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## **State Medicaid Health Information Technology Plan (SMHP)**

### **V4.0**

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## Revision History

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3.0	6/14/2011	Final approved version.
3.1	7/19/2016	Updated draft delivered to client.
3.2	8/3/2016	Updated document based on 7/29/2016 client review meeting.
3.3	9/6/2016	Updated document based on reconciliation with the State Health IT Plan.
3.4	10/4/2016	Updated document based on feedback from HIT Stakeholders.
3.5	10/11/2017	Updated based on CMS feedback received after reviewing v.3.4 submission.
3.6	3/15/2019	Updated ongoing HIT promotion activities.
4.0	2/14/2020	Updated draft delivered to CMS. The Document reorganized to match CMS Guidance, to address specific CMS requirements, and for updates to all sections.

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## Executive Summary

The West Virginia (WV) Department of Health and Human Resources (DHHR) Bureau for Medical Services (BMS) initially developed this State Medicaid Health Information Technology (HIT or Health IT) Plan (herein referred to as the Plan or the SMHP) in 2011, to chart the path forward for the adoption, meaningful use (MU), and expansion of health IT to support the West Virginia Medicaid Enterprise. The current Plan builds on the success of West Virginia’s prior SMHP iterations and serves as a guide to the path forward while maintaining alignment with the Bureau’s health IT priorities and mission statement:

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*BMS is committed to administering the Medicaid Program, while maintaining accountability for the use of resources, in a way that assures access to appropriate, medically necessary, and quality healthcare services for all members; provide these services in a user-friendly manner to providers and members alike; and focus on the future by providing preventive care programs.*

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The SMHP is a vision document that includes a current assessment of West Virginia’s health IT landscape, a vision of the health IT future in the year 2020 and following years, and a roadmap that serves as a strategic pathway to move from the State’s “As-Is” health IT landscape to the “To-Be” health IT vision. The Plan has been developed in accordance with guidance provided in the Code of Federal Regulations (CFR): 42 CFR §495.332, as amended by the Center for Medicare and Medicaid Services (CMS).

### Overview of the SMHP

The American Recovery and Reinvestment Act (ARRA) of 2009 permitted a 100 percent federal financial assistance to States as incentive payments to Medicaid providers to adopt, implement, upgrade, and meaningfully use electronic health record technologies as well as 90 percent match for State administrative costs related to the incentive program. The Centers for Medicare and Medicaid Services (CMS) provided guidance to State’s regarding the administration of incentive programs and laid forth minimal requirements for States continued eligibility for federal funding. States must:

1. Demonstrate incentive payments to Medicaid eligible professionals and eligible hospitals;

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#### **CMS GUIDANCE OVERVIEW**

THIS ITERATION OF THE SMHP IS DESIGNED TO ADDRESS SPECIFIC CMS GUIDANCE REQUIREMENTS. IN THIS DOCUMENT, SECTIONS WILL HAVE A SIDE BAR SIMILAR TO THIS AND EACH WILL CONTAIN SPECIFIC LANGUAGE FROM THE CMS SMHP GUIDANCE DOCUMENT (OMB APPROVAL NUMBER 0938-1088). CONTENT OF THE SECTION WILL ADDRESS THE SPECIFIC CMS GUIDANCE LANGUAGE.

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2. Demonstrate oversight and recording of meaningful use reports;
3. Demonstrate initiatives that encourage the adoption of certified electronic health record technologies for the promotion of care quality and the electronic exchange of information.

Therefore, the State Medicaid Health Information Technology Plan (SMHP) is designed to address the current progress in these areas of the incentive program and summarize the States anticipated path forward in the promotion of health information technology. Those guidelines, and therefore this document, are organized according to the following general sections:

- A. West Virginia's "As-Is" HIT Environment
- B. The WV Health IT "To-Be" Environment
- C. Incentive Program Administration & Oversight
- D. The State's Audit Strategy
- E. The State's HIT Roadmap

As the Health Information Technology for Economic and Clinical Health (HITECH) Act funding available by ARRA ends, the State developed a plan on how to transition and sustain the interoperability program, as well as, other HITECH funded projects through the Maintenance Management Information System (MMIS) funding. The State implemented a two-pronged approach to incorporating the multitude of HITECH initiatives into their MMIS:

- BMS' Project Management Organization (PMO), Berry Dunn, used the Medicaid Information Technology Architecture (MITA) State Self-Assessment to identify business areas where there was overlap between MMIS and HITECH.
- WV's Health Information Exchange, the West Virginia Health Information Network (WVHIN), worked with Audacious Inquiry to develop a roadmap for implementation as well as a financial strategy.

The State Medicaid Health Information Technology Plan (SMHP) is a "living" document with content, goals, and reported outcomes that will be evaluated and updated as needed or on an annual basis. An updated version of the WV SMHP is to be sent annually to the Centers for Medicare and Medicaid Services for review and approval.

## Section A: West Virginia’s “As-Is” HIT Environment

BMS partnered with stakeholders across the State to review existing documents, policies, and procedures to assess the current status of the Electronic Health Record Incentive Program. This section of the Plan presents information on the current, “As-Is,” HIT environment of the State of West Virginia.

### WV EHR Incentive Program Overview

The State’s Provider Incentive Program (PIP), also now known as the Interoperability Program, offers incentives to providers participating in Medicaid programs that adopt and successfully demonstrate meaningful use of certified EHR technology (CEHRT). The PIP essentially consists of two sub-programs that, in total, span a six year period from registration to final payment.

Providers must meet the same eligibility requirements for all six years and attest to those annually. The program compliance requirements for Year 1 adoption, implementation, or upgrade incentives, however, differ substantially from the meaningful use (MU) requirements. Meaningful use is defined by the use of certified EHR technology in a meaningful manner (i.e. electronic medication tracking) as well as connecting in a way that allows for the electronic exchange of health information with the overall goal to improve the quality of care.

### Incentive Program Participation to Date

The final year for Eligible Professionals (EPs) and Eligible Hospitals (EHs), collectively referred to as Eligible Providers, to enroll for Year 1 payments was 2016; therefore, final incentive payments are anticipated to be made on December 31, 2021. Table A-1 summarizes the number of eligible providers attesting to program year requirements during state fiscal years 2013 to 2020. This shows retention and growth in the Interoperability Program. Table A-4, Table A-5, and Table A-6 summarize EP participation and payments while EH data is found in Table A-7, Table A-8, and Table A-9. Further detailed information regarding the number of enrolled EPs and EHs, along with payment information, can be found in Section A.1: of this document.

Eligibility Year	State Fiscal Year							
	2013	2014	2015	2016	2017	2018	2019	2020
1	108	246	141	77	125	49	-	-
2	44	192	176	71	88	48	62	5
3	-	-	137	98	75	60	30	39
4	-	-	6	54	87	66	32	14
5	-	-	-	-	46	49	26	12
6	-	-	-	-	-	38	26	14

Table A-1: EHR Incentive Program Participants per Eligibility and Fiscal Years

Since beginning in 2011, the Incentive Program has paid hospitals and providers nearly \$70 million to incentivize the adoption, meaningful use, and interoperability of technology in the WV Medicaid Enterprise. Figure A-1 illustrates the distribution of payments, from the eight fiscal years, to counties in the state. This aids in visualizing where the incentive program was most utilized and identifying regions where the focus of continued or future programming should be directed. Similar maps, specific to each state fiscal year, are available in Appendix I.

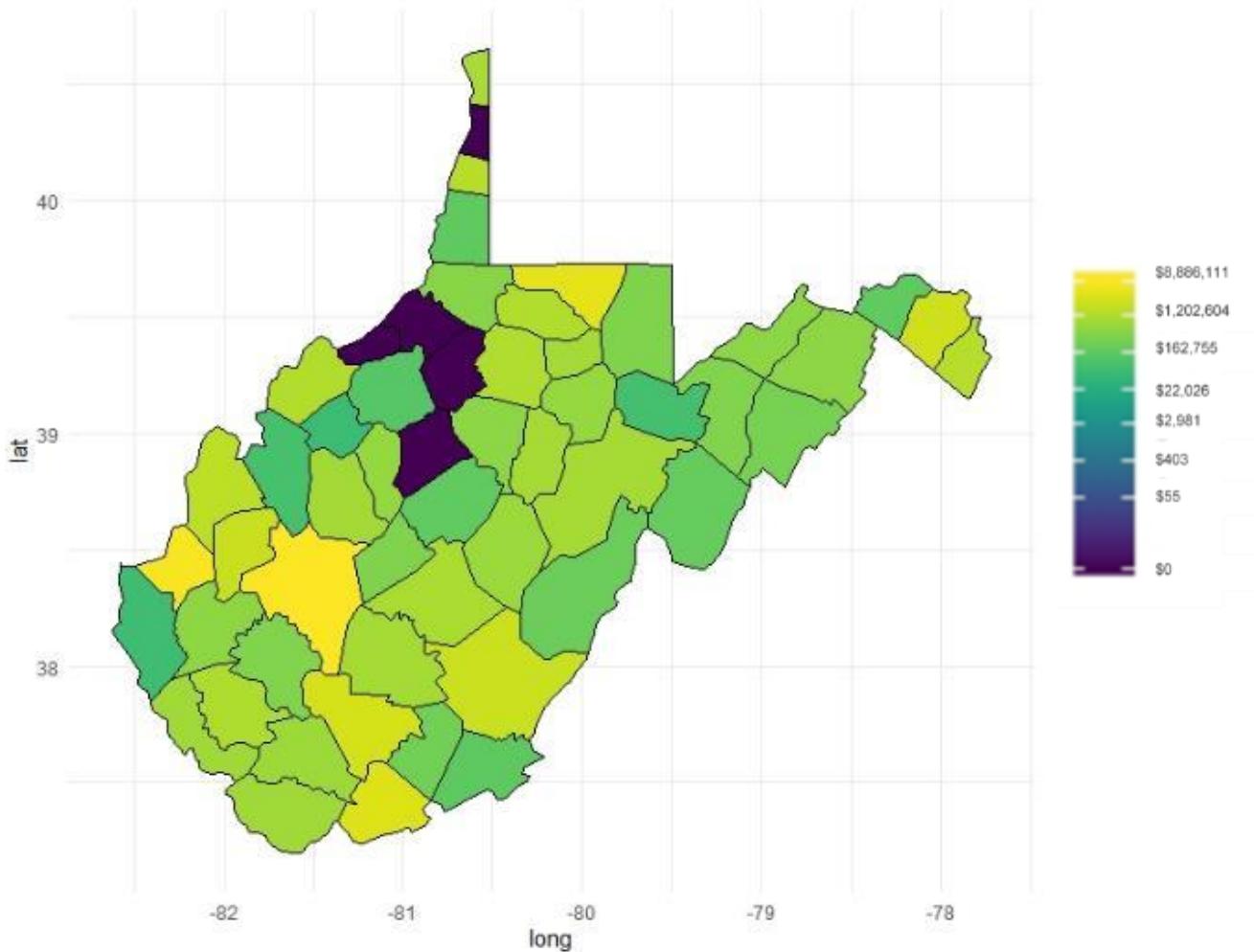


Figure A-1: Total Incentive Payments to WV Counties, SFY 2013 to SFY 2020

As evident from the map, payments from the incentive program were well disbursed to providers across the state; however, the following five counties, to date, have no eligible providers or hospitals participating in the incentive program:

- Brooke County
- Doddridge County
- Gilmer County
- Pleasants County
- Tyler County

The median payment to all incentive/interoperability program participants over this period was \$699,698. The three counties which received the most payments from the incentive program are:

- Kanawha County – \$9.5 million
- Cabell County – \$8.3 million
- Monongalia County – \$5.2 million

## Section A.1: Scope of HIT Adoption and Interoperability

BMS, the State Medicaid Agency (SMA), is the department responsible for overseeing the EHR Provider Incentive Payment (PIP) program. BMS compiled information on HIT system adoption and growth in West Virginia by storing attestation information in the State Level Registry (SLR). Since initiating the incentive program in 2011, a total of 2,341 eligible professional and 142 eligible hospitals attested to adoption, implementation, and upgrade (AIU) as well as meaningful use (MU). Each component of AIU is briefly described as:

- **Adoption** – an actual purchase/acquisition or installation has occurred;
- **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);
- **Upgrade** – the provider expanded the functionality of the certified EHR technology (i.e. addition of clinical decision support or e-prescribing functionality).

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### CMS GUIDANCE A.1.

WHAT IS THE CURRENT EXTENT OF EHR ADOPTION BY PRACTITIONERS AND BY HOSPITALS? HOW RECENT IS THIS DATA? DOES IT PROVIDE SPECIFICITY ABOUT THE TYPES OF EHRs IN USE BY THE STATE’S PROVIDERS? IS IT SPECIFIC TO JUST MEDICAID OR AN ASSESSMENT OF OVERALL STATEWIDE USE OF EHRs? DOES THE SMA HAVE DATA OR ESTIMATES ON ELIGIBLE PROVIDERS BROKEN OUT BY TYPES OF PROVIDER? DOES THE SMA HAVE DATA ON EHR ADOPTION BY TYPES OF PROVIDER (E.G. CHILDREN’S HOSPITALS, ACUTE CARE HOSPITALS, PEDIATRICIANS, NURSE PRACTITIONERS, ETC.)?

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The following subsections summarize the participation and payments made to eligible providers and eligible hospitals, respectively, since the PIP implementation.

Also, since going live in 2012, the West Virginia Health Information Network (WVHIN) has been the health information exchange (HIE) network for the State; further information on the success, goals, and barriers to implementing the State's information exchange can be found in Section A.7.:

#### Section A.1.1: "As-Is" HIT Environmental Survey

This section presents data collected from a state-wide, online survey sent to providers, hospitals, and agencies involved in providing, administering, or billing in the healthcare industry. The target population for this environmental survey was not limited to those solely in the Medicaid Enterprise. Unfortunately, due to the specific technical detail requested, the survey had a low response rate of 49 participants with not all participants completing the entire survey instrument, as will be noted in the individual responses summarized below. Therefore, comparisons between previous survey results from 2011 and 2016, each with low response rates themselves, are difficult to make. The 2011 and 2016 survey results, as presented in the SMHP v3.6 can be found in Appendix J. We attribute the low response rate to the specific technical detail being requested, and the limited information available to identify what individuals should be targeted for the survey. Only 24 (53%) of the participants provided the type of facility in which they work, as depicted by the bar chart in Figure A-2. Those that selected "Other" did not provide a category or explanation when prompted.



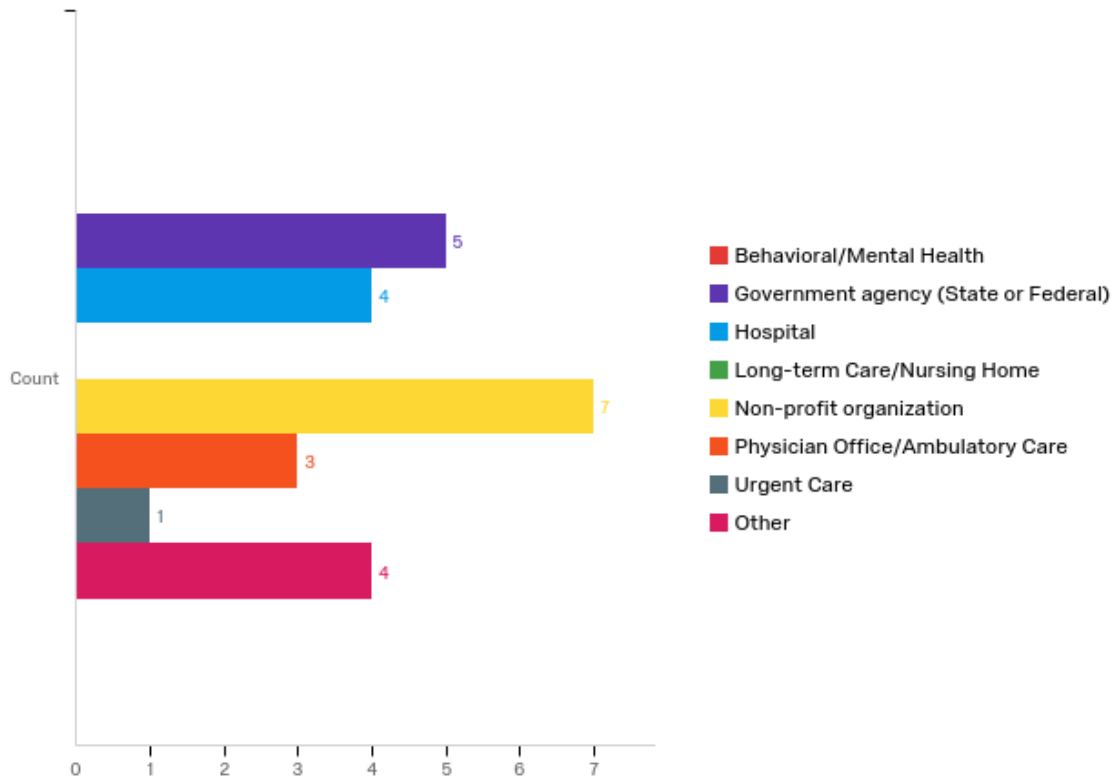


Figure A-2: Type of Facility for Survey Participants, Environmental Survey Results 2019

Sixteen facilities represented in the figure above are federally qualified health centers (FQHC). When asked if HIT systems had been implemented at their organization, 21 responded in the affirmative. Not all respondents were affiliated with organizations that required the use of such systems (e.g. DHHR).

Only eight respondents provided information about when EHR systems had first been implemented. The earliest HIT had been adopted is reported to be 2005 and the latest year reported is 2017. At the time of this survey (August – October 2019), there was one organization currently installing HIT systems for the first time. These comments show that EHR and HIT adoption is a continuing process within the State. Nine participants reported upgrading their HIT systems within the past 12 months; upgrades included security and malware installations, updating servers, and addressing known bugs and enhancing patient portal functionality.

Six participants responded in the affirmative that their organization would be updating HIT systems over the next five years while five were unsure whether or not this would happen.

Table A-2 below shows the reported vendors currently in use. Only nine participants provided this information; 33% of the facilities reported using Greenway Health as an EHR vendor. Note that all of the EHR vendors in the table are listed on the Certified Health IT Product List (CHPL).

EHR Vendor Name	Percent Using (Response Count)
AdvancedMD	11.1% (1)
Athena Health	11.1% (1)
Cerner	11.1% (1)
Greenway Health	33.3% (3)
Medhost	11.1% (1)
MUMMS Software	11.1% (1)
Nexgen	11.1% (1)

Table A-2: Reported EHR Vendors, Environmental Survey Results 2019

Overall, the most common use of HIT is for EHR management (11.76%), followed closely by e-Prescribing, clinical quality measures tracking, and billing management (each at 10.59%); this can be seen below in Figure A-3 below. Looking further into responses revealed that there are differences between how types of healthcare facilities use HIT systems within their business practices. Table A-3 below summarizes the reported use of systems for hospitals, physician offices/ambulatory care settings, non-profit organizations, and other healthcare facilities. Interestingly, there are gaps in the available data and rather than attributing this to those facilities not using specific services (i.e. hospitals not using HIT for billing purposes), as noted above, it is likely the survey did not reach people responsible for these functions.

Finally, since a majority of respondents to the survey were federally qualified health centers, Figure A-4 compares the reported business practices between non-FQHCs and FQHCs.

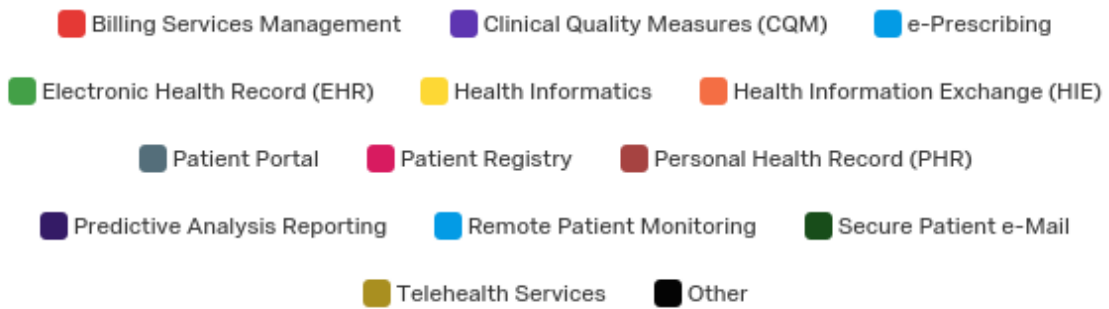
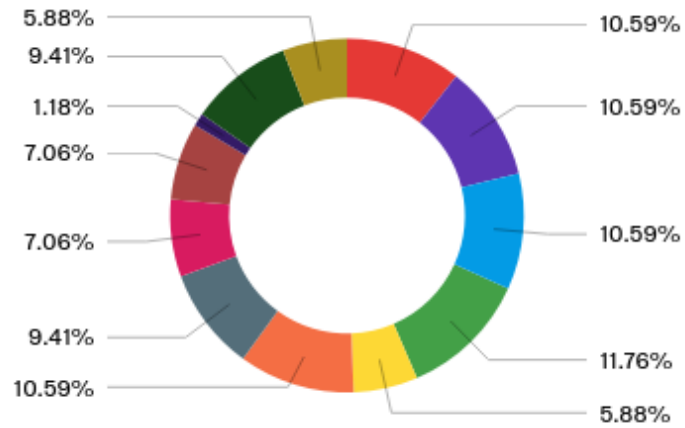


Figure A-3: EHR Use in Business Practices (Aggregate), Environment Survey 2019

EHR Functionality	Practice Type			
	Hospital	Physician Office / Ambulatory Care	Non-Profit	Other
Billing Services Management	-	10.71%	11.11%	12.50%
Clinical Quality Measures	-	10.71%	11.11%	12.50%
E-Prescribing	16.97%	10.71%	7.41%	12.50%
Electronic Health Record (EHR)	16.97%	10.71%	11.11%	12.50%
Health Informatics	-	3.57%	11.11%	4.17%
Health Information Exchange (HIE)	16.97%	10.71%	11.11%	8.33%
Patient Portal	16.97%	10.71%	7.41%	8.33%
Personal Health Record (PHR)	-	7.14%	7.41%	8.33%
Predictive Analysis Reporting	-	7.14%	7.41%	8.33%
Remote Patient Monitoring	-	-	-	4.17%
Secure Patient e-Mail	-	-	-	-
Telehealth Services	16.97%	10.71%	7.41%	8.33%

Table A-3: EHR Use in Business by Practice Types, Environmental Survey 2019

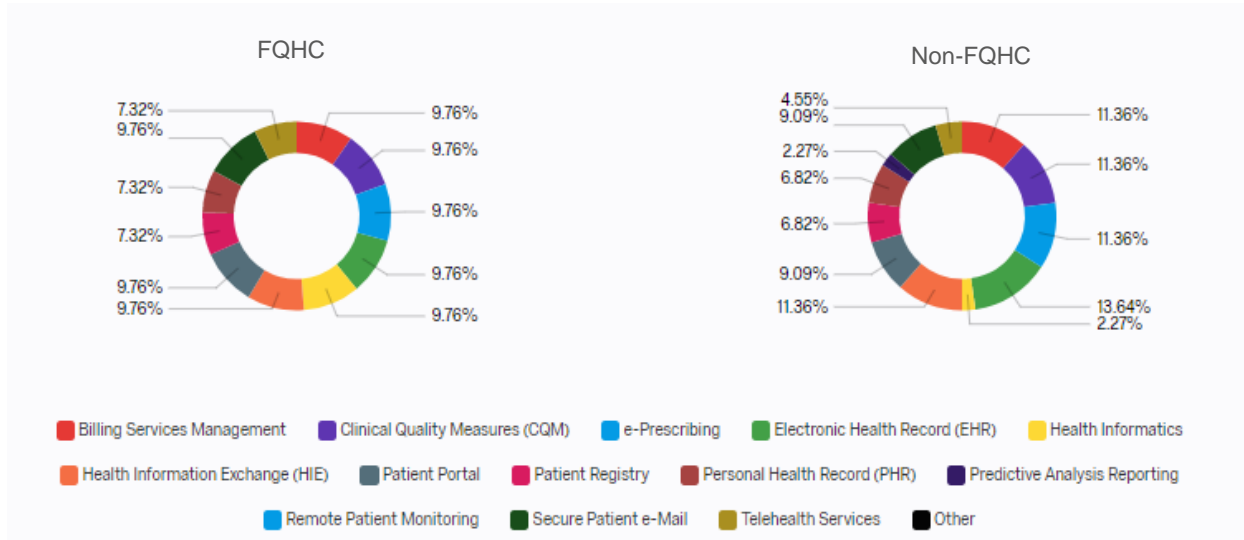


Figure A-4: HIT Use in FQHC and Non-FQHC Settings, Environmental Survey 2019

### Section A.1.2: HIT Adoption by Eligible Professionals

West Virginian office-based physicians, according to ONC’s 2017 data, surpass the national level of certified EHR adoption by 15%. Participation and payment data are summarized in Table A-4 (state fiscal year 2013 to 2015), Table A-5 (state fiscal year 2016 to 2018), and Table A-6 (state fiscal years 2019 and 2020) below. Data concerning state fiscal year 2020 participation is partial current as of October 2019. Physicians were the most common EP to take advantage of the EHR incentive payments every year between SFY 2013 to 2020. Nurse practitioner participant numbers were consistent throughout these years as well, especially between SFY 2014 to 2018. Participation peaked in SFY 2015 with 460 EPs receiving a payment. A decline in participation since 2017 is expected since eligibility is only for 6 years.

EP Type	State Fiscal Years					
	2013		2014		2015	
Physician	100	\$1,639,087	279	\$3,871,755	319	\$9,188,972
Nurse Practitioner	25	\$429,250	71	\$1,292,000	82	\$1,202,333
Certified Nurse – Midwife	1	\$21,250	13	\$187,000	15	\$366,643
Dentist	21	\$420,750	42	\$892,500	25	\$289,000
Physician Assistant	5	\$106,250	33	\$484,500	19	\$222,417
<b>Total</b>	<b>152</b>	<b>\$2,616,587</b>	<b>438</b>	<b>\$6,727,755</b>	<b>460</b>	<b>\$11,269,365</b>

Table A-4: Eligible Professional Attestation and Payment Totals SFY 2013 to SFY 2015

EP Type	State Fiscal Years					
	2016		2017		2018	
Physician	198	\$2,035,759	269	\$2,861,673	204	\$2,042,838
Nurse Practitioner	70	\$964,750	108	\$1,568,250	74	\$794,750
Certified Nurse – Midwife	6	\$76,500	6	\$1,804,112	2	\$17,000
Dentist	10	\$174,250	19	\$301,750	12	\$191,250
Physician Assistant	16	\$161,500	19	\$289,000	18	\$165,750
<b>Total</b>	<b>300</b>	<b>\$3,412,759</b>	<b>421</b>	<b>\$6,824,785</b>	<b>310</b>	<b>\$3,211,588</b>

Table A-5: Eligible Professional Attestation and Payment Totals SFY 2016 to SFY 2018

EP Type	State Fiscal Years			
	2019		2020	
Physician	118	\$997,334	63	\$535,500
Nurse Practitioner	40	\$340,000	15	\$127,500
Certified Nurse – Midwife	4	\$34,000	3	\$25,500
Dentist	5	\$42,500	1	\$8,500
Physician Assistant	9	\$76,500	2	\$17,000
<b>Total</b>	<b>176</b>	<b>\$1,490,334</b>	<b>84</b>	<b>\$714,000</b>

Table A-6: Eligible Professional Attestation and Payment Totals SFY 2019 to SFY 2020; Data for 2020 is as current as of October 2019.

Figure A-5 below shows the total amount of EHR Incentive Payments made to EPs, per county during state fiscal year 2019. Raleigh (approximately \$815,000) and Kanawha (approximately \$568,000) counties were the two regions from which EPs benefited the most from the incentive program payments during this period. The counties where EPs received the lowest amounts were Mineral, Taylor, and Pendleton each at approximately \$8,500.

