeframe.
Telehealth Expansion – Expand use of telehealth to enhance care management capabilities.
Insurance Exchange ~ Medicaid Initiative – The Bureau will collaborate with the Insurance Commission to evaluate opportunities for sharing processes and technology that could be used to benefit the Medicaid population and avoid redundant costs.

The table that follows depicts the relationship between these HIT initiatives and the Bureau's strategic goals and objectives.

Table 6: Alignment of HIT Initiatives with Strategic Goals and Objectives

ID	Goals & Objectives by Business Area	Supporting Initiatives
Gen	**High-Level Administrative and Management Goals and Objectives**	
Gen 3.0	Goal: Leverage technology to enhance performance and decision making.	
Gen 3.1	Enhance reporting capabilities to allow for more efficient and effective performance monitoring.	MMIS Re-procurement Initiative Data Warehouse and Decision Support Initiative
Gen 3.2	Improve data access, analysis and reporting to support decision making.	MMIS Re-procurement Initiative Data Warehouse and Decision Support Initiative
Gen 4.0	Goal: Assess, implement, and monitor compliance with all relevant federal laws and regulations (e.g. PPACA, State Medicaid Manual, HIPAA).	
Gen 4.4	Verify and monitor MMIS and Fiscal Agent operations to ensure transactions are processed in accordance with all relevant federal laws and regulations.	MMIS Re-procurement Initiative
Gen 5.0	Goal: Ensure program quality.	
Gen 5.2	Design and configure systems and processes to support the Quality Plan.	MMIS Re-procurement Initiative Data Warehouse and Decision Support Initiative
Gen 5.3	Enhance ability to measure compliance with quality indicators.	MMIS Re-procurement Initiative Data Warehouse and Decision Support Initiative
Gen 6.0	Goal: Enhance and improve efficient, effective and meaningful outreach and communication.	
Gen 6.1	Improve communication with providers and	Outreach and Communication

ID	Goals & Objectives by Business Area	Supporting Initiatives
	members.	Initiative BMS Health Information Exchange Initiative
Gen 6.2	Rebrand Medicaid as another provider of healthcare coverage.	Outreach and Communication Initiative
OM	**Operations Management**	
OM 1.0	Goal: Improve operational efficiency and reduce costs in the healthcare system.	
OM 1.3	Enhance and automate reporting capabilities to measure compliance with operational performance measures.	MMIS Re-procurement Initiative
OM 2.0	Goal: Improve access to information necessary for operations management.	
OM 2.1	Enhance cost avoidance capability by improving access to accurate other third party payer information.	MMIS Re-procurement Initiative BMS Health Information Exchange Initiative
OM 2.2	Establish integration with other entities to further reduce the potential for redundancy of service and payment.	MMIS Re-procurement Initiative Data Warehouse and Decision Support Initiative BMS Health Information Exchange Initiative Insurance Exchange ~ Medicaid Initiative
OM 3.0	Goal: Improve provider access to real-time data.	
OM 3.1	Enhance provider portal to support clinical decisions and to provide real-time access to cost settlement and rebate data.	MMIS Re-procurement Initiative BMS Health Information Exchange Initiative
OM 3.2	Implement real time access to data based on claim adjudication results.	MMIS Re-procurement Initiative
OM 3.3	Integrate automated prior authorization capability to provide real time approval or rejection of routine Pharmacy prior authorizations.	MMIS Re-procurement Initiative Pharmacy Automated Prior Authorization Project BMS Health Information Exchange Initiative
ME	**Member Management**	
ME 1.0	Goal: Enhance ability for members to participate in and exercise responsibility for their personal health choices.	
ME 1.1	Explore capabilities to establish and allow member access to a personal health record.	MMIS Re-procurement Initiative
ME 1.2	Provide automated administration of a member incentive program as designed by BMS and approved by CMS.	MMIS Re-procurement Initiative
ME 1.3	Provide for automated administration of personal Health Improvement Plans.	MMIS Re-procurement Initiative

ID	Goals & Objectives by Business Area	Supporting Initiatives
ME 1.4	Empower members by providing access to information and tools that can be used to improve their health.	MMIS Re-procurement Initiative MCO Expansion Initiative BMS Health Information Exchange Initiative
ME 1.5	Simplify and streamline eligibility determination to enhance access to care.	Medicaid Eligibility Initiative Insurance Exchange ~ Medicaid Initiative
PG	**Program Management**	
PG 1.0	Goal: Enhance the Bureau's ability to analyze the effectiveness of potential and existing benefits and policies.	
PG 1.1	Integrate reconciled claims data with clinical data.	MMIS Re-procurement Initiative Data Warehouse and Decision Support Initiative BMS Health Information Exchange Initiative
PG 1.2	Improve tools and provide training for data analysis to help improve healthcare decision making.	Data Warehouse and Decision Support Initiative
PG 2.0	Goal: Improve consistency of Program management processes and effective communication of policy.	
PG 2.2	Establish reporting capabilities to measure compliance with performance measures.	MMIS Re-procurement Initiative
PM	**Provider Management**	
PM 1.0	Goal: Simplify process for submission of provider information.	
PM 1.1	Improve provider enrollment and administration processes.	MMIS Re-procurement Initiative BMS Health Information Exchange Initiative
PM 1.2	Provide capability for online submission of standard forms and reports by providers.	MMIS Re-procurement Initiative BMS Health Information Exchange Initiative
PM 1.3	Integrate automated prior authorization capability to provide real time approval or rejection of routine prior authorizations. Both the pilot and planned integration of this functionality will apply to pharmacy, not medical/dental.	ePrescribing Pilot Project BMS Health Information Exchange Initiative
CM	**Care Management**	
CM 1.0	Goal: Improve healthcare outcomes for members.	
CM 1.1	Establish access to data from sister-agencies and programs within the Department of Health and Human Resources.	MMIS Re-procurement Initiative Data Warehouse and Decision Support Initiative
CM 1.2	Improve access to clinical and encounter	MMIS Re-procurement Initiative

ID	Goals & Objectives by Business Area	Supporting Initiatives
	data.	Data Warehouse and Decision Support Initiative
CM 1.3	Enhance ability to measure quality of healthcare outcomes for members.	MMIS Re-procurement Initiative Data Warehouse and Decision Support Initiative
CM 1.4	Evaluate alternatives to enhance care management capabilities.	Telehealth Expansion
CM 2.0	Goal: Increase use of evidence based clinical and appropriate services.	
CM 2.1	Increase the use of evidence based clinical and appropriate services, including preventive services.	Data Warehouse and Decision Support Initiative Patient Care Web Portal Project ePrescribing Pilot Project
CM 2.2	Provide technical capability for Pay-for-Performance reimbursement model.	MMIS Re-procurement Initiative Data Warehouse and Decision Support Initiative EHR Provider Incentive Program
CM 2.3	Increase meaningful use of Electronic Health Records among Medicaid providers.	EHR Provider Incentive Program
CO	**Contractor Management**	
CO 1.0	Goal: Enhance the Bureau's ability to monitor contractor performance against approved measures.	
CO 1.1	Establish reporting capabilities to measure contractor compliance with performance measures.	MMIS Re-procurement Initiative
CO 1.2	Create automated functions to establish and monitor corrective action plans for contractors not meeting approved performance measures.	MMIS Re-procurement Initiative

The Bureau will conduct initial project planning to scope component projects in support of the initiatives identified in the strategic plan. Key resources will be identified including designation of a project sponsor. Project objectives, products and services will be identified. A preliminary budget will be estimated and funding sources will be identified and funding will be applied for.

4.2 Participation in Health Information Exchange

The Bureau will conduct the BMS Health Information Exchange Initiative to evaluate opportunities and implement necessary technology to achieve desired health information exchange capabilities to benefit the West Virginia Medicaid population.

4.3 Annual Benchmarks

The Bureau will measure the performance of the Provider Incentive Program (PIP) through the successful implementation of the PIP according to the project implementation schedule. This includes but is not limited to monitoring when project milestones and deliverables are met on time according to the project implementation schedule. Key milestones to be measured are registration, attestation, payments, and auditing implementation. Future benchmarks will include continuing to measure timeliness of payments to providers, efficiency and integrity of audit reports, and provider community feedback through customer satisfaction surveys.

5.0 EHR Provider Incentive Program (PIP) Design

5.1 Environmental Scan

BMS elected to conduct an online survey to solicit information from providers as one component of planning West Virginia's (WV) Electronic Health Record (EHR) Provider Incentive Program (PIP). Incentive payments authorized under Section 4201 of the American Recovery and Reinvestment Act of 2009 (Recovery Act, ARRA) are available to eligible professionals (EPs) and eligible hospitals participating in Medicare and Medicaid programs that adopt and become meaningful users of certified EHR technology and meet specified other criteria.

Survey design and content was based on several factors including research into similar surveys issued by other states, input from BMS and other members of the WV HIT Project Planning Team, the need for the gathered data to fulfill a specified purpose and the overall project plan. Two survey tracks were developed in consideration of the differing needs and requirements of hospitals and EPs, and to best help BMS understand the factors that may influence the use of EHRs.

The survey was opened to providers through the Survey Monkey online service on October 25, 2010 and was also available in paper form upon request. Marketing the survey to providers consisted of weekly banner messages issued with Medicaid Remittance Advices and messages sent to provider associations for distribution to their members. Information was also posted on the BMS website. The survey was administered by BDMP under contract to BMS. For the purposes of completing this report survey response data was downloaded the morning of November 22, 2010. The survey remains open online to continue gathering provider input.

Survey Response and Findings

Survey response was low with a total of 80 surveys begun and 50 considered complete. The 50 are comprised of 16 hospital responses (with a 17th substantively complete) and 34 EP responses. In developing findings, all responses to individual questions have been counted whether or not the associated survey was fully completed.

Findings are put forth below. The responses received provide information for consideration even though the data is not based on a statistically valid sample and cannot be assumed to be representative of the entire Eligible Professional or hospital population.

Information About The Provider

- Provider engagement: It is obvious from the low number of responses received that providers did not engage with the survey process, but we cannot presume to know why they did not engage. It may potentially indicate that providers are not engaged in the adoption and meaningful use of EHRs and health information technology, but there are a number of other potential underlying causes for the low response rate.

Responding hospitals:

- 77% are located in rural settings and 23% in urban settings

- 94% expect to participate in both the Medicare and Medicaid incentive programs. One hospital was unsure at this time
- 53% stated that 11-20% of their patients have historically been covered by Medicaid; 35% stated that 21-30% of their patients have historically been Medicaid eligible
- Most hospitals responding are somewhat or fully aware of the incentive payment programs, EHR certification rules and requirements, meaningful use rules, the National Level Repository (NLR) and attestation, but there is room for further education

Responding Eligible Professionals:

- Most responding EPs practice in small offices of one to several practitioners of various types. A few mid-size and larger practices also responded.
- 44% of practices see over 200 patients each week, with about 20% seeing 101-200 patients and another 20% seeing 51-100 patients per week.
- 31% of respondents stated that over 50% of their patients were covered by Medicaid, and another 26% of respondents serve a patient mix that is 31-50% Medicaid eligible.
- Rural practices comprised 64% of respondents, with the balance equally split between urban and “both”.
- A high percentage of responding EPs is somewhat aware of the incentive payment programs, EHR certification rules and requirements, and meaningful use rules, but a low percentage is aware of the NLR and attestation.
- 40% of respondents will choose the Medicaid incentive, 20% will choose Medicare and 40% are unsure.

Information About the Technology

- Provider EHR adoption: Based on the statistics derived from the responses there seems to be some evidence that the majority of the hospitals and EPs who completed the survey are already knowledgeable of and engaged with EHR adoption and associated requirements on some level, or have an awareness of the need to be. It may be speculated that the large number of non-responders, especially among the EP group, are less knowledgeable and engaged.

Responding hospitals:

- All responding hospitals have internet access through wired broadband or better.
- 82% of hospitals reported that they electronically exchange medical information and all own an EHR system.
- 35% of the hospital’s EHR systems are on the list of CCHIT certified systems, but 41% are not and 24% are unsure.
- 82% of responding hospitals believe they will meet Stage 1 Meaningful Use criteria by the deadline, and 59% are already underway with making needed changes. 18% are awaiting further guidance and 1 hospital has not begun.

- Improved quality of care was selected as the greatest benefit to be achieved by EHR implementation, but hospitals believe that many benefits will result.
- Hospitals indicated that funding/cost was the greatest challenge to EHR adoption, but resistance to change, staffing resources and disruption to practice were also key concerns.
- Almost 80% of hospitals stated their level of awareness of HIE and RHITEC activities in WV as "Somewhat Knowledgeable".

Responding Eligible Professionals:

- All EPs responding had internet access available to them. Over 50% subscribed to DSL, with the second choice being cable. Several had T1 lines.
- Two-thirds of respondents reported that they already own or are purchasing an EHR. Of the one-third that had not purchased an EHR, two-thirds planned to purchase at some point in the future.
- Of the responding EPs who had fully implemented their EHR, 45% said they were generally pleased with the results.
- Five respondents do not intend to purchase an EHR: two will be retiring in the next few years, one doesn't see the benefit, another likes the way they do things now and one indicated they might not be an "eligible" professional. Three of the five indicated some possibility of reconsidering their decision if they were eligible for an incentive payment.
- 52% of responding EPs stated that they electronically exchange medical data with other health professionals and 64% reported that their system was capable of doing so, but 20% were unsure.
- Only 24% of EP respondents were underway with the changes needed to achieve meaningful use. 36% are awaiting more guidance and details.
- EPs chose improved documentation as the greatest benefit of EHR implementation, but they also saw other benefits, such as improved quality of care and the ability to share and access information.
- Respondents selected funding/cost as the greatest barrier to EHR adoption, with disruption to practice and staffing resources selected as 2nd and 3rd choices.
- 62% of EPs are somewhat knowledgeable of WV HIE activities, but 35% are not at all knowledgeable. 56% of EPs are not at all knowledgeable of WV RHITEC activities.

<u>Information About Preferences and Needs</u>

- Provider Education and Outreach: Both hospital and EP responders indicated that they would be interested in receiving information in a variety of ways, and they generally appear to want education and outreach. Only one hospital and a couple of EPs indicated they were not interested in learning more or receiving support. Both hospital and EP survey takers most want to know more about the details of the WV Provider Incentive Payment program, how BMS plans to proceed and where to go for information and assistance. Interest was also expressed by both hospitals and EPs in a number of choices such as integration of

EHR and HIT with provider practice workflow and practice management system and technology evaluation and selection. A number of hospitals and EPs indicated a willingness to participate in future information gathering activities, and contact information is provided in Appendix C as well as through a separately delivered spreadsheet.

- Provider Incentives: Hospitals selected demonstrated improvements in care and health as the greatest incentive with additional financial compensation their second choice. EPs selected the same two choices, although additional financial compensation was most important to them.

Responding hospitals:

- Hospitals want to know more about a number of things, with information about Health Information Exchange opportunities in WV second to the incentive payment program.
- Responding hospitals indicated a preference for receiving education, training, outreach and communication through webinars, web-based training modules and teleconferences.
- The support tactics that would be most useful to hospitals are web meetings, group meetings with other hospitals and an informational website.

Responding Eligible Professionals:

- EPs want to learn more about Meaningful Use issues and HIE opportunities as 2nd and 3rd choices after the incentive payment program.
- The top three choices of EPs to receive education, training, outreach and communication were webinars, email/e-newsletter and mailings of reading materials.
- The support approach most useful to EPs is an informational website, with mailings and web meetings also strong selections.

In conclusion, because survey response was limited the value of the data and use of any associated findings must be carefully evaluated. It appears, however, that the data does provide indicators which can be of value for planning purposes and that form a foundation for future interactions with providers.

Survey Report Presentation

More detailed data is presented in Appendix C, which is comprised of two sections: Hospital Survey Responses, and Eligible Professional Survey Responses. Survey Monkey reporting has been used as the primary tool to format the data.

Question numbers, which were not visible to survey takers, have been retained to ease discussion. These numbers are Survey Monkey assigned numbers used for internal tracking, and due to skip logic or the absence of data some numbers are missing or may seem out of order. For example, a hospital that does not own an EHR is taken through a different set of questions than one that does. Because all hospitals responding to the survey already own an EHR, the “No” path did not contain any data and those questions were eliminated from the report. These numbers were not viewed by survey takers. Hospitals answered a maximum of 25 questions and EPs a maximum of 28 questions.

Data captured through open end responses, such as answers to “Other” or contact information is reported using text boxes or tables. High numbers of “skipped question” responses are indicated because all surveys begun are counted in the universe by the Survey Monkey tool. Raw data can be made available, as can individual responses, upon request.

5.2 Communication Plan

Clear and well-timed communication is vital to the success of any project. To date four major agents have been engaged in communicating information about EHR Provider Incentive Program to West Virginia providers. The agents include the federal government in terms of the HITECH Act itself and three State bodies which are the Governor’s Office of Health Enhancement and Lifestyle Planning (GOHELP), West Virginia Regional HIT Extension Center (WVRHITEC), and the West Virginia Health Information Network (WVHIN). The GOHELP, WVRHITEC and WVHIN have already dedicated great efforts to presenting outreach to West Virginia provider community. A detailed table of their invested communication is included in Appendix D. The role of each is bulleted below.

- ***GOHELP:*** Pursuant to §16-29H-6, GOHELP’s role in HIT is that of a coordinator. To that end, GOHELP facilitates discussion and assists constituent state agencies with HIT initiatives.

- ***WVRHITEC:*** Regional health information technology extension centers (RECs) were created out of the ARRA HITECH Action – Section 3012, and are under the U.S. DHHS Office of the National Coordinator for Health Information Technology (ONC). The WVRHITEC offers services/support (education, outreach, and guidance) to all health care providers in West Virginia — whether or not they have adopted electronic health record systems. Technical services also will be provided. Rural clinics and small practices may be eligible for subsidized services. WVRHITEC’s objective is to help 1,000 eligible health care providers become meaningful users of health IT by 2011 so they can qualify for federal health IT incentive payments.

- ***WVHIN:*** The WVHIN was designated by former Governor Joe Manchin III in 2006 to participate in a multi-state collaborative to address privacy and security concerns with EHR/HIT. The WVHIN is charged with building a secure electronic health information system for the exchange of patient data among physicians, hospitals, diagnostic laboratories, other care providers, and other stakeholders.

The West Virginia (WV) Bureau for Medical Services (BMS, Bureau) will implement many communication and outreach mechanisms to educate WV Medicaid providers about the Bureau’s EHR Provider Incentive Program (PIP, Program). A communication plan has been developed to include communication objectives, key messages, stakeholder analysis, a strategy chart, and communication methods regarding eligibility, enrollment, payments, attestation, recoupment, appeals and access to program information and technical assistance for the WV EHR Provider Incentive Program. The WV Communication, Outreach and Education (COE) workgroup, which will consist of individuals from the stakeholder groups, will be assembled and will meet periodically to further plan and strategize the execution of the WV PIP Communication Plan.

Communication Objectives

The EHR PIP Communication Plan has been developed to provide education in support of the WV EHR Provider Incentive Program for a target audience. The WV PIP is designed under the provisions of the American Recovery and Reinvestment Act (ARRA) and offers incentive payments to Eligible Professionals (EP) and eligible hospitals for the Meaningful Use (MU) of certified EHR technology.

The communication plan outlines the high-level objectives as described below:

- Build awareness of the WV PIP among all stakeholder groups.
- Secure the commitment of the stakeholders to the WV PIP key messages.
- Influence specific policies or policymakers around key aspects.
- Encourage participation among stakeholder partner bodies such as state agencies / supporting organizations, WV medical associations, and the state legislature.

Key Messages

The EHR PIP Communication Plan's key messages are designed to enlighten, inform, and engage stakeholders, EPs and hospitals throughout the life of the EHR PIP. These key messages will be used to promote the WV EHR PIP and educate the audiences about program details:

- Nationwide adoption of EHR technology is one of the Medicaid provisions under the American Recovery and Reinvestment Act (ARRA).
- Medicare and Medicaid will help EPs and hospitals pay for and maintain their certified EHR technology.
- Adopting certified EHR systems will allow EPs and hospitals to receive incentive payments from the WV EHR PIP.
- Following the program criteria will ensure EPs and hospitals receive the maximum amount of incentive payments.
- Technical assistance will be available for EPs and hospitals that adopt, implement, upgrade, and meaningfully use EHR technology.

5.2.1 Stakeholder Analysis

A preliminary stakeholder analysis has been done to identify key stakeholders, assess their interests, and identify the ways in which they may influence and impact the WV EHR PIP. As the COE workgroup assembles they will review, refine and amend the stakeholder groups and their needs on an ongoing basis. A stakeholder analysis contributes to program design by helping to identify appropriate forms of stakeholder participation. Stakeholders are individuals and groups with a multitude of interests, expectations, and demands as to what the WV EHR PIP should provide. Stakeholder management involves the iterative process of identifying stakeholders, documenting the communication needs, analyzing stakeholders' interests and influence, managing their expectations, and taking action. Stakeholder management is a key initial step in developing a proper communication plan. The below diagram illustrates the stakeholder management process.

Figure 8: Stakeholder Management

The initial phase of identifying stakeholders has been established. As the WV EHR PIP progresses, the stakeholders may change, and the varying information each stakeholder group needs may also be adjusted. Identified below are the current stakeholder groups.

Figure 9: West Virginia EHR Provider Incentive Program Stakeholder Groups

5.2.2 Stakeholder Interest and Influence

Assessing the interest and the influence of the stakeholders is integral to the success of the WV EHR PIP. It will aid in determining strategies for delivering information to each stakeholder group. The bullets below suggest the level of engagement and amount of effort to employ depending on the level of interest and influence of the stakeholder.

- ***High Influence, High Interest***: These stakeholders should be fully engaged in the process.

- ***High Influence, Low Interest:*** These stakeholders should be provided with information appropriate to their communication needs. Care should be taken not to overload this group with communication by providing more than what is strictly necessary.

- ***Low Influence, High Interest:*** These stakeholders should be kept adequately informed, and periodic meetings should be held to ensure that no major issues are arising. These stakeholders may become very helpful with the details of the WV EHR PIP.

- ***Low Influence, Low Interest:*** These stakeholders should not be inundated with excessive communication.

Table 7: Stakeholder Analysis

Stakeholder Group	Potential Project Role	Stakeholder Matrix Position (X)			
		HIGH Influence HIGH Interest	HIGH Influence LOW Interest	LOW Influence HIGH Interest	LOW Influence LOW Interest
Eligible Professionals (EP) and Eligible Hospitals	Target audience for receiving and adhering to the WV EHR PIP	X			
West Virginia Associations	Assisting in disseminating information to EPs and Hospitals	X			
Bureau for Medical Services	Spearheading the WV EHR PIP	X			
HIT Project Management Team	Oversee project management of the WV's HIT related projects			X	
Communication, Outreach and Education Workgroup	Managing, assessing, and realigning communication plan and strategies	X			
State Agencies / Supporting Organizations	Subject matter experts who will assist in the WV EHR PIP design and implementation		X		
State Legislature	Not directly involved in design or implementation of WV EHR PIP, but may be impacted.		X		
EHR PIP Contractors	Provide technical or business assistance to West Virginia as they design and implement the WV EHR PIP			X	

5.2.3 Communication Strategy

A communication strategy and plan has been developed to help ensure stakeholder groups understand BMS's goals and objectives and the provider incentive payment program.

The outreach and communication activities will be conducted with the collaboration of key stakeholders and stakeholder groups including, but not limited to, the following:

- Governor's Office of Health Enhancement and Lifestyle Planning (GOHELP)
- West Virginia Health Information Network (WVHIN)
- Bureau for Public Health
- Bureau for Behavioral Health and Health Facilities
- Governor's Office of Technology
- WV Department of Commerce
- WV Health Care Authority
- Tele-Health Alliance
- WV Department of Military Affairs and Public Safety
- WV Insurance Commission
- DHHR Office of Secretary
- Bureau for Children and Families
- Public Employees Insurance Agency
- State Children's Health Insurance Program
- WV Health Improvement Institute
- Community Health Network of WV
- WVRHITEC
- Primary Care Association
- WV Hospital Association
- WV State Medical Association

Outreach and Communication Timeframes

May 2011

- Finalize Public Education Material (pre-registration checklist, FAQs, surveys, etc…)
    - Provider Workshop material
    - Bureau for Medical Services website
    - Providers Association material
    - Information to be mailed to provider community through Fiscal Agent mail room
- Education and training sessions with provider associations

June 2011

- WV PIP information posted on Bureau for Medical Services website
- WV PIP system testing
- Provide demo of WV PIP to CMS
- Provider workshop training
- WV PIP information disseminated through provider associations
- WV PIP information mailed to providers through Fiscal Agent mail room

July 2011

- Webinar/conference call made available for providers to attend

- Public media announcement about WV PIP launch
    - News papers
    - Governor or Secretary's Press Conference, subject to approval
- WV PIP program launches

August 2011 – December 2011

- Continue communication and outreach activities
    - Guest speak at conferences and public community events
    - Survey provider community for program feedback
    - Public announcements about success of program

The costs associated with the outreach and communication activities were allocated appropriately in accordance with the Bureau's established processes and procedures.

An outline of the strategy and plan is provided below. The Communication Strategy table illustrates the what, who, why, when, and how of the communication plan. Many communication methods will be used to deliver key messages and educate stakeholders about the WV EHR PIP. The Communication, Outreach and Education (COE) workgroup will meet regularly to assess and realign the strategies that have been outlined in the chart below.

Table 8: Communication Overview

Communication / Information to Deliver (WHAT)	Stakeholder/Group (WHO)	Purpose (WHY)	Timing and Frequency (WHEN)	Type/Method/Vehicles (HOW)	Responsible
Planning and status meetings	• BMS • COE Workgroup • HIT Project Management Teams	To conduct PIP communication planning and/or update stakeholders on progress of the project and to review detailed plans (tasks, assignments, and action items)	Program initiation and ongoing as needed	• Meetings • Conference calls • Memo distribution	• BMS • HIT Project Management Teams • COE Workgroup • PIP Contractors
Executive level and project level reports	• WV Associations • BMS • COE Workgroup • State Agencies/Supporting Organizations • State Legislature	Update stakeholders on progress of the PIP project	Program initiation and ongoing as needed	• Document distributed via hardcopy or electronically • HIT SharePoint website	• BMS • HIT Project Management Teams • COE Workgroup • PIP Contractors
Identification and Determination of Eligible Professionals (EPs) and Eligible hospitals	• EPs Eligible Hospitals • BMS • COE Workgroup • State Agencies	Inform EPs and hospitals whether they have been deemed eligible for the PIP	Ongoing and as needed	• Outreach letters	• BMS • COE Workgroup • PIP Contractors

Communication / Information to Deliver (WHAT)	Stakeholder/Group (WHO)	Purpose (WHY)	Timing and Frequency (WHEN)	Type/Method/Vehicles (HOW)	Responsible
Education on adopting, implementing, upgrading, and meaningfully using EHR technology	• EP Eligible Hospitals • WV Associations • BMS • COE Workgroup • State Agencies/Supporting Organizations • PIP Contractors	Educate stakeholders on the federal rules and guidelines of adopting, implementing, upgrading, and meaningfully using EHR technology	Program initiation and ongoing as needed	• Training events • Association meetings • Multimedia presentations • Online training	• BMS • HIT Project Management Teams • COE Workgroup • PIP Contractors
Evaluation of benefits and costs of EHR technology and impacts of delaying implementation	• EPs Eligible Hospitals • WV Associations • BMS • COE Workgroup • State Agencies/Supporting Organizations	Provide an evaluation checklist of the benefits and cost to assist EPs and hospitals in their decision process of adopting, implementing, upgrading, and meaningfully using EHR technology	Program initiation and ongoing as needed	• Newsletter • HIT web portal checklist	• BMS • HIT Project Management Teams • COE Workgroup • PIP Contractors
Education on West Virginia's EHR Provider Incentive Program: How to enroll in the program and register with the National Level Repository (NLR)	• All stakeholders	Educate stakeholders about the PIP the state of West Virginia has designed	Program initiation and ongoing as needed	• Training events • Association meetings • Multimedia presentations • Online training	• BMS • HIT Project Management Teams • COE Workgroup • PIP Contractors

Communication / Information to Deliver (WHAT)	Stakeholder/Group (WHO)	Purpose (WHY)	Timing and Frequency (WHEN)	Type/Method/Vehicles (HOW)	Responsible
West Virginia's EHR Provider Incentive Program criteria and reporting requirements and compliance	• EPs Eligible Hospitals • BMS • COE Workgroup • State Agencies/Supporting Organizations	Provide a general access area for stakeholders to access WV's PIP criteria, reporting requirements, and compliance requirements	Prescribed depending of parameters of project	• Online training • HIT web portal postings	• BMS • Project Management Teams • COE Workgroup • PIP Contractors
How, when, and how often will payments be made	• EPs Eligible Hospitals • BMS • COE Workgroup • State Agencies/Supporting Organizations	Provide information on how, when, and how often payments will be made to EPs and hospitals	Program initiation and potentially ongoing as needed	• Newsletter • HIT web portal posting • Remittance Advice banners	• BMS • HIT Project Management Teams • COE Workgroup • PIP Contractors
Technical assistance and information related to EHR adoption, implementation, upgrade, and Meaningful Use (MU) of EHRs	• EPs Eligible Hospitals • BMS • COE Workgroup • State Agencies/Supporting Organizations	Provide information on how to access technical assistance and information related to EHR adoption, implementation, upgrade, and Meaningful Use (MU) of EHRs	Program initiation and potentially ongoing as needed	• Call center / Helpdesk	• BMS • HIT Project Management Teams • COE Workgroup • PIP Contractors

Communication / Information to Deliver (WHAT)	Stakeholder/Group (WHO)	Purpose (WHY)	Timing and Frequency (WHEN)	Type/Method/Vehicles (HOW)	Responsible
EP and Eligible Hospital PIP Question / Answer platform	• All stakeholders	Provide a general public access area for EPs and hospitals to ask questions and receive answers that all stakeholders have access to	Program initiation and potentially ongoing as needed	• HIT web portal posting • FAQs	• BMS • HIT Project Management Teams • COE Workgroup • PIP Contractors

5.2.4 Communication Methods

The following methods and tools will be used between and among WV EHR PIP stakeholders to communicate the Programs' messages and to give and receive input. Information will be disseminated using the below described tools based on the most effective method of delivery.

Meetings: BMS, the COE workgroup and HIT Project Management teams will meet regularly throughout the duration of the WV EHR PIP. Depending on the timing and agenda for a particular meeting, these may occur in person at the BMS office or via teleconference.

Reports (print or softcopy): Planning and status reports will be delivered regularly and, as needed, throughout the span of the WV EHR PIP. The planning and status reports will update various stakeholders on the progress of the WV EHR PIP.

Web-based Documentation Repository: Various Microsoft SharePoint sites will be used as repositories of program documents. The SharePoint sites will contain secure access to folders and files. The various SharePoint sites include:

- BMS HIT SharePoint
- Governor's Office of Health Enhancement and Lifestyle Planning (GOHELP) SharePoint
- Berry, Dunn, McNeil & Parker's (BDMP) KnowledgeLink site

BMS HIT Web Portal: The Bureau will maintain a portal containing program information such as FAQs, eligibility requirements, potential benefits and costs of an EHR, the impacts of delaying implementation, criteria, compliance and reporting requirements, and when and how often incentive payments will be made.

Molina Web Portal: The WV EHR PIP will maintain a provider portal containing WV EHR PIP application, attestation, acceptance, meaningful use and other pertinent Program information

Online Training: The Bureau will utilize numerous methods to conduct online training including the Medicaid Learning Center (MLC), webinars through the West Virginia Regional HIT Extension Center (WVRHITEC), and social networking tools to provide both training (for education on adopting, implementing, upgrading and meaningfully using EHR technology) and supply general information about the WV EHR PIP.

Multimedia Presentations: Microsoft tools such as PowerPoint will be used to convey messages and educate stakeholders in settings such as medical association events, state meetings, program team meetings, public hearings and training events.

Email and Postal Mail: Email and postal mail, such as newsletters, invitations, brief and direct letters, will be used to disseminate information for a targeted and specific audience.

Remittance Advice Banners: Brief messages regarding the WV EHR PIP will be transmitted through the use of remittance advice banners.

Surveys, Focus Groups, and Interviews: In order to gather information from various individuals, stakeholders, or stakeholder groups, face-to-face or phone interviews, surveys, or focus groups may be conducted.

5.3 EHR Provider Incentive Program (PIP) Administration and Oversight

Summary:

The West Virginia Bureau for Medical Services (BMS) has developed a plan to implement the Medicaid provisions of the Electronic Health Record (EHR) Incentive Program established by Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA). The EHR Incentive Program provides incentive payments to providers participating in Medicaid programs that adopt and successfully demonstrate meaningful use of certified EHR technology. Included in the BMS plan is a description of the processes and procedures BMS will employ to ensure that eligible professionals (EPs) and eligible hospitals (EHs) (collectively "providers") have met Federal and State statutory and regulatory requirements in order to receive EHR incentive payments.

The program essentially consists of two sub-programs that, in total, span a six (6) year period from registration to the final payment:

1. Incentives for adoption/implementation/upgrades (A/I/U) of EHR technology (Year 1 payments only)
2. Incentives for meaningful use (MU) of EHR technology (Year 2 – 6 payments, for Year 1 adopters, Year 1 – 6 payments for early adopters)

Providers must meet the same eligibility requirements for all six (6) years, and attest to those annually. The program compliance requirements for Year 1 A/I/U incentives, however, differ substantially from the MU requirements.

In order to receive Year 1 payments providers must attest to the adoption, implementation or upgrade (A/I/U) of EHR technology during the year, or, for early adopters, meaningful use.

In order to receive Year 2 – 6 payments), providers must attest to and document their achievement of MU objectives. They must demonstrate compliance with the measurement thresholds by submitting calculations that meet the threshold percentages. BMS will agree measurement data to the supporting documentation supplied by the provider in the pre-payment verification process, and corroborate the supporting documentation with other provider records and MMIS data for a sample of recipients during post-payment verification.

Payments to EPs for Year 1 are computed based on a Federal benchmark referred to as the Net Average Allowable Cost (NAAC), which has been established at $25,000 for Year 1. Year 1 incentive payments are calculated as 85% of the NAAC, or $21,250. An exception to the payment calculation exists for pediatricians who don't meet the standard patient volume requirements, but do meet a lower, alternative, volume requirement. EPs qualifying under this exception receive 2/3 of the standard payment amount, or $14,167.

Payments to EPs for Years 2 through 6 are also computed based on the NAAC, which has been established at $10,000 for these payment years. Year 2 through 6 incentive payments are calculated as 85% of the NAAC, or $8,500. Consistent with the Year 1 rules, an exception to the payment calculation exists for pediatricians who don't meet the standard patient volume requirements, but do meet a lower, alternative, volume requirement. EPs qualifying under this exception receive 2/3 of the standard payment amount, or $5,667.

Refer to Table 10 for schedules of payments to EPs who qualify for the standard payment and either adopt/implement/upgrade or demonstrate MU in the first year, and then demonstrate MU for five successive years.

Payments to EHs are calculated as the Medicaid share of the "EHR amount". The EHR amount is computed using a base amount, established discharge amounts, and transition factors for a hypothetical 4 year period. BMS can allocate payments of the calculated amount over a 3 to 6 year period. Refer to Table 9 for a detailed description of the EH incentive payment computation.

BMS will distribute payments on an annual basis. Payments will be disbursed to EPs consistent with a calendar year and to EHs consistent with the Federal fiscal year.

The BMS plan is organized around the business processes required to administer and oversee the Medicaid EHR Incentive Program. The fundamental business processes are independent of the technology used to process the data and interface with providers and various databases. The plan focuses on the significant interactions with providers, key decision points, and critical actions required by BMS that are required to conduct an effective and efficient incentive program. This includes streamlined provider registration and compliance procedures to ensure that the program is effective in distributing payments in a manner that achieves the program objectives. It also includes implementing pre-payment and post-payment verification procedures to ensure that the prevention and detection of fraud, waste and abuse is adequately addressed.

It is important to note that BMS' fiscal agent, Molina Medicaid Solutions (Molina), has designed and will operate the automated data collection and processing system that supports most of the critical functions of the program. Molina refers to this automated system as the Provider Incentive Program Solution (PIPS). The critical functions provided by PIPS include:

- Portal for providers to submit applications and attestations
- Interface with the MMIS
- Interface with the National Level Repository (NLR)
- Payment calculation
- Calculation of eligibility and program compliance measurements
- Program reporting
- Tools for review and approval

The BMS plan identifies five (5) high level business processes that comprise the EHR Incentive Program: 1) register provider, 2) verify eligibility, 3) process payments, 4) verify program compliance – pre-payment, and 5) verify program compliance – post-payment. These processes correlate to three of the MITA Business Process Model business areas as follows:

1 - PM - Provider Management
    - Register Provider
    - Verify Eligibility
2 – OM - Operations Management
    - Process Payments
3 - PI - Program Integrity Management
    - Verify Program Compliance – pre-payment
    - Verify Program Compliance – post-payment

The EHR Incentive Program will be administered by BMS and will utilize available capabilities whenever practical. Significant areas where efficiencies will be obtained by using available resources and functions in-place include the following:

- Verify Eligibility
  - Review MMIS database for verification of identifying information and attestation assertions related to professional and regulatory matters, practice type, patient volume, and non-duplication of registration
  - Utilization of existing appeal process for denied applications contested by providers

- Verify Program Compliance – Pre-Payment
  - Verification of denominator amounts in Stage 1 measurements of MU utilizing MMIS
  - Utilization of existing appeal process for denied applications contested by providers

- Process Payments
  - Utilization of MMIS Add Pay functionality for delivery of payments

- Verify Program Compliance – Post-Payment
  - Identification of high risk cases for testing using identification information in MMIS
  - Review of claims data in MMIS to corroborate patient volume percentage data
  - Utilization of existing appeal process for improper payment determinations contested by providers
  - Utilization of Flexi Financials for recoupment of improper payments
  - Referral of incidences of suspected fraud to the West Virginia Fraud and Abuse Unit

Ongoing process review and improvement will be important to the success of the program. In order to ensure adherence to this quality commitment, BMS will schedule and conduct periodic meetings with stakeholders to review the effectiveness of the program, identify inefficiencies and solicit concerns about potential fraud, waste and abuse.

<u>Implementation Planning Considerations:</u>

In addition to developing the business processes necessary to administer and oversee the EHR Incentive Program, BMS considered numerous planning and technical matters related to implementation:

- Information technology system changes required – Prior to July 20, 2011.
  - Modifications to the MMIS provider portal to create a separate security role/feature for designating attestation authority to the user associated with a particular provider ID
  - Modifications to the MMIS provider portal to allow them to pass security/authentication to the PIPS
  - Expansion of the code sets utilized to process incentive payments to easily identify all payments issued
  - Changes to payment reporting (such as the CMS 64) to reflect/include the incentive payments
  - Changes in the current policy to not enroll Physician Assistants in order to validate their Medicaid status as an eligible provider for the State when they attest

- Plan for accepting registration data from the NLR

- The NLR requires that the States receive/send data to the NLR using their directed interface approach. Specifications have been provided to the Stage 1 States – CMS Interface Control Document v2.0 8/24/2010, and in an update of HITECH System Interactions and Interface Control Document v3.0 State Interfaces only; dated October 26, 2010. Each interface has its own specified delivery and response method. Interfaces are daily and some require an immediate response by the receiving system.
- From the NLR HITECH Interface Control Document 2.0:
  - The HITECH NLR application will receive and deliver the required registration and inquiry fields in an Extensible Markup Language (XML) formatted message delivered by the connectivity software.
  - WebSphere® is the software required for all of the NLR interfaces to process inbound and outbound transactions from NLR.
  - WebSphere Integration Broker is used as the Message Broker.
  - Gentran, Connect Direct, and Cyber Fusion are used as the file transfer software to send and receive files. These are the standard file transfer mechanisms in the CMS environment.

- NLR Readiness Testing
  - NLR testing slot assigned
  - Customization of PIPS interface with BMS MMIS datamart for access to local provider data complete
  - Completed March 2011

- Approach to website interface for providers
  - PIPS includes dedicated web pages for provider incentive payment policy and related document and link display and review

- Anticipated modifications to MMIS – timing of I-APD not yet established
  - There will likely be changes regarding which populations of providers are generally enrolled vs. which ones are not (i.e. managed care only providers seeing Medicaid patients, Physician Assistants with an FQHC or RHC)

- HIPAA and privacy considerations
  - BMS is reviewing HIPAA provisions and other privacy requirements to determine whether further changes will be required in the MMIS, the PIPS or state databases

- Federal fund accounting
  - BMS will track Federal participation for incentive payments (100%) as well as the HIT administrative match (90%). Funds received will be reconciled to funds disbursed for each funding stream separately, to ensure that the funds are not commingled with each other or with other Medicaid funds.

5.3.1 Register Provider

5.3.1.1 Description

The first step required for a provider to receive EHR incentive payments is registration. The registration process includes the following provider activities: registration with the National Level Repository (NLR) maintained by CMS, completion of an application at the BMS web portal, and

submission of an attestation and supporting documentation at the BMS web portal. Providers will be instructed that upon completion of their registration process with the NLR, they should wait 24 hours before beginning the registration process with the State.

EP's registering and attesting in the BMS PIPS portal will login to the portal using their Medicaid MMIS login account information to register and attest. The BMS PIPS portal will prepopulate registration NLR data it receives about the EP. The EP will confirm the information on each screen during registration. If EP and EH requirements are the same then the assumption of "provider" is made, and the requirements are detailed in the SMHP only in cases where they differ. .

The provider portal application interface requires completion of the data fields containing the necessary information in order for an application to be accepted. The attestation interface requires positive affirmations of required statements as well as certain input resulting in the calculation of acceptable measurement thresholds in order to avoid automatic suspension of the application. If the application is suspended, the system will generate notifications to contact the applicant, notify them of the suspension, identify the missing information and provide instructions for re-application and/or re-attestation.

Appendix G contains sample screen shots of the BMS PIP web portal however a provider user guide has not yet been developed as that effort will be part of DDI

5.3.1.2 Trigger Event

Receipt of registration notification from the NLR.

5.3.1.3 Result

Documentation of application and attestation reviews indicating status of application.

5.3.1.4 Business Process Steps

1. Application
    a. Receive registration notification from the NLR. (Initial application only)
    b. Send application instructions to the provider (Year 1 only), including notification of the following requirements:
        i. Any information the provider submits must be verifiable through documentation available for review by BMS.
        ii. Applications must be submitted annually in order to receive Year 2 – 6 MU payments.
        iii. Documents supporting attestations for eligibility, A/I/U and MU, upon which incentive payments are based, must be retained for a period of 6 years after receipt of those payments.
    c. Provider logs into the application interface at the BMS web portal.
    d. The following identifying information will be pre-populated based on information received from the NLR:
        i. National Provider Identifier (NPI)
        ii. CMS Certification Number (CCN) (EH only)
        iii. Tax Identification Number (TIN)
        iv. Provider type

v. Provider name

e. Additional information will be required from the State during the registration process but will be pre-populated (where possible) from data stored within the MMIS. The provider will be required to designate a "pay to" selection utilizing a drop down box which displays the providers current "pay to" affiliations established in the MMIS.

f. Check the identifying information for completeness (automatic).

g. If application is incomplete**,** the system will generate a rejection notification and refuse acceptance (automatic).
   i. Notification will include list of missing information (automatic)

h. Check the identifying information for consistency with MMIS records (automatic).

i. If identifying information is inconsistent with MMIS records, the system will generate a rejection notification and refuse acceptance (automatic).
   i. Notification will include list of inconsistent information (automatic).

j. If the provider completes the application following notification, return to step c.

k. If application is complete, the system will generate a record and direct the provider to the attestation interface.

2. <u>Attestation</u>
   a. Provider enters the attestation interface at BMS web portal.
   b. Provider indicates year for which payment is being requested.
   c. Provider attests to the following assertions:
      i. Provider is not hospital based (EPs only)
         1. Provider will select "yes" or "no" from a drop down menu to answer the question:
            a. Did you perform 90% of your services in an inpatient hospital or emergency room hospital setting?
      ii. Provider is an eligible type
         1. Provider will select one of the eligible types from a drop-down menu:
            a. EP
               i. Physician
               ii. Nurse Practitioner
               iii. Certified Nurse Midwife
               iv. Dentist
               v. Physician Assistant in FQHC or RHC led by Physician Assistant, where "led" is defined as:
                  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
            b. EH
               i. Acute Care Hospital
                  1. Defined as having an average length of stay of 25 days or fewer, and with a CCN that falls in the range 0001-0879 or 1300-1399
                  2. Includes:
                     1. Cancer Hospital
                     2. Critical Access Hospital (CAH)
                  3. If Acute Care Hospital is selected, provider will select "yes" or "no" from a drop down menu to answer the question:

1. Is your average length of stay 25 days or less?

ii. Children's Hospital
1. Defined as being separately certified as a children's hospital, with a CCN in the 3300-3399 series and predominantly treating individuals under age 21

iii. Provider has not submitted duplicate registrations.
1. Provider will select applicable statements with the following options:
a. EP (all options must be selected for acceptance)
i. Not registered in another state
ii. Not registered under another NPI
iii. Not registered in Medicare
b. EH (all options must be selected for acceptance)
i. Not registered in another state
ii. Not registered under another NPI

iv. Provider has adopted, implemented or upgraded EHR technology, or is in the process of doing so in the payment year (Year 1 adopters only).
1. The provider must select one of the following options from a drop down menu:
a. Adoption: an actual purchase/acquisition or installation has occurred.
b. Implementation: the provider's certified EHR technology is being used in his or her clinical practice (i.e. staff training or data entry of the patients' demographic data)
c. Upgrade: the provider expanded the functionality of the certified EHR technology (i.e. addition of clinical decision support or e-prescribing functionality)

v. EHR product used by the provider utilizes certified technology.
1. Provider will select one of the technologies from a list of certified technology as posted on the ONC website.
2. Certified technologies are listed on the Office of the National Coordinator (ONC) website.
3. System shall validate Federal Certified EHR Product information in accordance with the Federal EHR program requirements.

vi. Provider has met all core set MU criteria and 5 menu set MU criteria for a 90 day period in the payment year (Year 1 for early adopters, Year 2 for Year 1 adopters).
1. Indicate a start and end date of 90-day period use.
2. Provider will enter numerator and denominator amounts for each measurement utilized in Tables 11 and 12
3. The system calculates the providers MU measurement objective results based on numerator and denominator inputs (automatic)
a. If any measurement results fail to meet thresholds, the system will generate a rejection notification and refuse acceptance (automatic).
4. Provider will be prompted to upload MU reports supporting the measurement data through the portal.

vii. Provider has met all core set MU criteria and 5 menu set MU criteria for a 12 month period in the payment year (Year 2 – 6 for early adopters, Year 3 – 6 for Year 1 adopters)

1. Provider will enter numerator and denominator amounts for each measurement utilized in tables 11 and 12 in section 5.3.6.
2. The system calculates the providers MU measurement objective results based on numerator and denominator inputs (automatic)
    a. If any measurement results fail to meet thresholds, the system will generate a rejection notification and refuse acceptance (automatic).
3. Provider will be prompted to upload MU reports supporting the measurement data through the portal.

viii. Provider meets patient volume criteria for a 90 day period.
1. Provider will input the 90 day period used.
2. Provider will select one of the following options from a drop-down menu:
    a. EP
        i. EPs not practicing at an FQHC or RHC
            1. Physicians (including pediatricians qualifying for full payment) – 30% Medicaid patient encounters
            2. Pediatricians (qualifying for alternative payment) – 20% Medicaid patient encounters
            3. Dentists – 30% Medicaid patient encounters
            4. Certified Nurse Midwives – 30% Medicaid patient encounters
            5. Nurse Practitioner – 30% Medicaid patient encounters
        ii. EPs practicing at an FQHC or RHC
            1. Physicians Assistants practicing at an FQHC or RHC led by a Physician Assistant – 30% needy individual encounters
            2. EPs other than Physician Assistants practicing predominantly at an FQHC or RHC – 30% needy individual encounters
                a. Practicing predominantly defined as: When the clinical location for over 50% of the provider's total patient encounters over a period of 6 months occur at an FQHC or RHC.
                b. Provider will be prompted to enter numerator and denominator for patient encounters, and the 6 month period used.
    b. EH
        i. Acute Care Hospital – 10% Medicaid patient encounters
            1. Includes critical access hospitals and cancer hospitals
        ii. Children's Hospital – No threshold
3. The following definition will be provided for this attestation item:
    a. An encounter is defined as an unduplicated direct personal contact (or series of contacts occurring within the same day)

between a member and a provider for reimbursable services for which Medicaid paid for all or part of the services.

b. Needy individuals are defined as meeting one of the following criteria:
    i. Medicaid and Children's Health Insurance Program enrollees
    ii. Patients furnished uncompensated care by the provider
    iii. Patients furnished services at either no cost or on a reduced cost basis.

4. Provider will input the following data for the 90 day measurement period:
    a. Medicaid or needy individual encounters (numerator)
    A count of unduplicated per patient, per date of service Medicaid Claim Based Encounters in the 90 day period. Includes: All Medicaid paid encounters including inpatient (POS 21) and emergency room (POS 23) services. West Virginia will run a report from the MMIS system for FFS for a pre-payment validation of the numerator.
    b. Total patient encounters (denominator)
    A report from the Practice Management System (PMS) that supports a provider's denominator must be uploaded into the completed registration/attestation submission screen of the State Level Registration. This is required as part of the pre-payment validation process.
    c.
5. System will calculate and display patient volume percentage (automatic).
6. EP must meet patient volume requirements as specified in the final rule.

d. If attestation is complete, the system will:
    i. Calculate the incentive payment
    ii. Notify the applicant of the acceptance of the application and attestation
    iii. Generate a record of the application and attestation
    iv. Generate a message indicating that the eligibility review process can be initiated for the accepted application and attestation.