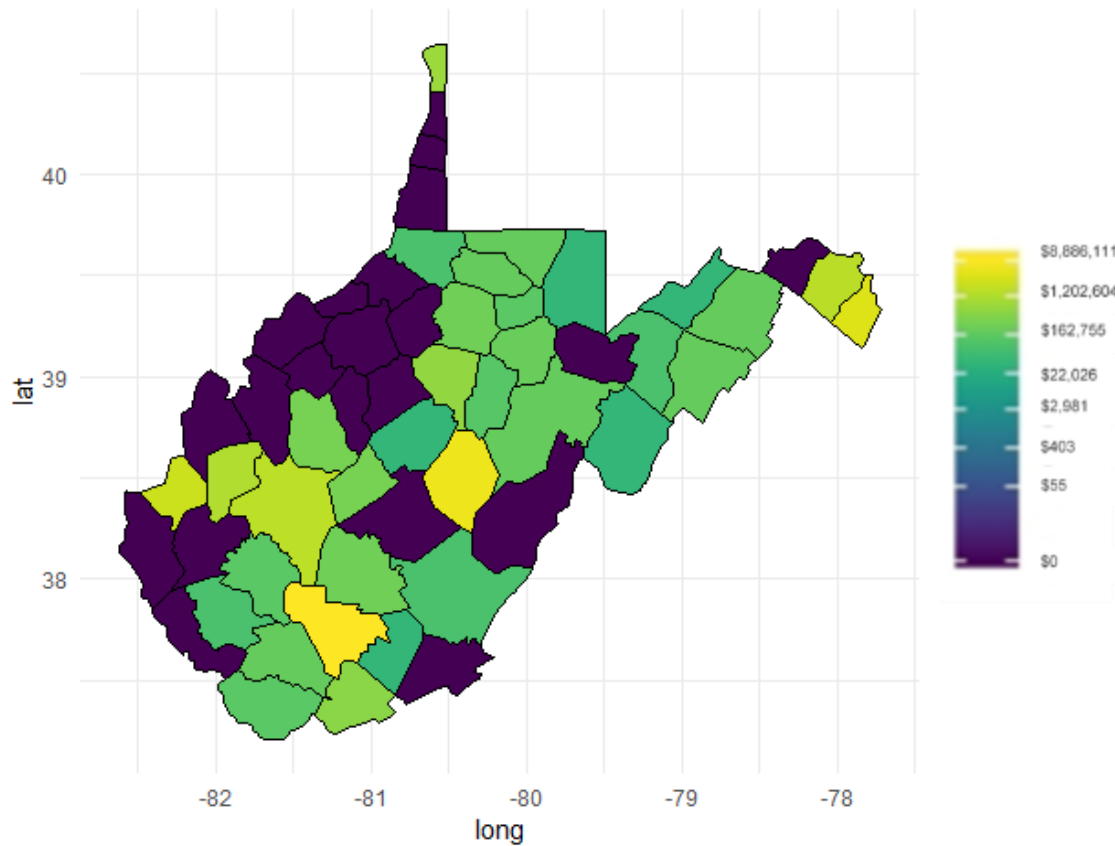


Figure A-5: EHR Incentive Payments to EPs, per County, SFY 2019

### Section A.1.3: HIT Adoption by Eligible Hospitals

The Office of the National Coordinator for Health Information Technology tracks EHR adoption for all non-federal acute care hospitals and office-based providers in the state. According to data collected in 2017, the ONC reports that 89% of hospitals in West Virginia have adopted a certified EHR system which, however, lags behind the national rate of 96% adoption. Although acute care hospitals make up a small percentage of overall incentive program participants, payments disbursed to their entities are large. Table A-7 (state fiscal years 2013 to 2015), Table A-8 (state fiscal years 2016 to 2018), and Table A-9 (state fiscal years 2019 and 2020) below shows the total amount of payments disbursed to EH's between state fiscal year 2013 to 2020. EH participation reached its maximum a year earlier than EPs; however, there has been a visible increase in participation during SFY 2020.

EH Type	State Fiscal Years					
	2013		2014		2015	
Acute Care Hospitals	15	\$12,074,252.00	30	\$14,103,948	20	\$253,584.00
<b>Total</b>	<b>15</b>	<b>\$12,074,252.00</b>	<b>30</b>	<b>\$14,103,948</b>	<b>20</b>	<b>\$253,584.00</b>

Table A-7: Eligible Hospital Attestation and Payment Totals SFY 2013 to SFY 2015

EH Type	State Fiscal Years					
	2016		2017		2018	
Acute Care Hospitals	14	\$3,340,914	10	\$1,804,123	4	\$997,301
<b>Total</b>	<b>14</b>	<b>\$3,340,914</b>	<b>10</b>	<b>\$1,804,123</b>	<b>4</b>	<b>\$997,301</b>

Table A-8: Eligible Hospital Attestation and Payment Totals SFY 2016 to SFY 2018

EH Type	State Fiscal Years			
	2019		2020	
Acute Care Hospitals	19	\$2,178,019	28	\$2,079,976
<b>Total</b>	<b>19</b>	<b>\$2,178,019</b>	<b>28</b>	<b>\$2,079,976</b>

Table A-9: Eligible Hospital Attestation and Payment Totals SFY 2019 to SFY 2020; Data for 2020 is as current as of October 2019.



## Section A.2: Broadband Internet Coverage

A successful EHR program requires an adequate level of network capacity. Realizing the need to improve the State's broadband network to further economic, education, and healthcare success, the WV Legislature formed the WV Broadband Enhancement Council (Council) within the WV Department of Commerce (DOC) in 2016 to develop broadband in underserved and unserved regions of the state. The Council has been integral in securing capital for the State's improvement of broadband infrastructure. The Council also plays a role in encouraging local community advocates to move beyond planning and into implementation.

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### CMS GUIDANCE A.2.

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

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### Section A.2.1: Broadband Availability & Challenges

The Broadband Council's 2020-2025 Plan notes that, according to the Federal Communications Commission (FCC), over 80 percent of West Virginian's have access to broadband (>25mbps); however, the basis for this statistic is self-reporting by service providers to the FCC. The Council believes this reporting may have been inaccurate and, in turn, began conducting speed tests. The approximately 600,000 test results are not yet mapped or analyzed; however, Figure A-6 **Error! Reference source not found.** below depicts the available fixed wireline speeds from 2018 data, released by the FCC in 2019, as the latest data available as of January 2020. According to the map, there are scattered areas of the state without any fixed wirelines. A full set of maps showing coverage in West Virginia, based on data published by the latest data available from the FCC, are included in Appendix C of this document. This Appendix includes a map for each of West Virginia's 55 counties. Maps are also maintained and updated at the Broadband Council's website: <https://broadband.wv.gov/maps/west-virginia-broadband-fixed-wireline-speeds-by-county/>

West Virginia's mountainous topography and low population density pose challenges in broadband deployment. However, recent grant awards, detailed in this section, demonstrate the state's growing capacity for broadband development.

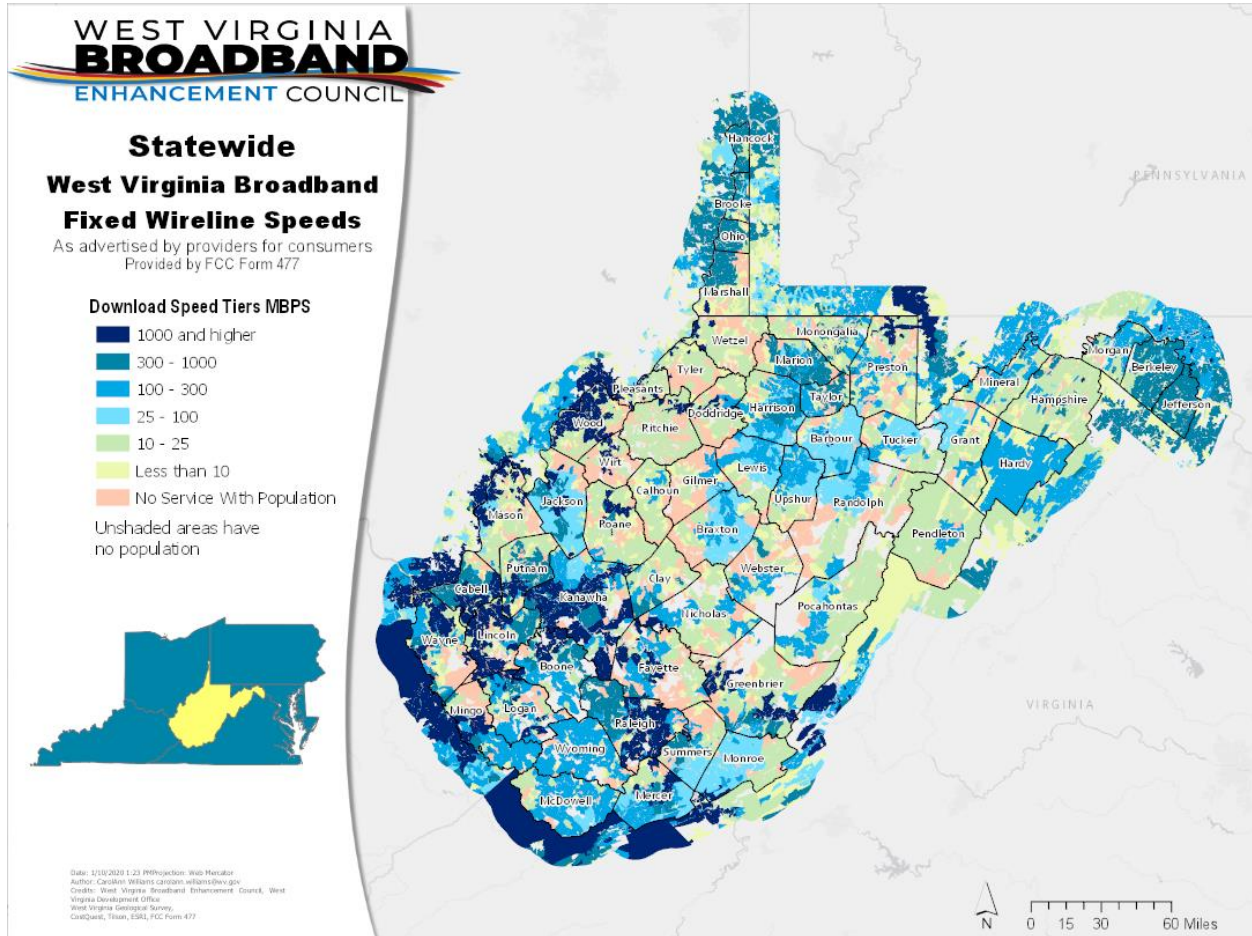


Figure A-6: West Virginia Broadband Council Fixed Wireline Speed Map, 2018

The WV Broadband Council is concerned with accurate reporting of broadband availability to the FCC; they write in the 2018 annual report “Simply stated, inaccurate data can render a community ineligible for certain types of broadband funding and assistance.” Therefore, accurate and reliable mapping of available broadband and internet services across West Virginia should be a priority to further advance HIT initiatives. The WV Broadband Council has updated its 5-year plan (2020-2025) and information regarding new broadband installation and expansion efforts will be updated in this section accordingly, when available.

### Section A.2.2: Funding Broadband Expansion in West Virginia

In 2015, President Obama issued a Memorandum on “...Expanding Broadband Deployment and Adoption by Addressing Regulatory Barriers and Encouraging Investment and Training” and professed that “...access to high-speed broadband is no longer a luxury, but a necessity for American families, businesses, and consumers.” In response to the Memorandum, the U.S. Department of Housing and Urban Development’s (HUD) also believes that access to broadband services is essential for child development and education. Therefore, HUD has expanded federal funding availability for communities to help address development needs because current conditions posed a threat to the health and welfare of the community. Community Development Block Grants (CDBG), from HUD have provided approximately \$2 million in funding statewide across two fiscal years. Table A-10 and Table A-11 show projects that have been funded from the CDBG program since for fiscal years 2017 and 2018.

<b>2017 Community Development Block Grant Funded Projects</b>	
<b>Project Name</b> († designates CDBG Infrastructure Grant)	<b>Local Government</b>
Calhoun-Clay-Roane Regional Plan	Clay County - Lead Application for 3-County Regional Project
Fayette County Broadband Plan	Fayette County
Fixed Wireless Design Plan	Gilmer County & Braxton County
† Capon Bridge Broadband Fiber Expansion Project	Hampshire County
† Sandyville Tower Wireless Project	Jackson County
Mingo-Town of Gilbert Plan	Mingo County
Morgan County Broadband Plan	Morgan County
† Richwood-Hinkle Mountain Pilot Project	Nicholas County – Richwood
Regional Broadband Strategic Plan, includes Taylor, Doddridge, Harrison, Marion, Monongalia, and Preston counties	Taylor County-Lead Application for 6-County Regional Project
Tyler County Broadband Plan	Tyler County
Broadband Initiative for Southern WV. Plan includes Webster, Fayette, Greenbrier, Nicholas, Pocahontas and Summers counties	Webster County - Lead Applicant for 6-County Regional Plan in conjunction with Wyoming County

Table A-10: Community Development Block Grant Broadband Projects, Fiscal Year 2017

2018 Community Development Block Grant Funded Projects	
Project Name († designates CDBG Infrastructure Grant)	Local Government
Brooke-Hancock Regional Plan	Brooke County – Lead for Regional Project
Grant County Broadband Plan	Grant County
Jefferson County Broadband Plan	Jefferson County
† Southern Lewis County Expansion Project	Lewis County
Marshall-Ohio-Wetzel Regional Broadband Plan	Marshall County - Lead for Regional Project
Mason County Broadband Plan	Mason County
† Bull Creek – Isaban Area Expansion Project	McDowell County
† Cumberland Industrial Park Expansion Project	Mercer County
† Hinkle Mountain – Little Laurel Expansion Project	Nicholas County
Pocahontas County Broadband Plan	Pocahontas County
Wayne County Broadband Plan	Wayne County

Table A-11: Community Development Block Grant Broadband Projects, Fiscal Year 2018

Another broadband stakeholder and source of funding for broadband expansion in the State is the Appalachian Regional Commission (ARC). The ARC is “a regional economic development agency that represents a partnership of federal, state, and local governments.” It was established by Congress in 1965 and is composed of the governors of the 13 Appalachian states and a federal co-chair, appointed by the president. The WV Broadband Council is anticipating \$3.4 million in funds from the ARC (FY 2019) to support projects in Boone, Clay, Lincoln, Logan, McDowell, Mingo, Webster, and Wyoming counties.

**Section A.2.2.1: USDA Community Connect Projects**

The U.S. Department of Agriculture (USDA) Rural Development team partnered with the Council to conduct a series of workshops in 2018 and 2019 to detail program requirements and encourage the development of project proposals from West Virginia. Training events focused on three primary USDA broadband programs, including:

- Community Connect,
- ReConnect, and

- Distance Learning and Telemedicine.

One such program, the USDA Community Connect, accepts applications annually during specific application cycles. For more information on this USDA program, visit <https://www.rd.usda.gov/programs-services/community-connect-grants>. Proving that communities in West Virginia can successfully compete for this funding, the emphasis on broadband development has resulted in project applications recently selected for USDA Community Connect funding, detailed in Table A-12 below.

USDA Community Connect Projects in West Virginia		
Provider	Award Amount	Counties
Central West Virginia Development Association, MicroLogic	\$3,000,000	Barbour, Randolph, Upshur
Preston County Economic Development Authority, Digital Connections	\$3,000,000	Preston
Clear Fiber	\$1,960,000	Marion, Monongalia

Table A-12: USDA Community Connect Projects

**Section A.2.2.2: USDA ReConnect**

In December 2018, the U.S. Department of Agriculture (USDA) announced details regarding its \$600 million ReConnect Program. In 2019, during the first round of USDA ReConnect, five proposals, representing approximately \$45 million in broadband infrastructure investment, were submitted to USDA ReConnect program from West Virginia. These applications represented \$25 million requested for grant-only funding, and nearly \$20 million requested for grant-loan combinations.

A second round of USDA ReConnect funding availability begins in early 2020. Applications are due by March 16, 2020. For more information about USDA ReConnect, visit <https://www.usda.gov/reconnect>. USDA ReConnect first-round funding awards for projects in the State, announced in 2019, are listed in Table A-13.

USDA ReConnect Projects in West Virginia			
Provider	Project Cost	Funding Type	County
Tyler County Development Authority, CityNet	\$3,516,00	50/50 Loan-Grant	Tyler
Regional Economic Development Partnership (RED), CityNet	\$4,189,000	50/50 Loan-Grant	Wetzel

Table A-13: USDA ReConnect Projects

*Section A.2.2.3: USDA Distance Learning and Telemedicine*

The USDA Distance Learning and Telemedicine program helps rural communities use the unique capabilities of telecommunications to connect to each other and to the world, overcoming the effects of remoteness and low population density. For more information, visit <https://www.rd.usda.gov/programs-services/distance-learning-telemedicine-grants>. A list of distance learning and telemedicine grants awarded in the State are listed in Table A-14.

<b>Distance Learning and Telemedicine Grants Awarded in West Virginia</b>		
<b>Fiscal Year Awarded</b>	<b>Applicant</b>	<b>Grant Amount</b>
2019	Cabell Huntington Hospital Foundation, Inc.	\$206,000
2019	Salem University, LLC	\$231,436
2018	Charleston Area Medical Center Health Education and Research Institute	\$163,223
2018	CHANGE, Inc.	\$500,000
2018	Toronto Board of Education†	\$500,000
2017	Lincoln County Board of Education	\$440,295
2017	Charleston Area Medical Center Health Education and Research Institute	\$100,079
† designates a grant made to an Ohio based applicant; however, the project has benefited a hub site in Weirton, WV		

Table A-14: Distance Learning and Telemedicine Grants

### Section A.2.3: Environmental Survey Results – Broadband

The Fall 2019 survey asked participants to disclose their facilities internet service as either broadband, dial-up, satellite, other, or no service. All responses to this question (9) were that broadband was used by their healthcare facilities. A second question regarding barriers to upgrading internet revealed that 40% of respondents considered their internet service adequate for business needs. Reported barriers to upgrading included costs associated with upgrading (30%), a lack of availability and coverage in their region (20%) and an inherent resistance to change at their site (10%). Figure A-7 below shows these results.

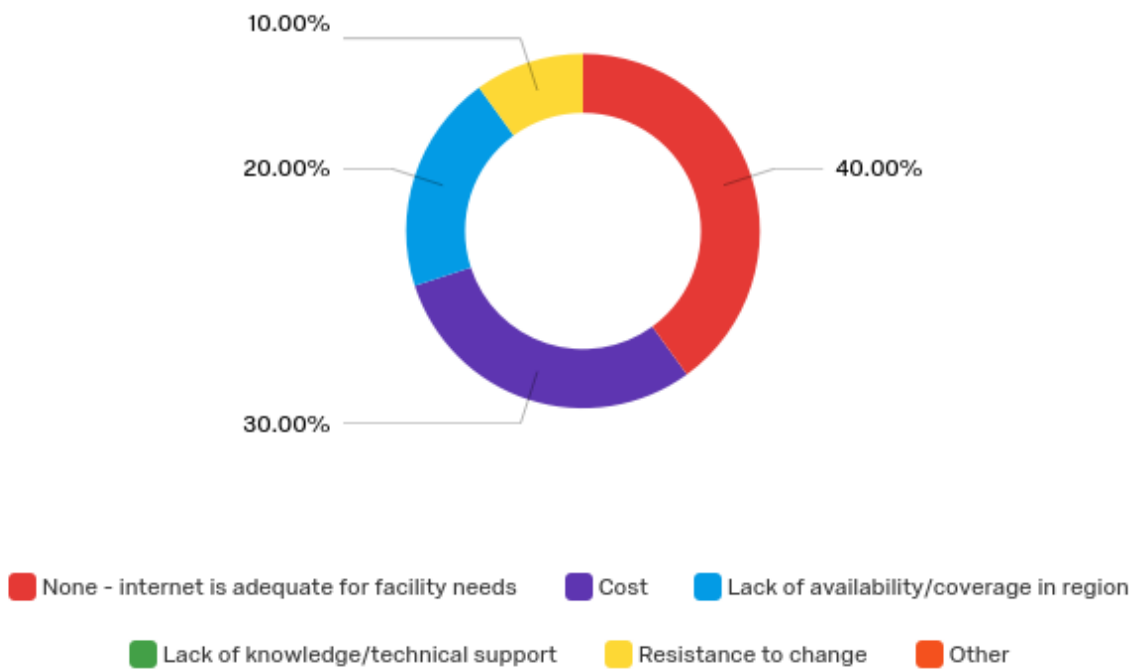


Figure A-7: Barriers to Upgrading Internet Services, Environmental Survey 2019



## Section A.3: HRSA Funding for HIT Projects

West Virginia receives funding from the Health Resources & Services Administration (HRSA) annually in order to help serve unserved and underserved citizens. The median household income for families in West Virginia is approximately \$44,000 with nearly 153,000 households making 2-times less than the federal poverty level. Improving the HIT landscape of the State may help federally qualified health centers (FQHC) function more efficiently and improve care for the underserved and impoverished citizens of the state. The West Virginia Primary Care Association (WVPCA) has been the State's designated Health Center Controlled Network.

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### **CMS GUIDANCE A.3.**

DOES THE STATE HAVE FEDERALLY-QUALIFIED HEALTH CENTER NETWORKS THAT HAVE RECEIVED OR ARE RECEIVING HIT/EHR FUNDING FROM THE HEALTH RESOURCES SERVICES ADMINISTRATION (HRSA)? PLEASE DESCRIBE.

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### Section A.3.1: Health Center Controlled Network IT Funding

Since 2011, six major grants have been received from HRSA for the improvement of health technology systems in the State. Funding for Patient Centered Medical Home – Facility Improvements was awarded in 2014 for \$1.4 million. Finally, a School-Based Health Centers Capital Program (\$5.8 million) and a Health Infrastructure Investment Program (\$8.2 million), awarded in 2011 and 2015 respectively, the latter ended in fiscal year 2019.

### Section A.3.2: Federally Qualified Health Center HIT Funding

Given the economic disparities in West Virginia, federal assistance is vital to delivering quality healthcare to the lower income citizens of the state. More recently during fiscal year 2018, HRSA provided funding to 68 grants in West Virginia totaling \$102,224,592. Loan and scholarship funding for the same period came to approximately \$4 million. Funding was also provided to health centers, defined as a community-based and patient directed organization which delivers comprehensive and high-quality primary care services in a culturally appropriate manner. Funding for these organizations was approximately \$72.5 million. Finally, between Health Center Controlled Networks and the Primary Care Associations in the state, a total of \$1,775,880 from HRSA was awarded.

These reported levels of funding are provided by the 2018 HRSA Fact Sheet and it is not possible to identify which grants or money had been designated to specifically accomplish HIT or EHR related projects.



## Section A.4: Veterans Administration and Indian Health Services

There are 25 Department of Veterans Affairs (VA) medical facilities, including four VA Medical Centers. These facilities are located throughout the state and provide assistance to the veterans of each region of West Virginia; Figure A-8 below depicts the location and type of each VA associated facility.

The WVHIN is working to expand data sources available to their connected partners. One of the new sources identified is the Department of Veterans Affairs medical facilities. As of the fall of 2019, the WVHIN is testing connections with the eHealth Exchange which would allow future connections to be made with the Department of Defense and the VA. The VA awarded Cerner a contract to replace their existing EHR system with a commercial-off-the-shelf version, Cerner Millennium, which is used by the Department of Defense (DoD). The VA reports that this step forward will facilitate interoperability across the VA and DoD and make it easier for active duty service member's transition to Veteran status.

The State of West Virginia does not have any Indian Health Service (IHS) facilities located in its borders.

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### **CMS GUIDANCE A.4.**

DOES THE STATE HAVE VETERANS ADMINISTRATION OR INDIAN HEALTH SERVICE CLINICAL FACILITIES THAT ARE OPERATING EHRs? PLEASE DESCRIBE

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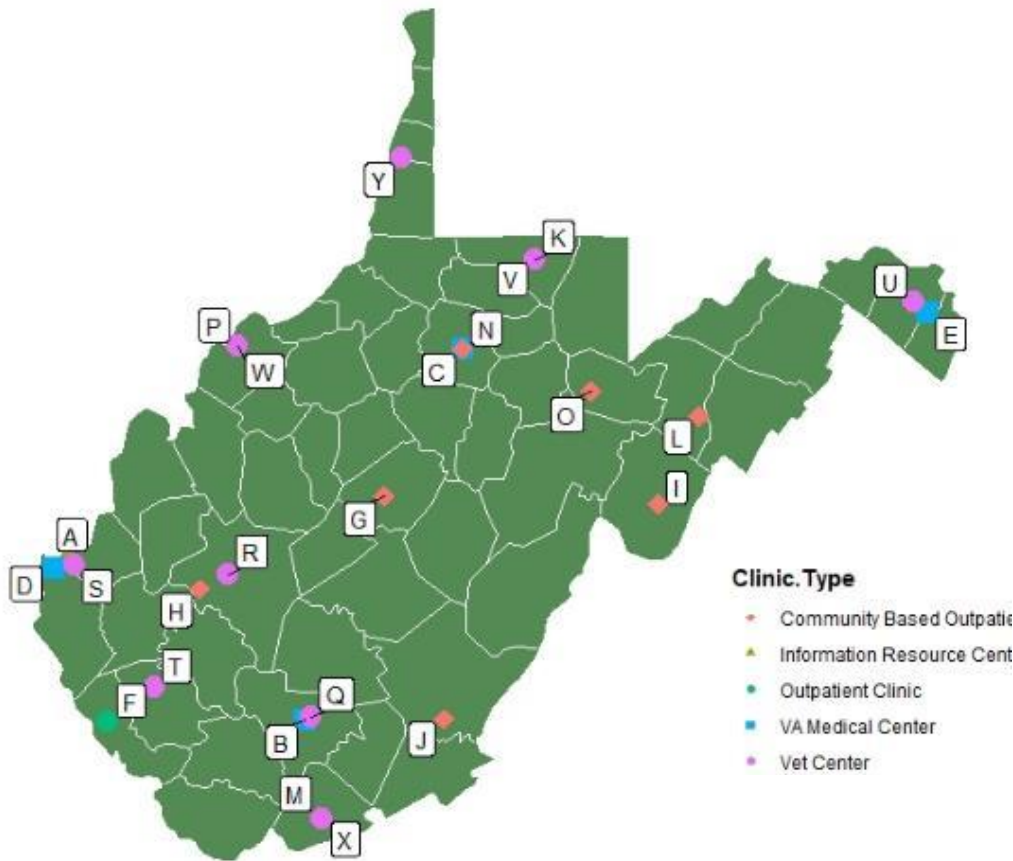


Figure A-8: Veteran Affairs Health Clinics in West Virginia

<b>A</b>	Homeless Veterans Resource Center (Huntington, WV)	<b>K</b>	Franklin Community Based Outpatient Clinic	<b>U</b>	Monongalia County (540GD)
<b>B</b>	Beckley VA Medical Center	<b>L</b>	Greenbrier County VA Clinic	<b>V</b>	Petersburg Community Based Outpatient Clinic
<b>C</b>	Clarksburg – Louis A. Johnson VA Medical Center	<b>M</b>	Monongalia County (540GD)	<b>W</b>	Princeton VA Clinic
<b>D</b>	Hershel “Woody” Williams VA Medical Center	<b>N</b>	Petersburg Community Based Outpatient Clinic	<b>X</b>	Princeton Vet Center
<b>E</b>	Martinsburg VA Medical Center	<b>O</b>	Princeton VA Clinic	<b>Y</b>	Wheeling Vet Center
<b>F</b>	Lenore VA Clinic	<b>P</b>	Rural Mobile Unit (540)		
<b>G</b>	Braxton County CBOC (540GC)	<b>Q</b>	Tucker County CBOC (540GA)		
<b>H</b>	Beckley VA Medical Center	<b>R</b>	Charleston VA Clinic		
<b>I</b>	Clarksburg – Louis A. Johnson VA Medical Center	<b>S</b>	Franklin Community Based Outpatient Clinic		
<b>J</b>	Charleston VA Clinic	<b>T</b>	Greenbrier County VA Clinic		

## Section A.5: West Virginia HIT and HIE Stakeholders

As BMS manages the WV Medicaid Enterprise, there are a variety of significant stakeholders. Three such actors who influencing the HIT and HIE environments are listed in the subsections below.

### Section A.5.1: BerryDunn

Berry, Dunn, McNeil & Parker, LLC (BerryDunn) is an account and management firm which assists BMS with conducting attestation reviews, performing post-payment audit functions. BerryDunn also supports BMS in the appeals process of the Medicaid EHR Interoperability Program.

### Section A.5.2: DXC Technology

DXC Technology (formerly Molina), is BMS' fiscal agent. DXC performs pre-payment review and ensures the provider meets the EHR Interoperability Program guidelines. It should be noted that Molina designed and operated the automated data collection and processing system that supports most of the critical functions of the Interoperability Program; DXC continues to operate the system. Further information about the system can be found in Section C.14:.

### Section A.5.3: West Virginia Health Information Network

The West Virginia Health Information Network plays a large role within the Health Information Technology for Economic and Clinical Health (HITECH) activities as the WV Health Information Exchange. More information about the State's HIE can be found in Section A.7:.

## Section A.6: BMS Relationship with the State HIE

The BMS partnership with the West Virginia Health Information Network has provided HIE services for the State of West Virginia since 2010 after DHHR received \$7.8 million as part of the State HIE Cooperative Agreement Program. WVHIN transitioned from a state government entity to a private nonprofit corporation in 2018. BMS has chosen to continue to support the WVHIN to enable Eligible Providers, Eligible Hospitals, Critical Access Hospitals and Dual-Eligible Hospitals to exchange clinically relevant health information for their patients at the point of care.

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### **CMS GUIDANCE A.5.**

WHAT STAKEHOLDERS ARE ENGAGED IN ANY EXISTING HIT/E ACTIVITIES AND HOW WOULD THE EXTENT OF THEIR INVOLVEMENT BE CHARACTERIZED?

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### **CMS GUIDANCE A.6.**

DOES THE SMA HAVE HIT/E RELATIONSHIPS WITH OTHER ENTITIES? IF SO, WHAT IS THE NATURE (GOVERNANCE, FISCAL, GEOGRAPHIC, SCOPE, ETC.) OF THESE ACTIVITIES?