5.3.2 Verify Eligibility

5.3.2.1 Description

Providers must meet eligibility requirements in order to qualify for EHR incentive payments. The requirements include: professional and regulatory compliance, provider practice type, Medicaid patient volume, and non-duplication of registration for incentive payments. BMS will verify the information submitted by the provider, as well as the identity of the provider, to ensure that the requirements are met.

It is the intention of BMS to conduct a provider re-enrollment currently targeted to begin 3Q11. This effort will address the screening requirements set forth in Federal Register, Vol. 76, No. 22 which includes reference to the "*Best Practices for Medicaid Program Integrity Units' Collection of Disclosures in Provider Enrollment"*.

EP's registering and attesting in the BMS PIPS portal will login to the portal using their Medicaid MMIS login account information to register and attest. The BMS PIPS portal will prepopulate registration NLR data it receives about the EP. The EP will confirm the information on each screen during registration. If EP and EH requirements are the same then the assumption of "provider" is made, and the requirements are detailed in the SMHP only in cases where they differ. Appendix G contains sample screen shots of the BMS PIP web portal however a provider user guide has not yet been developed as that effort will be part of DDI.

5.3.2.2 Trigger Event

Completion of the registration process, resulting in documentation of the satisfactory results of the application and attestation reviews.

5.3.2.3 Result

BMS determination of whether provider meets eligibility requirements for EHR incentive payment program.

5.3.2.4 Business Process Steps

1. Provider Identity Verification
    a. Verify that the identifying information submitted in the application is consistent with information on file in the MMIS for the NPI provided (automatic).
    b. Verify that the provider has an enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS) (automatic). (EHs only)

2. Professional and Regulatory Verification
    a. Verify that the applicant is properly licensed based on query of the MMIS (automatic).
    b. Verify that the applicant is not sanctioned based on query of the exclusion database (automatic).
    c. Verify that the applicant is not a party excluded from receiving Federal financial assistance based on query of the Excluded Parties List System (EPLS) (manual).
    d. Verify that the applicant is not a party excluded from receiving State of West Virginia financial assistance (manual).
    e. Verify that the applicant is not deceased, base on a death certificate query (manual).

3. Practice Type Verification
    a. If the applicant is an EP, verify, through query of claims data in MMIS, that the EP is not hospital based.
        i. BMS will initially review claims for place of service codes 21 and 23. If these service codes appear to be predominant, documentation will be requested from the provider to support the attestation of 90% of services occurring outside of hospitals.
    b. If the applicant is an acute care hospital, verify, through use of a consultant, that the average length of stay is less than 25 days.

4. Patient Volume Verification
    Patient volume data will be validated by performing a match with the MMIS once the provider has submitted their State Level Registration (SLR). BMS expects the information submitted for Medicaid volume matches closely to what the provider has submitted in Medicaid Claims and/or Encounters.
    a. [Verify that the applicant meets the minimum Medicaid patient volume thresholds. This verification occurs automatically during the provider attestation submission.]
    b. [Verify that an appropriate patient volume measurement period of 90 days has been utilized. This verification occurs automatically during the provider attestation submission.]

c. Verify Medicaid data used in patient volume thresholds based on claims in MMIS (automatic).

5. Non-duplication Verification
    a. Verify that the provider is not registered for Medicare incentives or Medicaid incentives with another state by query of the NLR.
        i. Hospitals can receive incentive payments from both Medicare and Medicaid.
        ii. If a provider is eligible for multiple incentive programs, whether it be in multiple states or both Medicare and Medicaid, the provider has discretion relative to which states/programs to receive payments from.
    b. Verify that the provider has a single application with BMS by query of the MMIS.

6. Notification of Suspension/Denial
    a. If the provider does not meet eligibility requirements, send the following documents to the applicant by postal service and email (if email address provided):
        i. Denial form
        ii. Submission of appeal form
    b. If an appeal is submitted, execute the following appeal process steps:
        i. Log and track
        ii. Triage to appropriate reviewers
        iii. Research
        iv. Issue additional information requests as necessary
    c. Schedule hearing, if necessary
    d. If a hearing is scheduled, ensure that it is conducted in accordance with legal requirements and that a ruling is made based upon the evidence presented.
    e. Document the results of the hearing and distribute relevant documents to the applicant or member and store in the applicant or member information file.

7. Completion of Eligibility Verification
    a. If all eligibility verification reviews are satisfactory
        i. The system will generate a record of the eligibility verification
        ii. The system will generate a message indicating that pre-payment program compliance for the eligible provider can be initiated

5.3.3 Verify Program Compliance – Pre-payment

5.3.3.1 Description

Pre-payment program compliance verification includes a recalculation of the payment amount that providers are eligible to receive based upon information submitted in the annual application and attestations. BMS also verifies certified technology requirements for Year 1 payments and MU requirements for Year 2-6 payments. (Year 1 adopters) and Year 1 payments (early adopters only).

5.3.3.2 Trigger Event

Completion of the provider eligibility verification process, resulting in documentation of the satisfactory results of the eligibility reviews.

5.3.3.3 Result

BMS recalculates the incentive payment amount the provider is eligible to receive and verifies A/I/U and technology certification requirements (Year 1) or MU requirements (Years 2 – 6) prior to disbursement.

5.3.3.4 Business Process Steps

1. Patient Volume Requirements
   This is an identified risk and is critical for the MU provider eligibility determination; yet, it requires data that does not currently exist.

   WV is following the regulation established criteria for EPs who are not pediatricians or FQHCs/RHCs that the EPs have a minimum of 30 percent of all patient encounters attributable to Medicaid (20 percent for pediatricians) over any continuous 90-day period within the most recent calendar year prior to the reporting calendar year.

   For Medicaid EPs practicing predominantly in an FQHC or RHC, they must have a minimum of 30 percent patient volume attributable to “needy individuals” over any continuous 90-day period within the most recent calendar year prior to the reporting calendar year. In order to standardized and implement, the state has determine that no out of state enrollees will be included in either the numerator or denominator, no minimum number of patient volume/encounters is required, the provider can choose the 90 day period within the calendar year.

   If and when appropriate, WV will implement the following methodology provided in the regulation for Medicaid enrollees of Medical Homes or MCOs: {[Total (Medicaid) patients assigned to the provider in any representative continuous 90-day period in the preceding calendar year, with at least one encounter taking place during the calendar year preceding the start of the 90-day period] + [Unduplicated (Medicaid) encounters in the same 90-day period]/[Total patients assigned to the provider in that same 90-day period, with at least one encounter taking place during the calendar year preceding the start of the 90-day period] + [All unduplicated encounters in that same 90-day period]} * 100

   The denominator is all patient encounters for the same individual professional over the same 90-day period as the numerator. The data source will run a report from the provider’s internal management system, which the provider will attach as a PDF to his/her submission. Hospitals are eligible for both Medicare and Medicaid using their CMS certification number (one certification number = one hospital). An acute hospital must have a patient volume of 10% Medicaid. No out of state enrollees will be in the numerator or denominator and there is no minimum number of patient volume/encounters.

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

   {[Total (Medicaid) patients assigned to the provider in the first quarter of the preceding calendar year, with at least one encounter taking place during the calendar year preceding the start of the 90-day period] + [Unduplicated (Medicaid) encounters in the same 90-day period]/[Total patients assigned to the provider in that same 90-day period, with at least one encounter taking place during the calendar year preceding the start of the 90-day period] + [All unduplicated encounters in that same 90-day period]} * 100. The data source is the

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

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

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

WV will include general short-term hospitals, cancer hospitals, and critical access hospitals that meet the Medicaid patient volume criteria. WV will allow clinics and group practices to use the practice or clinic management system as the data source for the denominator and the WV MMIS for the Medicaid patient volume (or needy individual patient volume, insofar as it applies) and apply it to all EPs in their practice under three conditions: clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP; there is an auditable data source to support the clinic's patient volume determination; and the practice and EPs decide to use one methodology in each year.

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

At this time, BMS is unable to define the estimated turnaround timeframes for manual processes. However, as requirements are further refined, those timeframes will be defined and incorporated into the Bureau’s business processes.

2. <u>Payment Amount Verification (All Years)</u>
    a. Identify payment year (i.e. Year 1, Year 2 etc.) from attestation
    b. Verify that the year of the payment request complies with the following guidelines:
        i. A/I/U payments must commence prior to 2017
        ii. MU payments must commence prior to 2022

3. Technology Certification Verification (Year 1 Payments)
    c. [Verify that the technology reported as being used by the providers is certified as eligible by the ONC, by review of the ONC website. This verification occurs automatically during the provider attestation submission.]

4. MU Requirement Verification (Year 2 – 6 Payments for Year 1 adopters, Year 1 – 6 Payments for early adopters)
    d. BMS or contracted vendor manually reviews the MU measurements reported on the MU reports from the provider for the reporting period
        i. Assess compliance with the reporting objectives in tables 11 and 12 below
        ii. Determine whether provider has met:
            1. all the core set meaningful use criteria
            2. 5 out of 10 menu set meaningful use criteria
        iii. Determination is based on review of:
            1. EHR system reports
            2. Clinical data review
            3. Quality outcome analysis
            4. Other documentation that the provider believes will attest to meaningful use and is agreed to by BMS

5. Notification of Suspension/Denial
    e. If the provider does not meet program compliance requirements for A/I/U and/or MU, send the following documents to the applicant by postal mail and email (if email address provided):
        i. Denial form
        ii. Submission of appeal form
    f. If an appeal is submitted, execute the following appeal process steps:
        i. Log and track
        ii. Triage to appropriate reviewers
        iii. Research
        iv. Issue additional information requests as necessary
    g. Schedule hearing, if necessary
    h. If a hearing is scheduled, ensure that it is conducted in accordance with legal requirements and that a ruling is made based upon the evidence presented.
    i. Document the results of the hearing and distribute relevant documents to the applicant or member and store in the applicant or member information file.
    j. Verify provider is not on pay hold or have an active lien.

6. Completion of Pre-Payment Program Compliance Verification
    k. If all pre-payment program compliance verification reviews are satisfactory
        i. BMS or designated vendor will sign off indicating approval of program compliance
        ii. The system will generate a record of the program compliance verification
        iii. The system will generate a message indicating that payment processing can be initiated

5.3.4 Process Payment

5.3.4.1 Description

Payment processing occurs after the registration, eligibility verification and pre-payment program compliance verifications processes are complete. This process includes the procedures required to generate a cash disbursement to a provider via interface with Molina and the State of West Virginia Treasury Department. The proper recording and tracking of those disbursements are also a crucial part of the provider incentive program that must be carefully managed during payment processing.

Incentive payments will be processed for payment once all registration/attestation and/or MU requirements verification procedures are completed. Once verification and approval is completed, incentive payments will be input to the MMIS as an adpay (gross payment) claim. This claim type allows the payment to bypass normal aging requirements for payment selection and will allow the incentive payment to be selected for payment immediately once the weekly process moves all clean claims into Accounts Payable.

5.3.4.2 Trigger Event

Completion of pre-payment program compliance for a provider, resulting in documentation of satisfactory results of the A/I/U and MU requirement reviews, and determination of eligibility for a specific payment amount.

5.3.4.3 Result

State of West Virginia Treasury issues a cash disbursement to an eligible provider in the proper amount, pursuant to a properly verified application.

5.3.4.4 Business Process Steps

1. Update non-duplication verification as follows:
    a. Verify that the provider is not registered for Medicare incentives or Medicaid incentives or Medicaid incentives with another state by query of the NLR.
    b. Verify that the provider has a single application with BMS by query of the MMIS.
2. Lock application to prevent changes by the provider. Providers will be provided two days to review and submit changes to initial application. Upon expiration of the two day period the system will lock the application and indicate that it is approved for payment.
3. Submit request for incentive payment information to Molina.
4. Notify the NLR that a payment has been disbursed.
5. Document payment disbursement in MMIS.
6. Verify that payment amounts distributed by the state agree to the amounts reported to the NLR.

5.3.5 Verify Program Compliance – Post-Payment

5.3.5.1 Description

The objective of post-payment verification is to provide assurance that the providers who have received EHR incentive payments:

- are properly registered

- have met eligibility requirements
- have met certified technology, A/I/U and/or MU (when applicable) requirements
- received the proper payment amount

These objectives are met through testing compliance with program criteria for a sample of recipients.

The Finance group within the Bureau will be responsible for the oversight of the post payment compliance auditing.

5.3.5.2 Trigger Event

Disbursement of incentive payment funds to an established number of recipients and/or passage of established time periods for the operation of the program.

5.3.5.3 Result

Documentation of program compliance for specified incentive payment disbursement period.

5.3.5.4 Business Process Steps

1. Planning
    a. Identify compliance criteria for post-payment verification, based on following requirements:
        i. Attestation assertions:
            1. The incentive payment was not made by another state or by Medicare (the provider only has one NPI in the national database).
            2. Providers who received Year 1 payments have completed, or are in the process of, adopting, implementing, or updating, or achieved meaningful use.
            3. Providers receiving Year 2 – 6 payments meet the meaningful use criteria.
        ii. Payment propriety:
            1. Eligible payment year
            2. Exceeding maximum annual and program total payments
    b. Determine criteria for sample selection
        i. Identify characteristics of high risk cases, including:
            1. The providers' practice address is:
                a. The address of a hospital
                b. The address of a FQHC/RHC
                c. Outside of West Virginia
                d. Shared with other providers.
            2. The provider is a Medicare provider
        ii. Determine parameters for statistical sampling of population not identified as high-risk
        iii. Ensure that the risks of internal control weaknesses and deficiencies have been considered in the identification of compliance criteria and sample selection
            1. For example, verify that there were no changes made to the provider's application after eligibility was determined, indicating that the application was not locked

c. Design tests
    i. Tests of controls
        1. Re-performance of pre-payment program compliance and eligibility verification procedures
        2. Tests of BMS or contracted vendor review and approval processes
        3. Tests of provider controls
        4. Review independent service auditor's report on controls (SAS 70) for fiscal agent
    ii. Compliance testing
        1. Tests of A/I/U
        2. Tests of MU

2. Testing
    a. Select sample
        i. Select high risk cases based on an analysis of provider database for characteristics identified in planning
        ii. Apply statistical sampling approach to non-high risk population
    b. Contact the providers selected for testing and request the documentation to verify the following data submitted in application.
        i. Total patient encounters and Medicaid encounters
        ii. Meaningful use
        iii. Adoption, implementation, or updating of EHR technology
    c. Apply test procedures
        i. Eligibility
            1. Re-perform eligibility verification procedures
            2. Verify patient volume statistics by prepayment review of:
                a. MMIS - claims data will be used to verify Medicaid patient encounters
                b. Billing records - Providers are expected to track receivables from all entities (including Medicaid) associated with specific patients. The receivables tracking provides information to verify encounter data. Some providers may use practice management systems that track other information useful for verification purposes.
        ii. Payment amount
            1. Re-perform payment amount calculations
            2. Agree payment calculation input data to cost reports (EHs only) .
        iii. A/I/U
            1. Re-perform pre-payment verification procedures
            2. Test ownership of technology through:
                a. Physical inspection
                b. Purchase vouching (accounts payable and cash disbursement records)
                c. Vendor confirmation
                d. Confirmation of contracts and purchases with vendors
                e. Review of original documents in cases where copies were provided
        iv. Meaningful use
            1. Re-perform pre-payment verification procedures
            2. Verify numerator and denominator
    d. Summarize results of initial testing.

e. Identify providers subject to follow-up procedures.
f. Conduct follow-up procedures

3. Analysis and Reporting
   a. Summarize results of follow-up procedures and disposition of exceptions
   b. Investigate cause of exceptions and calculate improper payment amount
   c. Prepare report summarizing test results for test period.

4. Disposition of Findings
   a. If it is determined that an improper payment amount was distributed to an EHR program participant, implement procedures to recoup the payment.
   b. Forward improper payment amount information to Flexi Financials, which manages payment recoupment and will withhold payment until the amount is repaid in full.
   c. If fraud is suspected in any of the provider attestations or in the payment process, notify the West Virginia Medicaid Fraud Control Unit for possible investigation.
   d. Ensure that steps are taken to prevent the provider from receiving further incentive payments until the improper payment issue is resolved.

5. Notification of Suspension/Denial
   a. If a payment is determined to be improper, send the following documents to the applicant by postal mail and email (if email address provided):
      i. Denial form
      ii. Submission of appeal form
   b. If an appeal is submitted, execute the following appeal process steps:
      i. Log and track
      ii. Triage to appropriate reviewers
      iii. Research
      iv. Issue additional information requests as necessary
   c. Schedule hearing, if necessary
   d. If a hearing is scheduled, ensure that it is conducted in accordance with legal requirements and that a ruling is made based upon the evidence presented.
   e. Document the results of the hearing and distribute relevant documents to the applicant or member and store in the applicant or member information file.

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

5.3.6 Provider Incentive Program Tables

Table 9: Payment Calculation – Hospitals

Payment Calculation Formulas - Hospitals
Step1: Calculate EHR Amount = The sum of the following calculations for each year in a hypothetical 4 year period. The base amount of $2,000,000 plus the discharge related amount - $200 for the 1,150th through the 23,000th discharge for each 12 month period. **Multiplied by:** the transition factor for the year: 1 – for year 1 3/4 – for year 2 1/2 – for year 3 1/4 – for year 4 **Step 2:** Calculate Medicaid Share = (Estimated Medicaid inpatient-bed-days + estimated Medicaid managed inpatient-bed-days) **Divided by:** (Estimated total inpatient-bed-days * (estimated total charges – charity care charges))/estimated total charges **Step 3:** *EHR Amount* ***** *Medicaid Share* **Step 4:** Ensure compliance with hospital specific guidelines: 1. The last year that a hospital may begin receiving Medicaid incentive payments is 2016. 2. Payments made over a minimum of 3 years and a maximum of 6 years. 3. No annual payment may exceed 50% of the total calculation; no 2-year payment may exceed 90%

Table 10A: Payment Scenarios for Medicaid EPs Who Begin Adoption in the First Year

Calendar of Payments for Providers						
Calendar Year	Medicaid EPs who begin adoption in					
	2011	2012	2013	2014	2015	2016
2011	$21,250					
2012	$8,500	$21,250				
2013	$8,500	$8,500	$21,250			
2014	$8,500	$8,500	$8,500	$21,250		
2015	$8,500	$8,500	$8,500	$8,500	$21,250	
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017		$8,500	$8,500	$8,500	$8,500	$8,500
2018			$8,500	$8,500	$8,500	$8,500
2019				$8,500	$8,500	$8,500
2020					$8,500	$8,500
2021						$8,500
Total	**$63,750**	**$63,750**	**$63,750**	**$63,750**	**$63,750**	**$63,750**

Table 10B: Maximum Incentive Payments for Medicaid EPs Who Are Meaningful Users in the First Payment Year

Calendar of Payments for Providers						
Calendar Year	Medicaid EPs who begin meaningful use of certified EHR technology in--					
	2011	2012	2013	2014	2015	2016
2011	$21,250					
2012	$8,500	$21,250				
2013	$8,500	$8,500	$21,250			
2014	$8,500	$8,500	$8,500	$21,250		
2015	$8,500	$8,500	$8,500	$8,500	$21,250	
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017		$8,500	$8,500	$8,500	$8,500	$8,500
2018			$8,500	$8,500	$8,500	$8,500
2019				$8,500	$8,500	$8,500
2020					$8,500	$8,500
2021						$8,500
Total	**$63,750**	**$63,750**	**$63,750**	**$63,750**	**$63,750**	**$63,750**

Table 11: Meaningful Use Criteria – Core Set

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Meaningful Use Criteria - Core Set		
An eligible hospital or CAH must meet all Stage 1 meaningful use criteria.		
Stage 1 objectives (EP)	**Stage 1 objectives (Hospitals)**	**Stage 1 measures**
Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines	More than 30% of all unique patients with at least one medication in their medication list seen by the EP or admitted to the EH of CAH's inpatient or emergency department have at least one medication order entered using CPOE
Implement drug-drug and drug-allergy checks	Implement drug-drug and drug-allergy checks	The EP/ eligible hospitals/CAH has enabled this functionality for the entire EHR reporting period
Generate and transmit permissible prescriptions electronically		More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology
Record Demographics - Preferred Language - Gender - Race - Ethnicity - Date of Birth	Record Demographics - Preferred Language - Gender - Race - Ethnicity - Date of Birth - Date and preliminary cause of death in the event of mortality in the eligible hospital of CAH	More than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department have demographics recorded as structured data
Maintain an up-to-date problem list of current and active diagnoses	Maintain an up-to-date problem list of current and active diagnoses	More than 80% of all unique patients seen by the EP or admitted to the eligible hospitals or CAH's inpatient or emergency department have at least one entry or an indication that no problems are known for the patient recorded as structured data

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Meaningful Use Criteria - Core Set		
An eligible hospital or CAH must meet all Stage 1 meaningful use criteria.		
Stage 1 objectives (EP)	**Stage 1 objectives (Hospitals)**	**Stage 1 measures**
Maintain an active medication list	Maintain an active medication list	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department have at least one entry or an indication that the patient is not currently prescribed any medication recorded as structured data
Maintain an active medication allergy list	Maintain an active medication allergy list	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department have at least one entry or an indication that the patient is no known medication allergies recorded as structured data
Record and chart changed in vital signs: - Height - Weight - Blood Pressure - Calculate and display BMI - Plot and display growth charts for children 2-20 years, including BMI	Record and chart changed in vital signs: - Height - Weight - Blood Pressure - Calculate and display BMI - Plot and display growth charts for children 2-20 years, including BMI	For more than 50% of all unique patients age 2 and over seen by the EP or admitted to eligible hospital's or CAH's inpatient or emergency department, height, weight, and blood pressure are recorded as structured data
Record smoking status for patients 13 years or older	Record smoking status for patients 13 years or older	More than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department have "smoking status" recorded as structured data
Implement one clinical decision support rule relevant to specialty or high clinical priority with the ability to track compliance to that rule	Implement one clinical decision support rule relevant to specialty or high clinical priority with the ability to track compliance to that rule	Implement one clinical decision support rule

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Meaningful Use Criteria - Core Set		
An eligible hospital or CAH must meet all Stage 1 meaningful use criteria.		
Stage 1 objectives (EP)	**Stage 1 objectives (Hospitals)**	**Stage 1 measures**
Report ambulatory quality measures to CMS or the states	Report ambulatory quality measures to CMS or the states	For 2011, provided aggregate numerator and denominator through attestation as discussed in section II (A) (3) of the final rule. For 2012, electronically submit the measures as discussed in section II (A) (3) of the final rule
Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication list, allergies), upon request	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication list, allergies, discharge summary, procedures), upon request	More than 50% of all patients of the EP or the inpatient or emergency departments of the eligible hospital or CAH who request an electronic copy of their health information are provided within 3 business days
	Provide patients with an electronic copy of their discharge instructions at the time of discharge, upon request	More than 50% of all patients who are discharged from an eligible hospital or CAH's inpatient or emergency department and who request an electronic copy of their discharge instructions are provided it
Provide clinical summaries for patients for each office visit		Clinical summaries provided to patients for more than 50% of all office visits within 3 business days
Capability to exchange key clinical information among providers of care and patient authorized entities electronically	Capability to exchange key clinical information among providers of care and patient authorized entities electronically	Performed at least one test of certified EHR technologies capacity to electronically exchange key clinical information
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process

Table 12: Meaningful Use Criteria – Menu Set

Page 1 of 3		
Meaningful Use Criteria - Menu Set		
An eligible hospital or CAH must meet all 5 of 10 Menu Set meaningful use criteria.		
Stage 1 objectives (EP)	**Stage 1 objectives (Hospitals)**	**Stage 1 measures**
Implement drug-formulary checks	Implement drug-formulary checks	The EP/eligible hospital/CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period
	Record advance directives for patient 65 years or older	More than 50% of unique patients 65 years or older admitted to the eligible hospital's or CAH's inpatient department have an indication of an advance directive status recorded
Incorporated clinical lab-test results into EHR as structured data	Incorporated clinical lab-test results into EHR as structured data	More than 40% of all clinical lab tests results ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach	Generate at least one report listing patients of the EP, eligible hospital, or CAH with a specific condition
Send reminders to patients per patient preference for preventive/ follow up care		More than 20% of all unique patients 65 years or older of 5 years old or younger were sent an appropriate reminder during the EHR reporting period

Page 2 of 3		
Meaningful Use Criteria - Menu Set		
An eligible hospital or CAH must meet all 5 of 10 Menu Set meaningful use criteria.		
Stage 1 objectives (EP)	**Stage 1 objectives (Hospitals)**	**Stage 1 measures**
Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies) within four business days of the information being available to the EP		More than 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information
Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate	More than 10% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient emergency department are provided patient-specific education resources
The EP, eligible hospital or CAH who receives a patient from another setting of care or believes an encounter is relevant should perform medication reconciliation	The EP, eligible hospital or CAH who receives a patient from another setting of care or believes an encounter is relevant should perform medication reconciliation	The EP, eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department
The EP, eligible hospital or CAH who transitions their patient to another setting of care or refers their patient to another provider of care should provide summary care records for each transition of care and referral	The EP, eligible hospital or CAH who transitions their patient to another setting of care or refers their patient to another provider of care should provide summary care records for each transition of care and referral	The EP, eligible hospital or CAH who transitions or refers their patient to another setting of care or provider of care should provide a summary of care record for more than 50% of transitions of care and referrals

Page 3 of 3		
Meaningful Use Criteria - Menu Set		
An eligible hospital or CAH must meet all 5 of 10 Menu Set meaningful use criteria.		
Stage 1 objectives (EP)	**Stage 1 objectives (Hospitals)**	**Stage 1 measures**
Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice	Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful
	Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice	Performed at least one test of certified EHR technology's capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful
Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful

Appendix A: Landscape Assessment Tool

State of West Virginia
State Medicaid HIT Plan
Landscape Assessment

Organization Name: _____

Respondent Name and Title: _____

Respondent Email: _____Phone # _____

Does your organization have current HIT systems in place?

___Secure Patient e-mail
___Remote Patient Monitoring
___Health Information Exchange
___Outcome Reporting System
___Patient Registry
___Electronic Health Record
___Personal Health Record
___Patient Portal
___E-prescribing
___Telehealth

If “Yes”, please identify and give a brief description of each system.

Has your organization made any upgrades in the last 12 months to current HIT systems?

- ☐ Yes
- ☐ No

If “Yes”, please describe upgrade and new functionality if applicable.

Does your organization plan to implement HIT systems in the near future?

- ☐ Yes
- ☐ No

If “Yes”, please list new systems and briefly describe the functionality.

Is your organization involved with any other health related initiatives/agencies?

- ☐ Yes
- ☐ No

If “Yes”, who are you collaborating with and how are you collaborating?

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9. Has your organization received any State and/or federal funding for HIT related projects?
   - ☐ Yes
   - ☐ No

10. If “Yes”, how much did the organization receive and how are the funds being spent?

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11. Do any of your organization’s current HIT activities affect Medicaid members?
   - ☐ Yes
   - ☐ No

12. If “Yes”, please describe how.

---

13. Do any of your organization’s current HIT activities cross state borders?
   - ☐ Yes
   - ☐ No

14. If “Yes”, please list border states and identify the shared activities.

---

15. Is your organization currently providing any outreach functions/activities to the provider community?
   - ☐ Yes
   - ☐ No

16. If “Yes”, please describe.

---

17. Does your organization currently have any channels for reaching providers?
   - ☐ Yes
   - ☐ No

18. If “Yes”, please describe.

---

19. Is your organization providing any financial support to providers to help them with EMR's and achieving meaningful use?

- ☐ Yes
- ☐ No

20. If "Yes", please describe how.

Agency Specific Questions
If your organization is listed below please answer specific questions to your agency.

Regional Health IT Extension Centers
What specific activities is the RHITEC doing to assist Medicaid EP's in implementing certified EHR systems and achieve meaningful use?

Community Health Network
Which facilities are using the RPMS EHR system?

Broadband – Department of Commerce/WV Telehealth Alliance
What specific activities are you doing to expand Broadband into WV's rural area?

Bureau for Public Health
What is the current interoperability status of the State Immunization registry and Public Health Surveillance reporting database?

Bureau for Medical Services

What is Medicaid's relationship with the HIT Coordinator?

What activities does Medicaid currently have underway that will influence the direction of the EHR Incentive Program over the next five years?

Are there a significant number of members crossing state lines to access health care services?

Governor's Office of Health Enhancement & Lifestyle Planning
Has the state coordinated the HIT Plan with the MITA transition plans? If so briefly describe how.

West Virginia Health Information Network
Please list the services that will be offered by the WVHIN and provide a brief description.

Office of Technology
What level of service is being provided to the Broadband Initiative and what is the current status?

Appendix B: Bureau for Medical Services Strategic Plan (Fall 2010)

1.0 Background

Strategic planning is not a one-time activity. The transformation of state Medicaid programs will be an ongoing, iterative process. Each successive effort would be more inclusive and result in broader change than the last. To that end, BMS periodically revisits its strategic goals and objectives in light of changes in the program environment.

The strategic planning efforts conducted by the Department of Health and Human Resources Bureau for Medical Services in the Fall of 2010 built upon the strategic foundation and direction provided by the following:

- Former Governor Manchin's Healthy West Virginia (HealthyWV) Strategic Plan completed and published in April 2007[6]
- CMS Medicaid Information Technology Architecture (MITA) State Self-Assessment (SS-A) requirements[7]
- West Virginia Health Information Technology Statewide Strategic Plan[8]
- Medicaid provision of the American Recovery and Reinvestment Act of 2009[9]
- Medicaid provisions of the Patient Protection and Affordable Care Act of 2010[10]

1.1 Healthy West Virginia (HealthyWV) Strategic Plan

The HealthyWV Plan established the following guiding principles for the Governor's administration:

- Medicaid provisions of the Patient Protection and Affordable Care Act of 2010
- The ultimate purpose of West Virginia's health system should be to ensure the best possible health outcomes for all West Virginians. Physical and mental health are essential components of overall health and well-being.
- Prevention and health promotion must be cornerstones of West Virginia's health policy.
- All West Virginians should be informed and active partners in taking care of their own health, making wise use of health care resources, and contributing financially to their

[1] Former Governor Manchin's Healthy West Virginia (HealthyWV) Strategic Plan completed and published in April 2007 (http://www.gohelp.wv.gov/AdvisoryCouncil/Meetings/Documents/West%20Virginia's%20Health%20Information%20Technology%20Initiative%207.pdf).

[7] CMS Medicaid Information Technology Architecture (MITA) State Self-Assessment (SS-A) requirements (https://www.cms.gov/MedicaidInfoTechArch/04_MITAFramework.asp).

[8] West Virginia Health Information Technology Statewide Strategic Plan (http://www.wvhealthimprovement.org/wvhii/Attachment443.aspx)

[9] Medicaid provision of the American Recovery and Reinvestment Act of 2009 (http://www.recovery.gov)

[10] Medicaid provisions of the Patient Protection and Affordable Care Act of 2010 http://ritterim.files.wordpress.com/2010/03/healthcarereformbill_final.pdf

health care to the extent that they are able – and all should have the opportunity to obtain the information they need to do so.

- All West Virginians should have the opportunity to obtain health care that is affordable.
- The health care system must provide care of the highest value and efficiency for the resources allocated.
- Responsible use of government funds to ensure high-quality, affordable health care requires a partnership between the private sector and government.
- The overall costs of the health system must be sustainable over time for individuals, families, government and employers.

1.2 Medicaid Information Technology Architecture (MITA) State Self-Assessment (SS-A)

Nationwide, the Medicaid Program serves millions of Americans in need every year and represents the largest budget expense for most states. The Centers for Medicare and Medicaid Services (CMS) implemented a nationwide effort to update and improve the Program via its state partners. CMS developed the Medicaid Information Technology Architecture (MITA) to standardize the Medicaid business model and provide a framework for maturing Medicaid business processes and improving supporting information systems. MITA outlines planning steps and specific processes.

As a condition of receiving federal funding, all states are required to review their current capabilities and identify desired capabilities using a prescribed assessment protocol. The assessment defines the maturity levels the state selects to achieve over a span of five to ten years and may involve a phased approach for completion.

The West Virginia Department of Health and Human Services, Bureau for Medical Services completed its initial MITA State Self-Assessment in 2009.

1.3 West Virginia Health Information Technology Statewide Strategic Plan

The West Virginia Health Information Technology Statewide Strategic Plan issued in draft by the West Virginia Health Improvement Institute in September of 2009 set forth a vision for “West Virginia where health information technology plays a critical role in bridging gaps to access and quality of service for the purpose of improving the health and well-being of all West Virginians.”

1.4 American Recovery and Reinvestment Act of 2009

On February 17, 2009, President Obama signed into law the American Recovery and Reinvestment Act of 2009 (ARRA), a nearly $790 billion spending and tax cut package aimed at stimulating the sagging economy.

Section 4201 of ARRA amends 42 U.S.C. § 1396b to set forth the funding rules and guidelines for helping “Medicaid providers” establish an EHR system. It authorizes a total of $300 million to be used for the set up and operation of EHR systems by Medicaid providers, and describes how those funds are to be distributed by a state’s Medicaid agency. The amount allocated will provide $40 million annually between 2009 and 2015, and $20 million for 2016.

2.0 State Medicaid Health Information Technology Planning Initiative

The Bureau for Medical Services leadership engaged in a series of facilitated work sessions to revisit and update strategic goals, objectives and supporting initiatives based upon recent and

significant changes in the program environment. Changes included both regulatory changes and the opportunities presented by new and enhanced funding.

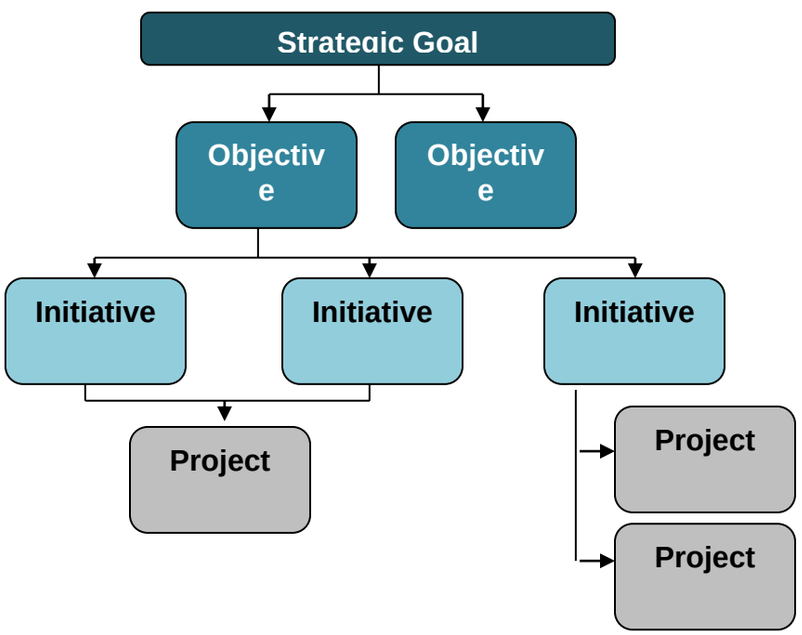
2.1 Strategic Planning Terms

Early in the strategic planning process, Bureau leadership discussed the meaning of such terms as “goal”, “objective” and “initiative” and adopted the following definitions for purposes of the of the strategic planning effort conducted in 2010.

Strategic Goals and Objectives	Strategic goals represent what the organization is committed to achieving in the next several years. Strategic objectives are significant results and outcomes the organization will achieve in support of those goals.
Initiatives	Initiatives are programs or groups of projects that are identified to achieve or support one or more objectives.
Projects	Projects are endeavors undertaken in support of an initiative. Projects differ from operations in that operations are continuous and focused on the repetition of outcomes while projects are temporary and focus on creation of a unique product, service or outcome.

These concepts form the building blocks used by the Bureau for planning. The following diagram illustrates the relationship between these concepts and the structure and terminology used in the remainder of this report.

Diagram 1: BMS Planning Structure



As noted in the diagram above, objectives are derived from strategic goals. Initiatives are defined to achieve one or more objectives. Initiatives are further broken down into one or more discrete projects.

2.2 Strategic Goals and Objectives

The following table lists the Bureau's strategic goals and objectives as updated in December 2010.

Table1: BMS Goals & Objectives

ID	Goals & Objectives by Business Area
Gen	**High-Level Administrative and Management Goals and Objectives**
Gen 1.0	Goal: Improve BMS effectiveness and efficiency.
Gen 1.1	Align resources with core business functions.
Gen 1.2	Secure necessary resources.
Gen 1.3	Establish and provide necessary professional education and training to enhance staff performance.
Gen 1.4	Develop MMIS Roadmap to support future business needs.
Gen 1.5	Implement performance management and measurement principles within BMS.
Gen 2.0	Goal: Minimize risk and maximize value from contracted services and products.
Gen 2.1	Streamline and improve procurement business functions.
Gen 2.2	Continuously improve project management capabilities.
Gen 2.3	Implement performance management and measurement principles.
Gen 3.0	Goal: Leverage technology to enhance performance and decision making.
Gen 3.1	Enhance reporting capabilities to allow for more efficient and effective performance monitoring.
Gen 3.2	Improve data access, analysis and reporting to support decision making.
Gen 4.0	Goal: Assess, implement, and monitor compliance with all relevant federal laws and regulations (e.g. PPACA, State Medicaid Manual, HIPAA).
GEN 4.1	Establish a team and process for assessing compliance with new laws and regulations. .
GEN 4.2	Establish a team and process for implementation of changes necessary to comply with new laws and regulations.
GEN 4.3	Establish a team and process for monitoring compliance with laws and regulations.
Gen 4.4	Verify and monitor MMIS and Fiscal Agent operations to ensure transactions are processed in accordance with all relevant federal laws and regulations.
Gen 5.0	Goal: Ensure program quality.
Gen 5.1	Develop and execute a Quality Management Plan.
Gen 5.2	Design and configure systems and processes to support the Quality Plan.
Gen 5.3	Enhance ability to measure compliance with quality indicators.
GEN 6.0	Goal: Enhance and improve efficient, effective and meaningful outreach and communication.
GEN 6.1	Improve communication with providers and members.
GEN 6.2	Rebrand Medicaid as another provider of healthcare coverage.
OM	**Operations Management**
OM 1.0	Goal: Improve operational efficiency and reduce costs in the healthcare system.
OM 1.1	Document operations management roles, responsibilities and business processes.
OM 1.2	Analyze operations management organization structure to align resources with core business functions.

ID	Goals & Objectives by Business Area
OM 1.3	Enhance and automate reporting capabilities to measure compliance with operational performance measures.
OM 2.0	Goal: Improve access to information necessary for operations management.
OM 2.1	Enhance cost avoidance capability by improving access to accurate other third party payer information.
OM 2.2	Establish integration with other entities to further reduce the potential for redundancy of service and payment.
OM 3.0	Goal: Improve provider access to real-time data.
OM 3.1	Enhance provider portal to support clinical decisions and to provide real-time access to cost settlement and rebate data.
OM 3.2	Implement real time access to data based on claim adjudication results.
OM 3.3	Integrate automated prior authorization capability to provide real time approval or rejection of routine Pharmacy prior authorizations.
ME	**Member Management**
ME 1.0	Goal: Enhance ability for members to participate in and exercise responsibility for their personal health choices.
ME 1.1	Explore capabilities to establish and allow member access to a personal health record.
ME 1.2	Provide automated administration of a member incentive program as designed by BMS and approved by CMS.
ME 1.3	Provide for automated administration of personal Health Improvement Plans.
ME 1.4	Empower members by providing access to information and tools that can be used to improve their health.
ME 1.5	Simplify and streamline eligibility determination to enhance access to care.
PG	**Program Management**
PG 1.0	Goal: Enhance the Bureau's ability to analyze the effectiveness of potential and existing benefits and policies.
PG 1.1	Integrate reconciled claims data with clinical data.
PG 1.2	Improve tools and provide training for data analysis to help improve healthcare decision making.
PG 2.0	Goal: Improve consistency of Program management processes and effective communication of policy.
PG 2.1	Document Program management roles, responsibilities and business processes.
PG 2.2	Establish reporting capabilities to measure compliance with performance measures.
PG 2.3	Design policy management workflow to ensure alignment of law/regulation, policy, system processing and provider communication.
PM	**Provider Management**
PM 1.0	Goal: Simplify process for submission of provider information.
PM 1.1	Improve provider enrollment and administration processes.
PM 1.2	Provide capability for online submission of standard forms and reports by providers.
PM 1.3	Integrate automated prior authorization capability to provide real time approval or rejection of routine prior authorizations. Both the pilot and planned integration of

ID	Goals & Objectives by Business Area
	this functionality will apply to pharmacy, not medical/dental.
CM	**Care Management**
CM 1.0	Goal: Improve healthcare outcomes for members.
CM 1.1	Establish access to data from sister-agencies and programs within the Department of Health and Human Resources.
CM 1.2	Improve access to clinical and encounter data.
CM 1.3	Enhance ability to measure quality of healthcare outcomes for members.
CM 1.4	Evaluate alternatives to enhance care management capabilities.
CM 1.5	Establish Health Home for members with chronic conditions.
CM 2.0	Goal: Increase use of evidence based clinical and appropriate services.
CM 2.1	Increase the use of evidence based clinical and appropriate services, including preventive services.
CM 2.2	Provide technical capability for Pay-for-Performance reimbursement model.
CM 2.3	Increase meaningful use of Electronic Health Records among Medicaid providers.
CO	**Contractor Management**
CO 1.0	Goal: Enhance the Bureau's ability to monitor contractor performance against approved measures.
CO 1.1	Establish reporting capabilities to measure contractor compliance with performance measures.
CO 1.2	Create automated functions to establish and monitor corrective action plans for contractors not meeting approved performance measures.
CO 1.3	Include deliverable expectations and quality indicators as part of solicitations and resulting contracts in alignment with the Bureau's Quality Management Plan.
PI	**Program Integrity Management**
PI 1.0	Goal: Improve effectiveness and efficiency of Program Integrity Management function.
PI 1.1	Analyze Program Integrity Management business area structure to align roles, responsibilities, identify necessary skill sets and appropriately assign resources.
PI 1.2	Improve tools and provide training to automate and streamline investigations and case management.
PI 1.3	Monitor MMIS security and controls.
BR	**Business Relationship Management**
BR 1.0	Goal: Enhance the security, timeliness and accuracy of data exchanged with authorized and authenticated business partners.
BR 1.1	Document business relationship management roles and responsibilities.
BR 1.2	Standardize processes for data validation and reconciliation.
BR 1.3	Standardize process for capture of report and data exchange requirements.

2.3 BMS Initiatives Supporting Goals and Objectives

The following table describes the initiatives the Bureau has identified as necessary to achieve its strategic goals and objectives.

Table 2: Catalog of BMS Initiatives

ID	Initiative Name
A	**MMIS Re-procurement Initiative** - The MMIS Re-procurement Initiative includes the MITA State Self-Assessment, development of an Advance Planning Document (APD), and the execution of the Bureau's plan for re-procurement of the Fiscal Agent Contract.
B	**Data Warehouse and Decision Support Initiative** - The data warehouse developed under this initiative will contain reconciled claims, encounter, financial and clinical data. The decision support system will allow BMS to run standard management reports, ad hoc queries to analyze trends, and conduct what-if analysis.
C	**Procurement Process Improvement Initiative** - This initiative will identify improvements to existing procurement procedures and identify methods to minimize risks and impacts associated with current practices.
D	**BMS PMO Initiative** - This initiative is intended to identify and help to support the use of effective and appropriately scaled project management principles, processes, tools and techniques within the Bureau.
E	**Re-building & Staffing Initiative** - This initiative will align organizational structure to support transformation goals and the desired Concept of Operations. It will develop and execute a plan to meet evolving resource needs and continuously build desired skill sets. Technology initiatives will be undertaken to facilitate internal communication, education, training and knowledge sharing within the Bureau and across the Medicaid enterprise.
F	**BMS Business Process Inventory and Improvement Initiative** - This general initiative builds on work conducted during the SS-A. Processes documented during MITA work sessions will be further reviewed by process and business area owners to reconcile discrepancies, eliminate redundant effort and refine process execution.
G	**BMS Performance Management Initiative** - This general initiative will clarify expectations and increase accountability within the Bureau, between the Bureau and other agencies and in contractor relationships.
H	**TPL Recovery Services Re-procurement Initiative** - This initiative will solicit and evaluate proposals from the vendors for the provision of TPL Recovery Services and develop a recommendation for award of the TPL Recovery Services contract.
I	**Pharmacy Services: Automated Prior Authorization Project** - The Automated Prior Authorization program allows BMS to use an Automated PA application to approve routine prior authorization of pharmacy services. This reduces the number of calls to the pharmacy clinical help desk, reduces administrative costs and allows for tighter management of the pharmacy program without adding additional administrative burden to healthcare providers. This project is presently funded through a Transformation Grant. The scope of this functionality applies to pharmacy only, not medical/dental processing.
J	**Patient Care Web Portal Project** - This pharmacy services initiative will give providers access to data that could enhance the quality of health care provided to Medicaid member and allow the program to avoid the cost of duplications of medical procedures, diagnostic testing and therapeutic duplications of medications. This project is presently funded through a Transformation Grant.
K	**ePrescribing Pilot Project** - The ePrescribing Pilot Project, presently funded through a Transformation Grant, will enhance the function of the patient care web portal by providing electronic prescribing software for prescribers (at no cost to them), while providing clinical decision support in the same application. ePrescribing has been proven to save money for pharmacy programs by preventing therapeutic duplications,

ID	Initiative Name
	reducing fraud, promoting preferred drug list compliance and coordinating TPL.
L	**Strategic Planning Initiative** - This initiative will revisit the goals and objectives of the Bureau's first MITA State Self-Assessment and plan for the next iteration of this exercise.
M	**Compliance Initiative** – This initiative will put in teams and processes for the assessment of new laws and regulations, implementation of changes necessary to comply with new laws and regulations and monitoring of compliance with laws and regulations.
N	**Quality Management Initiative –** The Bureau will conduct quality planning to develop a Quality Management Plan to support desired program and clinical outcomes. Quality assurance responsibilities and processes will be defined and quality controls identified to help ensure adherence to the Quality Management Plan.
O	**Outreach and Communication Initiative –** The Bureau will undertake an effort to rebrand the program so that Medicaid is viewed as another healthcare coverage provider as opposed to a "welfare program". As part of this initiative, the Bureau will also evaluate and implement technologies to improve outreach and communication capabilities.
P	**MCO Expansion Initiative –** This initiative will leverage the infrastructure of managed care organizations to simplify administration, provide financial stability, and enhance care management capabilities for targeted Medicaid populations.
Q	**Medicaid Eligibility Initiative –** The Bureau desires to avoid redundant spending and enhancing access to care. To this end, the Bureau intends to evaluate opportunities for collaboration and implement processes and technologies that simplify and streamline eligibility determination.
R	**BMS Health Information Exchange Initiative –** The Bureau will evaluate opportunities and implement necessary technology to achieve desired health information exchange capabilities to benefit the West Virginia Medicaid population.
S	**EHR Provider Incentive Program –** The Bureau will develop a program design and implement capabilities for the administration and oversight of incentive payments to providers who achieve meaningful use of certified EHR technology within a specified timeframe.
T	**Telehealth Expansion –** Expand use of telehealth to enhance care management capabilities.
U	**Money Follows the Person (MFP) Initiative –** The Bureau will undertake projects designed to reduce reliance on institutional care and develop community-based long term care services which support individuals' independence and full participation in the community.
V	**Traumatic Brain Injury Initiative** – This initiative will evaluate opportunities and implement solutions to enhance care management capabilities for members who have suffered traumatic brain injury.
W	**Health Homes Initiative** – This initiative will conduct projects designed to improve healthcare outcomes for members by establishing health homes for members with chronic conditions.
X	**Family Planning State Plan Amendment (SPA) Initiative –** The Bureau will study the feasibility of early expansion for specific populations for specific services. If the early expansion is deemed feasible, the Bureau will develop a SPA to implement the early expansion.

ID	Initiative Name
Y	**Insurance Exchange ~ Medicaid Initiative –** The Bureau will collaborate with the Insurance Commission to evaluate opportunities for sharing processes and technology that could be used to benefit the Medicaid population and avoid redundant costs.

2.4 Alignment of Initiatives with Goals and Objectives

Table 3 depicts the relationship between the BMS initiatives and BMS goals and objectives.