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## Section A.7: WVHIN – The State Designated Health Information Exchange

As the state-designated Health Information Exchange (HIE), the West Virginia Health Information Network (WVHIN) is responsible for connecting healthcare stakeholders across the state including hospitals, Federally Qualified Health Centers (FQHCs), long-term care providers, ambulatory providers, payers, and the DHHR which includes both the BMS and the Bureau for Public Health (BPH). The WVHIN has provided HIE services for the State of West Virginia since 2010 and is governed by a 17-member public/private board of directors.

### CMS GUIDANCE A.7.

SPECIFICALLY, IF THERE ARE HEALTH INFORMATION EXCHANGE ORGANIZATIONS IN THE STATE, WHAT IS THEIR GOVERNANCE STRUCTURE AND IS THE SMA INVOLVED? \*\*HOW EXTENSIVE IS THEIR GEOGRAPHIC REACH AND SCOPE OF PARTICIPATION?

The role of the WVHIN is to facilitate the acceleration of the number of Medicaid providers who are active in their use of WVHIN for health information exchange so they can meet Stage 2 and Stage 3 Meaningful Use requirements and enhance the quality of care to their patients. In addition, improved access to health information about specific patient health status or recent health care experiences with other providers will facilitate the coordination of transitions of care and will improve their ability to meet the goals of better healthcare of West Virginia citizens. The board is comprised of HIE stakeholders from across the state including representatives from hospital and physician associations, nursing homes, medical schools, the WV Health Care Authority (HCA), health plans, government, and others. The WVHIN is the ONC State Designated Entity (SDE) for HIE.



Figure A-9: WVHIN Services and Connections

Figure A-9 provides an overview of the services connected to the health information exchange.

The WVHIN connects physicians, hospitals, labs, health plans, and others together so that patient health information can be received at the point of care, securely, within a matter of seconds. The information exchange service allows unrelated EHR systems, and other HIT systems, that cannot communicate with one another, to share patient health information securely and seamlessly.

Through these services, the HIE assists participants with meeting MU and the Quality Payment Program (QPP) requirements including Promoting Interoperability by connecting health care providers with each other and to other providers serving West Virginia patients. Further, WVHIN facilitates connections to Public Health Reporting and West Virginia's Controlled Substance Monitoring Program. Participation in the HIE also supports better transitions of care and improves the management of complex patients including those with Substance Use Disorder and its consequences. The WVHIN provides:

- A platform to facilitate Electronic Referral Loops and Transitions of Care / Referral Summaries by allowing for exchange, storage and retrieval of summary records as required for patient transition and referral to other health care providers and settings. The Provider or Hospital may call the HIE through its Electronic Health Record or access through the WVHIN web portal
- Direct Services for transport of Care Coordination Transition of Care records that meet §170.202 requirements
- Connections to Public Health Reporting including:
  - Immunization Registry Reporting
  - Syndromic Surveillance Reporting
  - Electronic Reportable Lab Result Reporting
- Query of West Virginia's Controlled Substance Monitoring Program via NarxCare, an analytical tool assisting with identifying, preventing and managing substance use disorder. The Provider or Hospital may call NarxCare via the WVHIN through its Electronic Health Record or access through the WVHIN web portal.

In addition, the WVHIN web portal allows for enhanced delivery of care to patients by their providers by consolidating:

- Access to West Virginia's eDirective Registry for End-of-Life advance directives and medical orders
- List of identified patient Care Team members
- Identified patient conditions
- List of providers and encounters
- Care alerts
- Lab results
- Radiology results
- Transcriptions
- Patient demographics
- Immunizations
- Medicaid claims
- Other clinical documents

The WVHIN web portal provides several opportunities for Eligible Providers to identify and connect to their patients' other care providers as required under the QPP for meeting Quality Measures. Care can also be enhanced by enrolling in WVHIN's Encounter Notification Services (ENS) to receive near real-time patient encounters from participating organizations.

#### Section A.7.1: WVHIN Partnerships

Many patients receive care outside of West Virginia borders. WVHIN is working to connect to a number of regional and national networks so that seamless sharing of crucial patient information can continue outside of West Virginia if needed. WVHIN is a participant in the Strategic Health Information Exchange Collaborative (SHIEC) Patient Centered Data Home (PCDH) initiative. PCDH is a network of HIEs across the country who share Admission, Discharge, Transfer notifications (ADTs). This allows each HIE to notify a participating provider when one of their patients receives care in another state. To share clinical information associated with events, WVHIN is connected to Carequality and is in the final stages of completing its connection to the eHealth Exchange, both national networks. The connection to the eHealth Exchange will also allow interoperability with the Veterans Health Administration providers.

Upon patient match through successful query, the WVHIN currently receives patient scheduling information (SIU) directly from the Kentucky Health Information Exchange and sends and receives all varieties of clinical information with the Chesapeake Regional Information System for our Patients (CRISP), the HIE serving Maryland and the District of Columbia. Partnerships such as these further the vision of the Office of the National Coordinator for Health Information Technology's strategic vision for collaboration and sharing information to improve health outcomes. An updated list of all West Virginia Health Information Network participants can be viewed on the WVHIN website (<https://www.wvhin.org/connected-providers/>).

### Section A.7.2: WVHIN Services

The State's health information exchange provides five distinct services to the hospitals, ambulatory and urgent care, post-acute care (i.e. hospice, long-term care facilities), health plans, and other state HIEs. These services currently include:

1. Information Exchange;
2. Encounter Notification Service;
3. WV Direct;
4. Ambulatory Integration; and
5. WV e-Directive Registry.

Each service is briefly summarized in the sections below.

#### *Section A.7.2.1: Encounter Notification Service (ENS)*

The ENS allows medical providers to receive real-time alerts whenever a patient has a hospital encounter. The WVHIN ENS sends a customizable secure email message to providers for encounters most relevant to them, such as admission or discharge as well as emergency room visits.

#### *Section A.7.2.2: WV Direct*

WV Direct is a simple, encrypted messaging solution for health care providers. Essentially secure email, subscribing to WV Direct allows health care providers to quickly share messages and health information needed to provide patient care. Figure A-10 below illustrates how the WV Direct functionality works.

#### *Section A.7.2.3: Ambulatory Integration*

This service focuses on expanding integration with providers in multiple care settings beyond hospitals so as to include both physician practices and post-acute care facilities. Information is exchanged over the WVHIN HIE and allows care providers to use the information for decision-making at the point of care. Only providers affiliated with the patient's care are able to access the data.

#### *Section A.7.2.4: WV e-Directive Registry*

The WVHIN allows connected providers to access the e-Directive Registry. This registry is hosted by the WV Center for End of Life Care and contains the most detailed online all-inclusive advance directive and medical order registry in the nation.



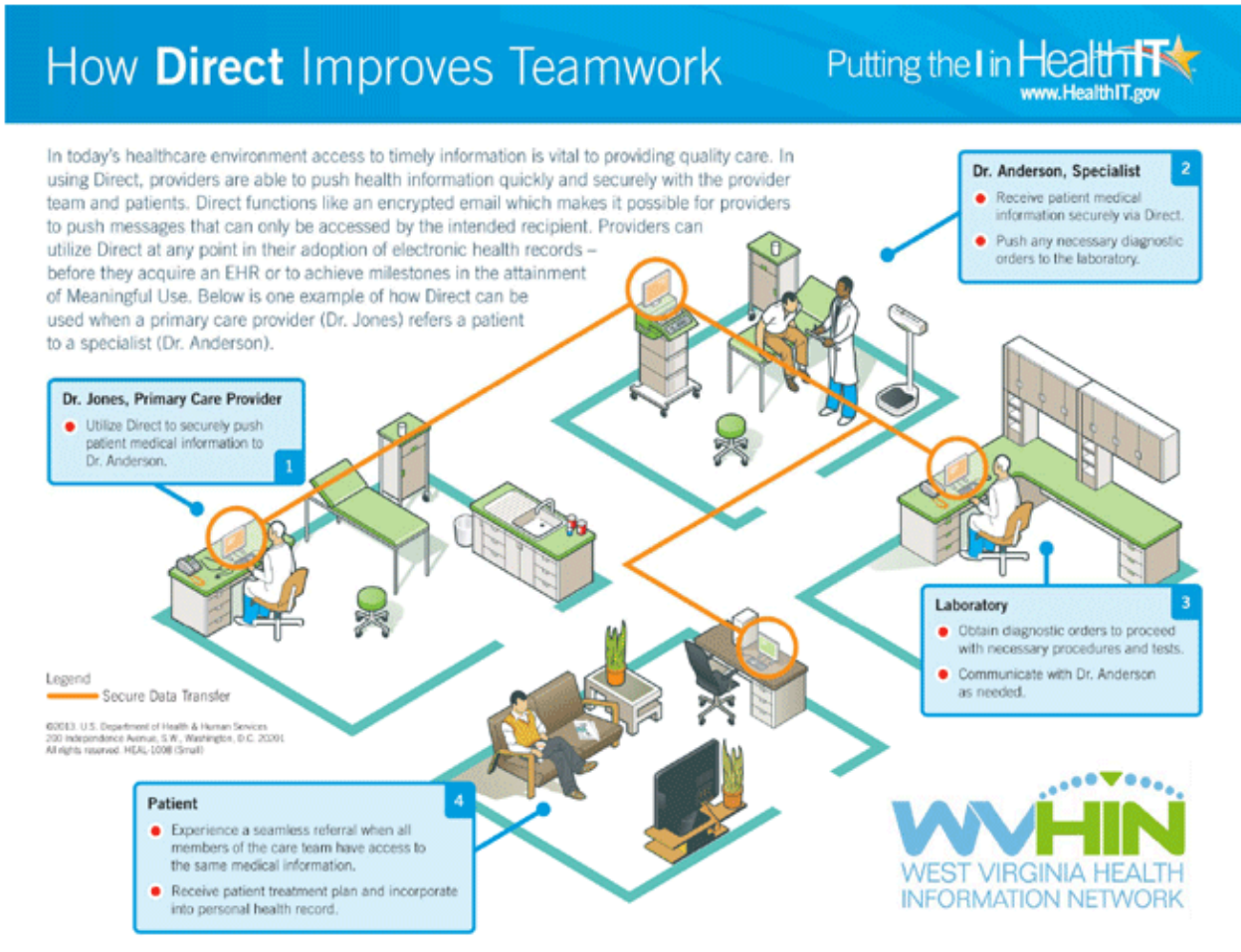


Figure A-10: WV Direct Process Example

### Section A.7.3: Transition from HITECH to MMIS Funding

The WVHIN has received a portion of its funding through HITECH funding streams. With HITECH funding ending in fiscal year 2021, CMS has provided guidance in State Medicaid Director Letters on how the Medicaid Enterprise might replace a portion of the HITECH funding that supported HIEs by substituting funds for Medicaid Enterprise Systems (MES) / Medicaid Management Information Systems (MMIS). Currently, the maturity, functionality, and statewide participation in the WVHIN allows assets to provide value to the Medicaid Enterprise through health information exchange and connecting providers with clinical information to help guide care.

The WVHIN, in conjunction with BMS, is actively planning for a post-HITECH future. Work is underway to identify portions of the existing and future HIT capabilities that benefit the Medicaid Enterprise. Based on these findings, the WVHIN and BMS will identify a path for transitioning from HITECH to MMIS funding, including submission of the associated funding request to CMS.



## Section A.8: MMIS Role and MITA Alignment with HIT and HIE Environment

The Medicaid Information Technology Architecture (MITA) initiative of the Center for Medicaid & State Operations (CMSO) “...is intended to foster integrated business and IT transformation across the Medicaid enterprise.” This is done by establishing a set of national guidelines that enable improvement of Medicaid Enterprise administration. BMS continues to be committed to utilizing MITA principles to conduct business and information technology planning activities. Commitment to this standard created an environment where MITA principles are embraced and understood within BMS, thereby creating a common language which allows for more efficient and effective strategic and tactical planning activities.

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### **CMS GUIDANCE A.8.**

PLEASE DESCRIBE THE ROLE OF THE MMIS IN THE SMA’S CURRENT HIT/E ENVIRONMENT. HAS THE STATE COORDINATED THEIR HIT PLAN WITH THEIR MITA TRANSITION PLANS AND IF SO, BRIEFLY DESCRIBE HOW.

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Through embracing MITA principles, BMS developed a State Self-Assessment (SS-A) Roadmap, which provided a strategic planning foundation that informs all the projects that the Bureau undertakes. The most recent SS-A was completed in December 2018; this report is available in Appendix H.

A MITA assessment of the EHR Incentive Program and HITECH infrastructure systems is limited to determination of “as-is” and “to-be” system maturity. Since an SS-A of the WV EHR Incentive Program and HITECH infrastructure systems is on a limited scope of systems, data, and business processes, much of the business process modeling activities and MITA transformation efforts performed in a full MMIS assessment are not required. For an SMA’s EHR Incentive Program and HITECH infrastructure, the MITA assessment of business processes will be limited to the eight MITA business areas of Business Relationship Management, Care Management, Financial Management, Plan Management, Provider Management, Eligibility and Enrollment Management, Member Management, and Performance Management. Assessment of the Member Management business area is dependent on the release of MITA 3.0 enhancements, which include descriptions and details of corresponding business processes when they are finalized by CMS.

The Medicaid Management Information System, for the purposes of the HITECH Act and the EHR PIP, performs the pre-payment review tasks to ensure the provider meets the program guidelines. BMS, with assistance from a contractor, is working on sustainability of the HITECH activities and a transition to MITA.

### Section A.8.1: Data Warehouse (DW) and Decision Support System (DSS)

The initial MITA SS-A (2008-09) identified the need for enhanced reporting and decision-support capabilities that were not available. At the time of the MITA 2.0 SS-A, the State's reporting needs were handled by a static reporting database. This was designed for specific monthly, quarterly, and annual reports generated by SQL queries, Excel spreadsheets, and Crystal Reports. These reports often required manual reconciliation. Additionally, data was housed in multiple locations and could be difficult to access.

At the time, the State envisioned implementing a robust data warehouse (DW) and decision support system (DSS) that facilitated attaining management and administrative reports (MAR), surveillance and utilization review reports (SUR), and ad hoc queries to respond to information requests. During 2011-2014, BMS conducted design, development, and implementation phases of the DW/DSS system to improve the State's reporting capabilities. BerryDunn is contracted by DHHR to assist.

### Section A.9: Facilitating EHR and HIE Adoption

A current champion for facilitating HIT adoption is the state designated health information exchange, the WVHIN. Since the start of the EHR Incentive Program in 2011, BMS has issued a total of \$74,785,565 in incentive payments to eligible participants within the Medicaid Enterprise. The WVHIN continues to promote the use of the state HIE through a variety of mechanisms including, but not limited to:

- Outreach and Account Management staff who:
  - Identify and enroll new WVHIN participants
  - Serve as liaisons to WVHIN participants to ensure the WVHIN tools are providing value and
  - Provide on-going training and technical assistance to mitigate barriers.
- Plan and sponsor the West Virginia Statewide Health Information Technology (HIT) Summit.
- Plan and conduct WVHIN User Group Meetings.
- Attend and exhibit at a variety of health care professional conferences statewide.
- Participate as members in state and national professional HIT and HIE organizations, including Health Information Management Systems Society (HIMSS), WVHIMSS, and Strategic Health Information Exchange Collaborative (SHIEC).
- Offer ongoing training programs, both in-person and on-line trainings.

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#### **CMS GUIDANCE A.9.**

WHAT STATE ACTIVITIES ARE CURRENTLY UNDERWAY OR IN THE PLANNING PHASE TO FACILITATE HIE AND EHR ADOPTION? WHAT ROLE DOES THE SMA PLAY? WHO ELSE IS CURRENTLY INVOLVED? FOR EXAMPLE, HOW ARE THE REGIONAL EXTENSION CENTERS (RECs) ASSISTING MEDICAID ELIGIBLE PROVIDERS TO IMPLEMENT EHR SYSTEMS AND ACHIEVE MEANINGFUL USE?

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- Produce and distribute newsletters.
- Develop and implement social media campaigns.

Please reference Section A.7: for information related to WVHIN activities for assisting participants with meeting MU and Quality Payment Program requirements. Another champion for HIT adoption was the West Virginia Regional Health Information Technology Extension Center; more information about the history of this advocate can be found in Section A.10.:

## Section A.10: State HIT Coordinator and Regional Extension Centers

In 2010, the ONC awarded the West Virginia Health Improvement Institute (WVHII) a cooperative agreement, through the American Recovery and Reinvestment (ARRA) and Health Information Technology for Economic and Clinical Health (HITECH) Act, to serve as the regional extension center (REC) for health IT in the state. With this funding, the West Virginia Regional Health Information Technology Extension Center (WVRHITEC) was established as one of 62 REC's nationally. WVRHITEC's original goal was to assist

1,000 priority primary care providers in the state to achieve meaningful use of technology. Currently, the State HIT Coordinator is housed within BMS and also serves as the Medicaid Enterprise Systems Contract Management Director. The BMS acts as the SMA and is housed within DHHR.

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### **CMS GUIDANCE A.10.**

EXPLAIN THE SMA'S RELATIONSHIP TO THE STATE HIT COORDINATOR AND HOW THE ACTIVITIES PLANNED UNDER THE ONC-FUNDED HIE COOPERATIVE AGREEMENT AND THE REGIONAL EXTENSION CENTERS (AND LOCAL EXTENSION CENTERS, IF APPLICABLE) WOULD HELP SUPPORT THE ADMINISTRATION OF THE EHR INCENTIVE PROGRAM.

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### Section A.10.1: WV Regional Health Information Technology Extension Center

The Regional Extension Center served West Virginia as 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 was 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 included 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).

Over the course of the REC program, WVHII assisted 1,545 participating providers (including more than 1,200 priority primary care providers) and helped more than 1,000 eligible primary care providers attain meaningful use of Health IT to improve health outcomes and earn meaningful use incentives under the Centers for Medicare and Medicaid Services (CMS) health IT incentive program. Many of these providers also participated in medical home pilots with WVHII and have achieved, or are in the process of pursuing, National Committee for Quality

Assurance (NCQA) accreditation as medical homes.

The West Virginia Health Improvement Institute, which served as the grantee on the WVRHITEC project, had experience in working with healthcare providers in West Virginia and supporting HIT systems. The Institute supported 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 HealthMountaineer 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 assisted 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 supported at least nine commercial off-the-shelf (COTS) EHR vendor solutions. The WVRHITEC enrolled nearly 1000 priority providers (including many that serve the Medicaid population) and assisted them with reaching Meaningful Use. The priority provider target market included all of the Federally Qualified Health Centers which serve a disproportionate share of the Medicaid population. Federal funding for the REC program ceased through ONC at the end of 2016 and the WVRHITEC concluded its activities shortly thereafter.

### Section A.11: Current Projects Impacting the Incentive Program

West Virginia health information technology initiatives listed in Table B-1 may or may not impact meaningful use attestations for the remaining few years of the Interoperability Program. Furthermore, updates to the Provider Incentive Program Solution system are completed as described in Section C.15:.

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#### **CMS GUIDANCE A.11.**

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

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## Section A.12: Changes to State Laws Impacting the Incentive Program

There have been no recent, nor are there anticipated, changes to State law governing or impacting the delivery of the EHR Provider Incentive Program.

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### **CMS GUIDANCE A.12.**

HAVE THERE BEEN ANY RECENT CHANGES (OF A SIGNIFICANT DEGREE) TO STATE LAWS OR REGULATIONS THAT MIGHT AFFECT THE IMPLEMENTATION OF THE EHR INCENTIVE PROGRAM? PLEASE DESCRIBE.

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## Section A.13: Interstate HIT and Health Information Exchange Activities

The West Virginia Health Information Network, the state designated HIE, upon patient match through successful query, currently receives patient scheduling information directly from the Kentucky Health Information Exchange. Additionally, it sends and receives a wide variety of clinical information with the Chesapeake Regional Information System for our Patients (CRISP), the HIE serving Maryland and the District of Columbia.

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### **CMS GUIDANCE A.13.**

ARE THERE ANY HIT/E ACTIVITIES THAT CROSS STATE BORDERS? IS THERE SIGNIFICANT CROSSING OF STATE LINES FOR ACCESSING HEALTH CARE SERVICES BY MEDICAID BENEFICIARIES? PLEASE DESCRIBE.

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As mentioned previously, a list of all West Virginia Health Information Network participants can be viewed on the WVHIN website (<https://www.wvhin.org/connected-providers/>).

## Section A.14: Interoperability of Public Health Surveillance Systems

The West Virginia Cancer Registry is supervised by the Office of Epidemiology & Prevention Services (OEPS). The registry provides de-identified data to the American Cancer Society and the Centers for Disease Control and Prevention. The Statewide Immunization Information System (WVSIIS) has been enrolling sites for Stage 3 MU and the Quality Payment Program (QPP); this is a bi-directional exchange of information. Likewise, the WV Electronic Disease Surveillance System (WVEDSS) is continuing to enroll hospitals to submit information electronically. Currently, paper copies are being sent to the WVEDSS. Systems, including, but not limited to, the WVSIIS and WVEDSS are working with the State designated HIE to accomplish their goals.

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### **CMS GUIDANCE A.14.**

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

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## Section A.15: Transformation and CHIPRA Funding for HIT Projects

State has not received HIT related grants within the past year. Funding from the Benedum Foundation was first provided in September 2017 to help facilitated the State’s first annual HIT Summit; additional funding from the Foundation was provided in 2018 in support of continuing the Summit. For more information on the HIT Summit, please reference Section B.5:.

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### **CMS GUIDANCE A.15.**

IF THE STATE WAS AWARDED AN HIT-RELATED GRANT, SUCH AS A TRANSFORMATIVE GRANT OR A CHIPRA HIT GRANT, PLEASE INCLUDE A BRIEF DESCRIPTION.

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## Section B: West Virginia’s “To-Be” HIT Environment

This section aligns the “As-Is” environment with the vision of the Medicaid Enterprise and its role in promotion, adoption, and interoperability of EHR systems to address the needs of the State.

### Section B.1: Goals and Objectives for West Virginia HIT

The strategic direction set out in this and other planning documents offered many challenging objectives. Since that time, BMS, and other State entities, have completed many strategic initiatives that have positioned West Virginia to better leverage health IT in support of its citizenry. The leadership of these State organizations understand that, in order to continue to build upon its strategic goals, strategic planning cannot be a one-time activity. The transformation of the Medicaid Enterprise, and the health IT solutions that support changes, will be an ongoing, iterative process. Each successive effort is expected to be more inclusive and result in broader change than the last. Table B-1 summarizes key HIT initiatives planned by the WV Medicaid Enterprise. This updated list was composed and published by BerryDunn as a part of the State’s annual MITA State Self-Assessment of 2017.

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#### CMS GUIDANCE B.1.

LOOKING FORWARD TO THE NEXT FIVE YEARS, WHAT SPECIFIC HIT/E GOALS AND OBJECTIVES DOES THE SMA EXPECT TO ACHIEVE? BE AS SPECIFIC AS POSSIBLE; E.G., THE PERCENTAGE OF ELIGIBLE PROVIDERS ADOPTING AND MEANINGFULLY USING CERTIFIED EHR TECHNOLOGY, THE EXTENT OF ACCESS TO HIE, ETC.

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ID	West Virginia’s Health IT Initiatives
1	<b>Re-procure Medicaid Enterprise Integrated Eligibility and Enrollment System (IES/PATH):</b> The IES Re-procurement project is designed to transform the eligibility system within the DHHR enterprise to provide West Virginians a better eligibility experience, transition the eligibility system from the legacy environment to a modern architecture, and simplify the administration of the technical aspects of the program administrations.
2	<b>Encourage the Meaningful Use (MU) of EHRs (Electronic Health Record):</b> Robust and meaningful data can be shared when EHR systems are deployed. West Virginia will continue to build on the foundation already provided through the Provider Incentive Payment (PIP) Program. Leveraging the EHR post-payment audit process, West Virginia will share lessons learned with providers to accelerate adoption and MU of EHR.
3	<b>Support Reimbursement Methods that Promote the Use of Technology:</b> Aligning the reimbursement system to support health IT adoption in the field can help promote the adoption of health IT. This could include differential payments that support health IT adoption goals.
4	<b>Encourage the Adoption of Telemedicine Technology:</b> Given the geography and demographics in West Virginia, telemedicine has the opportunity to support healthcare in West Virginia in meaningful ways. West Virginia’s Medicaid program already supports reimbursement for telemedicine.



ID	West Virginia's Health IT Initiatives
5	<b>Encourage E-Prescribing:</b> E-Prescribing allows physicians to order prescriptions through computers instead of using a paper-based Rx and handwritten signatures, thereby reducing medical errors and duplication of effort and prescriptions. West Virginia will continue to encourage E-Prescribing.
6	<b>Exchange Health Information:</b> West Virginia is committed to acting as an equal partner and continuing the dialogue on determining solutions for efficient, accurate, and secure exchanges of healthcare data between and among providers, consumers, and payers. This may take the form of participating in a national exchange, utilizing a state-based platform, or some combination that best meets HIE needs.
7	<b>Encourage Clinical Messaging:</b> Building on the adoption of EHR, West Virginia will continue to support clinical messaging. Clinical messaging is a leverage point to transition the provider community from paper to electronic transactions and a way to establish data exchange between separate health systems.
8	<b>Coordination and Continuity of Care:</b> BMS is taking action to improve the coordination and continuity of care, especially for those providers who may not have been eligible for the EHR provider incentive payments through PIP, in the form of a Substance Use Disorder (SUD) focused CMS 1115 Waiver that BMS is currently developing.
9	<b>Improve Quality and Value:</b> Quality of care and value is supported by data when data is leveraged for physician analysis, public health, clinical quality measures, and research.
10	<b>Leverage MITA to Enhance Business Processes Throughout BMS:</b> MITA provides a blueprint that West Virginia and other states are using to examine their business priorities, plan future improvements, and acquire technical applications that meet the health IT needs of both the State and Federal partners.
11	<b>Ensure Adoption of Key Standards to Guide HIT in the State:</b> West Virginia plans to work with its Federal partners to help ensure that HIT systems implemented in the state comply with standards adopted at the national level. Additionally, the West Virginia Office of Technology has issued State IT guidelines and standards that will be adhered to as statewide health IT systems are acquired.
12	<b>Establish Security Protocols and Guidelines for Protection and Use of Data:</b> In order to confidentially share information, West Virginia recognizes that it is necessary to have security protocols and guidelines for the protection of that information. To that end, West Virginia will continue to focus on security protocols, leveraging industry standards, such as National Institute of Standards and Technology (NIST) standards.
13	<b>Use Information to Drive Improvement in Key Areas of Need Throughout the State:</b> Having invested heavily in the data infrastructure within the state, West Virginia intends to use that infrastructure to drive improvements in key areas, including access to care and SUD.



ID	West Virginia’s Health IT Initiatives
14	<p><b>Reduce/Eliminate Duplication (Including Redundant Systems and Capabilities) Without Detracting From the State’s Ability to Serve the Public and Achieve Organizational Goals:</b> Reducing administrative complexity is a key strategy for West Virginia to generate cost savings. West Virginia is actively taking steps to do this, such as leveraging the recently implemented Medicaid Management Information System (MMIS) to support the West Virginia Children’s Health Insurance Program (WVCHIP).</p>
15	<p><b>Leverage Outside Partnerships:</b> West Virginia is committed to working with their Federal and other state partners. These relationships have allowed West Virginia to improve its health IT landscape, while also supporting the goals of its Federal and other partners. West Virginia also seeks to convene a state health IT summit that will further collaboration among health IT stakeholders.</p>
16	<p><b>Enhance the Role of the State in Driving Technology:</b> The State has the opportunity to drive the use of technology through the establishment of standards that set common expectations for how vendors and third parties interact with the State, especially when the State funding is part of the project.</p>
17	<p><b>Convene a Health IT Summit:</b> As BMS has taken the lead in advancing technology, there is a desire to promote this work so that healthcare delivery transformation continues to progress. One way this can happen is for the State to convene a health IT summit to facilitate additional collaboration among stakeholders (provider, consumers, and payers) from around West Virginia.</p>

Table B-1: WV Health IT Initiatives

## Section B.2: BMS IT System Architecture

As part of the State’s MITA 2.0 SS-A in 2009, the need for an updated MMIS solution became apparent. The version of HealthPAS-Online web portal that was used in the state was no longer supported by the developer of the core commercial off the shelf product. In short, this meant that any updates needed to correct system deficiencies or address program and regulatory changes would have to be developed specifically for the West Virginia system. In the long run, this approach would have proven inefficient and costly.

Between 2012 and 2014, West Virginia conducted its MITA 3.0 SS-A, which was approved by CMS in December 2015. In 2014, West Virginia became one of the first MMIS expedited certification states using CMS certification checklists that were aligned to MITA. The State conducted its first SS-A annual update in 2016 and continues to support the MMIS certification. Anticipating the transition from HITECH to MMIS funding, the Medicaid Enterprise continues to strive to conform to the end stages of MITA business practices. The most recent assessment was conducted and published by BerryDunn in 2018. This self-assessment is available in Appendix H.

In the same year that the annual MITA 3.0 SS-A’s began, West Virginia DHHR went live with an updated MMIS solution in January 2016. This work represents the culmination of more than seven years of analysis and preparation, leading to the DDI of the updated system. The solution is HealthPAS 5.0 and is managed by DXC Technology. The MMIS deployment also integrated enrollment and claims processing for WVCHIP. As a result of the work that has been done with West Virginia MMIS, “lessons learned” have been leveraged to support similar efforts in the US Virgin Islands and New Jersey.