Table 3: Mapping of Initiatives to BMS Goals & Objectives

ID	Goals & Objectives by Business Area	Supporting Initiatives
Gen	**High-Level Administrative and Management Goals and Objectives**	
Gen 1.0	Goal: Improve BMS effectiveness and efficiency.	
Gen 1.1	Align resources with core business functions.	E. Re-building & Staffing Initiative
Gen 1.2	Secure necessary resources.	E. Re-building & Staffing Initiative
Gen 1.3	Establish and provide necessary professional education and training to enhance staff performance.	E. Re-building & Staffing Initiative
Gen 1.4	Develop MMIS Roadmap to support future business needs.	L. Strategic Planning Initiative
Gen 1.5	Implement performance management and measurement principles within BMS.	F. BMS Business Process Inventory and Improvement Initiative G. BMS Performance Management Initiative
Gen 2.0	Goal: Minimize risk and maximize value from contracted services and products.	
Gen 2.1	Streamline and improve procurement business functions.	C. Procurement Process Improvement Initiative
Gen 2.2	Continuously improve project management capabilities.	D. BMS PMO Initiative
Gen 2.3	Implement performance management and measurement principles.	C. Procurement Process Improvement Initiative E. Re-building & Staffing Initiative F. BMS Business Process Inventory and Improvement Initiative G. BMS Performance Management Initiative
Gen 3.0	Goal: Leverage technology to enhance performance and decision making.	
Gen 3.1	Enhance reporting capabilities to allow for more efficient and effective performance monitoring.	A. MMIS Re-procurement Initiative B. Data Warehouse and Decision Support Initiative C. Procurement Process Improvement Initiative E. Re-building & Staffing Initiative G. BMS Performance Management Initiative
Gen 3.2	Improve data access, analysis and reporting to support decision making.	A. MMIS Re-procurement Initiative B. Data Warehouse and Decision Support Initiative

ID	Goals & Objectives by Business Area	Supporting Initiatives
		L. Strategic Planning Initiative
Gen 4.0	Goal: Assess, implement, and monitor compliance with all relevant federal laws and regulations (e.g. PPACA, State Medicaid Manual, HIPAA).	
GEN 4.1	Establish a team and process for assessing compliance with new laws and regulations. .	M. Compliance Initiative (New)
GEN 4.2	Establish a team and process for implementation of changes necessary to comply with new laws and regulations.	M. Compliance Initiative
GEN 4.3	Establish a team and process for monitoring compliance with laws and regulations.	M. Compliance Initiative
Gen 4.4	Verify and monitor MMIS and Fiscal Agent operations to ensure transactions are processed in accordance with all relevant federal laws and regulations.	A. MMIS Re-procurement Initiative F. BMS Business Process Inventory and Improvement Initiative G. BMS Performance Management Initiative
Gen 5.0	Goal: Ensure program quality.	
Gen 5.1	Develop and execute a Quality Management Plan.	N. Quality Management Initiative
Gen 5.2	Design and configure systems and processes to support the Quality Plan.	A. MMIS Re-procurement Initiative B. Data Warehouse and Decision Support Initiative F. BMS Business Process Inventory and Improvement Initiative G. BMS Performance Management Initiative N. Quality Management Initiative
Gen 5.3	Enhance ability to measure compliance with quality indicators.	A. MMIS Re-procurement Initiative B. Data Warehouse and Decision Support Initiative F. BMS Business Process Inventory and Improvement Initiative G. BMS Performance Management Initiative N. Quality Management Initiative
GEN 6.0	Goal: Enhance and improve efficient, effective and meaningful outreach and communication.	
GEN 6.1	Improve communication with providers and members.	O. Outreach and Communication Initiative R. BMS Health Information Exchange Initiative
GEN 6.2	Rebrand Medicaid as another provider of healthcare coverage.	O. Outreach and Communication Initiative
OM	**Operations Management**	
OM 1.0	Goal: Improve operational efficiency and reduce costs in the healthcare system.	
OM 1.1	Document operations management roles,	E. Re-building & Staffing Initiative

ID	Goals & Objectives by Business Area	Supporting Initiatives
	responsibilities and business processes.	F. BMS Business Process Inventory and Improvement Initiative G. BMS Performance Management Initiative
OM 1.2	Analyze operations management organization structure to align resources with core business functions.	E. Re-building & Staffing Initiative P. MCO Expansion Initiative
OM 1.3	Enhance and automate reporting capabilities to measure compliance with operational performance measures.	A. MMIS Re-procurement Initiative C. Procurement Process Improvement Initiative E. Re-building & Staffing Initiative G. BMS Performance Management Initiative P. MCO Expansion Initiative
OM 2.0	Goal: Improve access to information necessary for operations management.	
OM 2.1	Enhance cost avoidance capability by improving access to accurate other third party payer information.	A. MMIS Re-procurement Initiative H. TPL Recovery Services Re-procurement Initiative L. Strategic Planning Initiative R. BMS Health Information Exchange Initiative
OM 2.2	Establish integration with other entities to further reduce the potential for redundancy of service and payment.	A. MMIS Re-procurement Initiative B. Data Warehouse and Decision Support Initiative H. TPL Recovery Services Re-procurement Initiative L. Strategic Planning Initiative R. BMS Health Information Exchange Initiative Y. Insurance Exchange ~ Medicaid Initiative
OM 3.0	Goal: Improve provider access to real-time data.	
OM 3.1	Enhance provider portal to support clinical decisions and to provide real-time access to cost settlement and rebate data.	A. MMIS Re-procurement Initiative R. BMS Health Information Exchange Initiative
OM 3.2	Implement real time access to data based on claim adjudication results.	A. MMIS Re-procurement Initiative
OM 3.3	Integrate automated prior authorization capability to provide real time approval or rejection of routine Pharmacy prior authorizations.	A. MMIS Re-procurement Initiative I. Pharmacy Automated Prior Authorization Project R. BMS Health Information Exchange Initiative
ME	**Member Management**	
ME 1.0	Goal: Enhance ability for members to participate in and exercise responsibility for their personal health choices.	

ID	Goals & Objectives by Business Area	Supporting Initiatives
ME 1.1	Explore capabilities to establish and allow member access to a personal health record.	A. MMIS Re-procurement Initiative L. Strategic Planning Initiative P. MCO Expansion Initiative
ME 1.2	Provide automated administration of a member incentive program as designed by BMS and approved by CMS.	A. MMIS Re-procurement Initiative
ME 1.3	Provide for automated administration of personal Health Improvement Plans.	A. MMIS Re-procurement Initiative
ME 1.4	Empower members by providing access to information and tools that can be used to improve their health.	A. MMIS Re-procurement Initiative P. MCO Expansion Initiative R. BMS Health Information Exchange Initiative
ME 1.5	Simplify and streamline eligibility determination to enhance access to care.	Q. Medicaid Eligibility Initiative Y. Insurance Exchange ~ Medicaid Initiative
PG	**Program Management**	
PG 1.0	Goal: Enhance the Bureau's ability to analyze the effectiveness of potential and existing benefits and policies.	
PG 1.1	Integrate reconciled claims data with clinical data.	A. MMIS Re-procurement Initiative B. Data Warehouse and Decision Support Initiative R. BMS Health Information Exchange Initiative
PG 1.2	Improve tools and provide training for data analysis to help improve healthcare decision making.	B. Data Warehouse and Decision Support Initiative E. Re-building & Staffing Initiative
PG 2.0	Goal: Improve consistency of Program management processes and effective communication of policy.	
PG 2.1	Document Program management roles, responsibilities and business processes.	E. Re-building & Staffing Initiative F. BMS Business Process Inventory and Improvement Initiative G. BMS Performance Management Initiative
PG 2.2	Establish reporting capabilities to measure compliance with performance measures.	A. MMIS Re-procurement Initiative C. Procurement Process Improvement Initiative E. Re-building & Staffing Initiative G. BMS Performance Management Initiative
PG 2.3	Design policy management workflow to ensure alignment of law/regulation, policy, system processing and provider communication.	F. BMS Business Process Inventory and Improvement Initiative
PM	**Provider Management**	
PM 1.0	Goal: Simplify process for submission of provider information.	

ID	Goals & Objectives by Business Area	Supporting Initiatives
PM 1.1	Improve provider enrollment and administration processes.	A. MMIS Re-procurement Initiative F. BMS Business Process Inventory and Improvement Initiative R. BMS Health Information Exchange Initiative
PM 1.2	Provide capability for online submission of standard forms and reports by providers.	A. MMIS Re-procurement Initiative R. BMS Health Information Exchange Initiative
PM 1.3	Integrate automated prior authorization capability to provide real time approval or rejection of routine prior authorizations. Both the pilot and planned integration of this functionality will apply to pharmacy, not medical/dental.	K. ePrescribing Pilot Project R. BMS Health Information Exchange Initiative
CM	**Care Management**	
CM 1.0	Goal: Improve healthcare outcomes for members.	
CM 1.1	Establish access to data from sister-agencies and programs within the Department of Health and Human Resources.	A. MMIS Re-procurement Initiative B. Data Warehouse and Decision Support Initiative L. Strategic Planning Initiative
CM 1.2	Improve access to clinical and encounter data.	A. MMIS Re-procurement Initiative B. Data Warehouse and Decision Support Initiative L. Strategic Planning Initiative
CM 1.3	Enhance ability to measure quality of healthcare outcomes for members.	A. MMIS Re-procurement Initiative B. Data Warehouse and Decision Support Initiative N. Quality Management Initiative
CM 1.4	Evaluate alternatives to enhance care management capabilities.	P. MCO Expansion Initiative T. Telehealth Expansion U. Money Follows the Person Initiative V. Traumatic Brain Injury (TMI) Initiative X. Family Planning State Plan Amendment Initiative
CM 1.5	Establish Health Home for members with chronic conditions.	W. Health Homes Initiative
CM 2.0	Goal: Increase use of evidence based clinical and appropriate services.	
CM 2.1	Increase the use of evidence based clinical and appropriate services, including preventive services.	B. Data Warehouse and Decision Support Initiative J. Patient Care Web Portal Project K. ePrescribing Pilot Project
CM 2.2	Provide technical capability for Pay-for-Performance reimbursement model.	A. MMIS Re-procurement Initiative B. Data Warehouse and Decision Support Initiative

ID	Goals & Objectives by Business Area	Supporting Initiatives
		S. EHR Provider Incentive Program
CM 2.3	Increase meaningful use of Electronic Health Records among Medicaid providers.	S. EHR Provider Incentive Program
CO	**Contractor Management**	
CO 1.0	Goal: Enhance the Bureau's ability to monitor contractor performance against approved measures.	
CO 1.1	Establish reporting capabilities to measure contractor compliance with performance measures.	A. MMIS Re-procurement Initiative C. Procurement Process Improvement Initiative
CO 1.2	Create automated functions to establish and monitor corrective action plans for contractors not meeting approved performance measures.	A. MMIS Re-procurement Initiative C. Procurement Process Improvement Initiative F. BMS Business Process Inventory and Improvement Initiative
CO 1.3	Include deliverable expectations and quality indicators as part of solicitations and resulting contracts in alignment with the Bureau's Quality Management Plan.	C. Procurement Process Improvement Initiative F. BMS Business Process Inventory and Improvement Initiative M. Compliance Initiative N. Quality Management Initiative
PI	**Program Integrity Management**	
PI 1.0	Goal: Improve effectiveness and efficiency of Program Integrity Management function.	
PI 1.1	Analyze Program Integrity Management business area structure to align roles, responsibilities, identify necessary skill sets and appropriately assign resources.	E. Re-building & Staffing Initiative
PI 1.2	Improve tools and provide training to automate and streamline investigations and case management.	F. BMS Business Process Inventory and Improvement Initiative
PI 1.3	Monitor MMIS security and controls.	F. BMS Business Process Inventory and Improvement Initiative M. Compliance Initiative
BR	**Business Relationship Management**	
BR 1.0	Goal: Enhance the security, timeliness and accuracy of data exchanged with authorized and authenticated business partners.	
BR 1.1	Document business relationship management roles and responsibilities.	E. Re-building & Staffing Initiative
BR 1.2	Standardize processes for data validation and reconciliation.	F. BMS Business Process Inventory and Improvement Initiative
BR 1.3	Standardize process for capture of report and data exchange requirements.	F. BMS Business Process Inventory and Improvement Initiative

3.0 Next Steps

The Bureau will conduct initial project planning to scope component projects in support of the initiatives identified in the strategic plan. Key resources will be identified including designation of a project sponsor. Project objectives, products and services will be identified. A preliminary budget will be estimated and funding sources will be identified and funding will be applied for.

Appendix C: Environmental Scan: EHR Provider Incentive Program Survey Detail (November 24, 2010)

Hospital Survey Responses

Question 1 sorted survey responders into either the hospital or eligible professional category.

Section 1: Information about the Hospital

2. The person completing this survey is: Note: Please assign one person from your hospital to complete this survey.

	Response Percent	Response Count
Hospital Administrator	35.3%	6
Other Hospital Manager	35.3%	6
Other (please specify)	29.4%	5
4 - Chief Financial Officer 1 - VP Information Technology	*answered question*	17
	skipped question	63

3. We believe our hospital will be eligible for a Medicaid EHR incentive payment as a:

	Response Percent	Response Count
Acute care hospital	58.8%	10
Critical access hospital	41.2%	7
Probably not eligible	0.0%	0
	answered question	17
	skipped question	63

4. If eligible, specify how your hospital intends to participate in the Medicare and Medicaid EHR incentive programs created under the American Recovery and Reinvestment Act of 2009:

	Response Percent	Response Count
WV Medicaid	0.0%	0
Medicaid in another state	0.0%	0
Medicare	0.0%	0
Both Medicare and Medicaid	**94.1%**	**16**
Neither - Will not participate	0.0%	0
Unsure at this time	5.9%	1
answered question		17
skipped question		63

5. Estimate the historical percentage of your hospital's patients who are Medicaid eligible:

	Response Percent	Response Count
0-10%	0.0%	0
11-20%	**52.9%**	**9**
21-30%	35.3%	6
31-50%	5.9%	1
Over 50%	5.9%	1
answered question		17
skipped question		63

6. How would you best describe your hospital's location?

	Response Percent	Response Count
Urban	23.5%	4
Rural	76.5%	13
answered question		17
skipped question		63

7. Please rate your hospital's awareness of the following:

	Not Aware	Somewhat Aware	Fully Aware	Response Count
The availability of Medicaid EHR provider incentive payments under the American Recovery and Reinvestment Act	0.0% (0)	41.2% (7)	**58.8% (10)**	17
Electronic Health Record certification rules and requirements as issued by the Office of the National Coordinator for Health Information Technology in June 2010	5.9% (1)	**52.9% (9)**	41.2% (7)	17
Meaningful Use final rules as issued in July 2010 by the U.S. Department of Health and Human Services	0.0% (0)	41.2% (7)	**58.8% (10)**	17
In order to receive an incentive payment, the need to register with the National Level Repository (NLR)	11.8% (2)	**58.8% (10)**	29.4% (5)	17
In order to receive an incentive payment, the need to attest to specific criteria at a state website	0.0% (0)	**64.7% (11)**	35.3% (6)	17
answered question				17
skipped question				63

Section 2: Information About the Technology

8. What type of internet connection do you primarily rely on at your hospital?

	Response Percent	Response Count
Dial-up	0.0%	0
Wired broadband (e.g., DSL or cable) or faster connection (such as T1 or T3 line)	**100.0%**	**17**
Satellite	0.0%	0
Internet is available, but my hospital does not subscribe	0.0%	0
No internet connection is available in this area	0.0%	0
Other (please specify)	0.0%	0
answered question		17
skipped question		63

9. Does your hospital currently have, or are you in the process of acquiring or implementing, an electronic health record (EHR), a system that tracks patient medical information (e.g., lab results and patient visits)?

	Response Percent	Response Count
Yes	**100.0%**	**17**
No	0.0%	0
answered question		17
skipped question		63

10. Please provide the name of the primary EHR system (and version, if known) your hospital has purchased or selected for purchase:

1- Cerner	1 - Healthland version 9.5
1- Meditech C/S Version 5.6.4	1- Siemans
2- Meditech	1- Siemans/Invision
1- Soarian Release 3.2	1- Healthcare Management Systems
5- CPSI	2- Non answers
1- Epic	

	Response Count
	17
answered question	17
skipped question	63

11. Is your current EHR system certified on the list issued by CCHIT in October 2010?

	Response Percent	Response Count
Yes	35.3%	6
No	41.2%	7
Unsure	23.5%	4
answered question		17
skipped question		63

12. Do you believe your hospital will meet Stage 1 Meaningful Use criteria by the mandated deadlines?

	Response Percent	Response Count
Yes	82.4%	14
No	0.0%	0
Unsure	17.6%	3
answered question		17
skipped question		63

13. Where are you in the process of achieving "Meaningful Use"?

	Response Percent	Response Count
Already underway with needed changes	**58.8%**	**10**
Awaiting more guidance and detail	17.6%	3
In our planning process	17.6%	3
Not started	5.9%	1
Don't know enough about meaningful use to start	0.0%	0
What is meaningful use?	0.0%	0
answered question		17
skipped question		63

14. Does your hospital currently electronically exchange any medical information (e.g., electronic prescribing and electronic lab results) with medical professionals outside your hospital?

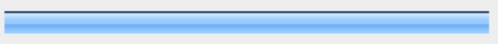
	Response Percent	Response Count
Yes	**82.4%**	**14**
No	17.6%	3
Unsure	0.0%	0
answered question		17
skipped question		63

18. What are the top benefits that your hospital has achieved or expects to achieve through EHR adoption? (check all that apply)

	Response Percent	Response Count
Improved patient safety	88.2%	15
Improved quality of care	**94.1%**	**16**
Ability to share and access information	82.4%	14
Operational improvements (e.g., workflow efficiencies, cost reduction)	35.3%	6
Improved documentation	70.6%	12
Better reporting	88.2%	15
Interconnectivity with partner organizations (e.g., hospital, other practice locations)	70.6%	12
Improved statutory compliance (e.g., HIPAA)	41.2%	7
None	0.0%	0
Other (please specify) lkj	5.9%	1
answered question		17
skipped question		63

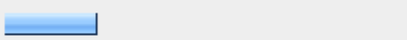
Note: The data inserted in the text box in questions 18 and 19 is what was found in Survey Monkey and has been left even though BDMP does not know if it has any meaning. A similar situation presents itself in question 26.

19. What are the top challenges that your hospital experienced, or expects to experience, during EHR acquisition, implementation and adoption? (check all that apply)



	Response Percent	Response Count
Funding/cost	**94.1%**	**16**
Disruption to practice	58.8%	10
Resistance to change	82.4%	14
Staffing resources	70.6%	12
Security and privacy concerns	23.5%	4
Audit/risk management concerns	29.4%	5
Lack of customization to the hospital's specific needs	23.5%	4
Difficulty selecting the right EHR system and vendor	5.9%	1
None	0.0%	0
Other (please specify) lkj	5.9%	1
answered question		**17**
skipped question		**63**

20. How would you rate your hospital's knowledge of Health Information Exchange (HIE) activities in WV?



	Response Percent	Response Count
Very knowledgeable	17.6%	3
Somewhat knowledgeable	**76.5%**	**13**
Not at all knowledgeable	5.9%	1
answered question		**17**
skipped question		**63**

21. How would you rate your hospital's knowledge of Regional Health Information Technology Extension Center (RHITEC) activities in WV?

	Response Percent	Response Count
Very knowledgeable	5.9%	1
Somewhat knowledgeable	**76.5%**	**13**
Not at all knowledgeable	17.6%	3
answered question		17
skipped question		63

Section 3: Information About Hospital Preferences and Needs

22. Our hospital would like to receive more information about: (check all that apply)

	Response Percent	Response Count
How to participate in the WV Provider Incentive Program	**70.6%**	**12**
Certified EHR technology product evaluation, selection and procurement	29.4%	5
"Meaningful Use" definition, criteria, and reporting requirements	35.3%	6
Managing a successful EHR implementation	29.4%	5
Integrating an EHR into workflow and clinical decision making	41.2%	7
Patient engagement and education	35.3%	6
Health Information Exchange opportunities in WV	52.9%	9
EHR support and technical services provided by the WV Regional HIT Extension Center (RHITEC)	41.2%	7
Don't need further information	23.5%	4
Other (please specify)	0.0%	0
answered question		17
skipped question		63

23. Regarding how the State of West Virginia is handling the Medicaid EHR Provider Incentive Program and encouraging adoption of EHR technology, we would like to receive information about: (check all that apply)

	Response Percent	Response Count
The WV process for paying provider incentives and its status	**82.4%**	**14**
What to expect from the Bureau for Medical Services (BMS)	**82.4%**	**14**
Where to go for information	76.5%	13
Where to go for help	41.2%	7
Statistics	35.3%	6
Don't want any further information	5.9%	1
Other (please specify)	0.0%	0
answered question		17
skipped question		63

24. Our hospital would benefit from learning about the Medicaid EHR Provider Incentive Program, EHR technology and the State's activities through: (check all that apply)

	Response Percent	Response Count
Webinars	**82.4%**	**14**
Web based training modules	58.8%	10
Mailings of reading materials	29.4%	5
Live presentations or meetings	52.9%	9
Teleconferences	58.8%	10
One-on-one discussions	29.4%	5
Individual phone calls	23.5%	4
Information provided by email/e-newsletters	52.9%	9
Not interested	5.9%	1
Other (please specify)	0.0%	0
answered question		17
skipped question		63

25. Regarding the Medicaid EHR Provider Incentive Program and the adoption of EHR technology and other State activities, our hospital would benefit from the following types of support: (check all that apply)

	Response Percent	Response Count
Group meetings with other hospitals	70.6%	12
Web meetings	**76.5%**	**13**
Call center	23.5%	4
Informational website	70.6%	12
Regular mailings	47.1%	8
We would not take advantage of any support offerings	0.0%	0
Don't need any support	5.9%	1
Other (please specify)	0.0%	0
	answered question	17
	skipped question	63

26. The items listed below are thought to be possible incentives for hospitals to adopt EHR technology and to achieve Meaningful Use. Please rate them in order of importance to you from 1 (greatest incentive) to 5 (least incentive)

	1	2	3	4	5	Rating Average	Response Count
Enhanced ability to electronically exchange information (WV Health Information Exchange functionality)	0.0% (0)	**29.4% (5)**	23.5% (4)	23.5% (4)	23.5% (4)	3.41	17
Additional financial compensation	17.6% (3)	**47.1% (8)**	23.5% (4)	11.8% (2)	0.0% (0)	2.29	17
Rewards for achieving goals	17.6% (3)	0.0% (0)	17.6% (3)	**41.2% (7)**	23.5% (4)	3.53	17
Demonstrated improvements in care and health	**41.2% (7)**	17.6% (3)	17.6% (3)	11.8% (2)	11.8% (2)	2.35	17
Avoid financial penalties	23.5% (4)	5.9% (1)	17.6% (3)	11.8% (2)	**41.2% (7)**	3.41	17
456	Other: Please enter any other incentives not already listed that you would be interested in.						1
						answered question	17
						skipped question	63

Question 27 requested hospital contact information. Sixteen hospitals provided contact information which is presented in the table below. Question 28 asked whether responders would be interested in participating in other information gathering processes, such as interviews or focus groups. Thirteen hospitals indicated that they would be interested.

Contact Name	Organization	Contact Information	Interested in Participating (Y/N)
Brian Connelly, Finance	Potomac Valley Hospital of WV	Brian_Connelly@verizon.net 410-643-3393	Y
Brian Lowther, CEO	Sistersville General Hospital	brianl@sistersvillegeneral.com 304-447-2504	Y
John A. May, Chief Financial Officer	Wetzel County Hospital	jmay@wetzelhealth.org 304-455-8013	Y
Chad Carpenter, CFO	Pocahontas Memorial Hospital	ccarpenter@pmhwv.org 304-799-7400	Y
Rebecca Hammer, CFO	Davis Memorial Hospital	hammerr@davishealthsystem.org 304-637-3156	Y
Warren Kelley, CIO	Reynolds Memorial Hospital	wnk@reymem.com 304 843-3327	Y
Frank Sinicrope, CFO	Princeton Community Hospital	fsinicrope@pchonline.org 304-487-7263	N
Jeff Powelson, CEO	Broaddus	powelsonj@davishealthsystem.org 304-457-1760	N
Brian Williams, Director of Information Systems	St. Joseph's Hospital of Buckhannon, Inc.	brian.williams@stj.net 304-473-2171	Y
Brent Barr, CIO	Minnie Hamilton Health Care Center	bbarr@mhhcc.com 304-354-9244	Y
Bruce McClymonds, President & CEO	WVU Hospitals	mcclymondsb@wvuh.com 304-598-4355	N
Tommy H. Mullins, Administrator	Boone Memorial Hospital	TMULLINS@BMH.ORG 304-369-1230 EXT 266	Y
Lynn Brookshire, VP for Information Services and CIO	CAMC Teays Valley Hospital	Lynn.Brookshire@camc.org 304-388-9705	Y
Brian Kelbaugh, CFO	Grafton City Hospital	bkelbaugh@graftonhopsital.com 304-265-6445	Y
Rick Holsclaw, Vice President – Information Technology	City Hospital	rholsclaw@wvuh-east.org 304 264-1216	Y
David Monte Ward, CFO	Cabell Huntington Hospital	mward@chhi.org 304-526-2274	Y

Eligible Professional Survey Responses

Section 1: Information About the Provider

29. The person answering this survey is: Note: Please assign one person from your practice to complete this survey on behalf of your entire practice.

	Response Percent	Response Count
Provider	20.5%	8
Office Manager	30.8%	12
Other (please specify)	**48.7%**	**19**
answered question		39
skipped question		41

11- CEO	1- Executive Director
2- Billing, Accounts Receivable	1- Admin
1- Utilization Manager	1- EHR Project Manager
1- Controller	1- Insurance Clerk

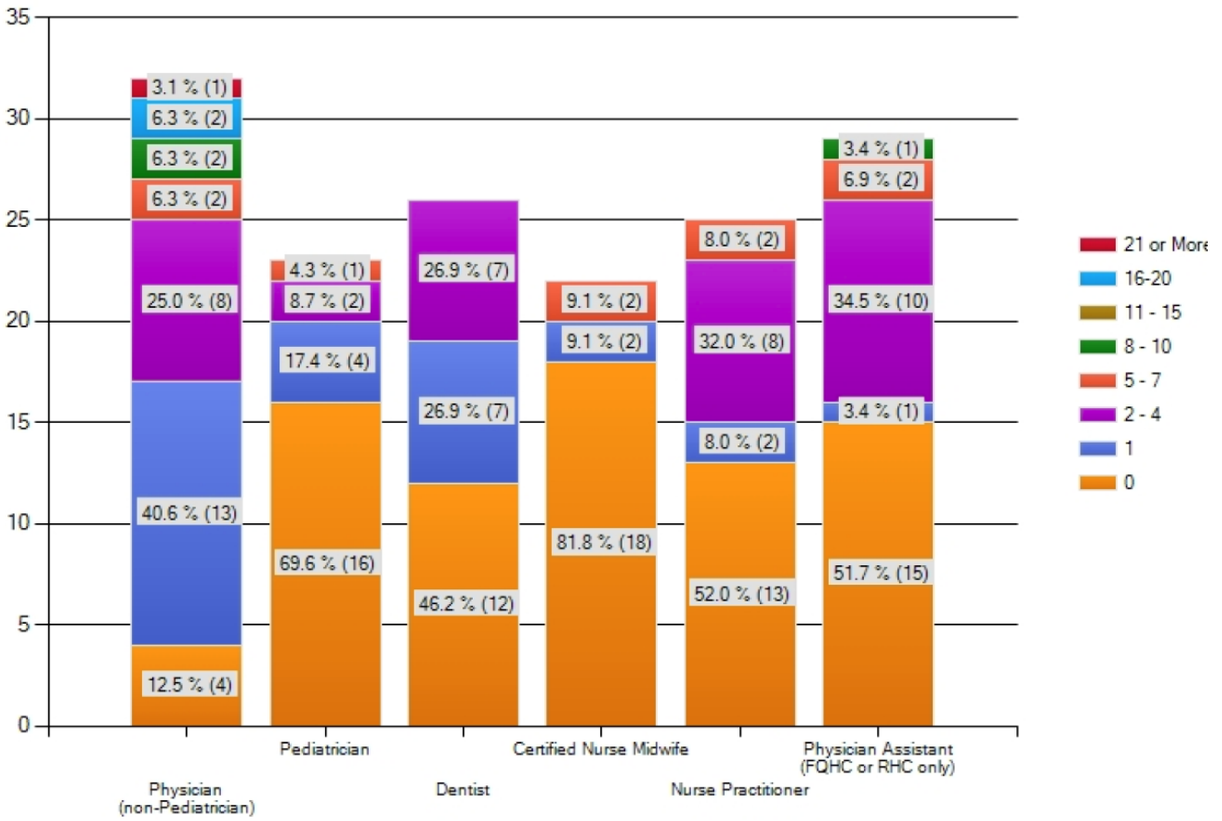
30. How many in your practice are there of each of the following provider types?

	0	1	2 - 4	5 - 7	8 - 10	11 - 15	16-20	21 or More	Response Count
Physician (non-Pediatrician)	12.5% (4)	**40.6% (13)**	25.0% (8)	6.3% (2)	6.3% (2)	0.0% (0)	6.3% (2)	3.1% (1)	32
Pediatrician	**69.6% (16)**	17.4% (4)	8.7% (2)	4.3% (1)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	23
Dentist	**46.2% (12)**	26.9% (7)	26.9% (7)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	26
Certified Nurse Midwife	**81.8% (18)**	9.1% (2)	0.0% (0)	9.1% (2)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	22
Nurse Practitioner	**52.0% (13)**	8.0% (2)	32.0% (8)	8.0% (2)	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)	25
Physician Assistant (FQHC or RHC only)	**51.7% (15)**	3.4% (1)	34.5% (10)	6.9% (2)	3.4% (1)	0.0% (0)	0.0% (0)	0.0% (0)	29
					Other (please specify provider type and how many)				8
					answered question				39
					skipped question				41

Dental Assistants and Hygienists
CNS
Psychologist
Licensed Social Worker
OBGYN
Behavioral Health Providers

Note: Because the table presented above is complex, the chart below presents another view of the data in question 30.

How many in your practice are there of each of the following provider types?



31. How many total patients on average do you see each week?

	Response Percent	Response Count
Less than 25	7.7%	3
26- 50	7.7%	3
51 - 100	20.5%	8
101 -200	20.5%	8
201 or more	**43.6%**	**17**
	answered question	**39**
	skipped question	**41**

32. Estimate the percentage of your practice's patients who are Medicaid eligible:

	Response Percent	Response Count
0-10%	5.1%	2
11-20%	17.9%	7
21-30%	20.5%	8
31-50%	25.6%	10
Over 50%	30.8%	12
answered question		39
skipped question		41

Question 33 asked providers to "check the boxes for the county(ies) where your office(s) is/are located". Thirty-seven providers responded regarding sixty-four locations.

County	Response #	County	Response #	County	Response #
Barbour		Kanawha	5	Preston	
Berkeley	1	Lewis		Putnam	2
Boone	1	Lincoln	1	Raleigh	1
Braxton	2	Logan		Randolph	1
Brooke	1	Marion		Ritchie	3
Cabell	2	Marshall		Roane	2
Calhoun	2	Mason		Summers	
Clay		McDowell		Taylor	
Doddridge	1	Mercer	2	Tucker	1
Fayette	2	Mineral	6	Tyler	1
Gilmer	1	Mingo		Upshur	
Grant		Monongalia	1	Wayne	1
Greenbrier	5	Monroe		Webster	1
Hampshire	2	Morgan	1	Wetzel	
Hancock	2	Nicholas	4	Wirt	
Hardy		Ohio		Wood	2
Harrison	1	Pendleton		Wyoming	2
Jackson	2	Pleasants	2		
Jefferson		Pocahontas	1		

34. How would you best describe your practice location?

	Response Percent	Response Count
Urban	17.9%	7
Rural	64.1%	25
Both	17.9%	7
answered question		39
skipped question		41

35. I am a provider who is considered a hospital-based professional (90% or more of my services are performed in a hospital inpatient or emergency room setting).

	Response Percent	Response Count
Yes	3.2%	1
No	**87.1%**	**27**
Unsure	9.7%	3
	answered question	**31**
	skipped question	**49**

36. Please rate your awareness of the following:

	Not Aware	Somewhat Aware	Fully Aware	Response Count
The availability of provider incentive payments through Medicaid under the American Recovery and Reinvestment Act	25.6% (10)	**43.6% (17)**	30.8% (12)	39
Electronic Health Record certification rules and requirements as issued by the Office of the National Coordinator for Health Information Technology in June 2010	30.8% (12)	**51.3% (20)**	17.9% (7)	39
Meaningful Use final rules as issued in July 2010 by the U.S. Department of Health and Human Services	30.8% (12)	**43.6% (17)**	25.6% (10)	39
In order to receive an incentive payment, must register with the National Level Repository (NLR)	**69.2% (27)**	20.5% (8)	10.3% (4)	39
In order to receive an incentive payment, must attest to specific criteria at a state website	**64.1% (25)**	23.1% (9)	12.8% (5)	39
			answered question	**39**
			skipped question	**41**

Section 2: Information about the Technology

37. What type of internet connection do you primarily rely upon at your office?

	Response Percent	Response Count
Dial-up	0.0%	0
DSL	53.8%	21
Cable	28.2%	11
Satellite	0.0%	0
Internet is available, but my office does not subscribe	0.0%	0
No internet connection is available in my area	0.0%	0
Other (please specify)	17.9%	7
answered question		39
skipped question		41

6- T1
1- 3mb point-to-point w/5 mb/3mb fiber

38. Does your practice currently use, or are you in the process of acquiring or implementing, an electronic health record (EHR), a system that tracks patient medical information (e.g., lab results and patient visits)?

	Response Percent	Response Count
Yes	66.7%	26
No	33.3%	13
answered question		39
skipped question		41

Survey takers who responded "No" to this question were directed to question 45.

39. Is the system you use, or are in the process of acquiring, capable of electronically exchanging information with other medical professionals, such as sharing information between offices or e-prescribing?

	Response Percent	Response Count
Yes	64.0%	16
No	16.0%	4
Unsure	20.0%	5
answered question		25
skipped question		55

40. Please provide the name of the system (and version, if known) you have purchased or selected for purchase:

	Response Count
	25
answered question	25
skipped question	55

System Name Responses	
Medinotes E	Success EHS 5.9
NextGen	Sage Version 5.5
NextGen	sage
SuccessEHS	Practice Fusion
RPMS	Sceris
Intgergy	QD systems
EHS	Amazing Charts
Biomedix	QD Clinical
Allscripts	Amazing Charts
RPMS through Community Health Network	SoftDent
Easy Dental	MacPractice
We have one more to look at then we will purchase one	Rx Cure
Kodak Softdent, Dentrix X-Ray Imaging	

41. What is the status of the use of your EHR?

	Response Percent	Response Count
We are purchasing or have purchased a system but have not yet started implementation.	12.0%	3
We are in the process of implementing.	12.0%	3
We have partially implemented our EHR system and are using some, but not all, of the EHR functionality.	28.0%	7
We have fully implemented our EHR and are generally pleased with the results.	**44.0%**	**11**
We have fully implemented our EHR system and it is falling short of expectations.	4.0%	1
	answered question	25
	skipped question	55

42. Do you currently electronically exchange any medical information (e.g., electronic prescribing and electronic lab results) with other medical professionals?

	Response Percent	Response Count
Yes	52.0%	13
No	40.0%	10
Unsure	8.0%	2
	answered question	25
	skipped question	55

43. Where are you in the process of achieving "Meaningful Use"?

	Response Percent	Response Count
Already underway with needed changes	24.0%	6
Awaiting more guidance and details	**36.0%**	**9**
In our planning process	16.0%	4
Not started	8.0%	2
Don't know enough about Meaningful Use to start	8.0%	2
What is Meaningful Use?	8.0%	2
answered question		25
skipped question		55

44. If you are eligible, will you choose the Medicare incentive?

	Response Percent	Response Count
Yes, will choose Medicare	20.0%	5
No, will choose Medicaid	**40.0%**	**10**
Unsure	**40.0%**	**10**
answered question		25
skipped question		55

Question 45 was asked only of those providers who did not own and were not in the process of purchasing an EHR.

45. Since you have not currently selected an EHR to implement, do you plan to purchase one?

	Response Percent	Response Count
Yes, within the next 12 months	23.1%	3
Yes, within the next 24 months	7.7%	1
Yes, but the timeline is unclear	30.8%	4
No	**38.5%**	**5**
answered question		13
skipped question		67

Survey responders who answered "No" to question 45 were asked questions 46 and 47.

46. What is the main reason that you do not plan to purchase an EHR?

	Response Percent	Response Count
Too expensive	0.0%	0
Too disruptive to the practice	0.0%	0
Concerned about privacy and security of information	0.0%	0
Happy with things the way they are	0.0%	0
Don't see or understand benefits	20.0%	1
I'll be retiring in a few years and will wait it out	**40.0%**	**2**
Other (please specify)	**40.0%**	**2**
	answered question	**5**
	skipped question	**75**

- Prefer to get current health info from patients on a day-to-day basis and keep in computer system.
- Reading radiologist

47. If you are not planning to implement an EHR would you reconsider if you are determined to be eligible for incentive funds?

	Response Percent	Response Count
Yes	40.0%	2
No	0.0%	0
Unsure	**60.0%**	**3**
	answered question	**5**
	skipped question	**75**

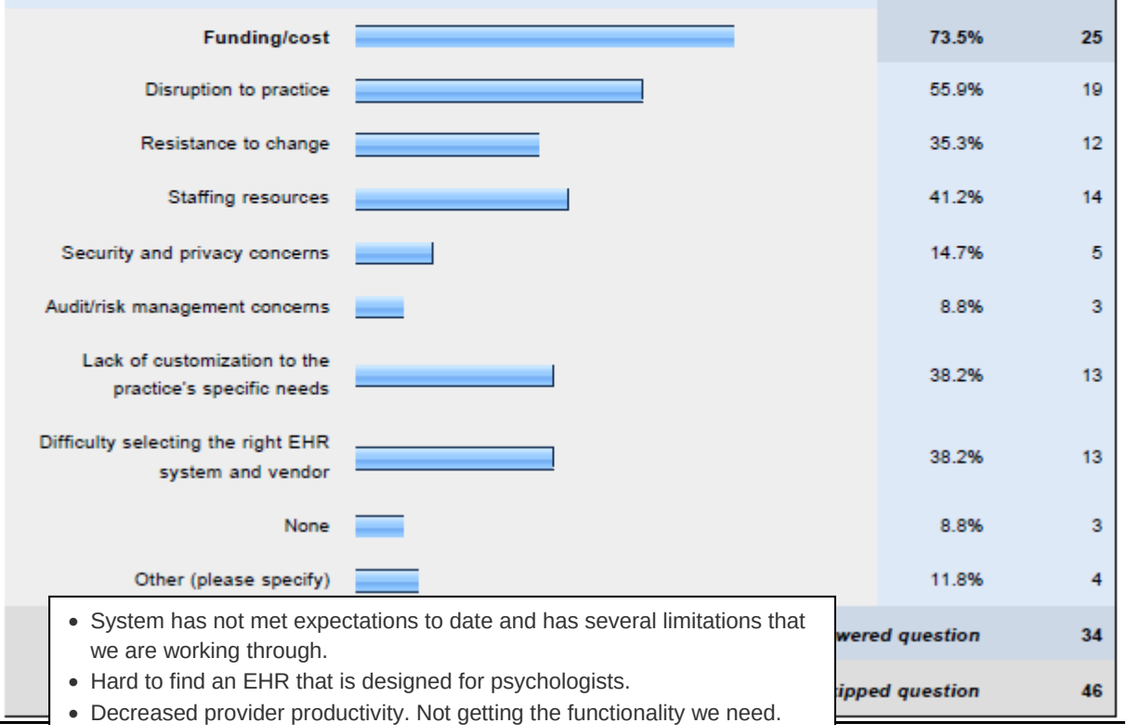
After completion of these questions, this set of providers was directed to the end of the survey where they could provide contact information if they were interested in receiving further information.

All survey responders who owned an EHR, were in the process of purchasing one or planned to purchase one were directed to questions 48-58.

48. What are the top benefits that you have achieved or expect to achieve through EHR adoption? (check all that apply)

	Response Percent	Response Count
Improved patient safety	52.9%	18
Improved quality of care	76.5%	26
Ability to share and access information	76.5%	26
Operational improvements (e.g., workflow efficiencies, cost reduction)	61.8%	21
Improved documentation	**82.4%**	**28**
Better reporting	58.8%	20
Interconnectivity with partner organizations (e.g., hospital, other practice locations)	32.4%	11
Improved statutory compliance (e.g., HIPAA)	38.2%	13
None	2.9%	1
Other (please specify)	0.0%	0
	answered question	**34**
	skipped question	**46**

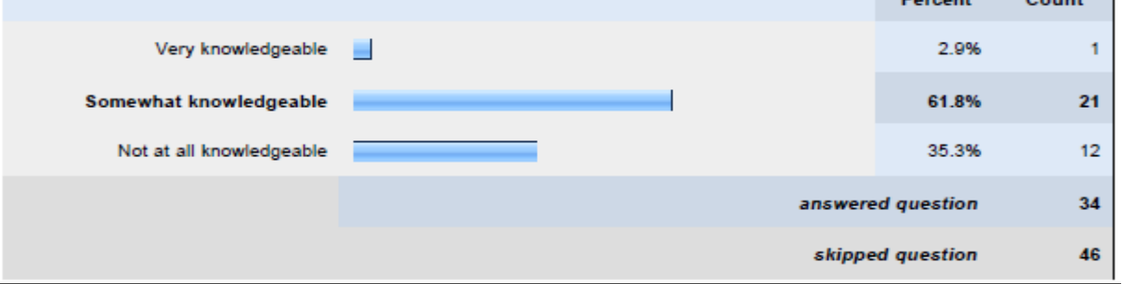
49. What are the top challenges that you experienced, or expect to experience, during EHR acquisition, implementation and adoption? (check all that apply)



	Response Percent	Response Count
Funding/cost	**73.5%**	**25**
Disruption to practice	55.9%	19
Resistance to change	35.3%	12
Staffing resources	41.2%	14
Security and privacy concerns	14.7%	5
Audit/risk management concerns	8.8%	3
Lack of customization to the practice's specific needs	38.2%	13
Difficulty selecting the right EHR system and vendor	38.2%	13
None	8.8%	3
Other (please specify)	11.8%	4
	wered question	**34**
	ipped question	**46**

- System has not met expectations to date and has several limitations that we are working through.
- Hard to find an EHR that is designed for psychologists.
- Decreased provider productivity. Not getting the functionality we need.
- Training

50. How would you rate your knowledge of Health Information Exchange (HIE) activities in WV?



	Response Percent	Response Count
Very knowledgeable	2.9%	1
Somewhat knowledgeable	**61.8%**	**21**
Not at all knowledgeable	35.3%	12
	answered question	**34**
	skipped question	**46**

51. How would you rate your knowledge of Regional Health Information Technology Extension Center (RHITEC) activities in WV?

	Response Percent	Response Count
Very knowledgeable	8.8%	3
Somewhat knowledgeable	35.3%	12
Not at all knowledgeable	**55.9%**	**19**
answered question		34
skipped question		46

Section 3: Information About Provider Preferences and Needs

52. I need to know more about: (check all that apply)

	Response Percent	Response Count
How to participate in the WV Provider Incentive Program	**87.9%**	**29**
Certified EHR technology product evaluation, selection and procurement	33.3%	11
"Meaningful Use" definition, criteria and reporting requirements	60.6%	20
Managing a successful EHR implementation	33.3%	11
Integrating an EHR into workflow and clinical decision making	27.3%	9
Patient engagement and education	12.1%	4
Health Information Exchange opportunities in WV	39.4%	13
EHR support and technical services provided by the WV Regional HIT Extension Center (RHITEC)	33.3%	11
Don't need further information	6.1%	2
Other (please specify)	3.0%	1
answered question		33
skipped question		47

We have totally absorbed the cost of purchasing and implementing our EHR and would have benefitted from funding incentives. Is it too late?

53. Regarding how the State of West Virginia is handling the Provider Incentive Program and encouraging adoption of EHR technology, I would like to receive information about: (check all that apply)

	Response Percent	Response Count
The WV process for paying provider incentives and its status	**81.8%**	**27**
What to expect from the Bureau for Medical Services (BMS)	**81.8%**	**27**
Where to go for information	54.5%	18
Where to go for help	42.4%	14
Statistics	21.2%	7
Don't want any further information	6.1%	2
Other (please specify)	0.0%	0
answered question		33
skipped question		47

54. I am most interested in learning about the Provider Incentive Program, EHR technology and the State's activities through: (check all that apply)

	Response Percent	Response Count
Webinars	**54.5%**	**18**
Web based training modules	39.4%	13
Mailings of reading materials	51.5%	17
Live presentations or meetings	36.4%	12
Teleconferences	24.2%	8
One-on-one discussions	12.1%	4
Individual phone calls	18.2%	6
Information provided by email/e-newsletters	**54.5%**	**18**
Not interested	3.0%	1
Other (please specify)	0.0%	0
answered question		33
skipped question		47

55. Regarding the Provider Incentive Program, the adoption of EHR technology and other State activities, I would benefit from the following types of support: (check all that apply)

	Response Percent	Response Count
Provider group meetings	24.2%	8
Web meetings	36.4%	12
Call center	24.2%	8
Informational website	**69.7%**	**23**
Regular mailings	45.5%	15
I would not take advantage of any support offerings	6.1%	2
I don't need any support	6.1%	2
Other (please specify)	0.0%	0
	answered question	33
	skipped question	47

56. The items listed below are thought to be possible incentives for providers to adopt EHR technology and to achieve Meaningful Use. Please rate them in order of importance to you from 1 (greatest incentive) to 4 (least incentive)

	1	2	3	4	Rating Average	Response Count
Enhanced ability to electronically exchange information (WV Health Information Exchange functionality)	18.2% (6)	24.2% (8)	24.2% (8)	**33.3% (11)**	2.73	33
Additional financial compensation	**39.4% (13)**	27.3% (9)	24.2% (8)	9.1% (3)	2.03	33
Rewards for achieving goals	9.1% (3)	24.2% (8)	**33.3% (11)**	**33.3% (11)**	2.91	33
Demonstrated improvements in care and health	**33.3% (11)**	24.2% (8)	18.2% (6)	24.2% (8)	2.33	33
Other: Please enter any other incentives not already listed that you would be interested in.						1
				answered question		33
				skipped question		47

Demonstrated improvement in workflow and time savings.

Question 57 collected contact information from providers who are interested in receiving further information about the Medicaid EHR Provider Incentive Program. The twenty-seven responders listed below provided their contact information.

Question 58 asked providers if they were interested in participating in additional information gathering processes, such as interviews or focus groups. Twenty responders indicated they would be interested in participating, although one of those responders failed to provide contact information. The other nineteen can be identified by the Y in the last column.

Contact Name	Organization	Contact Information	Interested in Participating (Y/N)
Danny Harper	Roane County Family Health Care, Inc	dharper@rcfhc.org 304-927-2241	N
Lori Goforth	Shenandoah Valley Medical	lgoforth@svms.net 304-263-4999	Y
Brent Barr	Minnie Hamilton Health System	bbarr@mhhcc.com 304-354-9726	Y
Judy Raveaux	CHANGE, Inc.	jraveaux@changeinc.org 304-797-7733	Y
Dee Scritchfield	WCHSA	dscritchfield@wchsa.com 304-275-8780	Y
Dave Sotak	New River Health	dave.sotak@pihn.org 304-929-6772	Y
Kristi Rader	Rainelle Medical Center	karader@rmchealth.org 304-438-6188	Y
Martha Carter	FamilyCare HealthCenter	martha.cookcarter@familycarewv.org 304-757-6999	Y
Chad J Lancaster	Chad J Lancaster DDS	braxtondds@gmail.com 304-364-8565	Y
Michael C Sheridan	Greenbrier Valley Mental Health, pllc	mikes@gvmentalhealth.com 304-520-0095	N
Cynthia Spaulding	Spaulding Psychological Services	cspaulding3@zoominternet.net 304-643-5399	N
Thelma Goliath	Gilbert Goliath MD	goliathped@gmail.com 304-444-3248	Y
Pat Harper	Avalon Radiology	pwharper@frontier.com 304-497-2500	Y
Judith Hamrick	Camden on Gauley Medical Center, Inc.	judy@cog-wv.org 304-226-5725 Ext. 130	N
Bill Snider	Ritchie County Primary Care	bill@rcpca.org 304-643-4005	Y
Steve Shattls	Valley Health	2585 3rd Ave Huntington, WV 25703	Y
Linda Hutchens	Bluestone Health Association	lhutchens@citlink.net 304-431-5499 Ext. 125	N
Bill Marrs	Westbrook Health Services	bmarrs@westbrookhealth.com 304-485-1721 ext 157	Y
Charles D Bess, MD	Charles D Bess MD Inc	charlesbess@yahoo.com 304-788-6462	N
THERESA GRAPES	MOUNTAIN ROSE FAMILY MEDICINE	mountainrosefamilymedicine@yahoo.com 304-597-2490	Y
William Scott Thomas, MD	New Creek Family Medicine	DrScottThomas@hotmail.com 304-788-9320	Y
Dr. Melissa Loya		304-597-2494	N
Anthony K. Haywood	Anthony K. Haywood DO	akhaywood@frontiernet.net	Y

DO		304-822-7866	
Beverly Johnson	Rebecca J Kucera, DDS, PLLC	beverly@drbecca.com 304-645-0251	Y
Dr. Stephen Durrenberger	Starlight Behavioral Health Services	admin@starlightbhs.com 304-302-2078	Y
Susan Dolin	Hans Lee, M. D., Inc.	kassilee@suddenlinkmail.com 304-342-1113	N
Kim	Tim Nichols DDS Inc	TNICHOLS08@atlanticbbn.net 304-822-4447	Y

Appendix D: EHR Provider Incentive Program (PIP) Communication, Outreach and Education Inventory To-date

Responsible:	Governor's Office of Health Enhancement and Lifestyle Planning (GOHELP)
Role:	Pursuant to 16-29H-6, GOHELP's role in HIT is that of a coordinator. To that end, GOHELP facilitates discussion and assists constituent state agencies with HIT initiatives.