### Section B.2.1: Data Visioning Project

BMS has contracted with BerryDunn to manage the state’s Data Visioning and Warehouse RFP Development and Procurement Assistance Project, often referred to as the Data Visioning Project. The purpose of the Visioning Project is to create and maintain a useful, objective, and comprehensive information database that can be used to promote better care, better health, and lower costs for West Virginians. Although the following information provides a high-level update on the progress of two main initiatives for this project, BerryDunn will continue to support DHHR with procurement, implementation, and certification support of the EDS through the EDS Implementation and CMS Certification Statement of Work.

#### *Section B.2.1.1: Enterprise Data Integration and Consolidation Progress*

This initiative focuses on the identification, consolidation, and subsequent retirement of duplicative WV DHHR databases and systems. To date, the following key tasks or deliverables have been completed/developed:

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#### **CMS GUIDANCE B.2.**

WHAT WILL THE SMA’S IT SYSTEM ARCHITECTURE (POTENTIALLY INCLUDING THE MMIS) LOOK LIKE IN FIVE YEARS TO SUPPORT ACHIEVING THE SMA’S LONG TERM GOALS AND OBJECTIVES? INTERNET PORTALS? ENTERPRISE SERVICE BUS? MASTER PATIENT INDEX? RECORD LOCATOR SERVICE?

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1. DHHR Data Dictionary Development, Collection, and Analysis
  - Identified data overlaps, sensitive data fields, duplicative data, and unique data fields across 139 active DHHR-identified applications.
2. Data Source Integration Roadmap
  - Outlined the methodologies, observations, and recommendations based on the activities of the Data Integration and Consolidation Initiative.
3. Database Consolidation and Retirement
  - Identified current and recommended database development and database management processes.

*Section B.2.1.2: Medicaid Enterprise Data Warehouse (DW) Solution RFP Progress*

This initiative focuses on the development of a Medicaid Enterprise DW RFP, as well as the subsequent evaluation and award of a solution to support the data warehousing, analytics, and reporting needs of WV DHHR. The RFP is known as the Enterprise Data Solution (EDS) RFP. To date, the following key tasks or deliverables have been completed/developed:

1. Cost Estimate and Procurement Budget
  - Outlined vendor cost projections for the funding and scope of the Medicaid EDS , Independent Verification and Validation (IV&V), project management services, Design, Development and Implementation (DDI), operational costs, as well as in-house versus procurement costs.
2. Joint Requirements Planning (JRP) Sessions
  - Facilitated JRP sessions between September to November 2018 with DHHR-identified stakeholders to assist in defining the EDS specification and mandatory requirements to be met.
3. Requirements Traceability Matrix (RTM)
  - Over 1,400 detailed specifications and 65 mandatory requirements
4. EDS RFP
  - The EDS RFP includes background information and documentation, service level agreements, mandatory requirements, cost workbook, deliverables and milestones, finalized EDS specifications, and standard procurement language provided by DHHR.
5. Test Scenarios
  - Test scenarios were developed to validate the testability and demonstrability of the EDS specifications and mandatory requirements and to inform the solution vendor's testing efforts.
6. Procurement Support

- Facilitation of the EDS RFP through the DHHR Purchasing, West Virginia Office of Technology (WVOT), federal partner review, and Department of Administration (DOA) review.
- Developed proposal evaluation packet including scoring criteria, evaluation committee structure and roles, and scoring tools.
- Facilitation of mandatory pre-bid conference, vendor oral demonstrations, vendor proposal evaluation sessions, and group scoring sessions.
- Developed proposal cost evaluation and technical scoring award memo.

7. Developed an Implementation Advanced Planning Document (IAPD)

### Section B.2.2: Electronic Visit Verification (EVV)

On December 13, 2016, the 21st Century Cures Act (Cures Act) was enacted into law. The Cures Act is designed to improve the quality of care provided to individuals through further research, enhanced quality control and strengthened mental health parity. An electronic visit verification (EVV) system is a telephone and computer-based system that electronically verifies service visits occur and documents the precise time service begins and ends. EVV applies to services rendered in the home under Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL), and home health skills.

The West Virginia DHHR has requested that BerryDunn provide project management services, needs assessment, advance planning document (APD) assistance, requirements development, testing, and certification assistance for the Electronic Visit Verification (EVV) Project. BerryDunn will work with DHHR-identified stakeholders to help ensure compliance with the requirements under Section 12006 of the 21st Century Cures Act (Cures Act).

On July 30, 2018, House of Representatives (H.R.) Bill 6042 was signed into law. This bill delays by one year (to January 1, 2020) the Medicaid federal matching rate reduction that is scheduled to take effect for states that fail to require an EVV system for PCS. The bill also excludes specified services from such verification system requirements, including inpatient hospital services and 24-hour residential group home services. In August 2019, BMS received approval for an extension of the Federal Medical Assistance Percentage (FMAP) reduction (monetary penalty) from the Centers for Medicare and Medicaid Services (CMS) until January 1, 2021. This extension allows the Bureau to implement the EVV solution after January 1, 2020.

## Section B.3: EHR Incentive Program User Access

The West Virginia Medicaid Management Information System (MMIS) provides a central hub for providing information to Medicaid members, providers, trading partners, and the public. The homepage for MMIS ([www.wvmmis.com](http://www.wvmmis.com)) provides links to current Medicaid news, an announcement section, and numerous links to instructions and guidance documents.

Providers are required to have an active WV Health PAS-Online account with DXC Technology (DXC, formerly Molina Healthcare, Inc.). Once provider information is registered and processed at both CMS' National Level Registry (NLR) and the WV Health PAS-Online system, they are able to submit their annual testament regarding adoption of HIT systems for consideration.

## Section B.4: Future HIT and HIE Governance

As previously described, the WVHIN is governed by a 17-member public/private board of directors. Governance of the state designated HIE will continue in this fashion; however, it is important to have representation from WV DHHR due to the continued partnership between the WVHIN and the State.

The WVHIN believes a major component in the future of HIEs data governance remains a large barrier to interoperability and partnerships, particularly regarding information from treatment of substance use disorders and meeting requirements outlined in 42 CFR Part 2. The WVHIN continues to work with leaders and colleagues to address privacy and confidentiality concerns as the field of health information exchanges continues to evolve and their role in facilitating healthcare for West Virginians grows moving forward.

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### **CMS GUIDANCE B.3.**

HOW WILL MEDICAID PROVIDERS INTERFACE WITH THE SMA IT SYSTEM AS IT RELATES TO THE EHR INCENTIVE PROGRAM (REGISTRATION, REPORTING OF MU DATA, ETC.)?

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### **CMS GUIDANCE B.4.**

GIVEN WHAT IS KNOWN ABOUT HIE GOVERNANCE STRUCTURES CURRENTLY IN PLACE, WHAT SHOULD BE IN PLACE BY 5 YEARS FROM NOW IN ORDER TO ACHIEVE THE SMA'S HIT/E GOALS AND OBJECTIVES? WHILE WE DO NOT EXPECT THE SMA TO KNOW THE SPECIFIC ORGANIZATIONS WILL BE INVOLVED, ETC., WE WOULD APPRECIATE A DISCUSSION OF THIS IN THE CONTEXT OF WHAT IS MISSING TODAY THAT WOULD NEED TO BE IN PLACE FIVE YEARS FROM NOW TO ENSURE HER ADOPTION AND MEANINGFUL USE OF EHR TECHNOLOGIES

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## Section B.5: Promoting HIT and Interoperability Adoption

Over the past several years, BMS, in partnership with DXC Technology, holds regional provider workshops twice a year. Workshop topics include HITECH initiatives such as the Promoting Interoperability Program and Health Information Exchange. In addition, the WV DHHR partnered with stakeholders to establish an annual Health Information Technology Summit. This statewide conference focuses on building technology partnerships across multiple sectors to help coordinate services to West Virginians impacted by various health and human services issues. The annual HIT Summit is designed to bring together WV DHHR leadership with a multitude of state and local entities, as well as, private stakeholders that are working to address a topic of interest through the use and innovation of health information technology.

The feedback received from each Summit will be used to update the SMHP as well as the State Health Information Technology Plan (SHIP).

### Section B.5.1: Inaugural 2018 HIT Summit

The first Summit took place in November 2018 and focused on the use of health information and technology to response to the substance use epidemic engulfing the state. The learning objectives for the 2018 HIT Summit included:

- Building partnerships and networks to deliver accurate, accessible, and actionable health information that targets substance use disorder;
- Facilitating the meaningful use of HIT and the exchange of health information among health care and public health professionals;
- Enabling quick and informed responses to health risk and public emergencies (i.e. Opioid Crisis, Hepatitis A Outbreak); and,
- Providing new opportunities to connect by increasing internet and mobile access to culturally diverse and hard-to-reach populations.

The 2018 HIT summit included the following seven presentations:

1. The State Drug Epidemic in West Virginia as it Impacts the Department of Health and Human Resources
2. Using Data in the Substance Use Disorder Crisis
3. Update on Broadband in West Virginia
4. Discussion on Local Efforts (Communities Spotlight: Cities of Huntington and Charleston, and Berkley County)
5. Innovations in Telehealth

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#### **CMS GUIDANCE B.5.**

WHAT SPECIFIC STEPS IS THE SMA PLANNING TO TAKE IN THE NEXT 12 MONTHS TO ENCOURAGE PROVIDER ADOPTION OF CERTIFIED EHR TECHNOLOGY?

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6. Recovery, Workforce Development and Social Enterprises
7. State Health Information Technology Plan Discussion

### Section B.5.2: The 2019 HIT Summit

The 2019 HIT Summit was convened on September 11, with the primary focus of using health technology to address the social determinants of health. This conference began with opening remarks from BMS Commissioner Cynthia Beane and was followed by a keynote address from Peter Eckart, the Director of the Center for Health Information Technology at the Illinois Public Health Institute.

Panels were designed to present different themes addressing the social determinants of health from different perspectives; one panel was community service workers, one healthcare providers, and the third, payers. The following topics were covered during these panel presentations:

- What is the Best Way for Patients to Access Services to Meet Social Determinant of Health Needs
- Who has Social Needs and Where Do I Send Them for Services
- When we Identify Social Needs in Our Membership, What Do We Do

Suggestions from the 2018 Summit revealed that participants wanted an opportunity to discuss topics and issues they've experienced; therefore, in for the 2019 Summit, four breakout sessions were included in the agenda. The following topics were discussed during these sessions:

1. How Do We Identify Common Data Elements?
2. How Do We Create Common Data Structures to Share Data?
3. How Should the Data Be Governed and How Should Consent be Managed?
4. How Can We Improve the Referral Process?

### Section B.5.3: Future HIT Summit Planning

The HIT Summit planning group consists of stakeholders from the Benedum Foundation, the state designated HIE, WV BMS, higher education institutes, health professional associations. Meetings of this stakeholder group will begin in early winter of each year to begin organizing the conference to be held in the fall. Funding for the past two HIT Summits had been provided through a Benedum Foundation grant, as well as money stemming from the HITECH plan in order to promote EHR use and interoperability. Future planning must prepare for the loss of HITECH funding and identify other assets to continue this important event.



## Section B.6: Leveraging HRSA Funds

The Health Resources Services Administration funds received by the WVPCA as part of the health center controlled network grant were outlined in Section A.3: In general, HRSA funding received was used to facilitate and provide many services to members, HIT technical assistance being one of them. These services are continuing, and the organization provides data-related technical assistance focused on health center development including: data integrity, report generation, quality improvement, interoperability, workflow assessment and redesign, and practice transformation. The WVPCA Data Services & Health Information Technology department also helps members use HIT to:

- Improve health care quality or effectiveness;
- Increase health care productivity or efficiency;
- Prevent medical errors and increase health care accuracy and procedural correctness;
- Reduce health care costs;
- Increase administrative and healthcare work processes;
- Decrease paperwork and unproductive work time;
- Extend real-time communications of health informatics among health care professionals; and
- Expand access to affordable care.

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### **CMS GUIDANCE B.6.**

\*\* IF THE STATE HAS FQHCs WITH HRSA HIT/EHR FUNDING, HOW WILL THOSE RESOURCES AND EXPERIENCES BE LEVERAGED BY THE SMA TO ENCOURAGE EHR ADOPTION?

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## Section B.7: EHR Incentive Program Technical Assistance

The State, in partnership with the fiscal agent DXC, provided multiple avenues for eligible participants to learn about the PIP as well as troubleshoot technical issues with the system. The MMIS webpage houses this information and can be accessed at [www.wvmmis.com](http://www.wvmmis.com).

Information on both sites directs West Virginia Medicaid providers to a single call center/helpdesk operated by the SMA's fiscal agent, DXC Technology, Inc. DXC (formerly Molina Medicaid Solutions), has a Helpdesk that may be reached at 888-483-0793 or via email at [edihesk@molinahealthcare.com](mailto:edihesk@molinahealthcare.com).

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### **CMS GUIDANCE B.7.**

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

---



Information on the Medicaid Management Information System (MMIS) provides support from 7:00a.m. to 7:00p.m. Monday through Friday. Help is available either by phone, e-mail, or online chat option. Figure B-1 below captures the contact webpage of the MMIS. MMIS also includes reference material and instructions about the PIP. It explains that eligible participants must register with the National Level Registry (NLR) and creating a WV Health PAS-OnLine account with DXC before submitting information to the incentive program.

The screenshot shows the 'Contact Us' page of the Medicaid Management Information System (MMIS). At the top, there is a navigation bar with links for Home, Contact Us (highlighted), Provider Directory, Reference Material, and News. A search bar is located on the right. Below the navigation bar, the 'Support Hours' section indicates that support is available Monday through Friday from 7:00 a.m. to 7:00 p.m. Eastern Standard Time. To the right of the support hours, there is a list of EDI Helpdesk Support Closures: January 1st, January 21st, February 18th, May 27th, June 20th, July 4th, September 2nd, and October 14th. Below the support hours, there are three main support options: Phone Support, Messaging Support, and Online Support. Each option includes a brief description and contact information.

For additional contact options including telephone/fax numbers, and email/physical mailing address, [Click here](#)

Figure B-1: MMIS Customer Support Contact Webpage

Training materials, worksheets, and checklists to help participants through the attestation process are also available. These documents are publicly available and contain detailed instructions on what data are needed for the attestation as well as how to complete the online attestation. Training materials and worksheets are separated into two categories: Eligible Hospitals and Eligible Professionals. Finally, the MMIS site also provides links to external sources at the bottom of the page. Figure B-2 below depicts the current WV Medicaid EHR Incentive Payment Information page provided by MMIS.

west virginia  
 Medicaid Management Information System

Enable Accessibility Help Sign In or Register

Search this site SEARCH

Home Contact Us Provider Directory Reference Material News

WV Medicaid EHR Incentive Payment Information

## WV Medicaid EHR Incentive Payment Information

Effective July 4th, 2011, providers eligible for the Provider Incentive Program (PIP) may register with the National Level Repository (NLR).

Providers are required to have an active WV HealthPAS Online account with Molina prior to attesting for their incentive payment. Please see the [WV TPA User Guides](#) for more details. If you need further assistance on obtaining a HealthPAS Online account, you may contact our EDI Helpdesk at 1-888-483-0793, option 6.

For those providers who have already registered with CMS' National Level Repository (NLR) for incentive payment, the transition from the CMS NLR Incentive Registration to the WV Medicaid EHR Incentive solution can take 48 hours. You will be notified by the email you provided to the CMS NLR Incentive Registration when we receive and process this information. At that time, providers may proceed with their attestations by logging into their WV HealthPAS Online and selecting the Provider Incentive Payment option.

### WV EHR Solution Provider Training Materials

West Virginia has created user manuals and companion worksheets for providers to utilize while they are using the system to complete their attestation. The workbooks have detailed instructions to the provider on what data they need to pull prior to attesting and how to complete their attestation online.

**PLEASE NOTE THAT IF YOU HAVE TROUBLE VIEWING THESE FILES THROUGH INTERNET EXPLORER, PLEASE USE AN ALTERNATE BROWSER SUCH AS GOOGLE CHROME TO ACCESS AND OPEN THE FILES.**

Name	Modified	File Size
2015 WV PIP Training Materials	... April 06, 2016	
Professional Provider EHR Incentive Registration Procedures	... November 30, 2018	892 KB

### Overview - West Virginia EHR Provider Incentive Program

The Electronic Health Records (EHR) Provider Incentive Payment (PIP) is a federal program offering financial support to assist eligible providers to adopt (acquire and install), implement (train staff, deploy tools, exchange data), or upgrade (expand functionality or interoperability) certified EHR technology.

The program goals are to improve outcomes, facilitate access, simplify care, and reduce costs of health care nationwide by:

- Enhancing care coordination and patient safety
- Reducing paperwork and improving efficiencies
- Facilitating information sharing across providers, payers, and state lines
- Enabling communication of health information to authorized users through state Health Information Exchange (HIE) and the National Health Information Network (NHIN).

Incentives are available through both Medicaid and Medicare. Eligible healthcare professionals will be required to choose between Medicaid and Medicare. Those in border counties should choose the state from which they will receive the incentive payments. Hospitals may be able to receive incentive funds from both programs. The Bureau for Medical Services (BMS) will administer the Medicaid EHR PIP program for West Virginia.

Select the links below to learn more about the Provider EHR Incentive payment program nationally and in West Virginia.

[CMS EHR Incentive Program](#)  
[List of Certified EHR Technology](#)  
[Office of the National Coordinator for Health Information Technology](#)  
[West Virginia Regional Health Information Technology Extension Center](#)  
[West Virginia Health Information Exchange](#)

**DXC** DXC.technology

Figure B-2: MMIS Hospital and Professional Resource Webpage

### Section B.7.1: Health Information Exchange Technical Assistance

The WVHIN performs outreach, onboarding, and implementation support to vendors for connecting to the State’s HIE. These activities include assistance in completing readiness documents, training, and coordination with the WVHIN as needed. WVHIN services assist EPs and EEs in achieving MU goals. A summary of WVHIN services is provided previously in Section A.7.:

### Section B.8: Identifying Population Needs

The West Virginia BMS is the single state agency responsible for the provision of the state’s Medicaid program. BMS provides health insurance coverage for nearly one-third of the state’s population with an annual budget of over \$3.5 billion. Because BMS covers so many people and is largely funded by local taxpayers, the agency has a vested interest in providing effective and fiscally responsible care for its members. To this end, the state has made great strides in leveraging available data resources to improve decision-making. Broadly speaking, the goals of these efforts are to:

1. Use data to better understand the Medicaid population, as well as identify any potential gaps in coverage or care.
2. Use data to evaluate program costs and effectiveness in meeting intended objectives.
3. Disseminate the results of policy analyses and program evaluations to key stakeholders within the DHHR as well as the public.

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#### **CMS GUIDANCE B.8.**

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

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#### Section B.8.1: State and University Partnerships

BMS has successfully crafted state-university partnerships to help achieve these objectives. These partnerships support BMS in performing highly skilled data analyses at a lower cost than would be available through private-sector consulting. Such partnerships have the added benefit of keeping funds in-state through locally employed individuals working for organizations that share the agency’s mission and values. These state-university partnerships also allow researchers at local universities to use Medicaid data resources to explore policy questions of mutual interest to the researchers as well as BMS leadership.

##### *Section B.8.1.1: Data Sources*

BMS maintains a Data Warehouse containing several rich data sources that may be used to support collaborative program evaluation and research with university partners. Some of the major data sources contained in the warehouse include:

- **Medicaid administrative claims and encounters data:** The BMS data warehouse contains almost 10 years of fee-for-service claims and managed care encounter data as well as information on Medicaid beneficiaries’ eligibility and demographic characteristics. These data include claims and encounters for all drugs, devices, and services covered by Medicaid. These files can provide diagnoses, demographics, and financial

information to enable better decision making for BMS leadership.

- **Vital statistics data:** The BMS Data Warehouse also includes vital statistics data from BPH. These data include birth and death certificate data for all births and deaths occurring in the state of West Virginia. Importantly, these data are integrated with the aforementioned claims data. Together with claims data, these vital statistics data allow for robust analyses that can answer many important policy questions of interest.

BMS also has access to other state data resources via its sister agencies within DHHR. Some examples include disease registry data from BPH, SNAP/TANF data from the Bureau for Children and Families, and data on nonfatal drug overdoses from the Office of Drug Control Policy. Some, but not all of these data sources may be linked at the individual level to Medicaid claims data. Regardless of ability to link these data sources, though, these data still provide valuable resources that may be used to support decision making by the Medicaid agency.

### Section B.8.2: Highlighted Initiatives

Much of the data analytics work conducted pursuant to West Virginia's state-university partnership falls within one of four categories: targeted program evaluations, ad-hoc data analytics, support for sister agencies, or independent research. Each of these four project categories can support Medicaid decision making in different ways, and examples of each category are presented below.

#### *Section B.8.2.1: Targeted Program Evaluations*

In addition to the standard suite of services available under the BMS state plan, the agency also operates many special programs targeted to specific individuals. For example, BMS operates programs that test different mechanisms of delivering and paying for care, and also programs that provide supplemental services to certain high-risk members. Regardless of the specific type of program, BMS has a vested interest in monitoring whether these programs are saving the agency money, and whether they are achieving their intended outcomes. In many cases, BMS lacks the necessary workforce capacity to perform these evaluations in-house, and as a result, contracts with local university partners to design and implement the evaluations. Some examples of recent program evaluations include:

- *1115 Substance Use Disorder (SUD) Waiver Evaluation (ongoing):* This is a five year longitudinal study evaluating whether expanded coverage of SUD treatment options is affecting outcomes including overdose deaths, SUD-related hospital admissions, etc. among Medicaid members.
- *Evaluation of Diabetes Health Home program (completed):* This mixed-methods study examined outcomes for Medicaid members enrolled in the Diabetes Health Home pilot program, a form of integrated care offering patient navigation services for individuals with diabetes or pre-diabetes also suffering from depression or anxiety. An econometric modeling analysis of claims data revealed lower overall spending and emergency department utilization among individuals enrolled in the Diabetes Health Home program relative to beneficiaries not enrolled in the program. Results from this analysis will be used by BMS leadership to help decide whether to expand the program state-wide at the

conclusion of the pilot period.

#### *Section B.8.2.2: In-house Data Analytics Support*

The targeted program evaluations and independent research discussed above are traditionally completed by teams of researchers working together over long periods of time to answer very specific policy questions of interest. However, the Medicaid agency also has a tremendous need for other ad-hoc data analyses that need to be completed in relatively short time frames. For example, BMS leadership may receive a request for information directly from the Cabinet Secretary or West Virginia Legislature. In these cases, it is helpful to have in-house data analytics support to tackle these questions quickly as they arise. Once again, though, BMS generally lacks sufficient workforce to adequately address these needs. Recently, BMS has begun working with its university partners to embed university employees within the Medicaid agency to assist with in-house data analytics support. These ‘embedded analysts’ are university employees who work full time out of the BMS offices in Charleston and are available to work on whatever pressing needs BMS leadership may have. There are currently two embedded analysts available to prepare data analyses, reports, and policy briefs as needed by BMS leadership. Examples of recent contributions include:

- Preparation of reports on trends in disease prevalence and cost of care for members with various conditions.
- Development of heat maps showing disease prevalence or service utilization which have aided BMS leadership in presentations to the state legislature and other DHHR stakeholders.
- Analyses of expected financial impact of various policies including changes to the specific service reimbursement rates.

#### *Section B.8.2.3: Supporting Sister Agencies*

The BMS data warehouse includes several very rich data resources that can be leveraged to improve decision making by the agency. Unfortunately, many of the Bureau’s sister agencies within DHHR don’t have access to similar data sources. Some of these agencies, such as the Bureau for Behavioral Health (BBH) and BPH, provide programs and services to many individuals who are also served by West Virginia Medicaid. Thus, Medicaid data sources may also be valuable to these agencies in terms of promoting planning and decision making. With that said, though, these agencies face the same problem as BMS in terms of lacking sufficient workforce that can put these data to use. To meet this need, embedded analysts within BMS have provided data analytics and reporting on Medicaid data sources for BPH, BBH, and the Office of Drug Control Policy. Some examples of this work include:

- *SUD Grant Application:* Analysts aided the BBH staff in the submission of an SUD Provider Capacity grant to the Centers for Medicare & Medicaid Services (CMS) through policy research on Medication Assisted Treatment (MAT) Centers of Excellence as well as claims analysis and reporting of SUD prevalence in the Medicaid population.
- *Hepatitis C Treatment Expansion:* Analysts embedded in BMS are currently assisting a

multidisciplinary effort spearheaded by BPH staff to evaluate the potential impact of expanding Hepatitis C treatment. As part of this project, analysts are evaluating the effectiveness of economic modeling tools in order to better inform decision making.

#### *Section B.8.2.4: Independent Research Supporting BMS Priorities*

Beyond the targeted program evaluations discussed above, BMS also has many other research questions of interest that may not be related to specific policies or programs. Once again, BMS does not have the necessary workforce capacity with the skills, expertise, or time to thoroughly investigate these questions. In these instances, BMS may allow university researchers to access Medicaid data in order to explore these questions. Alternatively, university researchers may propose their own research questions to BMS if they believe that answering these questions may ultimately support decision making at the Medicaid agency.

- *Unnecessary Imaging for Low Back Pain* (completed): A study utilizing claims data and national quality guidelines found that over one-third of WV Medicaid members with newly diagnosed low back pain received an unnecessary imaging study in 2017.
- *Early Elective Births* (planned): Researchers are currently seeking approval for an investigation into the number of early elective deliveries in the Medicaid population up to and after a switch to managed care compared to a control population which remained fee for service.

#### *Section B.8.3: Plans for Growing Partnerships*

BMS is currently in the process of strengthening its state-university partnership. One of the primary ways they are doing this is through the recently approved Data Analytics and Decision Support (DADS) project. This ongoing initiative will create institutional funding support for university partners, formalize partnership goals, and embed additional university data analysts within the agency. Additionally, BMS recently signed a new Memorandum of Understanding (MOU) with one of its university partners. Among the MOU's important changes is an improvement to the process connecting the research interests of BMS leadership to faculty willing to conduct independent research.

Finally, BMS plans to continue its active membership in Academy Health's State-University Partnership Learning Network (SUPLN). SUPLN is an ongoing collaboration between state agencies and their university partners who are engaged in work similar to that described here. Participation in SUPLN has allowed BMS to learn how these partnerships are employed in other states, and how they can better leverage their own partnership with local universities to better support the agency.



## Section B.9: Allocating State HIT Awards

As stated in Section A.15., there were no HIT related grants awarded to the State within the past year.

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### **CMS GUIDANCE B.9.**

IF THE STATE INCLUDED IN A DESCRIPTION OF A HIT-RELATED GRANT AWARD (OR AWARDS) IN SECTION A, TO THE EXTENT KNOWN, HOW WILL THAT GRANT, OR GRANTS, BE LEVERAGED FOR IMPLEMENTING THE EHR INCENTIVE PROGRAM, E.G. ACTUAL GRANT PRODUCTS, KNOWLEDGE/LESSONS LEARNED, STAKEHOLDER RELATIONSHIPS, GOVERNANCE STRUCTURES, LEGAL/CONSENT POLICIES AND AGREEMENTS, ETC.?

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## Section B.10: Novel Legislation Impacting the Incentive Program

As stated in Section A.12., There have been no recent, nor anticipated, changes to West Virginia legislation governing or impacting the continued delivery of the Interoperability Program.

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### **CMS GUIDANCE B.10.**

DOES THE SMA ANTICIPATE THE NEED FOR NEW OR STATE LEGISLATION CHANGES TO EXISTING STATE LAWS IN ORDER TO IMPLEMENT THE EHR INCENTIVE PROGRAM AND/OR FACILITATE A SUCCESSFUL EHR INCENTIVE PROGRAM (E.G. STATE LAWS THAT MAY RESTRICT THE EXCHANGE OF CERTAIN KINDS OF HEALTH INFORMATION)? PLEASE DESCRIBE.

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## Section C: Incentive Program Administration and Oversight

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 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.

The plan also includes implementing pre-payment and post-payment verification procedures. Verification and auditing practices for both the pre- and post-payment procedures are detailed in the following sections. Pre-payment program compliance verification includes a recalculation of the payment amount that providers are eligible to receive based on information submitted in the annual application and attestations. BMS also verifies certified technology requirements for Year 1 – 6 payments and meaningful use requirements for Year 2 – 6 payments (Year 1 adopters). The pre-payment verification includes both automated and manual checks. Post-payment audits of the Incentive Program began in the summer of 2014 and included submissions and payments spanning the first three years of the program.

It is important to note that BMS' fiscal agent, DXC Technology operates the automated data collection and processing system that supports most of the critical functions of the program. The automated system is referred to as the Provider Incentive Program Solution (PIPS).

### Business Process for PIP Solution

Providers must meet eligibility requirements in order to qualify for Incentive/Interoperability Program payments. The requirements include professional and regulatory compliance, provider practice type, Medicaid patient volume, and non-duplication of registration for incentive payments. Figure C-1 below visualizes the business steps of the pre-payment verification process. Content within this section clarifies how BMS verifies that these requirements have been met on an annual basis.

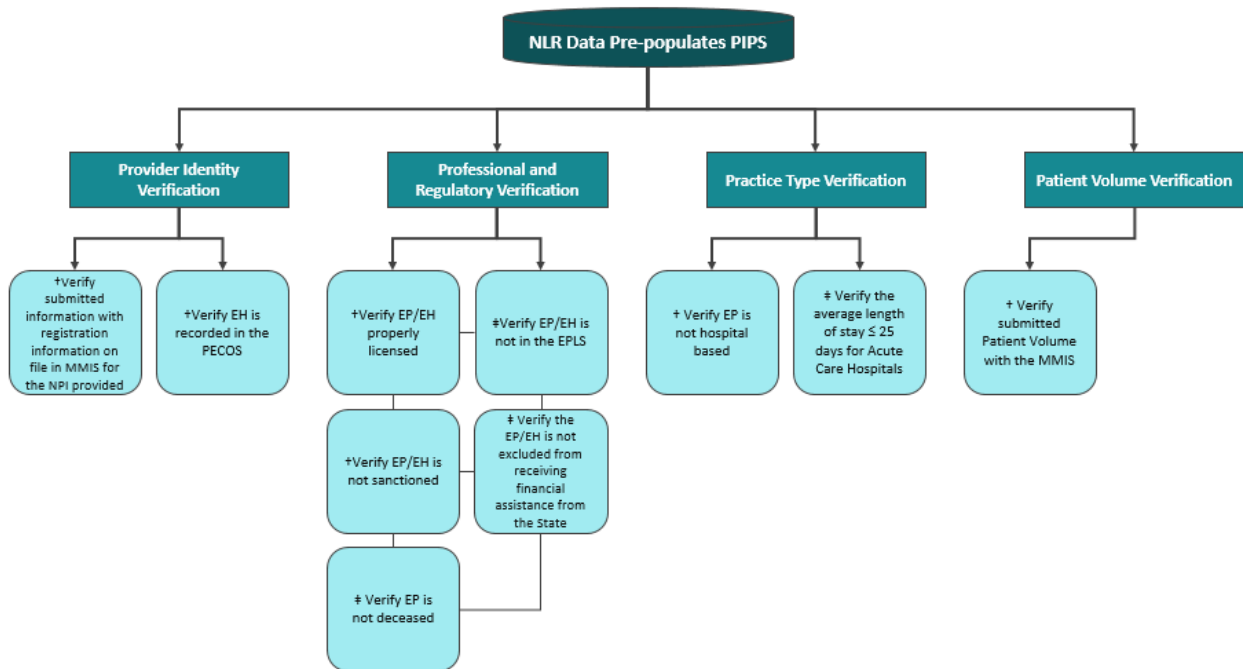


Figure C-1: Pre-payment Verification Processes (+ denotes an automatic process; ± denotes a manual process)

## Section C.1: Verification of Provider Licenses and Sanctions Status

Verification of EP and EH identification, licensures, and sanction status is done through a combination of automatic and manual procedures triggered from automatic events in the PIP Solution. The PIP Solution (aka. Solution) will automatically verify the identifying information submitted in the attestation is consistent with information the State maintains within the MMIS; likewise, the Solution automatically verifies that EHs have an enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS).

Following these automatic checks, the PIP Solution will automatically query the MMIS to verify that the applicant is properly licensed. Simultaneously, another query is sent to the exclusion database to verify that the applicant is not sanctioned.

Three manual checks are conducted by BMS or DXC personnel. The first manual verification is to identify if the applicant is excluded from receiving Federal financial assistance by referencing the Excluded Parties List System (EPLS). The second is to identify if the EP/EH is excluded from receiving State of West Virginia financial assistance. Finally, the third is to verify that the applicant is not deceased by using a death certificate query.

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### CMS GUIDANCE C.1.

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

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## Section C.2: Verification of Provider Practice Location

Whether the attesting party is an EP or EH will influence which procedure is used to verify the practice type. The following subsections outline the automatic and manual pre-payment verification procedures used by both the PIP Solution and the personnel of BMS.

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### **CMS GUIDANCE C.2.**

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

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### Section C.2.1: Eligible Provider Location Verification

EPs that dedicate 90% or more of their covered services in either an inpatient or emergency department annually are considered hospital based. Covered services are physician fee schedule services paid under §1848 of the Social Security Act and CMS utilizes the physician fee schedule data from the previous Federal fiscal year for which the EHR incentive payment is made to determine what percentage of covered services occurred in a hospital setting. West Virginia uses Medicaid encounter claims data in the MMIS to automatically validate the location.

BMS initially reviews claims for place of service codes 21 and 23; if these codes are predominant within the submitted attestation timeframe, BMS will request documentation from the provider supporting the attestation that 90% of services occurred outside of a hospital setting.

### Section C.2.2: Hospital-Based Status Determination

Attestation submissions made by acute care hospitals are verified via a consultant. The consultant manually determines that the average length of stay for patients is less than 25 days.

## Section C.3: Verification of Provider's Attestation

Figure C-2 provides an overview of the major steps BMS and its constituents take in order to verify submitted provider attestations prior to incentive payments being disbursed. WV BMS' fiscal agent, DXC, is charged with completing the pre-payment review while BerryDunn has been contracted to

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### **CMS GUIDANCE C.3.**

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

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ensure compliance and audit the post-payment program. Automated steps in the pre-payment verification process compare submitted information to that already available in either the NLR, PECOS, or the state MMIS system. Section C.1., Section C.2., Section C.5., Section C.7., Section C.8., and Section C.9: all contain more details regarding verification steps.

Manual checks are conducted by DXC to verify professional credentials and that the applicant is not deceased. The consultant also manually verifies that the mean length of stay is within the required range, for acute care hospitals.

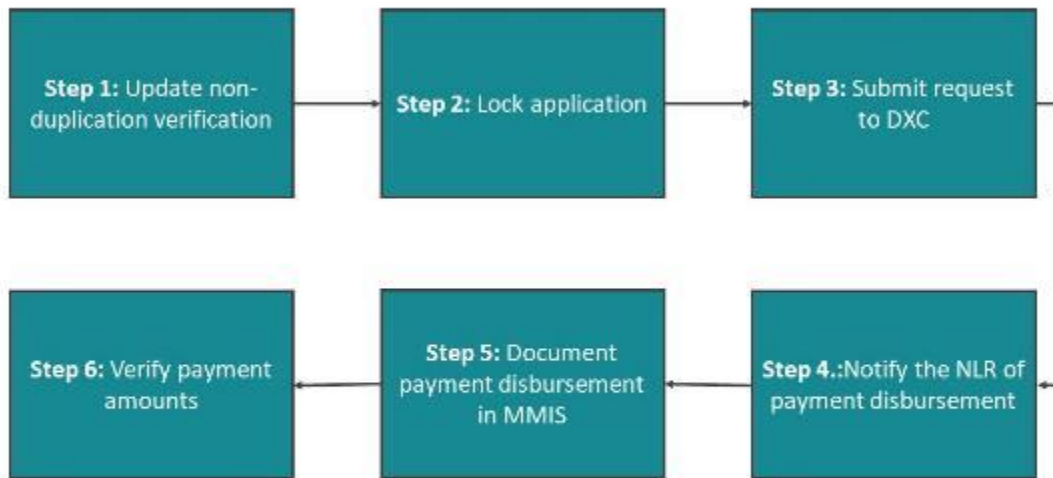


Figure C-2: Attestation Verification Steps

Pre-payment verification also 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 verified AIU and CEHRT requirements for Year 1 payments to eligible providers and continues to verify MU requirements for Year 2-6 payments prior to disbursement.

## Section C.4: Communication Methods

The EHR PIP uses a combination of physical and electronic communication methods to inform stakeholders and program participants about varying topics, including but not limited to eligibility requirements, payment's, and clarifications or updates to the program. The examples below are common means of communication between BMS, stakeholders, and eligible PIP participants:

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### **CMS GUIDANCE C.4.**

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

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- **BMS HIT Web Portal.** The Bureau maintains 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.  
(<https://dhhr.wv.gov/bms/Provider/EHR/Pages/default.aspx>)
- **MMIS Portal.** The MMIS Portal maintains pertinent information for EPs to use throughout the EHR PIP including, but not limited to, application and attestation instructions, as well as meaningful use requirements.  
(<https://www.wvmmis.com/default.aspx>)
- **E-mail and Postal Mail.** Newsletters, invitations, and direct letters are disseminated to targeted audiences or individuals, primarily using either e-mail or the postal service.
- **Remittance Advice Banners.** Brief messages regarding the WV EHR PIP are transmitted through the use of remittance advice banners.
- **Web-based Documentation Repository.** Various Microsoft SharePoint sites are used as repositories of program documents. The SharePoint sites will contain secure access to folders and files.

### Section C.4.1: Notification of Suspension or Denial

If a provider does not meet eligibility criteria, BMS will send a Denial Form and Submission of Appeal Form the applicant by postal service or via e-mail.

## Section C.5: Patient Volume Criteria and Calculation

Eligible professionals are able to select one or more clinical sites at which they practice, in order to calculate patient volume for their annual attestation. EPs may also elect to use their group practice/clinic locations encounter rates to attain the necessary patient volume; however, if this is done, all EPs

within the practice must report their patient volume the same way if they intend to attest for EHR incentive payments. In other words, group practices/clinics could not have some EPs reporting their individual volume of patients seen at the clinic while other EPs report the clinic-level patient volumes. There are three conditions that must be met when an EP attests to the patient volume of their group practice/clinic as a proxy for their own:

1. The clinic or group practice patient volume is appropriate as a patient volume methodology calculation for the EP. For example, if an EP only sees Medicare, commercial, or self-pay patients – this is not an appropriate calculation; and
2. There is an auditable data source to support the clinic’s patient volume determination; and
3. If the practice and EPs decide to use one methodology in each year. The clinic or practice must use the entire practice’s patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works in both the clinic and outside the clinic, then the clinic/practice level determination includes only those encounters associated with the clinic/practice.

The following subsection briefly details instructions provided to EPs to assist with patient volume calculations.

### Section C.5.1: Medicaid Patient Volume Formula

The overall Medicaid patient volume is calculated using the following formula:

$$Patient\ Volume\ (PV) = \frac{\#\ of\ Medicaid\ individual\ encounters}{Total\ patient\ encounters}$$

The numerator is the count of unduplicated per patient, per date of service Medicaid Claim Based encounters in the EP selected 90-day period. This should include all Medicaid encounters (inpatient, outpatient, and emergency services). Verification processes for submitted patient volumes are detailed in subsequent sections.

Criteria for minimum patient volumes attributable to needy individuals apply only to EPs practicing predominantly in an FQHC or Rural Health Center (RHC). These criteria do not apply to hospital patient volumes.

The WV PIP requires that EPs attest that 30% of their patient encounters are covered by Medicaid; pediatricians participating in the incentive program are able to attest that 20-30% are

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#### CMS GUIDANCE C.5.

WHAT METHODOLOGY WILL THE SMA USE TO CALCULATE PATIENT VOLUME?

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Medicaid encounters. It is important to note that, since there is no Medicaid patient volume for Children’s Hospitals, the State intends to assure no unnecessary barriers are established that could delay participation by Children’s Hospitals.

Provider Type	Patient Volume Requirement	Alternate Requirement
Physician	30%	-
Pediatrician	30%	20%
*Physician Assistant	30%	-
Certified Nurse – Midwife	30%	-
Dentist	30%	-
* Physician Assistants (PA) must be based in an FQHC or RHC led by a PA, 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.		

Table C-1: Patient Volume Thresholds for Providers

Provider Type	Patient Volume Requirement
Acute Care Hospital	10%
Children’s Hospital	-

Table C-2: Patient Volume Thresholds for Hospitals

The following formula is then used to identify whether the patient volume requirements are met for each provider type:

$$\text{Required EP Patient Volume Percentage} \leq \frac{\# \text{ of Medicaid individual encounters}}{\text{Total patient encounters}}$$

## Section C.6: Verifying Patient Volumes

Incentive program participant's patient volume data is validated by matching the attestation value with the MMIS once the provider has submitted their State Level Registration (SLR). BMS expects the information for volume measurements to closely match what the provider has submitted in the Medicaid Claims and/or Encounters database of the MMIS, which is the basis for assessing the provider's compliance with patient volume requirements.

Verification of meeting, or exceeding, minimum threshold requirements is automatically checked by the PIP Solution system. Another automatic check by the system verifies that the patient volume measurement period of 90 days was used in the attestation submission. Finally, the system automatically verifies Medicaid data used in the patient volume thresholds based on claims in the MMIS. During the auditing process, described in Section D:, BerryDunn works in tandem with BMS to verify each provider's Medicaid patient volume information.

## Section C.7: Verifying FQHC and Rural Health Center Locations

BMS personnel conduct a query of Medicaid claims data in the MMIS to verify that the incentive program applicant is not hospital-based. Initially, BMS reviews claims for place of service codes 21 and 23; if these service codes are predominant, additional documentation is requested from the provider to support the attestation of 90% of services occurring outside of hospitals.

Verification for acute care hospital attestations are done through the use of a consultant, currently DXC Technology. The consultant manually verifies that the average length of stay is less than 25 days.

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### **CMS GUIDANCE C.6.**

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

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### **CMS GUIDANCE C.7.**

HOW WILL THE SMA VERIFY THAT EPS AT FQHC/RHCS MEET THE PRACTICES PREDOMINATELY REQUIREMENT?

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## Section C.8: Verifying Adoption, Implementation, or Upgrades of CEHRTs

Adoption, implementation, and/or upgrading requirements are no longer being verified by the State; the final year to claim eligibility of the AIU incentives was 2016. Initially, West Virginia worked with a certified public accounting firm to develop risk assessment criteria based on CMS guidance provided through the Audit Toolkit, Community of Practice, CMS Frequently Asked Questions, as well as other materials. Using the risk assessment, the State and BerryDunn analyzed providers and selected a sample based on risk ratings; letters and questionnaires were then sent to notify providers of an initial desk audit.

The purpose of the desk audit was to obtain documentation supporting provider attestations regarding AIU of certified EHR technology as well as documentation to support the incentive payment amounts. Findings of the audits were documented in the audit template provided by CMS. If documentation was unclear after the desk review, an on-site review was scheduled, if necessary.

The on-site review was not required for all providers, as, in some instances, it was clear that the provider was out of compliance with program regulations. Upon completion of the audit, the State sent the summary audit sheets and a State letter to all providers to notify them of the results. Providers were also given the opportunity to appeal the audit findings.

## Section C.9: Verifying Meaningful Use of CEHRTs

The PIPS automatically verifies that submitted MU attestation data meets thresholds specified in the Interoperability Program objectives and measures specifications sheets for the attestation program year. PIPS also requires the attesting provider to upload an MU report from their CEHRT for the post-payment auditing conducted by BMS and BerryDunn. Either entity manually reviews the MU measurements reported in the provider submitted attestation for the reporting period. The State uses the definitions provided by CMS for Stage 3 MU objectives.

### Section C.9.1: Stage 1 Meaningful Use Verification

Appendix D shows Stage 1 Meaningful Use Objectives and Measures for the 2013 attestation year. The final year for Stage 1 attestations was 2014, per the “Stage 3 and Modifications to Meaningful Use in 2015 through 2017” Final Rule. Modified Stage 2 attestation in 2015 included alternate exclusions for providers scheduled for Stage 1. EP/EH compliance with Stage 1 objectives in Appendix D were assessed; the verifier must determine whether the EP/EH meets all core set meaningful use criteria as well as half (5 out of 10) of the menu set

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#### **CMS GUIDANCE C.8.**

HOW WILL THE SMA VERIFY *ADOPT, IMPLEMENT OR UPGRADE* OF CERTIFIED ELECTRONIC HEALTH RECORD TECHNOLOGY BY PROVIDERS?

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#### **CMS GUIDANCE C.9.**

HOW WILL THE SMA VERIFY *MEANINGFUL USE* OF CERTIFIED ELECTRONIC HEALTH RECORD TECHNOLOGY FOR PROVIDERS’ SECOND PARTICIPATION YEARS?

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MU criteria. BMS or their contracted party, will use EHR systems, the review of clinical data, quality outcome analysis, or other documentation submitted by the EP/EH to verify the required MU criteria are met. It is important to note that an eligible hospital or critical access hospital (CAH), a type of RHC, must have met all Stage 1 meaningful use criteria.

### Section C.9.2: Stage 2 Meaningful Use Verification

State and contracted employees use the same methods to verify that providers and hospitals meet the Stage 2 Meaningful Use Objectives in Table C-3 and Table C-5. These requirements are the same as those published by CMS in final rule of October 2016. Eligible Providers are required to meet ten objectives whereas hospitals are required to meet nine. The final year for Stage 2 attestations was 2018.

### Section C.9.3: Stage 3 Meaningful Use Verification

As with meaningful use Stage 2 requirements, the State and contracted employees use the same methods to verify that providers and hospitals meet the Stage 3 Meaningful Use Objectives in Table C-6 and Table C-6. Again, these requirements are the same as those published by CMS in final rule of October 2016. The final year for Eligible Hospitals to submit Stage 3 MU attestations was 2018. The EHR Incentive Program has always required CEHRT for an incentive payment attestation. The 2014 Edition CEHRT was required starting in 2015. Currently, the 2015 Edition CEHRT is required for Stage 3 attestations. PIPs automatically verifies CEHRT by using the CHPL web services as stated in Section C.11:.

Eligible Professional Meaningful Use Stage 2 Objectives and Measures		
EP- Stage 2 Objectives	Stage 2 Measures	Exclusions
Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EP's risk management process	
Use clinical decision support to improve performance on high-priority health conditions.	<p>EPs must satisfy both of the following measures in order to meet the objective:</p> <ul style="list-style-type: none"> <li>• Measure 1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.</li> <li>• Measure 2: The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.</li> </ul>	For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period.

<p>Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.</p>	<p>An EP, through a combination of meeting the thresholds and exclusions (or both), must satisfy all three measures for this objective:</p> <ul style="list-style-type: none"> <li>• Measure 1: More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.</li> <li>• Measure 2: More than 30 percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.</li> <li>• Measure 3: More than 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.</li> </ul>	<p>Measure 1: Any EP who writes fewer than 100 medication orders during the EHR reporting period.</p> <p>Measure 2: Any EP who writes fewer than 100 laboratory orders during the EHR reporting period.</p> <p>Measure 3: Any EP who writes fewer than 100 radiology orders during the EHR reporting period.</p>
<p>Generate and transmit permissible prescriptions electronically (eRx).</p>	<p>More than 50 percent of permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.</p>	<p>Any EP who:</p> <ul style="list-style-type: none"> <li>• Writes fewer than 100 permissible prescriptions during the EHR reporting period; or</li> <li>• Does not have a pharmacy within his or her organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her EHR reporting period.</li> </ul>
<p>The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.</p>	<p>The EP that transitions or refers their patient to another setting of care or provider of care must—</p> <ol style="list-style-type: none"> <li>1. Use CEHRT to create a summary of care record; and</li> <li>2. Electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.</li> </ol>	<p>Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period</p>

<p>Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.</p>	<p>Patient-specific education resources identified by CEHRT are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period.</p>	<p>Any EP who has no office visits during the EHR reporting period.</p>
<p>The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.</p>	<p>The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.</p>	<p>Any EP who was not the recipient of any transitions of care during the EHR reporting period.</p>
<p>Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.</p>	<p>EPs must satisfy both measures in order to meet this objective:</p> <p>Measure 1: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information.</p> <p>Measure 2: For an EHR reporting period in 2017, more than 5 percent of unique patients seen by the EP during the EHR reporting period (or his or her authorized representatives) view, download or transmit to a third party their health information during the EHR reporting period.</p>	<p>Measure 1: Any EP who neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information."</p> <p>Measure 2: Any EP who:</p> <ul style="list-style-type: none"> <li>• Neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information;" or</li> <li>• Conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.</li> </ul>

<p>Use secure electronic messaging to communicate with patients on relevant health information.</p>	<p>For an EHR reporting period in 2017, for more than 5 percent of unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period.</p>	<p>Any EP who has no office visits during the EHR reporting period, or any EP who conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.</p>
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<p>The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.</p>	<p>Measure 1: Immunization Registry Reporting: The EP is in active engagement with a public health agency to submit immunization data.</p> <p>Measure 2: Syndromic Surveillance Reporting: The EP is in active engagement with a public health agency to submit syndromic surveillance data.</p> <p>Measure 3: Specialized Registry Reporting: The EP is in active engagement to submit data to a specialized registry.</p>	<p>Measure 1 Exclusions: Any EP meeting one or more of the following criteria may be excluded from the immunization registry reporting measure if the EP:</p> <ul style="list-style-type: none"> <li>• Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the EHR reporting period;</li> <li>• Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or</li> <li>• Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the EP at the start of the EHR reporting period.</li> </ul> <p>Measure 2 Exclusions: Any EP meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure if the EP:</p> <ul style="list-style-type: none"> <li>• Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system;</li> <li>• Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or</li> <li>• Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs at the start of the EHR reporting period.</li> </ul> <p>Measure 3 Exclusions: Any EP meeting at least one of the following</p>
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		<p>criteria may be excluded from the specialized registry reporting measure if the EP:</p> <ul style="list-style-type: none"> <li>• Does not diagnose or treat any disease or condition associated with or collect relevant data that is required by a specialized registry in their jurisdiction during the EHR reporting period;</li> <li>• Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or</li> <li>• Operates in a jurisdiction where no specialized registry for which the EP is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period.</li> </ul>
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Table C-3: Stage 2 Meaningful Use Objectives - Eligible Providers



Eligible Hospital Meaningful Use Stage 2 Objectives and Measures		
EP- Stage 2 Objectives	Stage 2 Measures	Exclusions
Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the eligible hospital or CAH's risk management process.	
Use clinical decision support to improve performance on high-priority health conditions.	<p>In order for eligible hospitals and CAHs to meet the objective they must satisfy both of the following measures:</p> <p>Measure 1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an eligible hospital or CAH's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.</p> <p>Measure 2: The eligible hospital or CAH has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.</p>	

<p>Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.</p>	<p>An eligible hospital/CAH must meet the thresholds for all three measures:</p> <p>Measure 1: More than 60 percent of medication orders created by the authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.</p> <p>Measure 2: More than 30 percent of laboratory orders created by the authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.</p> <p>Measure 3: More than 30 percent of radiology orders created by the authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.</p>	
<p>Objective Generate and transmit permissible discharge prescriptions electronically (eRx).</p>	<p>More than 10 percent of hospital discharge medication orders for permissible prescriptions (for new and changed prescriptions) are queried for a drug formulary and transmitted electronically using CEHRT.</p>	<p>Any eligible hospital or CAH that does not have an internal pharmacy that can accept electronic prescriptions and is not located within 10 miles of any pharmacy that accepts electronic prescriptions at the start of their EHR reporting period.</p>

<p>The eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.</p>	<p>The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care must:</p> <ol style="list-style-type: none"> <li>1. Use CEHRT to create a summary of care record; and</li> <li>2. Electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.</li> </ol>	
<p>Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.</p>	<p>More than 10 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are provided patient-specific education resources identified by CEHRT.</p>	
<p>The eligible hospital or CAH that receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.</p>	<p>The eligible hospital or CAH performs medication reconciliation for more than 50 percent of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).</p>	

<p>Provide patients the ability to view online, download, and transmit their health information within 36 hours of hospital discharge.</p>	<p>Measure 1: More than 50 percent of all unique patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH are provided timely access to view online, download and transmit to a third party their health information.</p> <p>Measure 2: For an EHR reporting period in 2017, more than 5 percent of unique patients discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH (or patient authorized representative) view, download or transmit to a third party their health information during the EHR reporting period.</p>	<p>Measure 2: Any eligible hospital or CAH that is located in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.</p>
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<p>The eligible hospital or CAH is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.</p>	<p>Measure 1: Immunization Registry Reporting: The eligible hospital or CAH is in active engagement with a public health agency to submit immunization data.</p> <p>Measure 2: Syndromic Surveillance Reporting: The eligible hospital or CAH is in active engagement with a public health agency to submit syndromic surveillance data. •</p> <p>Measure 3: Specialized Registry Reporting: The eligible hospital or CAH is in active engagement to submit data to a specialized registry.</p> <p>Measure 4: Electronic Reportable Laboratory Result Reporting: The eligible hospital or CAH is in active engagement with a public health agency to submit electronic reportable laboratory (ELR) results.</p>	<p>Measure 1 Exclusions: Any eligible hospital or CAH meeting one or more of the following criteria may be excluded from the immunization registry reporting measure if the eligible hospital or CAH:</p> <ul style="list-style-type: none"> <li>• Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the EHR reporting period;</li> <li>• Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or</li> <li>• Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the eligible hospital or CAH at the start of the EHR reporting period.</li> </ul> <p>Measure 2 Exclusions: Any eligible hospital or CAH meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure if the eligible hospital or CAH:</p> <ul style="list-style-type: none"> <li>• Does not have an emergency or urgent care department;</li> <li>• Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from eligible hospitals or CAHs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or</li> <li>• Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from eligible hospitals or CAHs at the start of the EHR reporting period.</li> </ul> <p>Measure 3 Exclusions: Any eligible hospital or CAH meeting at least</p>
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		<p>one of the following criteria may be excluded from the specialized registry reporting measure if the eligible hospital or CAH:</p> <ul style="list-style-type: none"> <li>• Does not diagnose or treat any disease or condition associated with or collect relevant data that is required by a specialized registry in their jurisdiction during the EHR reporting period;</li> <li>• Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or</li> <li>• Operates in a jurisdiction where no specialized registry for which the eligible hospital or CAH is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period.</li> </ul> <p>Measure 4 Exclusions: Any eligible hospital or CAH meeting one or more of the following criteria may be excluded from the electronic reportable laboratory result reporting measure if the eligible hospital or CAH:</p> <ul style="list-style-type: none"> <li>• Does not perform or order laboratory tests that are reportable in their jurisdiction during the EHR reporting period;</li> <li>• Operates in a jurisdiction for which no public health agency is capable of accepting the specific ELR standards required to meet the CEHRT definition at the start of the EHR reporting period; or</li> <li>• Operates in a jurisdiction where no public health agency has declared readiness to receive electronic reportable laboratory results from eligible hospitals or CAHs at the start of the EHR reporting period.</li> </ul>
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Table C-4: Stage 2 Meaningful Use Objectives - Eligible Hospitals

Eligible Professional Meaningful Use Stage 3 Objectives and Measures		
EP- Stage 3 Objectives	Stage 2 Measures	Exclusions
Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical, administrative, and physical safeguards.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the security (including encryption) of data created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), implement security updates as necessary, and correct identified security deficiencies as part of the provider's risk management process.	
Generate and transmit permissible prescriptions electronically (eRx).	More than 60 percent of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.	
Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.	<p>EPs must satisfy both of the following measures in order to meet the objective:</p> <p>Measure 1: Implement five clinical decision support interventions related to four or more CQMs at a relevant point in patient care for the entire EHR reporting period. Absent four CQMs related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.</p> <p>Measure 2: The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.</p>	