Communication or Location of Information Delivered	Type/Method/Vehicles
HIT General Information http://www.gohelp.wv.gov/HIT/Pages/default.aspx	Electronic Information – GOHELP Web Portal
Health Information Technology (HIT) Links http://www.gohelp.wv.gov/HIT/Pages/HealthInformationTechnology(HIT)Links.aspx	Electronic Information – GOHELP Web Portal
West Virginia Regional HIT Extension Center (WVRHITEC) Link http://www.gohelp.wv.gov/HIT/Pages/WestVirginiaRegionalHITExtensionCenter.aspx	Electronic Information – GOHELP Web Portal
EHR Resources Links http://www.gohelp.wv.gov/HIT/Pages/EHRIncentives.aspx	Electronic Information – GOHELP Web Portal
HIT Legislation http://www.gohelp.wv.gov/HIT/Pages/HIT_Law.aspx	Electronic Information – GOHELP Web Portal
Healthcare Information and Management Systems Society (HIMISS) HIT Dashboard http://www.gohelp.wv.gov/HIT/Pages/HIT_DB.aspx	Electronic Information – GOHELP Web Portal
HIT Tools http://www.gohelp.wv.gov/HIT/Pages/HITools.aspx	Electronic Information – GOHELP Web Portal
News and Announcements regarding HIT: http://www.gohelp.wv.gov/news/Pages/default.aspx	Electronic Information – GOHELP Web Portal
WVHIN Proposed Privacy Policies: WVHIN Releases Privacy & Security Policies for Public Comment http://www.wvhin.org/news/Pages/WVHINReleasesPrivacySecurityPoliciesforPublicComment.aspx	Electronic Information – GOHELP Web Portal
ONC Gearing Up for Testing of NHIN Direct Health Data Exchange http://www.gohelp.wv.gov/news/Pages/ONC20101029.a	Electronic Information – GOHELP Web Portal

Communication or Location of Information Delivered	Type/Method/Vehicles
spx	
West Virginia Awarded Federal Grant to Assist Physicians in Implementing Electronic Health Records http://www.gohelp.wv.gov/news/Pages/RHITEC.aspx	Electronic Information – GOHELP Web Portal
Periodic emails with latest HIT information	Electronic Newsletters

Responsible:	West Virginia Regional HIT Extension Center (WVRHITEC)
Role:	Regional health information technology extension centers (RECs) were created out of the ARRA HITECH Action – Section 3012, and are under the U.S. DHHS Office of the National Coordinator for Health Information Technology (ONC). The WVRHITEC will offer services/support (education, outreach, guidance) to all health care providers in West Virginia — whether or not they have adopted electronic health record systems. Technical services also will be provided, and rural clinics and small practices may be eligible for subsidized services. WVRHITEC's objective is to help 1,000 eligible health care providers become "meaningful users" of health IT by 2011 so they can qualify for federal health IT incentive payments

Communication or Location of Information Delivered	Type/Method/Vehicles
W.Va. Academy of Family Physicians - 58th Annual Scientific Assembly April 23 - April 25, 2010 Ramada Inn, So. Charleston, WV	In person – Speaking opportunities
Partners In Health Board Meeting May 26, 2010, Charleston	In person – Speaking opportunities
Mid-Ohio Valley IPA Meeting June 3, 2010, 4:30 p.m. to 6:30 p.m. Wheeling Country Club, Wheeling	In person – Speaking opportunities
Public Health Cecil Pollard Meeting_Charleston June 4, 2010	In person – Speaking opportunities
Public Health Cecil Pollard Meeting_Charleston June 4, 2010	In person – Speaking opportunities
WVPCA Board of Directors' Annual Retreat and Succession Planning June 9 - 10, 2010, Stonewall Resort	In person – Speaking opportunities
WV Primary Care Association Health Information Technology Conference	In person – Speaking opportunities

Communication or Location of Information Delivered	Type/Method/Vehicles
June 23, 2010 Ramada Inn, South Charleston	
WVRHITEC Dinner Event With the W.Va. Medical Insurance Agency July 29, 2010, Summit Conference Center, Charleston	In person – Speaking opportunities
WVPCA Annual Conference August 11 - 13, 2010 Oglebay Resort and Conference Center	In person – Speaking opportunities
WV State Medical Association Healthcare Summit August 27, 2010 – 1:30 p.m. to 3:00 p.m. The Greenbrier, White Sulphur Springs	In person – Speaking opportunities
Physicians Meeting - St. Mary's Medical Center August 31, 2010, 6:00 p.m., Huntington, WV	In person – Speaking opportunities
CMS Webinar October 6, 3:30 p.m .	In person – Speaking opportunities
WV Office Managers Meeting Oct. 15, 2010, 8:30 a.m. Pullman Plaza Hotel, Huntington	In person – Speaking opportunities
W.Va. Academy of Family Physicians October 15, 2010 Bridgeport Conference Center, Bridgeport, WV	In person – Speaking opportunities
IPA Annual Meeting Oct. 19, 2010, 6 p.m. IPA Building, Wheeling, WV	In person – Speaking opportunities
WV Health Info. Management Association (WVHIMA) – Fall Retreat October 22, 1 p.m., Falcon Center, Fairmont State University	In person – Speaking opportunities
WVRHITEC Meeting with Marshall October 27, Huntington, WV	In person – Speaking opportunities
WV Osteopathic Annual Conference Nov. 5-7, 2010 White Sulphur Springs, WV	In person – Speaking opportunities

Communication or Location of Information Delivered	Type/Method/Vehicles
	Email communication and e-newsletters
	Press releases
	Direct discussions with providers
W.Va. Medical Journal, Sept./Oct. 2010 edition, and *W.Va. Physician* magazine, Vol. 1, Issue 3	Article in medical publication
www.wvrhitec.org	Web portal
Physician-to-physician outreach and education program designed to assist and help foster more widespread adoption and use of electronic health record systems in West Virginia.	West Virginia Meaningful Use Vanguard (MUV) Physician Group
Explanation of Registration and Attestation Procedures for Federal EHR Incentives Webinar Recording - December 08, 2010	Webinar hosted by WVRHITEC
Workflow and Staff Role Changes To Consider With An EHR System Webinar Recording - November 17, 2010 - Dr. Sarah Chouinard	Webinar hosted by WVRHITEC
Meaningful Use 101 for Private Practices and Solo Providers Webinar Recording - November 10, 2010 - Dr. Sarah Chouinard	Webinar hosted by WVRHITEC
Resources and Benefits Provided by the W.Va. Regional HIT Extension Center Webinar Recording - November 8, 2010 - Roger Chaufournier	Webinar hosted by WVRHITEC
ARRA Incentives (Medicare and Medicaid) for Health Care Providers Webinar Recording - November 3, 2010	Webinar hosted by WVRHITEC
Benefits of Using Electronic Health Records	Video posted to the WVRHITEC web portal
The Digitization of Medical Records and the Long-term Benefits of Electronic Health Records	Video posted to the WVRHITEC web portal
Electronic Health Records and Workflow Changes	Video posted to the WVRHITEC web portal
Electronic Health Records: Improving Patient Care and Outcomes	Video posted to the WVRHITEC web portal
Benefits of Joining the W.Va. Regional HIT Extension	Video posted to the WVRHITEC web

Communication or Location of Information Delivered	Type/Method/Vehicles
Center	portal
Understanding Meaningful Use and Stage 1 Requirements	Video posted to the WVRHITEC web portal
e-Prescribing	Video posted to the WVRHITEC web portal
Personal Electronic Health Records	Video posted to the WVRHITEC web portal
Health Information Exchange	Video posted to the WVRHITEC web portal

Responsible:	West Virginia Health Information Network (WVHIN)
Role:	WVHIN was designated by Former Governor Joe Manchin in 2006 to participate in a multi-state collaborative to address privacy and security concerns with EHR/HIT. The WVHIN is charged with building a secure electronic health information system for the exchange of patient data among physicians, hospitals, diagnostic laboratories, other care providers, and other stakeholders.

Communication or Location of Information Delivered	Type/Method/Vehicles
Statewide highly-visible presence at the statewide membership meetings	• WV State Medical Association • WV Academy of Family Physicians • WV Society of Osteopathic Physicians • Office Managers Association of WV • Medical Managers Association of WV • WV Primary Care Association • WV Hospital Association • WV Mutual Physicians Liability • WV Health Information and Management Systems Society • WV Nurses Association
Resource and informational tabs and sections will be created for physicians, hospitals, and other health providers.	WVHIN web portal
Direct communication with physicians	Electronic newsletter

Communication or Location of Information Delivered	Type/Method/Vehicles
Purpose, activities, and members of the WVHIN's Physician Advisory Council	Handout for exhibits
Benefits of being a participant in the WVHIN	Handout for exhibits
Medical Records Law Seminar Holiday Inn, Charleston, WV March 18, 2010	Presentation/Speaking Opportunity
WV State Bar Panel Discussion Health Care Law CAMC Charleston, WV March 19, 2010	Presentation/Speaking Opportunity
WV Academy of Family Physicians Ramada Inn South Charleston, WV April 23-25, 2010	Exhibit
WVU End of Life Care Symposium Stonewall Resort, Roanoke, WV May 11, 2010	Presentation/Speaking Opportunity
Thomas/St. Francis monthly physician CEU Embassy Suites Charleston, WV June 15, 2010	Presentation/Speaking Opportunity
WV Primary Care Association HIT Conference Ramada Inn, South Charleston, WV June 23, 2010	Presentation/Speaking Opportunity
DHHR HIT updates session Capitol Complex Charleston, WV July 12, 2010	Presentation/Speaking Opportunity
WV Annual Public Health Conference Canaan Valley Resort, WV September 22-24, 2010	Presentation/Speaking Opportunity and Exhibit
Office Managers Association Conference Pullman Plaza Hotel Huntington, WV October 15, 2010	Presentation/Speaking Opportunity and Exhibit
IPA Annual Meeting IPA Building Wheeling, WV October 19, 2010	Presentation/Speaking Opportunity

Communication or Location of Information Delivered	Type/Method/Vehicles
WV Osteopathic Annual Conference White Sulphur Springs, WV November 5-7, 2010	Presentation/Speaking Opportunity and Exhibit

Appendix E: Terms, Acronyms and Abbreviations

West Virginia
Bureau for Medical Services
State Medicaid Health Information Technology Plan Development Project

The following table contains a list of commonly used terms, acronyms and abbreviations related to the project.

Common Terms, Acronyms and Abbreviations	
Term/Acronym/Abbreviation	**Definition/Explanation**
AAC	Average Allowable Cost
A/I/U	Adopt, Implement, Upgrade
APD	Advance Planning Document
ARRA	American Recovery and Reinvestment Act of 2009
BCF	Bureau for Children and Families
BDC	Broadband Deployment Council
BDMP	Berry, Dunn, McNeil, and Parker
BMI	Body Mass Index
BMS	Bureau for Medical Services
BPH	Bureau for Public Health
BTOP	Broadband Technologies Opportunities Program
CAH	Critical Access Hospital
CCHIT	Certification Commission for Health IT
CCN	The Centers for Medicare & Medicaid Services Certification Number
CDEMS	Chronic Disease Electronic Management System
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHN	Community Health Network
CIO	Chief Information Officer
CMS	Centers for Medicare and Medicaid Services
COE Plan	Communication, Outreach and Education Plan

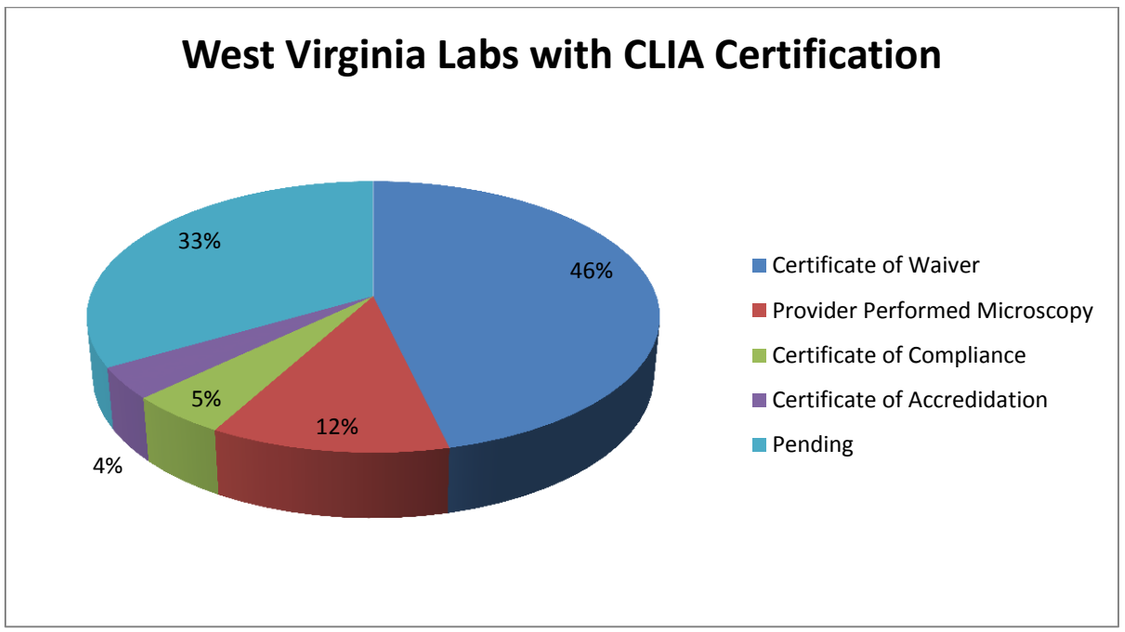
Common Terms, Acronyms and Abbreviations	
Term/Acronym/Abbreviation	**Definition/Explanation**
CON	Certificate of Need
COO	Chief Operating Officer
COTS	Commercial Off-the-Shelf
CPOE	Computerized Physician Order Entry
CY	Calendar Year
DHHR	Department of Health and Human Services
DHSEM	Division of Homeland Security and Emergency Management
DMAPS	Department of Military Affairs and Public Safety
DOC	Department of Commerce
EDSS	Electronic Disease Surveillance System
EH	Eligible Hospital
EHR	Electronic Health Record
EMR	Electronic Medical Record
EP	Eligible Professional
EP	Eligible Provider
EPLS	Excluded Parties List System
FCC	Federal Communications Commission
FFY	Federal Fiscal Year
FQHC	Federally Qualified Health Center
FTE	Full-Time Employees
GOHELP	Governor's Office of Health Enhancement & Lifestyle Planning
HCCN	Health Center Controlled Network
HIE	Health Information Exchange - as defined by the Office of the National Coordinator and the National Alliance for Health Information Technology (NAHIT), Health Information Exchange refers to the electronic movement of health-related information among organizations according to nationally recognized standards.
HII	Health Improvement Institute

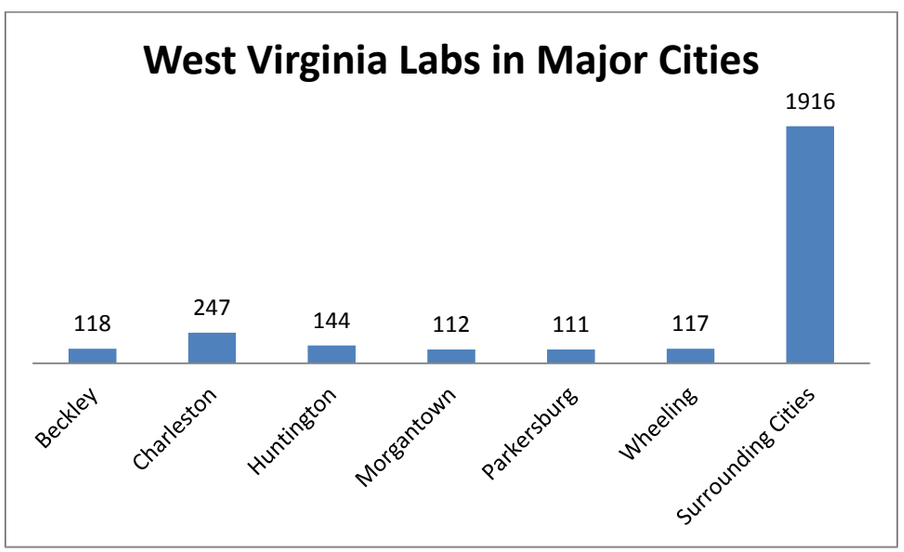
Common Terms, Acronyms and Abbreviations	
Term/Acronym/Abbreviation	**Definition/Explanation**
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HITECH	Health Information for Economic and Clinical Health – collectively refers to the health information technology provisions included at Title XIII of Division A and Title IV of Division B of the ARRA.
HRSA	Health Resources and Services Administration
I-APD	Implementation Advance Planning Document
IHS	Indian Health Service
InRoads	Resident Online Access and Delivery of Services
MCO	Managed Care Organization
MDTV	Mountaineer Doctor Television
MFP	Money Follows the Person
MITA	Medicaid Information Technology Architecture - an IT initiative intended to stimulate an integrated business and IT transformation affecting the Medicaid enterprise in all States. The MITA initiative's intention is to improve Medicaid program administration by establishing national guidelines for technologies and processes.
MLC	Medicaid Learning Center
MMIS	Medicaid Management Information System
Molina	MMIS Fiscal Agent for West Virginia
MU	Meaningful Use – as defined in the federal Final Rule (issued in July 2010), Stage 1 meaningful use has three main components: 1. Certified use of an EHR in a "meaningful" way, such as prescribing; 2. Certified use of an EHR technology for electronic exchange of information to improve quality of health care; and 3. The use of certified EHR technology to submit clinical quality and other measures.
MUSOM	Marshall University School of Medicine
MUV	West Virginia Meaningful Use Vanguard Physician Group
NAAC	Net Average Allowable Cost
NAIC	National Association of Insurance Commissioners

Common Terms, Acronyms and Abbreviations	
Term/Acronym/Abbreviation	**Definition/Explanation**
NEDSS	National Electronic Disease Surveillance System
NLR	National Level Repository
NPI	National Provider Identifier
ONC	Office of the National Coordinator of Health Information Technology
PA	Physician Assistant
P-APD	Planning-Advanced Planning Document
PECOS	The Provider Enrollment, Chain and Ownership System (PECOS) database run by CMS
PEIA	Public Employees Insurance Agency
PHR	Personal Health Record
PIP	Provider Incentive Program
PIPS	Provider Incentive Program Solution
PMO	Project Management Office
PPACA	Patient Protection and Affordable Care Act
REC (or RHITEC)	Regional Extension Center - as set out in the ARRA, Regional Extension Centers will be created by ONC to provide technical assistance and disseminate best practices and other information learned from the Health Information Technology Research Center to aid health care providers with the adoption of health information technology.
RFO	Request for Offer
RFP	Request for Proposal
RHC	Regional Health Center
RPMS	Resource and Patient Management System
SAS 70	Statement on Auditing Standards Number 70
SBS	State Based System
SDE	State Designated Entity
SERFF	System for Electronic Rate and Form Filing
SHAP	State Health Access Plan

Common Terms, Acronyms and Abbreviations	
Term/Acronym/Abbreviation	**Definition/Explanation**
SIIS	Statewide Immunization Information System
SMHP	State Medicaid Health Information Technology Plan
SPA	State Plan Amendment
SS-A	State Self-Assessment
TIN	Personal Tax Identification Number
TMI	Traumatic Brain Injury
TPL	Third Party Liability
SQL	Structured Query Language
W.A.R.N.	Wide Area Rapid Notification System
WV	West Virginia
WVHCA	West Virginia Healthcare Authority
WVHII	West Virginia Health Improvement Institute
WVHIN	West Virginia Health Information Network
WVRHITEC	West Virginia Regional HIT Extension Center
WVSOM	West Virginia School of Osteopathic Medicine
WVTA	West Virginia Telehealth Alliance
XML	Extensible Markup Language