<p>Use computerized provider order entry (CPOE) for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who can enter orders into the medical record per state, local, and professional guidelines.</p>	<p>An EP, through a combination of meeting the thresholds and exclusions (or both), must satisfy all three measures for this objective:</p> <p>Measure 1: More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.</p> <p>Measure 2: More than 60 percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.</p> <p>Measure 3: More than 60 percent of diagnostic imaging orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.</p>	<p>Measure 1: Any EP who writes fewer than 100 medication orders during the EHR reporting period.</p> <p>Measure 2: Any EP who writes fewer than 100 laboratory orders during the EHR reporting period.</p> <p>Measure 3: Any EP who writes fewer than 100 diagnostic imaging orders during the EHR reporting period.</p>
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<p>Patient Electronic Access - The EP provides patients (or patient-authorized representative) with timely electronic access to their health information and patient specific education.</p>	<p>EPs must satisfy both measures in order to meet this objective:</p> <p>Measure 1: For more than 80 percent of all unique patients seen by the EP: 1) The patient (or the patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information; and 2) The provider ensures the patient’s health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the provider’s CEHRT.</p> <p>Measure 2: The EP must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access to those materials to more than 35 percent of unique patients seen by the EP during the EHR reporting period.</p>	<p>Measure 1 and Measure 2: A provider may exclude the measures if one of the following applies:</p> <ul style="list-style-type: none"> <li>• An EP may exclude from the measure if they have no office visits during the EHR reporting period.</li> <li>• Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measure.</li> </ul>
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<p>Coordination of Care - Use CEHRT to engage with patients or their authorized representatives about the patient's care.</p>	<p>Providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective:</p> <p>Measure 1: For an EHR reporting period in 2017 and 2018 , more than 5 percent of all unique patients (or their authorized representatives) seen by the EP actively engage with the electronic health record made accessible by the provider and either:</p> <ol style="list-style-type: none"> <li>1. View, download or transmit to a third party their health information; or</li> <li>2. Access their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the provider's CEHRT; or</li> <li>3. A combination of (1) and (2)</li> </ol> <p>Threshold for 2019 and Subsequent Years: The resulting percentage must be more than 10 percent.</p> <p>Measure 2: For an EHR reporting period in 2017 and 2018, more than 5 percent of all unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient authorized representative), or in response to a secure message sent by the patient or their authorized representative. Threshold in 2018 and Subsequent Years: The resulting percentage must be more than 25 percent in order for an EP to meet this measure.</p>	<p>Measure 1, 2 and 3 Exclusion: A provider may exclude the measures if one of the following apply:</p> <ul style="list-style-type: none"> <li>• An EP may exclude from the measure if they have no office visits during the EHR reporting period, or;</li> <li>• Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measure.</li> </ul>
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	Measure 3: Patient generated health data or data from a nonclinical setting is incorporated into the CEHRT for more than 5 percent of all unique patients seen by the EP during the EHR reporting period.	
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<p>Health Information Exchange - The EP provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT.</p>	<p>Providers must attest to all three measures and must meet the threshold for at least two measures to meet the objective.</p> <p>Measure 1: For more than 50 percent of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care:</p> <ol style="list-style-type: none"> <li>1) Creates a summary of care record using CEHRT; and</li> <li>2) Electronically exchanges the summary of care record.</li> </ol> <p>Measure 2: For more than 40 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP incorporates into the patient's EHR an electronic summary of care document.</p> <p>Measure 3: For more than 80 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP performs a clinical information reconciliation. The provider must implement clinical information reconciliation for the following three clinical information sets: 1) Medication. Review of the patient's medication, including the name, dosage, frequency, and route of each medication. 2) Medication allergy. Review of the patient's known medication allergies.</p> <p>3) Current Problem list. Review of the patient's current and active</p>	<p>Measure 1: A provider may exclude from the measure if any of the following apply:</p> <ul style="list-style-type: none"> <li>• Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period.</li> <li>• Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measures.</li> </ul> <p>Measure 2: A provider may exclude from the measure if any of the following apply:</p> <ul style="list-style-type: none"> <li>• Any EP for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the EHR reporting period is excluded from this measure.</li> <li>• Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measures.</li> </ul> <p>Measure 3: Any EP for whom the total of transitions or referrals received and patient encounters in</p>
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	diagnoses	which the provider has never before encountered the patient, is fewer than 100 during the EHR reporting period is excluded from this measure.
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<p>Public Health Reporting - the EP is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.</p>	<p>Measure 1: Immunization Registry Reporting: The EP is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).</p> <p>Measure 2: Syndromic Surveillance Reporting: The EP is in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting.</p> <p>Measure 3: Electronic Case Reporting: The EP is in active engagement with a public health agency to submit case reporting of reportable conditions.</p> <p>Measure 4: Public Health Registry Reporting: The EP is in active engagement with a public health agency to submit data to public health registries.</p> <p>Measure 5: Clinical Data Registry Reporting: The EP is in active engagement to submit data to a clinical data registry.</p>	<p>Measure 1: Any EP meeting one or more of the following criteria may be excluded from the immunization registry reporting measure if the EP:</p> <ul style="list-style-type: none"> <li>Does not administer any immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period;</li> <li>Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or</li> <li>Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data as of 6 months prior to the start of the EHR reporting period.</li> </ul> <p>Measure 2: Any EP meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure if the EP:</p> <ul style="list-style-type: none"> <li>Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system;</li> <li>Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or</li> </ul>
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		<ul style="list-style-type: none"> <li>• Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs as of 6 months prior to the start of the EHR reporting period. •</li> </ul> <p>Measure 3: Any EP meeting one or more of the following criteria may be excluded from the case reporting measure if the EP:</p> <ul style="list-style-type: none"> <li>• Does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction’s reportable disease system during the EHR reporting period;</li> <li>• Operates in a jurisdiction for which no public health agency is capable of receiving electronic case reporting data in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or</li> <li>• Operates in a jurisdiction where no public health agency has declared readiness to receive electronic case reporting data as of 6 months prior to the start of the EHR reporting period. •</li> </ul> <p>Measure 4: Any EP meeting at least one of the following criteria may be excluded from the public health registry reporting measure if the EP:</p> <ul style="list-style-type: none"> <li>• Does not diagnose or directly treat any disease or condition associated with a public health registry in their jurisdiction during the EHR reporting period;</li> <li>• Operates in a jurisdiction for which no public health agency is capable of accepting electronic</li> </ul>
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		<p>registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or</p> <ul style="list-style-type: none"> <li>Operates in a jurisdiction where no public health registry for which the EP is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the EHR reporting period.</li> </ul> <p>Measure 5: Any EP meeting at least one of the following criteria may be excluded from the clinical data registry reporting measure if the EP:</p> <ul style="list-style-type: none"> <li>Does not diagnose or directly treat any disease or condition associated with a clinical data registry in their jurisdiction during the EHR reporting period;</li> <li>Operates in a jurisdiction for which no clinical data registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or</li> <li>Operates in a jurisdiction where no clinical data registry for which the EP is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the EHR reporting period.</li> </ul>

Table C-5: Stage 3 Meaningful Use Objectives - Eligible Professionals



Eligible Hospital Meaningful Use Stage 3 Objectives and Measures		
EP- Stage 3 Objectives	Stage 2 Measures	Exclusions
Protect electronic protected health information (ePHI) created or maintained by the certified electronic health record technology (CEHRT) through the implementation of appropriate technical, administrative, and physical safeguards	Security Risk Analysis: Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the security (including encryption) of data created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), implement security updates as necessary, and correct identified security deficiencies as part of the eligible hospital or critical access hospitals (CAH) risk management process.	
Generate and transmit permissible discharge prescriptions electronically	e-Prescribing: More than 25 percent of hospital discharge medication orders for permissible prescriptions (for new and changed prescriptions) are queried for a drug formulary and transmitted electronically using certified electronic health record technology (CEHRT).	Any eligible hospital or critical access hospital (CAH) that does not have an internal pharmacy that can accept electronic prescriptions and there are no pharmacies that accept electronic prescriptions within 10 miles at the start of their Promoting Interoperability (PI) reporting period.

<p>Provides patients (or patient authorized representative) with timely electronic access to their health information and patient specific education.</p>	<p>Eligible hospitals and critical access hospitals (CAHs) must satisfy both measures in order to meet the objective:</p> <p>Measure 1: Provide Patient Access – For more than 50 percent of all unique patients discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23):</p> <p>(A) The patient (or the patient authorized representative) is provided timely access to view online, download, and transmit his or her health information; and</p> <p>(B) The eligible hospitals or CAH ensures the patient’s health information is available for the patient (or patient authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the application programming interfaces (API) in the eligible hospitals or CAHs certified electronic health record technology (CEHRT).</p> <p>Measure 2: Patient-Specific Education – The eligible hospital or CAH must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access to those materials to more than 10 percent of unique patients seen by the eligible professional (EP) or discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the Promoting Interoperability (PI) reporting period.</p>	<p>Provide Patient Access and Patient-Specific Education – Any eligible hospital or CAH will be excluded from the measure if it is located in a county that does not have 50 percent or more of their housing units with 4Mbps broadband availability according to the latest information available from the Federal Communications Commission (FCC) at the start of the PI reporting period.</p>
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<p>Use certified electronic health record technology (CEHRT) to engage with patients or their authorized representatives about the patient's care.</p>	<p>Eligible hospitals or critical access hospitals (CAHs) must attest to all three measures and must meet the thresholds for at least two measures to meet the objective: View, Download, or Transmit – During the Promoting Interoperability (PI) reporting period, at least one unique patient (or their authorized representatives) discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) actively engage with the EHR made accessible by the provider and one of the following:</p> <p>(1) View, Download, or Transmit to a third party their health information; or</p> <p>(2) Access their health information through the use of an application programming interface (API) that can be used by applications chosen by the patient and configured to the API in the provider's CEHRT; or (i) A combination of (1) and (2)</p> <p>Secure Messaging – For more than 5 percent of all unique patients discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the PI reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative).</p> <p>Patient Generated Health Data Measure 3 – Patient generated health data or data from a nonclinical setting is incorporated into the CEHRT for more than 5 percent of all unique patients discharged from the eligible hospital</p>	<p>Use certified electronic health record technology (CEHRT) to engage with patients or their authorized representatives about the patient's care.</p>
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	or CAH inpatient or emergency department (POS 21 or 23) during the PI reporting period.	
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<p>The eligible hospital or critical access hospital (CAH) provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their electronic health record (EHR) using the functions of certified EHR technology (CEHRT).</p>	<p>Eligible hospitals or CAHs must attest to all three measures and must meet the thresholds for at least two measures to meet the objective.</p> <p>Send a Summary of Care – For more than 10 percent of transitions of care and referrals, the eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care:</p> <p>(1) Creates a summary of care record using CEHRT; and</p> <p>(2) Electronically exchanges the summary of care record.</p> <p>Request/Accept Summary of Care – For more than 10 percent of transitions or referrals received and patient encounters in which the eligible hospital or CAH has never before encountered the patient, the eligible hospital or CAH incorporates into the patient’s EHR an electronic summary of care document.</p> <p>Clinical Information Reconciliation – For more than 50 percent of transitions or referrals received and patient encounters in which the eligible hospital or CAH has never before encountered the patient, the eligible hospital or CAH performs a clinical information reconciliation. The eligible hospital or CAH must implement clinical information reconciliation for the following three clinical information sets: (1) Medication. Review of the patient’s medication, including the name, dosage, frequency, and route of each medication.</p> <p>(2) Medication allergy. Review of the patient’s known medication allergies.</p>	<p>Send a Summary of Care – Any eligible hospital or CAH will be excluded from the measure if it is located in a county that does not have 50 percent or more of their housing units with 4Mbps broadband availability according to the latest information available from the FCC at the start of the Promoting Interoperability (PI) reporting period.</p> <p>Request/Accept Summary of Care – An eligible hospital or CAH may exclude from the measure if any of the following apply: (i) Any eligible hospital or CAH for whom the total of transitions or referrals received and patient encounters in which the eligible hospital or CAH has never before encountered the patient, is fewer than 100 during the PI reporting period is excluded from this measure. (ii) Any eligible hospital or CAH that is located in a county that does not have 50 percent or more of their housing units with 4Mbps broadband availability according to the latest information available from the Federal Communications Commission (FCC) at the start of the PI reporting period.</p> <p>Clinical Information Reconciliation – Any eligible hospital or CAH for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the PI reporting period is excluded from this measure.</p>
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	(3) Current Problem list. Review of the patient's current and active diagnoses.	
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<p>The eligible hospital or critical access hospital (CAH) is in active engagement with a public health agency (PHA) or clinical data registry (CDR) to submit electronic public health data in a meaningful way using certified electronic health record technology (CEHRT), except where prohibited, and in accordance with applicable law and practice.</p>	<p>Immunization Registry Reporting – The eligible hospital or CAH is in active engagement with a PHA to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).</p> <p>Syndromic Surveillance Reporting – The eligible hospital or CAH is in active engagement with a PHA to submit syndromic surveillance data from an urgent care setting.</p> <p>Electronic Case Reporting – The eligible hospital or CAH is in active engagement with a PHA to submit case reporting of reportable conditions. NOTE: Electronic Case Reporting is not required until 2018.</p> <p>Public Health Registry Reporting – The eligible hospital or CAH is in active engagement with a PHA to submit data to public health registries.</p> <p>Clinical Data Registry Reporting – The eligible hospital or CAH is in active engagement to submit data to a CDR.</p> <p>Electronic Reportable Laboratory (ELR) Result Reporting – The eligible hospital or CAH is in active engagement with a PHA to submit ELR results.</p>	<p>Immunization Registry Reporting – Any eligible hospital or CAH meeting one or more of the following criteria may be excluded from the immunization registry reporting measure if the eligible hospital or CAH: (i) Does not administer any immunizations to any of the populations for which data is collected by their jurisdiction’s immunization registry or IIS during the Promoting Interoperability (PI) reporting period; (ii) Operates in a jurisdiction for which no immunization registry or IIS is capable of accepting the specific standards required to 2 Medicare Promoting Interoperability Program Stage 3 Eligible Hospitals, Critical Access Hospitals, and Dual-Eligible Hospitals Attesting to CMS Objectives and Measures for 2018 Objective 6 of 6 Updated: July 2018 meet the CEHRT definition at the start of the PI reporting period; or (i) Operates in a jurisdiction where no immunization registry or IIS has declared readiness to receive immunization data as of six months prior to the start of the PI reporting period.</p> <p>Syndromic Surveillance Reporting – Any eligible hospital or CAH meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure if the eligible hospital or CAH: (i) Does not have an emergency or urgent care department; (ii) Operates in a jurisdiction for which no PHA is capable of receiving electronic syndromic surveillance data from eligible hospitals or CAHs in the specific standards required to meet</p>
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		<p>the CEHRT definition at the start of the PI reporting period; or (iii) Operates in a jurisdiction where no PHA has declared readiness to receive syndromic surveillance data from eligible hospitals or CAHs as of six months prior to the start of the PI reporting period</p> <p>Electronic Case Reporting – Any eligible hospital or CAH meeting one or more of the following criteria may be excluded from the case reporting measure if the eligible hospital or CAH: (i) Does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction’s reportable disease system during the PI reporting period; (ii) Operates in a jurisdiction for which no PHA is capable of receiving electronic case reporting data in the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or (iii) Operates in a jurisdiction where no PHA has declared readiness to receive electronic case reporting data as of six months prior to the start of the PI reporting period.</p> <p>Public Health Registry Reporting – Any eligible hospital or CAH meeting at least one of the following criteria may be excluded from the public health registry reporting measure if the eligible hospital or CAH: (i) Does not diagnose or directly treat any disease or condition associated with a public health registry in their jurisdiction during the PI reporting period; (ii) Operates in a jurisdiction for which no PHA is capable of accepting</p>
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		<p>electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or(iii) Operates in a jurisdiction where no public health registry for which the eligible hospital or CAH is eligible has declared readiness to receive electronic registry transactions as of six months prior to the start of the PI reporting period.</p> <p>Clinical Data Registry Reporting – Any eligible hospital or CAH meeting at least one of the following criteria may be excluded from the CDR reporting measure if the eligible hospital or CAH: (i) Does not diagnose or directly treat any disease or condition associated with a CDR in their jurisdiction during the PI reporting period; (ii) Operates in a jurisdiction for which no CDR is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or (iii) Operates in a jurisdiction where no CDR for which the eligible hospital or CAH is eligible has declared readiness to receive electronic registry transactions as of six months prior to the start of the PI reporting period.</p> <p>ELR Result Reporting – Any eligible hospital or CAH meeting one or more of the following criteria may be excluded from the ELR result reporting measure if the eligible hospital or CAH: (i) Does not perform or order laboratory tests that are reportable in their jurisdiction during the PI reporting</p>
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		<p>period; (ii) Operates in a jurisdiction for which no PHA is capable of accepting the specific ELR standards required to meet the CEHRT definition at the start of the PI reporting period; or (iii) Operates in a jurisdiction where no PHA has declared readiness to receive ELR results from an eligible hospital or CAH as of six months prior to the start of the PI reporting period.</p>
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*Table C-6: Stage 3 Meaningful Use Objectives - Eligible Hospitals*

## Section C.10: Updating the Definition of Meaningful Use

WV reviews proposed rules by ONC as they are made available and will provide comment as necessary to facilitate the ONC's issuing of the final rule to states. WV aligns its meaningful use policies, clinical measures, and objectives according to the CMS Medicare policies, clinical measures, and objectives. This is intended to assist CMS and WV with establishing an equal baseline to assist each other in promoting better outcomes through providers using ONC CEHRT to meet meaningful use requirements. In general, meaningful use is

defined as the use of certified EHR technology in a meaningful manner (i.e. electronic medication tracking) as well as connecting in a way that allows for the electronic exchange of health information with the overall goal to improve the quality of care. There are three stages of MU defined by CMS and, as of now, the State implements these criteria when managing the EHR Incentive Program. Below are short summaries of the stages of meaningful use.

### Section C.10.1: Stage 1 Meaningful Use

The Stage 1 criteria for MU focuses on electronically capturing health information in a coded format. This format is used to track key clinical conditions, communicating that information for care coordination purposes, and initiating the reporting of clinical quality measures and public health information. Required and optional criteria for Stage 1 MU can be found in Appendix D.

### Section C.10.2: Stages 2 and 3 Meaningful Use

Stage 2's criteria is an expansion on Stage 1 criteria, specifically in the area of disease management, clinical decision support, and medication management. Also included in Stage 2 is support for patient access to their health information, transition of care, quality measurement and research, and bi-directional communication with public health agencies.

Stage 3 solely focuses on achieving improvements in quality, safety, and efficiency. It focuses on decision support for national high priority conditions, patient access to self-management tools, access to comprehensive data, and improving population health outcomes.

As of this time, the State is not proposing any change to the definitions or criteria for Meaningful Use expectations.

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#### **CMS GUIDANCE C.10.**

WILL THE SMA BE PROPOSING ANY CHANGES TO THE MU DEFINITION AS PERMISSIBLE PER RULE-MAKING? IF SO, PLEASE PROVIDE DETAILS ON THE EXPECTED BENEFIT TO THE MEDICAID POPULATION AS WELL AS HOW THE SMA ASSESSED THE ISSUE OF ADDITIONAL PROVIDER REPORTING AND FINANCIAL BURDEN.

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## Section C.11: Verification of CEHRT Use

The PIP Solution was developed to automatically cross-reference submitted attestations with the Office of the National Coordinator for Health Information Technology’s (ONC) Certified Health IT Products List (CHPL). The PIPS conducts this verification step while the attestation information is being entered by the provider. PIPS also verifies the CEHRT edition meets the requirements for the attestation program year and meaningful use stage (e.g., 2015 Edition CEHRT is required for Stage 3). Note that, starting in 2019, only Stage 3 attestation is available.

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### **CMS GUIDANCE C.11.**

HOW WILL THE SMA VERIFY PROVIDERS’ USE OF CERTIFIED ELECTRONIC HEALTH RECORD TECHNOLOGY?

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## Section C.12: Collection of Participant Meaningful Use Data

The State believes in reinforcing the six national quality strategy domains; Patient & Family Engagement, Patient Safety, Care Coordination, Population/Public Health, Efficient Use of Healthcare Resources, and Clinical Process/Effectiveness to focus on high-priority health conditions and best-practices for care delivery. Therefore, as previously mentioned, DXC designed the EHR Provider Incentive Program Solution as to collect and verify eligible provider attestation submissions for the State. As part of this process, the PIPS requires participants to submit data supporting their claims of meaningful use of health information technology. Meaningful use data will continue to be collected in this manner through 2021.

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### **CMS GUIDANCE C.12.**

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

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## Section C.13: Collection of Incentive Program Participant Data

Given that the MMIS system is a central repository a number of programs, this data should readily augment the performance of other programs.

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### **CMS GUIDANCE C.13.**

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

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## Section C.14: Interoperability Program Communication Systems

As previously mentioned in Section A.5., the State contracted with DXC to design, develop, and implement an online system for provider attestation submissions. The automated system is referred to as the Provider Incentive Program Solution (PIPS). The PIPS has provided the following critical functions since 2011:

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

Also, the WV Office of Management Information Services (OMIS) developed a centralized process for Enterprise Change Management. As part of routine operations, new rules, regulations, program guidance and/or directives are reviewed for impacts in three areas; which are policy, finance, and systems. The process ensures that any impact is researched and documented and that information is used to then make informed decisions about how DHHR prioritizes initiatives.

## Section C.15: Changes to Interoperability Program Systems

Since the Interoperability Program payments will be ending in 2022, the State does not anticipate any major changes to the PIPS; however, the Enterprise Change Management is the process used by DHHR to evaluate changes proposed to all State IT areas.

The meaningful use changes are implemented using industry standard best practices from the Systems

Development Life Cycle; changes are developed, tested, accepted, and implemented.

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### **CMS GUIDANCE C.14.**

WHAT IT, FISCAL AND COMMUNICATION SYSTEMS WILL BE USED TO IMPLEMENT THE EHR INCENTIVE PROGRAM?

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### **CMS GUIDANCE C.15.**

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

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## Section C.16: Timeline of Changes to the Interoperability Program

In the first quarter of each calendar year, CMS regulation changes are updated in the Provider Incentive Program Solution for the new Interoperability Program year. These modifications are now completed by DXC Technology. These changes require a week or two of development and testing including:

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### CMS GUIDANCE C.16.

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

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- Defining the program year's attestation questionnaire in the PIP database. This includes the metadata for MU measures and electronic care quality measures (eCQM) as specified in the latest CMS final rule.
- Update the PIPS if the QRDA III eCQM reporting file format has changed in the latest version to ensure that the PIPS will properly parse eCQM files uploaded by providers.
- Redirect the PIPS portal help links to the latest CMS Objectives and Measures specification sheets.

Overall, the IT environment in which the PIP system is running has been stable and unchanged over these program years. Figure C-3 summarizes the system modifications made within the past three years. It is anticipated that, as the program closes in 2021, additional modifications will be necessary; however, there are no details at this time. The latest changes have been achieved through a partnership for leverage and reuse through the state of New Jersey.

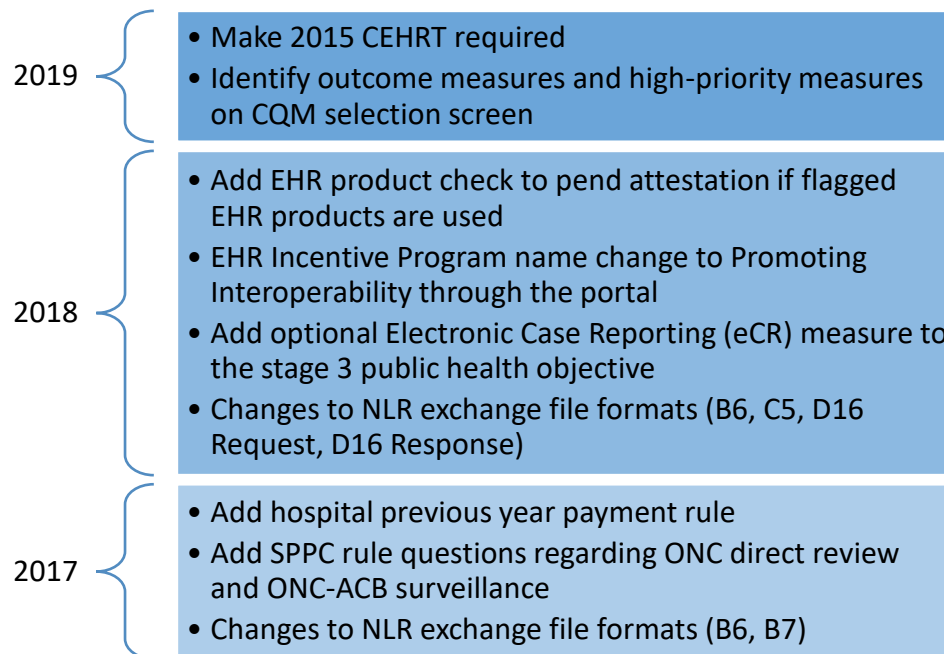


Figure C-3: PIPS System Modification History

## Section C.17: Interfacing with the National Level Repository

Prior to implementing the EHR Provider Incentive Program Solution system, in which eligible providers would register and submit attestation information, BMS worked with DXC to integrate the State's MMIS system with the National Level Repository. This interface was completed during the first quarter of 2011 and has been transferring information throughout the lifetime of the incentive program.

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### **CMS GUIDANCE C.17.**

WHEN DOES THE SMA ANTICIPATE BEING READY TO TEST AN INTERFACE WITH THE CMS NATIONAL LEVEL REPOSITORY (NLR)?

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## Section C.18: Procedures for Accepting NLR Data

Since the successful integration between the PIPS and the National Level Repository in 2011, the State has accepted and continues to accept the following registration data from the National Level Repository:

1. National Provider Identifier (NPI)
2. CMS Certification Number (CCN)
3. Tax Identification Number (TIN)
4. Provider type
5. Provider name

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### **CMS GUIDANCE C.18.**

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

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Data are transferred automatically from the NLR to the PIPS whenever an eligible provider updates their registration in the NLR. The registration data is only sent from the NLR to PIPS when the registration data changes. The transfer of data between the two systems is accomplished via:

- The HITECH NLR application 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 the 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.

The State is currently assessing the challenges and value with achieving interoperability between the Transformed Medicaid Statistical Information System (T-MSIS) and CHIP Program (MACPro).

## Section C.19: EHR Incentive Program Website

The West Virginia Medicaid Management Information System website ([www.wvmmis.com](http://www.wvmmis.com)), is the primary conduit for eligible providers to enroll and receive information regarding the West Virginia’s Interoperability Program. The MMIS portal allows providers to view and submit claims, referrals, and incentive program attestations for meaningful use (and previously A/I/U). Providers are alerted to any changes to the Medicaid Enterprise via this system. Webpages within the MMIS provide guidance and informational documents about the Interoperability Program. Figure C-4 is a screenshot of the current MMIS homepage.

### CMS GUIDANCE C.19.

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



Figure C-4: WV Medicaid Management Information System Homepage

System support is provided by DXC Technology. Contact information for dedicated help is available on the MMIS website and includes phone, e-mail, and live online chat support.



## Section C.20: Anticipated Modification to the MMIS I-APD

Modifications to the MMIS are currently performed through the Change Request (CR) process. The State currently uses a contracted finance bucket of 25,000 hours annually to conduct any changes, revisions, and/or enhancements to the system. All major enhancements to the system are included in the I-APDU. These I-APDUs include, but are not limited to, MMIS, MITA, and HITECH. There is current planning underway to transition all HITECH projects to the MMIS I-APDU that have a connection to the MMIS and that can be certified using the Outcomes Based Certification (OBC) process.

The MMIS I-APDU is submitted annually (at least 60 days prior to beginning of the Federal Fiscal Year) with updates on current projects, as well as, inclusion of any new project and/or initiative. The MMIS I-APDU can be updated and submitted throughout the year, as needed.

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### **CMS GUIDANCE C.20.**

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

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## Section C.21: Interoperability Program Technical Support

Technical support is provided by DXC Technology. The MMIS website contains a phone support line, multiple email addresses, and a live online chat system. Figure B-1 presents a screenshot of the contact information page from the MMIS website. In addition to the support systems, users are able to access guidance and instructional documents through the MMIS webpage.

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### **CMS GUIDANCE C.21.**

WHAT KINDS OF CALL CENTERS/HELP DESKS AND OTHER MEANS WILL BE ESTABLISHED TO ADDRESS EP AND HOSPITAL QUESTIONS REGARDING THE INCENTIVE PROGRAM?

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## Section C.22: Provider Appeals Process and Procedures

If a payment is determined to be improper as part of the audit process, it will be referred to the BMS Office of Program Integrity (OPI) for further investigation. If an appeal is submitted, per the following guidelines, it is documented and forwarded to the appropriate personnel for research and review; this includes assistance from BerryDunn as needed in resolving provider appeals that result from conclusions reached in post-payment reviews. This assistance will include assembling, reviewing, and analyzing supporting data gathered during the post-payment reviews.

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### **CMS GUIDANCE C.22.**

WHAT WILL THE SMA ESTABLISH AS A PROVIDER APPEAL PROCESS RELATIVE TO: A) THE INCENTIVE PAYMENTS, B) PROVIDER ELIGIBILITY DETERMINATIONS, AND C) DEMONSTRATION OF EFFORTS TO ADOPT, IMPLEMENT, OR UPGRADE AND MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY?

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Once BMS' intent to suspend payments is determined and sent to a provider, the milestones in the appeals process are followed:

1. Written evidence of the reason payment should not be suspended must be received by the Commissioner of BMS within five business days after receipt of the notice of intent to suspend. Upon review of submitted evidence, BMS will inform the provider whether the suspension is affirmed or reversed.
2. If, after reviewing the provider submitted evidence, BMS affirms the suspension of payment, the provider may request an evidentiary hearing. This request for an evidentiary hearing must be received by the Commissioner of BMS within 30 calendar days of the provider's receipt of the affirmation of the suspension of payment. The evidentiary hearing will be conducted as detailed in Chapter 300, Provider Participation Requirements, §300.30.2.
3. If a provider refuses or fails to submit written evidence within the specified time period, they shall have 30 calendar days from receipt of the notice of intent to suspend in which to request an evidentiary hearing. The evidentiary hearing will be conducted as detailed in Chapter 300, Provider Participation Requirements, §300.30.2.

### Section C.23: Accounting for Federal Funds

BMS tracks Federal participation for incentive payments (100%) as well as the HIT administrative match (90%). Funds received are 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.

West Virginia uses a combination of fiscal tools internally to assess claims on the CMS-64 form properly for the Federal Financial Participation, for HITECH, Eligibility and Enrollment, and MMIS projects and operations. One key tool the State uses for managing the budget is the State's cost accounting system, the Our Advanced Solution with Integrated Systems (OASIS, [www.wvoasis.gov](http://www.wvoasis.gov)).

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#### **CMS GUIDANCE C.23.**

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

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## Section C.24: Payment Disbursement Schedule

Incentive payments are disbursed to incentive payment providers on a rolling basis. As eligible providers submit their attestations, and they pass the pre-payment audit (detailed in Section C: and Section D:), payments are disbursed on the next weekly payment run. The State currently uses a bi-weekly payment schedule for all employees and disbursements.

BMS informs providers about payment changes with provider workshops, public website updates, webinars, and mass notifications (i.e. email, fax, mail). On a provider by provider basis, the provider is proactively notified according to their preferred remittance notification method and the PIPS web portal. Providers may also contact MMIS provider services to verify any information regarding their payment status.

## Section C.25: Payment Procedures

Payment processing occurs after the registration eligibility verification, and pre-payment program compliance verification processes are complete. This includes the procedures required to generate a cash disbursement to a provider via interface with DXC 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.

After the first non-duplication check, a second one is done to confirm that the EP/EH has a single application with BMS, as previously mentioned. At the same time, the application will lock to prevent edits to the submitted attestation by the provider. DXC is then sent a disbursement request and the NLR is notified of the incentive payment. Once completed, incentive payments will be input to the MMIS as an AD Pay (gross payment) claim. This claim type allows the payment to bypass normal aging requirements for payment selection and will allow the incentive to be selected for payment immediately once the weekly process moves all clean claims in Accounts Payable.

### Section C.25.1: Eligible Provider Payment Calculation

In order to have received Year 1 payments, providers must have attested to the adoption, integration, and/or upgrading of EHR technology during the year, or, for early adopters, meaningful use. For AIU, a provider did not need to have installed CEHRT, since the definition provided at 42 CFR 495.302 allowed the provider to demonstrate AIU by any of the following:

- Acquiring, purchasing, or securing access to CEHRT.

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#### **CMS GUIDANCE C.24.**

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

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#### **CMS GUIDANCE C.25.**

WHAT WILL BE THE PROCESS TO ASSURE THAT MEDICAID PROVIDER PAYMENTS ARE PAID DIRECTLY TO THE PROVIDER (OR AN EMPLOYER OR FACILITY TO WHICH THE PROVIDER HAS ASSIGNED PAYMENTS) WITHOUT ANY DEDUCTION OR REBATE?

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- Installing or commencing utilization of CEHRT capable of meeting meaningful use requirements.
- Expanding the available functionality of CEHRT capable of meeting MU requirements at the practice site, including staffing, maintenance, and training, or upgrade from an existing EHR technology to CEHRT per the Office of the National Coordinator for Health Information Technology (ONC) EHR certification criteria.

Payments to Eligible Professionals (EPs) for Year 1 were computed based on a Federal benchmark referred to as the Net Average Allowable Cost (NAAC), which was established at \$25,000 for Year 1. Year 1 incentive payments were calculated as 85% of the NAAC, or \$21,250. An exception to the payment calculation existed for pediatricians who did not meet the standard patient volume requirements, but did meet a lower, alternative, volume requirement. EPs qualifying under this exception received 2/3 of the standard payment amount, or \$14,167.

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 reviewed supporting documentation supplied by the provider in the pre-payment verification process, and corroborated the supporting documentation with other provider records and Medicaid Management Information System (MMIS) data for a sample of recipients during post-payment verification.

Payments to EPs for Years 2 – 6 are also computed based on the NAAC, which has been established at \$10,000 for these payment years. These payments are calculated as 85% of the NAAC, or \$8,500. Consistent with Year 1 rules, an exception to the payment calculation exists for pediatricians who do not 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.

### Section C.25.2: Eligible Hospital Payment Calculation

Unlike payments made to EPs participating in the EHR Interoperability Program, dually eligible hospitals may receive payment from Medicaid and Medicare and the Final Rule does not standardize EH incentive payment amounts for each payment year. Historical data from each EH is used to determine the EH's aggregate EHR incentive payment amount. The aggregate amount is determined by the State from which the eligible hospital receives its first payment year incentive. If a hospital receives incentive payments from other States in subsequent years, total incentive payments received over all payment years of the program can be no greater than the aggregate EHR incentive amount calculated by the initial State. The aggregate amount is the result of multiplying the overall EHR amount and Medicaid share.

Figure C-5 below is the formula used to calculate eligible hospital incentive payments.

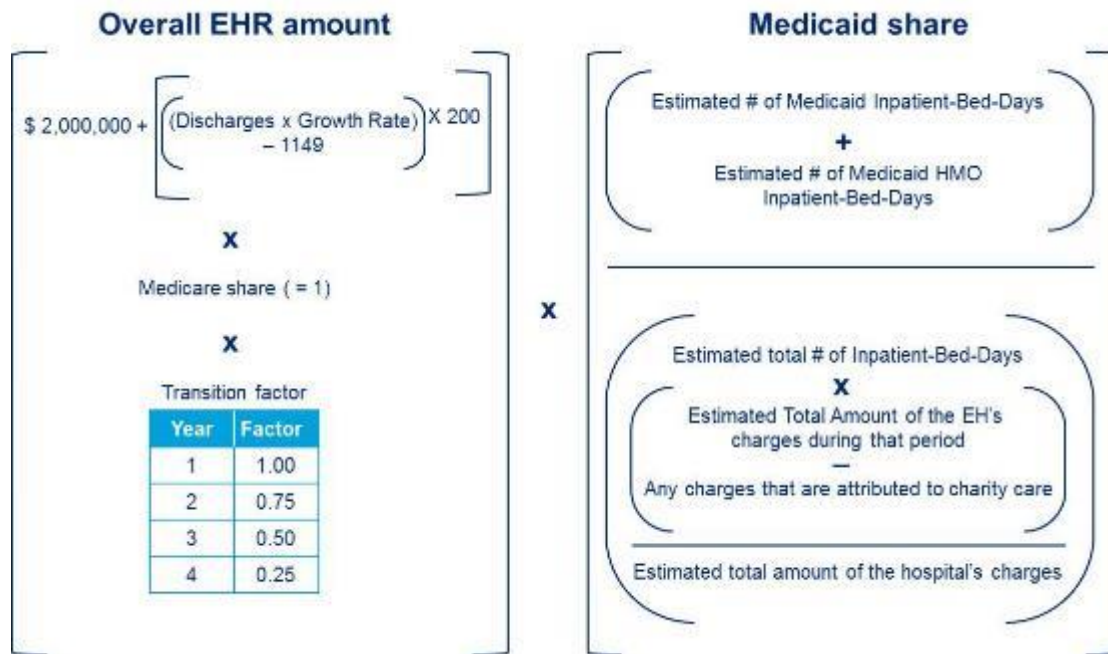


Figure C-5: Eligible Hospital Payment Calculation

## Section C.26: Assuring Payments to CEHRT Promoting Entities

The payee of the incentive payment is specified in the registration data received from the NLR. The payee cannot be changed in PIPS. If the MMIS has no payment affiliation between the attesting provider and the payee, then PIPS denies payment and directs the provider to either the CMS registration application to update the designated payee in their registration or the MMIS provider support to correct payment affiliation information in the MMIS.

In addition, The Office of Quality and Program Integrity, within BMS, and in conjunction with BerryDunn, review and audit payment records for the Interoperability Program. These parties follow the post-payment procedures outlined in the WV Audit Strategy 2019 to ensure that incentive payments are made to qualifying entities. The audit strategy document is lengthy and not included in the SMHP; however, it is available upon request.

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### CMS GUIDANCE C.26.

WHAT WILL BE THE PROCESS TO ASSURE THAT MEDICAID PAYMENTS GO TO AN ENTITY PROMOTING THE ADOPTION OF CERTIFIED EHR TECHNOLOGY, AS DESIGNATED BY THE STATE AND APPROVED BY THE US DHHS SECRETARY, ARE MADE ONLY IF PARTICIPATION IN SUCH A PAYMENT ARRANGEMENT IS VOLUNTARY BY THE EP AND THAT NO MORE THAN 5 PERCENT OF SUCH PAYMENTS IS RETAINED FOR COSTS UNRELATED TO EHR TECHNOLOGY ADOPTION?

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## Section C.27: Payments to Managed Care Plans

The Office of Quality and Program Integrity, in conjunction with BerryDunn, review and audit payment records for the Interoperability Program. These parties follow the post-payment procedures outlined in the WV Audit Strategy 2019 to ensure that incentive payments through managed care organizations does not exceed 105 percent.

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### **CMS GUIDANCE C.27.**

WHAT WILL BE THE PROCESS TO ASSURE THAT THERE ARE FISCAL ARRANGEMENTS WITH PROVIDERS TO DISBURSE INCENTIVE PAYMENTS THROUGH MEDICAID MANAGED CARE PLANS DOES NOT EXCEED 105 PERCENT OF THE CAPITATION RATE PER 42 CFR 438.6, AS WELL AS A METHODOLOGY FOR VERIFYING SUCH INFORMATION?

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## Section C.28: Assuring Eligible Provider and Hospital Payment Calculations

The WV BMS has contracted with BerryDunn to work in tandem with the Office of Program Integrity (OPI) for post-payment auditing and verifications of the Interoperability Program. To ensure the proper incentive payment amounts have been disbursed to eligible providers and hospitals, the contractor ensures that recipients:

- Are properly registered
- Meet eligibility requirements
- Meet CEHRT and MU requirements
- Receive the proper payment amount(s)

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### **CMS GUIDANCE C.28.**

WHAT WILL BE THE PROCESS TO ASSURE THAT ALL HOSPITAL CALCULATIONS AND EP PAYMENT INCENTIVES ARE MADE CONSISTENT WITH THE STATUTE AND REGULATION?

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Post-payment verifications are not conducted on every EP/EH attesting; instead, the processes described in Section D.5: are used to select the audit sample.

The contractor re-performs the payment calculations for all eligible hospitals and providers. Values used in these calculations are confirmed by documentation. Afterwards, the following steps are taken to further confirm payment amounts to eligible hospitals:

1. Review and Re-verification of Meaningful Use Measures
2. Hospital Eligibility Re-verification
3. Post-Desk Audit Provider Communication
4. Analysis and Reporting
5. On-site Review
6. Report Audit Results to CMS



There is no summary data currently available regarding audit findings and lessons learned on negative audit findings and lessons learned related to EP and EH calculations and payments. This will be included in the next iteration of the SMHP.

### Section C.28.1: Review and Re-verification of Meaningful Use Measures

Prior to reviewing the MU measures, the auditor will review and verify the following items:

1. EHR Certification ID – verify the EHR via the State Level Repository that the EHR systems is certified. If the provider invoked the 2014 Flexibility Rule, obtain documentation supporting that this invocation is appropriate.
2. Reporting period, payment year, and attestation all match. Verified via SLR.
3. 80% of all unique patients are in the CEHRT – validate via patient records or an EHR report listing of all patients that the provider has at least 80% of all its unique patients' data recorded in its CEHRT.
4. Validate that 50% of the patient encounters have occurred at location(s) with CEHRT – validate via EHR report list of all patients seen by the provider during the EHR reporting period. If a provider has multiple locations, then request that the location of the encounter also be reported. In addition, a practice with multiple locations, request a list for which locations have CEHRT installed and which do not. Multiple locations can be verified via the MMIS
5. Verify the numerator and denominator of every measure attested to, as well as patient volume documentation.

### Section C.28.2: Hospital Eligibility Re-Verification

The auditors utilize the audit toolkit, found in Appendix G, to perform the post-payment desk audits. For each eligibility requirement, BMS documents the data supporting each procedure performed in the Results/Calculations column, indicate if the hospital is eligible or not eligible, include a work paper reference to the documentation used to support the Results/Calculations and Conclusion columns, and document comments or areas of concern identified and BMS' recommended follow-up action in the Comments/Follow-up column.

If BMS identifies an area of concern relating to an eligibility requirement, BMS should discuss the concern with the hospital and continue to follow up to obtain the additional clarification and/or information needed to perform the procedure and conclude on the related results. The BMS should only deny a hospital's eligibility if BMS has made reasonable efforts to verify and conclude on each requirement.

### Section C.28.3: Post-desk Audit Communication

Additional documentation request letters will be sent out to all providers after their initial submitted documentation is evaluated. After reviewing all desk audit documentation, the providers are evaluated to see if an on-site visit is deemed necessary. If so, on-site letters (Appendix E and Appendix F) are then mailed to selected providers. A "Failure to Respond" letter is sent to the provider if no response is received from the initial letter.

#### Section C.28.4: Analysis and Reporting

BMS and BerryDunn summarize results of the follow-up processes and disposition of exceptions. Causes of exceptions, as well as improper payment amounts, are investigated for a root cause. All audit results are sent to the lead auditor, via a summary sheet, for a final quality assurance review and finalization. After final approval, a summary report of findings is prepared.

#### Section C.28.5: On-site Review and Reporting to CMS

Any selected providers that do not provide adequate documentation pursuant to a desk audit will be considered for an on-site audit. In addition, a sample of at least 10% of all desk audit providers will be selected for a field audit, regardless of adequacy of documentation. Field audits include an informal walkthrough of the EHR system along with a review of all outstanding documentation that is needed to verify and complete the audit.

Once completed, BMS will report the audit results to CMS with a E7 file.

#### Section C.29: Role of Contractors

The State contracts with two primary entities to implement the EHR Incentive/Interoperability Program. Each assumes specific roles and responsibilities, as outlined below. Note that these contractors have been mentioned throughout the SMHP and a more detailed account of their functions can be found in the corresponding sections of the document.

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#### **CMS GUIDANCE C.29.**

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

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DXC Technology, is the WV BMS fiscal agent. DXC performs pre-payment review and ensures the provider meets the EHR Interoperability Program guidelines. It should be noted that Molina designed and operated the automated data collection and processing system that supports most of the critical functions of the incentive/interoperability program; DXC continues to operate the system.

The second contractor is the account and management firm BerryDunn. BerryDunn assists the WV BMS with conducting attestation reviews and performing post-payment audit functions. BerryDunn also supports BMS in the appeals process of the Medicaid EHR Interoperability Program.



## Section C.30: Adapting to Guidance and Resource Availability

As mentioned in Section C.16:, the annual updates to the automated attestation submission and verification system, the Provider Incentive Program Solution, is implemented once CMS releases the updated requirements. Integration with the National Level Registry, as well as the IT troubleshooting services provided by DXC Technology, have been effective for a majority of the State's incentive program and minimal updates are anticipated.

Included within the State's SS-A (Appendix H) and in support of the broader West Virginia DHHR goal of establishing results-based accountability, BMS identified the following milestones to be used to measure the progress toward desired outcomes in maturing the State's HIT environment:

- Implement integrated eligibility system (IES);
- Accelerate Adoption and MU of EHR;
- Ensure Adoption of Key Standards to Guide HIT in the State; and
- Use Information to Drive Improvement in Key Areas throughout the State.

Finally, as previously mentioned in Section A.7:, the WVHIN is working to identify methods and projects in order to prepare for the end of HITECH funding, and a move to potential MMIS financial support. More information on this is included in the section referenced above.

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### **CMS GUIDANCE C.30.**

STATES SHOULD EXPLICITLY DESCRIBE WHAT THEIR ASSUMPTIONS ARE, AND WHERE THE PATH AND TIMING OF THEIR PLANS HAVE DEPENDENCIES BASED UPON:

- THE ROLE OF CMS (E.G. THE DEVELOPMENT AND SUPPORT OF THE NATIONAL LEVEL REPOSITORY; PROVIDER OUTREACH/HELP DESK SUPPORT)
  - THE STATUS/AVAILABILITY OF CERTIFIED EHR TECHNOLOGY
  - THE ROLE, APPROVED PLANS AND STATUS OF THE REGIONAL EXTENSION CENTERS
  - THE ROLE, APPROVED PLANS AND STATUS OF THE HIE COOPERATIVE AGREEMENTS
  - STATE SPECIFIC READINESS FACTORS
-

## Section D: Audit Strategy for the Interoperability Program

The WV Office of Program Integrity (OPI) is one of four Offices that form the Division of Plan Management and Integrity within WV BMS. OPI's primary objective is to detect abuse, fraud, and waste within the Medicaid Enterprise by conducting pre- and post-payment reviews of claims data in tandem with other investigative procedures. BMS has contracted with DXC Technology to conduct pre-payment verification procedures for the Interoperability Program; these steps are outlined and discussed throughout the previous section. Post-payment procedures are conducted in partnership between OPI and BerryDunn. They are designated to meet the requirements set forth in the federal regulations at 42 CFR §455.1, §455.13 §456.1, and §456.3.

OPI's post-payment functions within the Medicaid Enterprise include, but are not limited to, the following:

- Data Analysis and Review
- Post Payment Review
- Prevention versus Collection
- Medicaid Fraud Referrals
- Provider Eligibility

The primary audit objective is to ensure that state and federal funds are used appropriately and accounted for in a transparent manner. Process and procedures designed in tandem for BMS, primarily OPI, and BerryDunn are established to standardize attestation reviews, post-payment auditing, and the appeals process for the State's Promoting Interoperability Program. A full account of these procedures can be found in the WV Audit Strategy, 2019 document upon request.

### Section D.1: Detecting Fraud and Abuse

Variances between providers' self-reported attestations and BMS data and calculation are analyzed during the desk and/or on-site review process. During this process, BerryDunn assesses the extent to which a provider's statements and other documentation obtained can be verified through independent outside sources. In the event BMS is notified that audits have uncovered potential fraud, waste, or abuse – BMS will coordinate with BerryDunn to determine what additional procedures should be performed.

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#### **CMS GUIDANCE D.1.**

DESCRIBE THE METHODS THE SMA WILL EMPLOY TO IDENTIFY SUSPECTED FRAUD AND ABUSE, INCLUDING NOTING IF CONTRACTORS WILL BE USED. PLEASE IDENTIFY WHAT AUDIT ELEMENTS WILL BE ADDRESSED THROUGH PRE-PAYMENT CONTROLS OR OTHER METHODS AND WHICH AUDIT ELEMENTS WILL BE ADDRESSED POST-PAYMENT.

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The risk of undetected fraud, waste, or abuse remains low when providers' self-reported attestations can be verified using historical paid claims data, cost reports, or other financial reports. Examples of information that are not easily verified include Managed Care

Organization (MCO) claims due to omissions of encounters in MCO claims data, and FQHC/RHC claims data. There is a high risk that fraud, waste, or abuse may not be detected for self-reported patient volumes and other attestations for which there are no benchmarks or other reports to compare, such as discharges or encounters reported in the numerator for non-Medicaid patients.

## Section D.2: Auditing Overpayments

If a payment is determined to be improper as part of the audit process previously described, it will be referred to OPI for further investigation. If it is ultimately determined that an improper payment has been made, a Denial Form along with a Submission of Appeal Form will be sent to the applicant by postal mail and email (if an email address is provided), as well as the amount of the improper payment.

If an appeal is submitted, the appeal will be logged, forwarded to the appropriate personnel, researched, and additional information requested as necessary. If necessary, a hearing will be scheduled and conducted in accordance with legal requirements, with a ruling based on evidence presented. The provider will be contacted to arrange terms of repayment. Improper payments will be recuperated either through a check from the provider or through credits against future payments.

## Section D.3: Addressing Fraud or Abuse

If suspected fraud, waste, or abuse is identified, BMS and auditors will coordinate as needed until final resolution is achieved in the matter. OPI is responsible for investigating improper payments and notifying the West Virginia Medicaid Fraud Control Unit in cases where fraud is suspected in the provider attestations or payment process. All risk areas were considered when audit procedures were designed.

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### **CMS GUIDANCE D.2.**

HOW WILL THE SMA TRACK THE TOTAL DOLLAR AMOUNT OF OVERPAYMENTS IDENTIFIED BY THE STATE AS A RESULT OF OVERSIGHT ACTIVITIES CONDUCTED DURING THE FFY?

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### **CMS GUIDANCE D.3.**

DESCRIBE THE ACTIONS THE SMA WILL TAKE WHEN FRAUD AND ABUSE IS DETECTED.

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## Section D.4: Leveraging Data to Verify Meaningful Use

Currently, verification of meaningful use is done with registration on the [Meaningful Use Registration Site](#). This site targets the cancer registry, Electronic Lab Reporting, Immunization registry and/or Syndromic Surveillance. The registration gives information on the stage and the status the registration. When the specified electronic attestations have been met by Eligible Hospitals/Critical Access Hospitals and Eligible Professionals they can receive incentive payments from Medicaid/Medicare EHR Incentive Program. A letter is provided to the registrant indicating that they have met meaningful use criteria; this letter can then be submitted with their incentive program attestation.

Additionally, as part of the post-payment auditing procedures, desk audits and on-site reviews may be conducted (Section C.28:). A majority of information required to conduct these reviews is anticipated as being collected during the EP and EH attestation submission using the automated PIPS system. OPI and BerryDunn will leverage the information gathered and available so as not to burden providers with unnecessary requests.

## Section D.5: Audit Sampling Procedures

BMS, through the Office of Quality and Program Integrity, identifies cases, potentially requiring an audit, from three primary methods: referrals, case findings, and results from an analysis of system processes. Audit referrals may be received from many sources and come in varying degrees of completeness. Referrals are made by members, providers, BMS staff, WV DHHR staff, the Medicaid Fraud Control Unit (MFCU), and others.

OPI personnel may also identify cases by the use of outlier reports utilizing resources which may include, but are not limited to: current procedural terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); Current Dental Terminology (CDT); Medicare DRG Definitions Manual; Medicare Correct Coding Guide; and applicable pharmacy standards or research of manuals to identify qualifiers to services such as service limits, mutually exclusive codes, services which should be provided in a bundled rate, or services limited to certain eligibility groups.

Finally, OPI personnel identify potential cases for audit by conducting a systems analysis. For example, personnel compare like member and provider groups resulting in Exception Reports which identify Medicaid members whose utilization of services is aberrant when compared to members of similar health. These reports also identify providers whose practice patterns are

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### **CMS GUIDANCE D.4.**

IS THE SMA PLANNING TO LEVERAGE EXISTING DATA SOURCES TO VERIFY MEANINGFUL USE (E.G. HIES, PHARMACY HUBS, IMMUNIZATION REGISTRIES, PUBLIC HEALTH SURVEILLANCE DATABASES, ETC.)? PLEASE DESCRIBE.

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### **CMS GUIDANCE D.5.**

WILL THE STATE BE USING SAMPLING AS PART OF AUDIT STRATEGY? IF YES, WHAT SAMPLING METHODOLOGY WILL BE PERFORMED?\* (E.G. PROBE SAMPLING; RANDOM SAMPLING)

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aberrant when compared to their peer group. Also, the analyses identify increases or decreases in provider activity over time resulting in Spike Reports. These reports can be generated across all categories of providers and at an individual level and are focused to identify the appropriateness of a drug or procedure. Produced on an as-needed basis, Spike Reports are accompanied by documentation identifying the issues that cause the provider/member to be identified as an exception.

Whenever referrals are received by OPI, specific queries can be run on the data analysis system with specific parameters focused on the suspected fraud or abuse.

### Section D.6: Maintaining Efficacy & Integrity in Incentive Program Oversight

The Solution system was designed to automatically populate registration information from the National Level Registry, eliminating the risk of entry error as well as speed up the process of attesting. During the submission process, the PIPs automatically verifies eligibility, professional certifications, and patient volume calculations, along with other required incentive program criteria. This reduces burden on BMS, DXC, and BerryDunn auditors during their manual checks.

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#### **CMS GUIDANCE D.6.**

**\*\*WHAT METHODS WILL THE SMA USE TO REDUCE PROVIDER BURDEN AND MAINTAIN INTEGRITY AND EFFICACY OF OVERSIGHT PROCESS (E.G. ABOVE EXAMPLES ABOUT LEVERAGING EXISTING DATA SOURCES, PIGGY-BACKING ON EXISTING AUDIT MECHANISMS/ACTIVITIES, ETC.)?**

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### Section D.7: Responsible Parties for Program Integrity

As previously mentioned, the WV Office of Program Integrity (OPI) is one of four Offices that form the Division of Plan Management and Integrity within BMS. OPI's primary objective is to detect abuse, fraud, and waste within the Medicaid Enterprise by conducting post-payment reviews of claims data in tandem with other investigative procedures. The WV OPI works in tandem with two contractors: DXC

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#### **CMS GUIDANCE D.7.**

**WHERE ARE PROGRAM INTEGRITY OPERATIONS LOCATED WITHIN THE STATE MEDICAID AGENCY, AND HOW WILL RESPONSIBILITY FOR EHR INCENTIVE PAYMENT OVERSIGHT BE ALLOCATED?**

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Technology which is integral to the pre-payment auditing while BerryDunn is integral with the post-payment audits and verifications.

## Section E: The State’s HIT Roadmap

The 2016 MITA 3.0 SS-A established the strategic direction for the HIT outcomes, and the solutions that will achieve the outcomes, in the MITA Roadmap. This Roadmap is updated on an annual basis to continually adjust the State’s strategy to achieve desired outcomes in the business processes, information, and technology capability maturity. The strategic plan is aligned with the DHHR Strategic Plan, the State Health Information Plan (SHIP), and the CMS Seven Standards and Conditions.

### Section E.1: Roadmap Overview

The HITECH HIT assessment teams will use the HITECH Supplement to the MITA SS-A Companion Guide for tailored guidance on performing a MITA 3.0 SS-A on HITECH systems. The Supplement is designed to be used alongside the MITA 3.0 SS-A Companion Guide to determine the “as-is” and “to-be” maturity of HITECH systems.

For HITECH systems, CMS encourages a minimum “to-be” MITA Maturity of Level 4 to support MU

capabilities. The process for achieving MITA Maturity Levels 4 or 5 begins with a MITA SS-A on HITECH systems. The Supplemental Guide for a MITA SS-A provides tailored guidance to assist State Medicaid Agencies in performing a MITA SS-A on SMA systems supporting EHR Incentive Program and HITECH infrastructure systems. Performing a MITA SS-A on the incentive program and HITECH infrastructure systems is to assist the SMA in aligning systems development activities and help ensure MITA compliance.

The output of a MITA SS-A defines a “to-be” state of system maturity. For the State’s EHR Incentive Program and HITECH infrastructure systems, a minimum of Level 4 is recommended to support seamless communication and integration between the SMA and federal agencies.

A MITA assessment of the EHR Incentive Program and HITECH infrastructure systems is limited to determination of “as-is” and “to-be” systems maturity. Since an SS-A is on a limited scope of systems, data, and business processes, much of the business process modeling activities and MITA transformation efforts performed in a full MMIS assessment are not required. For an SMA’s EHR Incentive Program and HITECH infrastructure, the MITA assessment of business processes will be limited to the following eight MITA business areas: Business Relationship Management; Care Management, Financial Management, Plan Management, Provider Management, Eligibility and Enrollment Management, Member Management, and Performance Management. Assessment of the Member Management business area is dependent on the release of MITA 3.0 enhancements which include descriptions and details of corresponding business processes when they are finalized by CMS.

The HITECH assessment leverages the MITA 3.0 SS-A artifacts to tailor the MITA Business Architecture, Information Architecture, or Technical Architecture capability as defined in the

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#### **CMS GUIDANCE E.1.**

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

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respective MITA Capability Matrix. The assessment will document N/A (not applicable) capabilities or architectures and provide justification where appropriate.

To promote effective operational planning for HITECH systems, business leads from each Business Area validate that planning activities align with the MITA Framework. Since HIT is dispersed throughout the various business areas, the WV HITECH Steering Committee is made up of the WV Medicaid Enterprise business process owners. The MITA Maturity Planning Diagram is used in the SMHP to define the steps in the planning process for maturing HITECH systems and make recommendations based on the state goals and objectives in the MITA HITECH Roadmap. The workflow diagram in Figure E-1 describes the process used by the HIT Assessment team in conducting this assessment consistent with the guidance provided in the CMS MITA HITECH Toolkit.

Figure 1: Workflow Diagram

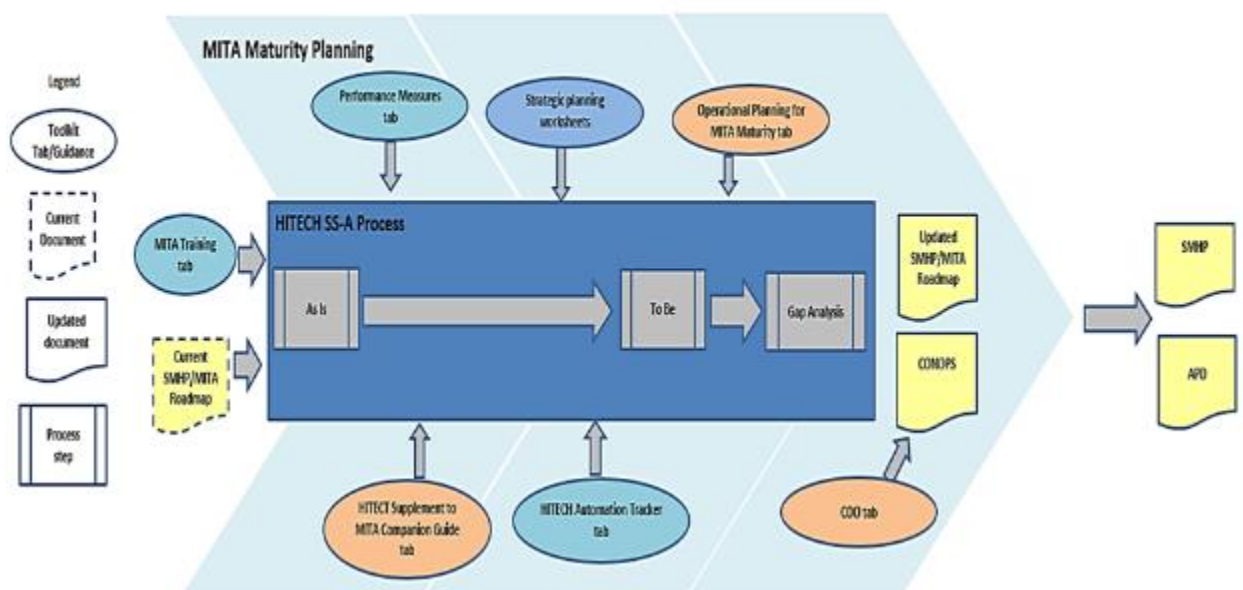


Figure E-1: Workflow Diagram

The following definitions correspond with the process steps identified in the figure above:

- **Business Improvement Case Studies** – Examples of how BMS can use HITECH capabilities to achieve business and strategic goals and direct discussions of State HIT systems development.
- **MITA 3.0 Roadmap** – BMS’ five-year plan for increasing the Electronic Health Record (EHR) Incentive Program’s and HITECH infrastructure systems’ MITA Maturity level. See the 2016 MITA SS-A Roadmap\*.
- **Supplemental Guide to MITA SS-A Companion Guide** – Tailored guidance to assist BMS in performing a MITA 3.0 SS-A on the State EHR Incentive Program and HITECH infrastructure systems, if applicable.