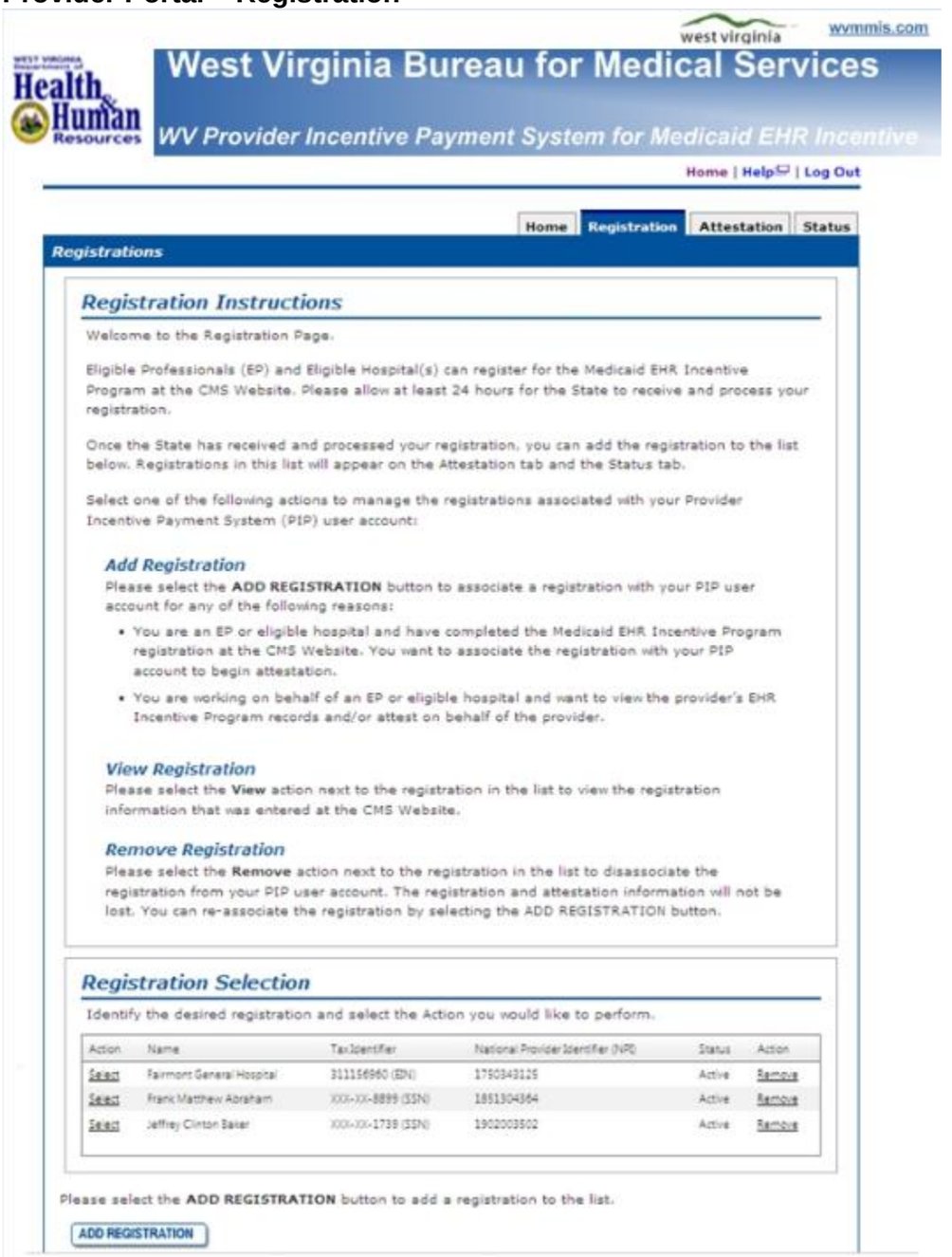
Appendix F: WV Lab Statistics



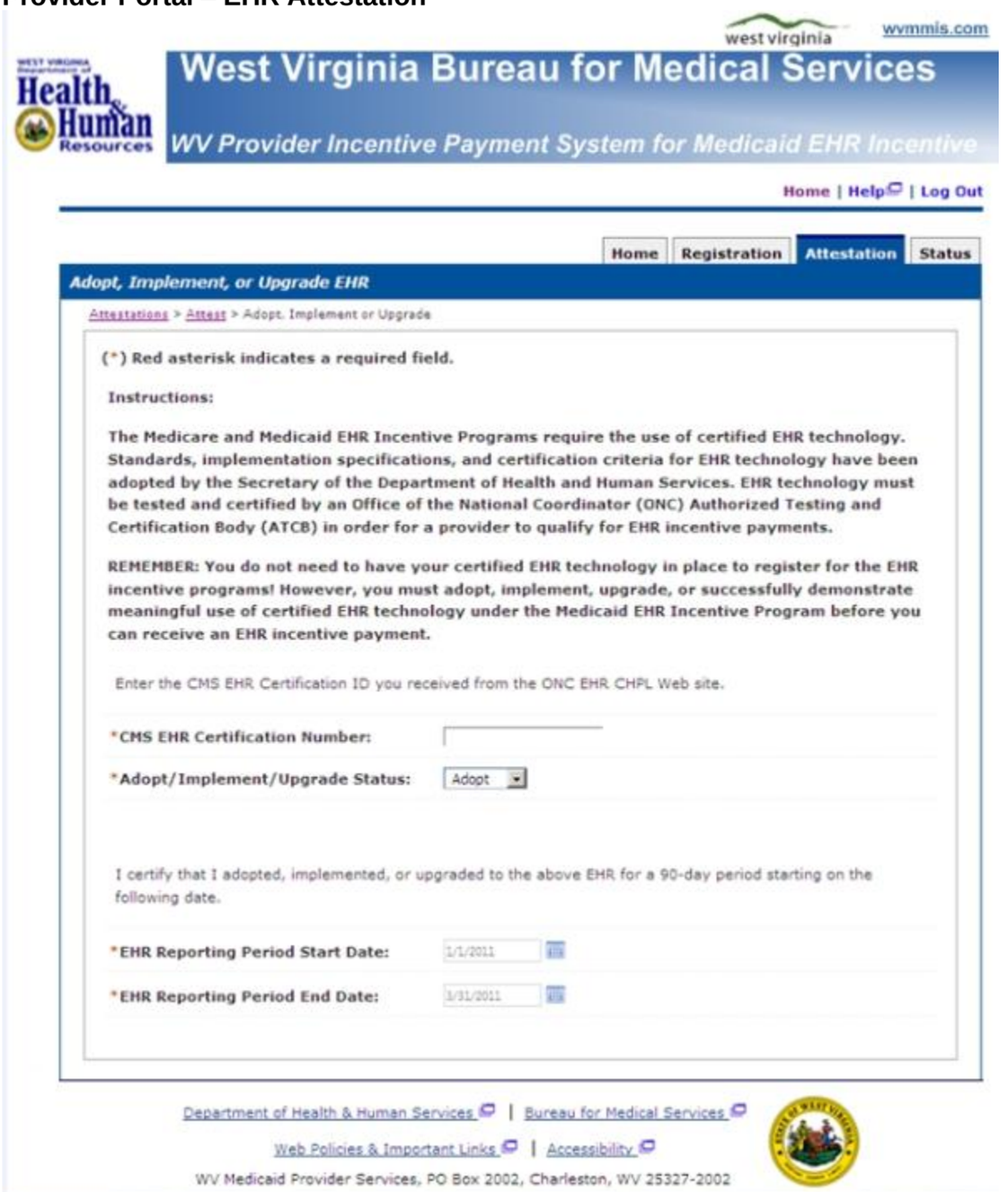


Appendix G: PIP Portal Sample Screen Shots

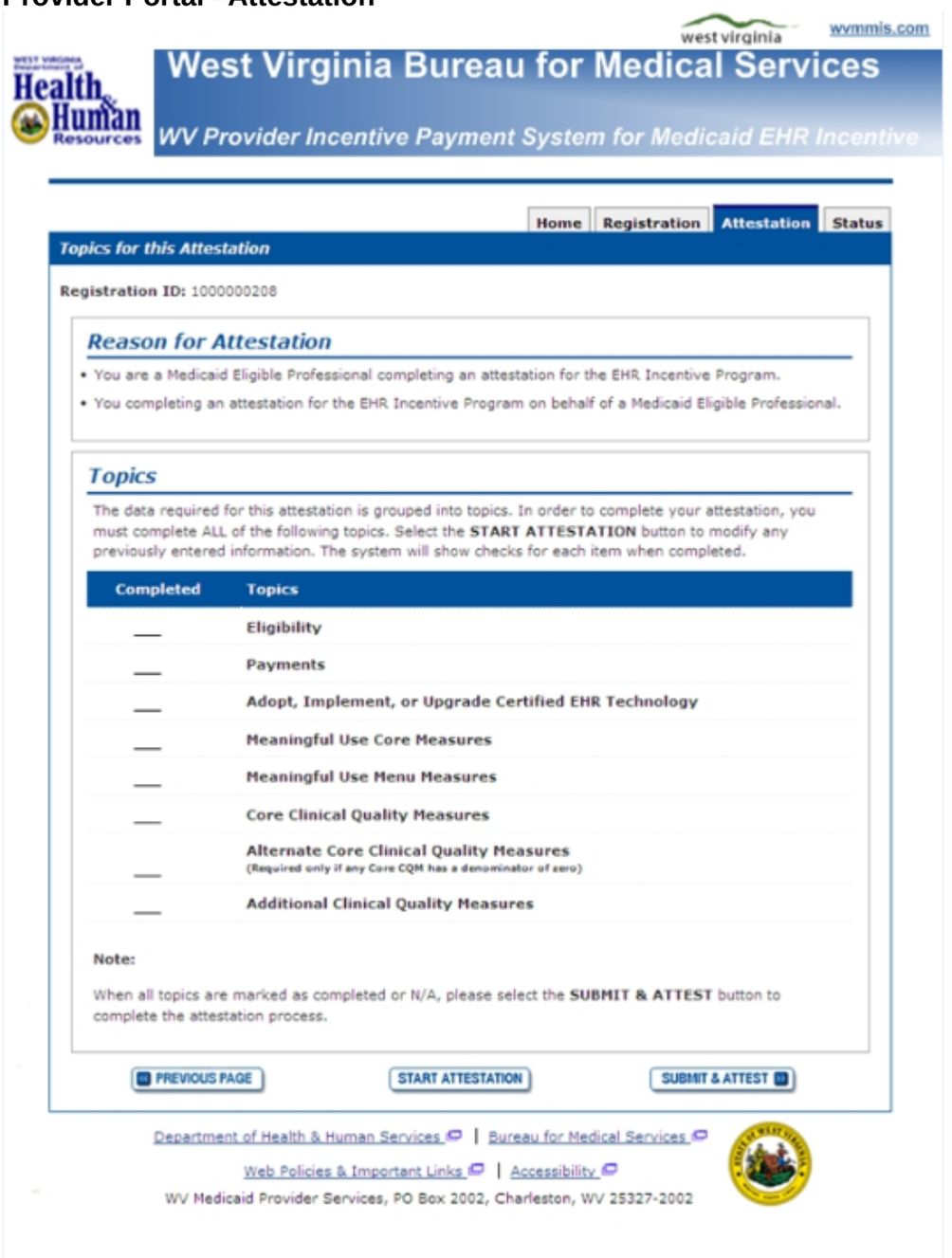
Provider Portal – Registration



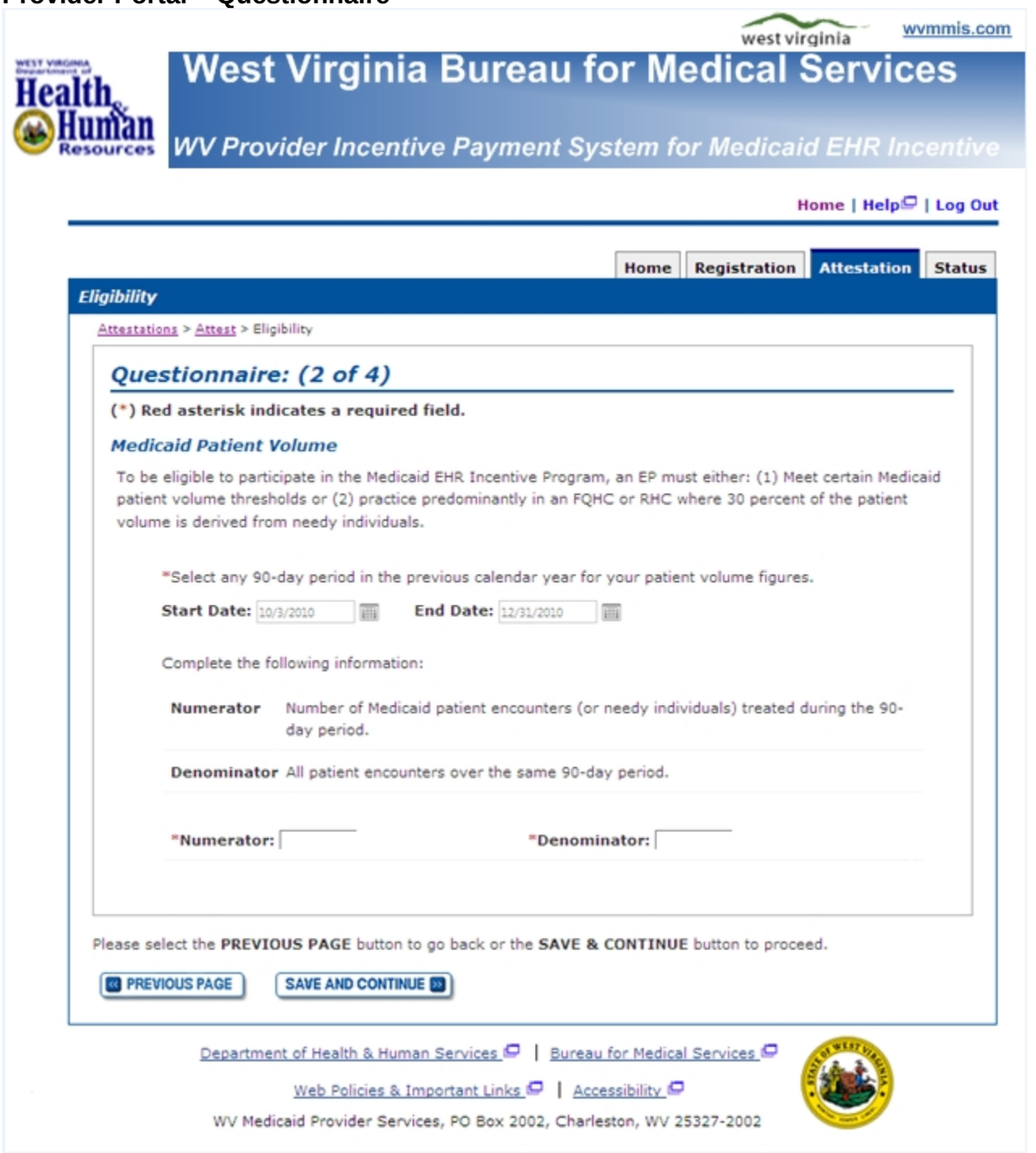
Provider Portal – EHR Attestation



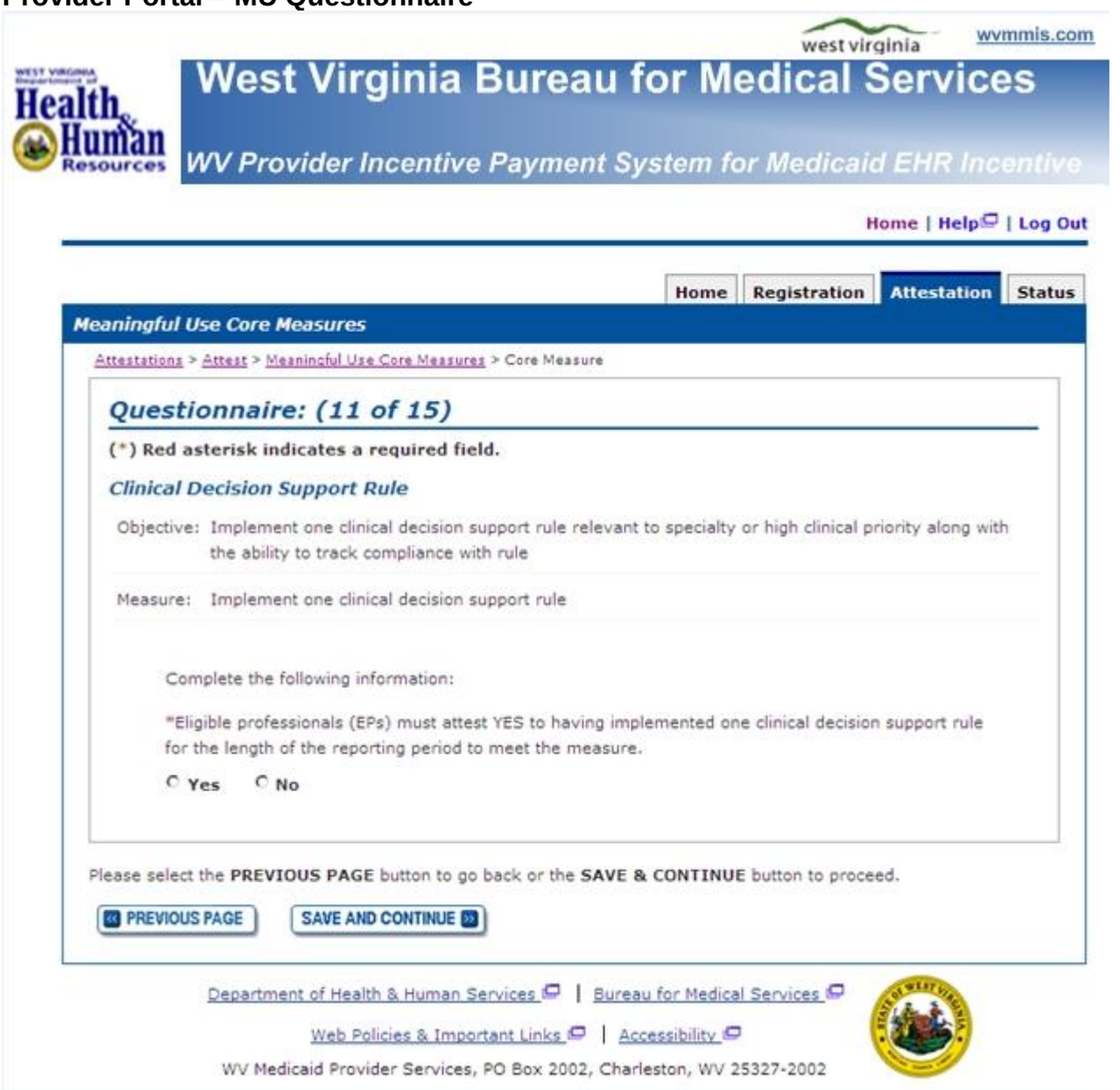
Provider Portal –Attestation



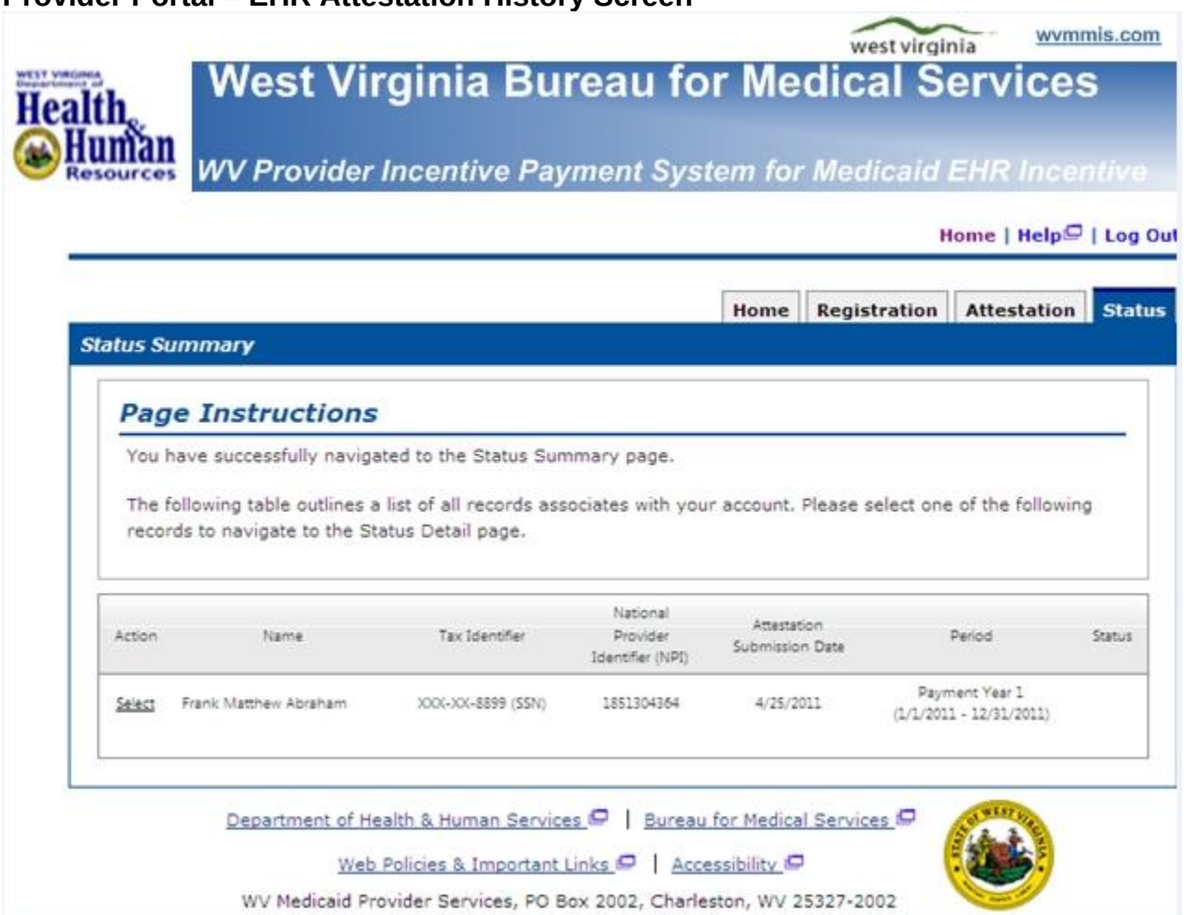
Provider Portal – Questionnaire



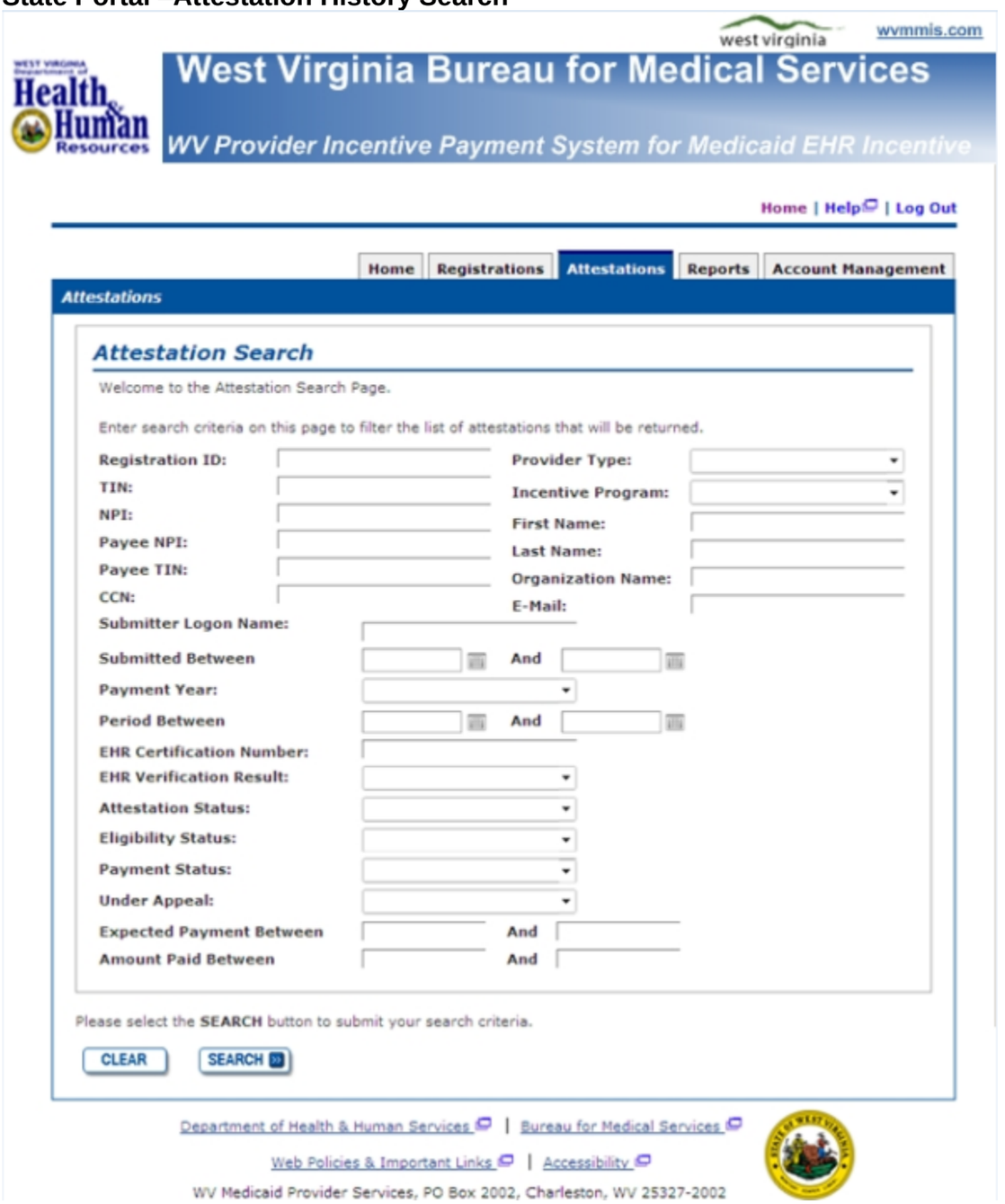
Provider Portal – MU Questionnaire



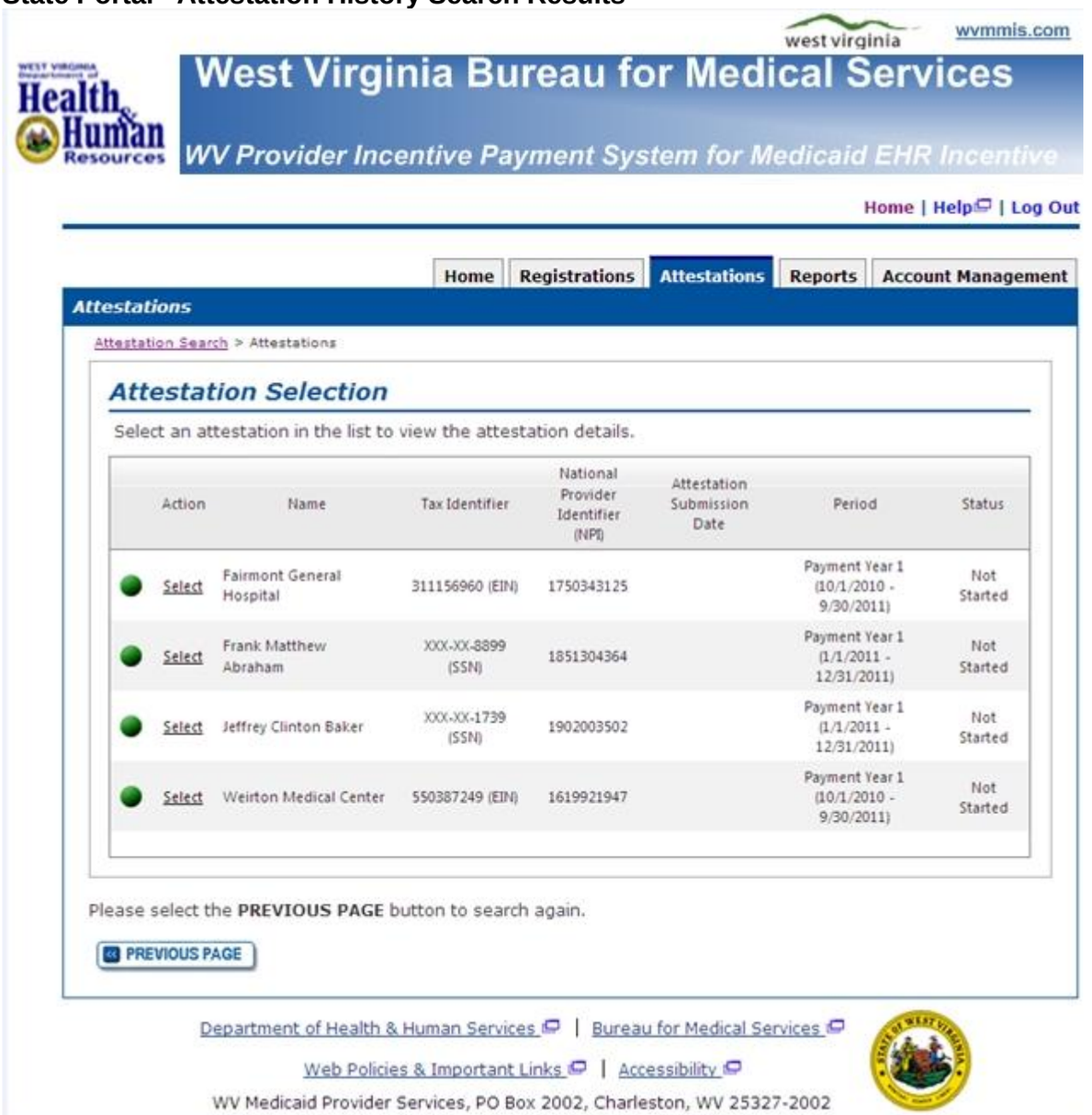
Provider Portal – EHR Attestation History Screen



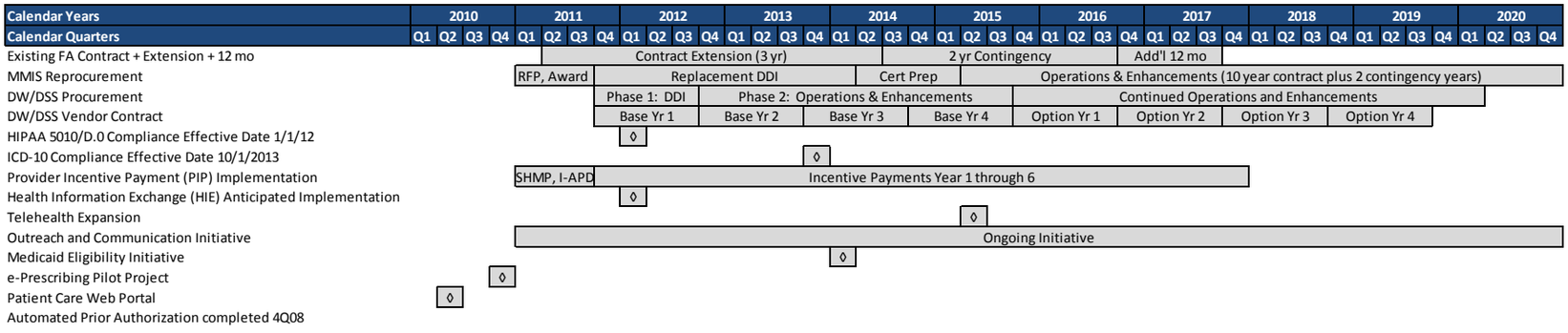
State Portal –Attestation History Search



State Portal –Attestation History Search Results



Appendix H: Medicaid Goals and Objectives Timeline



Assumptions:

Assumes MMIS DDI of 30 calendar months inclusive of 6 months UAT (max.)
Assumes DW/DSS RFP Award in Q311
Assumes DW/DSS DDI of 9 calendar months
Assumes NCCI Edit APD approval by Q211 and 8 month implementation
Health Insurance Exchange (HIX) timeline dependent on approved legislation