- **Concept of Operations (COO)** – COO for planned HITECH business operations, processes, and systems, including stakeholder and information interactions.
- **Operational Plan for MITA Maturity** – Guide for BMS on achieving MITA Business Architecture (BA), Information Architecture (IA), and Technical Architecture (TA) Maturity Levels 4 or 5 for its HITECH IT solutions.
- **Gap Analysis** – Comparison of the “as-is” and “to-be” MITA Maturity Levels for BMS’ EHR Incentive Program and HITECH infrastructure systems.
- **SMHP** – Provides information in State plans for HITECH implementation; West Virginia’s SMHP may require updating and renewing with MU.
- **Advance Planning Document (APD)** – APDs are required for several federally funded HIT initiatives; the State should regularly refer to this document while implementing EHR Incentive Program and HITECH infrastructure systems. The State can refer to these plans to understand the implementation plans and timeline for other HIT systems.

In addition to the work performed by BerryDunn, the WVHIN contracted with Audacious Inquiry (Ai) to conduct strategic planning and sustainability sessions regarding the transition of HIE activities from HITECH to MMIS funding. From the planning/ sustainability sessions, Ai mapped major health information technology capabilities from the Office of the National Coordinator (ONC) HIE Maturity Model against the 80 MITA Business Processes defined by CMS. To facilitate this mapping, Ai grouped the HIT capabilities into five functional categories.

1. **Service Delivery:** Includes ADT Events/Encounter alerting, advanced directives, care plans, e-Prescribing, EMS integration, image sharing, Immunization Registry, etc.
2. **Population Health:** Includes risk assessment, social determinants of health survey, population health information, analytics reporting, etc.
3. **Master Data Management:** Includes patient identifiers, provider attribution, patient record locator, Provider/Resource Directory, etc.
4. **Consumer:** Includes patient education, patient portal information, and patient-generated data.
5. **Administrative:** Includes claims information, death reporting, Disease and Public Health Registries, eligibility and benefits information, patient consent, etc.

Figure E-2 below illustrates the phased approach proposed by Ai to sustain current HIE projects while identifying future use cases.



## Guiding Principles for Determining Progression Paths

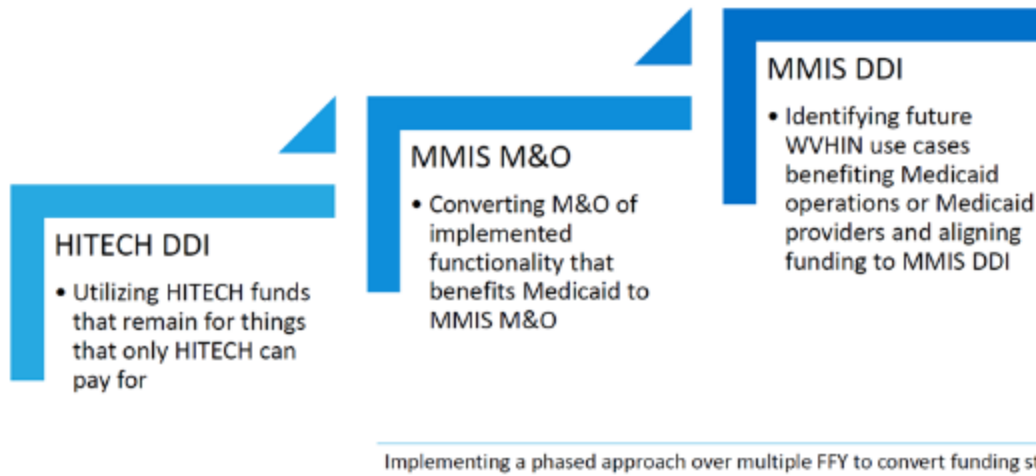


Figure E-2: Guiding Principles for Determining Progression Paths

### Section E.2: Benchmarks for EHR Adoption

West Virginia’s expectation is that both eligible and non-eligible providers meet meaningful use requirements. It is a hope that our state will collaborate with CMS by sharing information regarding WV providers to further assist with identifying not how many expected vs participated and dropped off, but whether they decided to participate in the Medicare or Medicaid EHR PIP or decided not to at all and why.

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#### **CMS GUIDANCE E.2.**

WHAT ARE THE SMA’S EXPECTATIONS FOR PROVIDER EHR TECHNOLOGY ADOPTION OVER TIME? ANNUAL BENCHMARKS BY PROVIDER TYPE?

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## Section E.3: Benchmarks for BMS Goals

Measurable activities and benchmarks set to monitor BMS' progress towards the initiatives, previously listed in Section B.1., are found and explained below in Table E-1.

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### CMS GUIDANCE E.3.

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

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ID	West Virginia's Health IT Initiatives Benchmarks
1	<p><b>Re-procure Medicaid Enterprise Integrated Eligibility and Enrollment System (IES):</b> The IES/WVPATH contract was awarded and began development in late 2017. It implements a new IES to help transform the eligibility system within the Medicaid enterprise to provide West Virginians a better eligibility experience. This includes a transition period from the current system to the new system, with new functionality beginning to come online in 2020.</p>
2	<p><b>Accelerate Adoption and MU of EHR:</b> As part of the current SMHP, West Virginia has targeted completing its post-payment audit of EHR PIP, providing feedback based on the audit findings to providers to help them improve their MU of EHR. Please see Section 3.6.2 of the SS-A for additional information about the post-payment audit.</p>
3	<p><b>Ensure Adoption of Key Standards to Guide Health IT in the State:</b> West Virginia will continue to leverage MITA as a key standard to help drive health IT in West Virginia, both within the Medicaid agency and throughout the state for Medicaid business processes. This effort and the MITA standard will help identify duplicated systems and processes that can be addressed to increase the efficiency and effectiveness of West Virginia's Medicaid program. Key standards could include:</p> <ul style="list-style-type: none"> <li>• Implementing a default EHR for all State hospitals</li> <li>• Developing a standard data interface</li> <li>• Ensuring compliance with federal security standards</li> </ul> <p>The State will endeavor to set standards for how data is received from providers. This could be from EHR systems or another HIE. For example, the cancer registry contains data from a multitude of sources. The State sets the parameters for collecting that data. Everything will be collected in one way, regardless of the source.</p> <p>Through the use of MITA as the baseline for assessing the DHHR enterprise, we move toward more standardization.</p>
4	<p><b>Establish Security Protocols and Guidelines for Protection and Use of Data:</b> West Virginia recognizes that it is necessary to have security protocols and guidelines for the protection of sensitive health information. To that end, West Virginia will continue to focus on security protocols and leveraging industry standards, such as National Institute of Standards and Technology (NIST) standards that are included in the Minimum Acceptable Risk Standards for Exchanges (MARS-E). BMS will demonstrate its commitment to security protocols by maintaining its Authority To Connect (ATC) to the Federal Data Services Hub (FDSH), which</p>

ID	West Virginia's Health IT Initiatives Benchmarks
	requires satisfying MARS-E requirements.
5	<p><b>Use Information to Drive Improvement in Key Areas throughout the State:</b> West Virginia is using the information that is now available due to the investment in its data warehouse to drive improvement in several areas. This includes:</p> <ul style="list-style-type: none"> <li>• <b>Substance Use Disorder (SUD):</b> Leveraging the relationship with its Federal partners, West Virginia is taking advantage of the opportunity to tackle the challenges that opioids present in West Virginia through a CMS Section 1115 waiver. This project is able to make more informed decisions, using information available because of enhancements in its health IT infrastructure, such as the data warehouse.</li> <li>• <b>Access to Care (AtC):</b> West Virginia is focusing on helping ensure care for its citizens across the state through an AtC monitoring plan. The information necessary to develop the plan and to monitor AtC is available because of enhancements in its health IT infrastructure, such as the data warehouse.</li> <li>• <b>WVCHIP:</b> WVCHIP recently transitioned to become part of DHHR in West Virginia. With this move, WVCHIP is also leveraging the health IT infrastructure available to DHHR to drive decisions with information. WVCHIP has partnered with WVU to embed a data analyst within WVCHIP to help them leverage information available in the data warehouse.</li> </ul> <p>Emergency Department Super-utilizers: Leveraging the information that is now available in the MMIS and data warehouse, including managed care encounters, West Virginia is examining how super-utilizers use the Emergency Department. This is leading to efforts to work with hospitals and MCOs to better manage for these individuals.</p>
6	<p><b>Leverage MITA to Enhance Business Processes throughout BMS:</b> BMS uses the MITA blueprint to examine business priorities, plan future improvements, and acquire technical applications that meet the health IT needs of both the State and Federal partners.</p>
7	<p><b>Leverage Outside Partnerships:</b> BMS is committed to working with their Federal (and other state) partners. This relationship has allowed West Virginia to improve its health IT landscape, while also supporting the goals of its Federal partners.</p>
8	<p><b>Enhance the State's Role in Driving Technology:</b> BMS has the opportunity to drive the use of technology through the establishment of standards that set common expectations for how vendors and third parties interact with the State, especially when State funding is supporting the project.</p>

Table E-1: WV Health IT Initiative Benchmarks, 2017

## Section E.4: Benchmarks for Auditing and Oversight

As previously mentioned, post-payment review of EHR Incentive Program to test calculations, obtain documentation supporting eligibility assertions made by providers as well as obtain documentation supporting attestations regarding the ongoing use of a CEHRT, and test calculations and obtain documentation supporting the payment amounts for providers.

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### **CMS GUIDANCE E.4.**

DISCUSS ANNUAL BENCHMARKS FOR AUDIT AND OVERSIGHT ACTIVITIES.

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Providers selected for desk reviews will be asked to submit documentation supporting their denominator and numerator supporting patient volume, discharges, and/or other reported information submitted during the attestation process. In addition, providers' documentation will be reviewed to determine the certified EHR technology documentation supports the attestation. To verify meaningful use, they will be required to provide documentation supporting the measures that were chosen during their attestation. On-site reviews are done on approximately 10% of the population of providers selected for audit. The on-site review is conducted as described in Section C.28.:

## Appendices

### Appendix A: Abbreviation and Definition List

Abbreviation	Definition
ACO	Accountable Care Organizations
ADL	Activities of Daily Living
ADT	Admission, Discharge, Transfer notifications
AI	Audacious Inquiry, LLC
AIU or A/I/U	Adoption/Implementation/Upgrade
APD	Advanced Planning Document
ARC	Appalachian Regional Commission
ARRA	American Recovery Reinvestment Act
AtC	Access to Care
BMS	Bureau for Medical Services
BPH	Bureau for Public Health
CAH	Critical Access Hospital
CDBG	Community Development Block Grant
CDEMS	Chronic Disease Electronic Management System
CDT	Current Dental Terminology
CEHRT	Certified Electronic Health Record Technology
CFR	Code of Federal Regulations
CHC	Community Health Center
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CHPL	Certified Health IT Product List
CIO	Chief Information Officer
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
CMSO	Center for Medicaid & State Operations

Abbreviation	Definition
COO	Concept of Operations
COTS	Commercial Off-the-Shelf
CPT	Current Procedural Technology
CQM	Clinical Quality Measures
CRISP	Chesapeake Regional Information System for our Patients
DADS	Data Analytics and Decision Support
DDI	Design, Develop and Implement
DHHR	Department of Health and Human Resources
DIHN	Delaware Health Information Network
DOA	Department of Administration
DOC	Department of Commerce
DoD	Department of Defense
DRG	Diagnosis Related Group
DSS	Decision Support System
DSS	Decision Support System
DW	Data Warehouse
eCQM	Electronic Clinical Quality Measure
EDS	Enterprise Data Solution
EH	Eligible Hospital
ENS	Encounter Notification Service
EP	Eligible Professional
EPLS	Excluded Parties List System
EVV	Electronic Visit Verification
FCC	Federal Communications Commission
FQHC	Federally Qualified Health Center
HCA	Health Care Authority
HCPCS	Healthcare Common Procedure Coding System
EHR	Electronic Health Record

Abbreviation	Definition
HIE	Health Information Exchange
HIS	Health Information Service
HISP	Health Information Service Providers
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health Act
HRSA	Health Resources and Services Administration
HUD	Department of Housing and Urban Development
I-APD	Interim Advanced Planning Document
IA	Information Architecture
IADL	Instrumental Activities of Daily Living
IAPD	Implementation Advanced Planning Document
IES	Integrated Eligibility System
IHS	Indian Health Service
IPA	Individual Practice Association
IT	Information Technology
JRP	Joint Requirements Planning
KHIE	Kentucky Health Information Exchange
LTC	Long Term Care
MACPro	Medicaid and CHIP Portal Program
MAR	Management and Administrative Reports
MCO	Managed Care Organization
MES	Medicaid Enterprise Systems
MITA	Medicaid Information Technology Architecture
MMIS	Medicaid Management Information System
MMIS FFP	Medicaid Management Information System/Federal Financial Participation
MOU	Memorandum of Understanding
MU	Meaningful Use
NAAC	Net Average Allowable Cost

Abbreviation	Definition
NCQA	National Committee for Quality Assurance
NIST	National Institute of Standards and Technology
NLR	National Level Registry
OEPS	Office of Epidemiology & Prevention Services
OMIS	Office of Management Information Services
ONC	Office of the National Coordinator
OPI	Office of Program Integrity
PATH	People's Access to Health
PCDH	Patient Centered Data Home
PECOS	Provider Enrollment, Chain and Ownership System
PHA	Public Health Agency
PHR	Personal Health Record
PIP	Provider Incentive Program
PIPS	Provider Incentive Program Solution
PMO	Project Management Office
POP	Patient Online Portal
QPP	Quality Payment Program
QRDA	Quality Reporting Document Architecture
REC	Regional Extension Centers
RFP	Request for Proposal
RHC	Rural Health Center
RTM	Requirements Traceability Matrix
SDE	State Designated Entity
SFY	State Fiscal Year
SHIEC	Strategic Health Information Exchange Collaborative
SHIP	State Health Information Plan
SIU	Scheduling Information
SLR	State Level Registry



Abbreviation	Definition
SMA	State Medicaid Agency
SMA IT	State Medicaid Agency Information Technology
SMHP	State Medicaid Health Information Technology Plan
SQL	Structured Query Language
SS-A	State Self-Assessment
SUPLN	State University Partnership Learning Network
SUR	Surveillance and Utilization Reports
T-MSIS	Transformed Medicaid Statistical Information Systems
TA	Technical Architecture
VA	Veterans Administration
WV	West Virginia
WV BEC	West Virginia Broadband Enhancement Council
WV DHHR	West Virginia Department of Health and Human Resources
WV DOC	West Virginia Department of Commerce
WV OPI	West Virginia Office of Program Integrity
WV PATH	West Virginia People's Access to Help
WV SHSIP	West Virginia State Health System Innovation Plan
WVHII	West Virginia Health Improvement Institute
WVHIMSS	West Virginia Health Information Management Systems Society
WVHIN	West Virginia Health Information Network
WVOT	West Virginia Office of Technology
WVPCA	West Virginia Primary Care Association
WVRHITEC	West Virginia Regional Health Information Technology Extension Center
WVSOM	West Virginia School of Osteopathic Medicine
WVTA	West Virginia Telehealth Association
WVU	West Virginia University
WVU OHSR	West Virginia University Office of Health Services Research
WVU-SON	West Virginia University School of Nursing

Abbreviation	Definition
XML	Extensible Markup Language

## Appendix B: 2020 “As-Is” HIT Environmental Survey

This appendix contains the questions, response options, and frequencies of responses for the Environmental Survey conducted as part of the 2020 SMHP. This survey was conducted during the autumn of 2019.

**Dear West Virginia Health Community,** The WV Department of Health and Human Services is revising the State Medicaid Health Technology Plan (SMHP) and is requesting your input. We need to update our understanding of the landscape for Medicaid-related health and healthcare information technology in West Virginia to help us plan improved health services. If you could take a few minutes to fill out this online survey, it will be of service to the state. The survey is focused on how information technology is being used in WV and does not collect any personal or health information. While we provide a place for names and organizations, you may omit that information if you wish to remain anonymous. You may skip any question and/or stop taking the survey at any time you wish. The 2011 version of the SMHP may be found at <https://dhhr.wv.gov/bms/Provider/EHR/Documents/SMHP.pdf> if you are interested.

After the 2020 plan is finalized, it will be available as well. Please feel free to pass this on to individuals or organizations in West Virginia that have interests and involvement in health-related information technology. The state of West Virginia appreciates your contribution to our planning process. If you have any questions about this survey, please contact Brandon Lewis, Health IT Director, WV Bureau for Medical Services, at 304-558-2419 or Dr. Robert Duval, WVU School of Public Health, at 304-581-1826. If you wish to continue to the survey, please select "yes" below.

#	Answer	%	Count
1	Yes	100.00%	49
2	No	0.00%	0
	Total	100%	49

**Please select which best describes your role at the organization.**

#	Answer	%	Count
1	Physician	0.00%	0
2	Nurse	2.70%	1
3	Physician Assistant	0.00%	0
4	Administrator	32.43%	12

5	Chief Information Officer (CIO)	16.22%	6
6	Other	48.65%	18
	Total	100%	37

**In what county is your healthcare facility/organization, where you see the majority of your clients/patients, located?**

#	Answer	%	Count
2	Berkeley	4.00%	1
6	Cabell	16.00%	4
7	Calhoun	4.00%	1
10	Fayette	4.00%	1
12	Grant	4.00%	1
17	Harrison	4.00%	1
20	Kanawha	32.00%	8
22	Lincoln	8.00%	2
27	McDowell	4.00%	1
31	Monongalia	12.00%	3
32	Monroe	4.00%	1
39	Preston	4.00%	1
	Total	100%	25

**Do any of your organization 's current HIT activities affect Medicaid members?**

#	Answer	%	Count
23	Yes	79.31%	23
24	No	20.69%	6
	Total	100%	29



**Select the category which best describe the healthcare facility/organization where you see the majority of your clients/patients.**

#	Answer	%	Count
4	Behavioral/Mental Health	0.00%	0
8	Government agency (State or Federal)	20.83%	5
1	Hospital	16.67%	4
3	Long-term Care/Nursing Home	0.00%	0
7	Non-profit organization	29.17%	7
2	Physician Office/Ambulatory Care	12.50%	3
5	Urgent Care	4.17%	1
6	Other	16.67%	4
	Total	100%	24

**Please select which best describes your Physicians Office/Ambulatory Care facility?**

#	Answer	%	Count
1	Primary Care	0.00%	0
2	Specialty Care	66.67%	2
3	Multi-Specialty Care	33.33%	1
4	Other	0.00%	0
	Total	100%	3

**Please specify the type of care provided at your clinic.**

Family medicine, pediatrics, behavioral health, dental, nephrology, osteopathic.

Internal medicine and Neurology, Neurophysiology

**Is your healthcare facility a Veterans Affairs (VA) facility?**

#	Answer	%	Count
1	Yes	0.00%	0
2	No	100.00%	23
	Total	100%	23

**Is your healthcare facility/organization a Federally Qualified Health Center (FQHC)?**

#	Answer	%	Count
1	Yes	95.24%	20
2	No	4.76%	1
	Total	100%	21

**Does your facility currently have Health Information Technology (HIT) systems in place?**

#	Answer	%	Count
1	Yes	95.24%	20
2	No	4.76%	1
	Total	100%	21

**What year were HIT systems first implemented?**

What year were HIT systems first implemented?

---

2005

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2009

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2012

---

Implementing now

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2011

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2012

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2017

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DK



**Please provide your vendor and software product information.**

Vendor Name	Software Name	Software Version
Nexgen	Nextgen Enterprise	5.9/8.4
athenahealth	athenaone	19.11
Medhost	Enterprise	2019 R1
MUMMS software	hummingbird	2.47
Greenway Healthcare	Intergy	11.10
Cerner; HIE	HealtheIntent	
Greenway	Intergy	11.10.00.51
Greenway Health	Greenway Intergy	11.10
AdvancedMD	AdvancedMD	N/A
DK	EOIC	DK
AdvancedMD	AdvancedMD	N/A
DK	EOIC	DK
Nexgen	Nextgen Enterprise	5.9/8.4
Medhost	Enterprise	2019 R1
MUMMS software	hummingbird	2.47
athenahealth	athenaone	19.11
Greenway	Intergy	11.10.00.51
Greenway Healthcare	Intergy	11.10
Greenway Health	Greenway Intergy	11.10
Cerner; HIE	HealtheIntent	

**Is your current Electronic Health Record (EHR) system certified on the Certified Health IT Product List (CHPL)?**

#	Answer	%	Count
1	Yes	90.91%	10
2	No	9.09%	1
	Total	100%	11

**Please indicate the HIT systems currently in place. Select all that apply.**

#	Answer	%	Count
1	Billing Services Management	10.59%	9
2	Clinical Quality Measures (CQM)	10.59%	9
3	e-Prescribing	10.59%	9
14	Electronic Health Record (EHR)	11.76%	10
4	Health Informatics	5.88%	5
5	Health Information Exchange (HIE)	10.59%	9
6	Patient Portal	9.41%	8
13	Patient Registry	7.06%	6
7	Personal Health Record (PHR)	7.06%	6
8	Predictive Analysis Reporting	1.18%	1
9	Remote Patient Monitoring	0.00%	0
10	Secure Patient e-Mail	9.41%	8
11	Telehealth Services	5.88%	5
12	Other	0.00%	0
	Total	100%	85

**Has your facility made HIT upgrades within the past 12 months?**

#	Answer	%	Count
1	Yes	75.00%	9
2	No	25.00%	3
	Total	100%	12

**Do any of your facility's current HIT activities affect Medicaid members?**

#	Answer	%	Count
1	Yes	100.00%	8
2	No	0.00%	0
	Total	100%	8

**Why has your facility not implemented HIT systems? Select all that apply.**

#	Answer	%	Count
1	Audit and/or risk management concerns	0.00%	0
2	Difficulty selecting the right EHR vendor	0.00%	0
3	Disruption to the practice	0.00%	0
4	Funding is unknown or unavailable	0.00%	0
5	Lack of custom options to meet the clinics needs	0.00%	0
6	Minimal staffing and/or training resources	0.00%	0
7	Not seen as a need for the organization	0.00%	0
8	Resistance to change	0.00%	0
9	Security/Privacy concerns	0.00%	0
10	Other	100.00%	1
	Total	100%	1

**Does your facility plan to upgrade HIT systems over the next 5 years?**

#	Answer	%	Count
1	Definitely yes	45.45%	5
2	Probably yes	9.09%	1
3	Might or might not	45.45%	5
4	Probably not	0.00%	0
5	Definitely not	0.00%	0
	Total		11

**Please indicate the HIT system upgrade(s) anticipated within the next 5 years.**

#	Answer	%	Count
1	Billing Services Management	7.00%	3
2	Clinical Quality Measures (CQM)	7.00%	3
3	e-Prescribing	9.00%	4
4	Electronic Health Record (EHR)	11.00%	5
5	Health Informatics	9.00%	4
6	Health Information Exchange (HIE)	4.00%	2
7	Patient Portal	4.00%	2
8	Patient Registry	7.00%	3
9	Personal Health Record (PHR)	7.00%	3
10	Predictive Analysis Reporting	7.00%	3
11	Remote Patient Monitoring	9.00%	4
12	Secure Patient e-Mail	4.00%	2
13	Telehealth Services	11.00%	5
14	Other	4.00%	2
	Total	100.00%	45

**Please specify the HIT system functionality anticipated within the next 5 years.**

**\*ONLY ANSWER**

Population Health Software – Cerner HealthIntent

**Why is your facility not planning to upgrade HIT systems within the next 5 years? Select all that apply.**

#	Answer	%	Count
1	Audit and/or risk management concerns	0.00%	0
2	Difficulty selecting the right EHR vendor	0.00%	0
3	Disruption to the practice	0.00%	0
4	Funding is unknown or unavailable	0.00%	0
5	Lack of custom options to meet the clinics needs	0.00%	0
6	Minimal staffing and/or training resources	0.00%	0
7	Not seen as a need for the organization	0.00%	0
8	Resistance to change	0.00%	0
9	Security/Privacy concerns	0.00%	0
10	Other	0.00%	0
	Total	0.00%	0

**Please specify why your facility is not planning to upgrade HIT systems within the next 5 years.**

N/A

**Which data do you send and/or receive electronically? Select all that apply.**

#	Answer	%	Count
1	Imaging	25.00%	5
2	Lab results	30.00%	6
3	Medication Lists	25.00%	5
4	Medication Allergies	15.00%	3
5	Other	5.00%	1

6	None – our facility does not send or receive information electronically	0.00%	0
Total			20

**Please specify which data you send and/or receive electronically.**

N/A

**Is your facility participating in the West Virginia Health Information Network (WVHIN), the health information exchange (HIE) for the State?**

#	Answer	%	Count
1	Yes	80.00%	8
2	No	20.00%	2
Total		100%	10

**Please rank the WVHIN services from 1 (most used) to 6 (least used). Skip this question if you do not know.**

#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
1	Ambulatory Integration	2.00	6.00	4.00	2.00	4.00	2
2	Encounter Notification Services (ENS)	1.00	6.00	2.25	2.17	4.69	4
3	Retrieve information about a patient (i.e. labs, discharge, etc.)	3.00	6.00	4.00	1.41	2.00	3

#	Field	Minimum	Maximum	Mean	Std Deviation	Variance	Count
4	Send information to another provider	4.00	4.00	4.00	0.00	0.00	2
5	WV Direct	3.00	6.00	4.50	1.12	1.25	4
6	WV e-Directive Registry	4.00	6.00	5.00	1.00	1.00	2

**What barriers have prevented your clinic from participating in the WVHIN? Select all that apply.**

#	Answer	%	Count
1	Audit and/or risk management concerns	20.00%	1
2	Difficulty selecting the right EHR vendor	20.00%	1
3	Disruption to the practice	0.00%	0
4	Funding is unknown or unavailable	20.00%	1
5	Lack of custom options to meet the clinics needs	0.00%	0
6	Minimal staffing and/or training resources	20.00%	1
7	Not seen as a need for the organization	20.00%	1
8	Resistance to change	0.00%	0
9	Security/Privacy concerns	0.00%	0
10	Other	0.00%	0
	Total		5

**Please specify the reason(s) your facility does not participate in the WVHIN.**

N/A

**If the barriers were eliminated, would you participate in the WVHIN?**

#	Answer	%	Count
1	Yes	100.00%	2
2	No	0.00%	0
	Total	100%	12

**Do you refer patients electronically?**

#	Answer	%	Count
1	Yes	44.44%	4
2	No	55.56%	5
	Total		9

**Do you receive referrals electronically?**

#	Answer	%	Count
1	Yes	33.33%	3
2	No	66.67%	6
	Total		9



**Do you receive electronic notifications if a patient is admitted or discharged from a hospital?**

#	Answer	%	Count
1	Notifications about admittance	0.00%	0
2	Notifications about discharge	0.00%	0
3	Both admittance and discharge notification	33.33%	3
4	None	66.67%	6
	Total		9

**Does your facility use Telemedicine services?**

#	Answer	%	Count
1	Yes	44.44%	4
2	No	55.56%	5
	Total		9

**What Telemedicine services does your facility offer?**

3 respondents answered with 3 different answers.

1. “telepsych”
2. “We utilize telehealth between our providers and specialist for our Ryan White program.”
3. “Behavioral”

**Why does your facility not offer Telemedicine services?**

4 respondents answered with 4 different answers.

1. “not feasible”
2. “We did when Dr. Deleportas was with us, but our remaining providers do not”
3. “We are not equipped to offer service yet”
4. “funding and staffing”

**In the last five years, has your facility or organization received any funding for HIT related projects? Select all that apply.**

#	Answer	%	Count
1	State funding only	15.38%	2
2	Federal funding only	23.08%	3
3	Other funding	15.38%	2
4	None	46.15%	6
	Total		13

**Please provide the total amount of State funds received in the last five years for HIT related projects and how they were spent.**

N/A

**Please provide the total amount of Federal funds received in the last five years for HIT related projects and how they were spent.**

1 respondent answered.

1. "Unknown"

**Please provide the total amount of Other funds received in the last five years for HIT related projects and how they were spent.**

N/A

**What type of internet access does your facility currently have?**

#	Answer	%	Count
1	Broadband (Cable/DSL/FiberOptics)	100.00%	9
2	Dial Up	00.00%	0
3	Satellite	00.00%	0
4	Other	00.00%	0
5	None	00.00%	0
	Total		9

**Please explain the type of internet used by your facility.**

N/A



**What barriers prevent your facility from obtaining or upgrading internet services? Select all that apply.**

#	Answer	%	Count
1	None – Internet is adequate for facility needs	40.00%	4
2	Cost	30.00%	3
4	Lack of knowledge/coverage in region	20.00%	2
4	Lack of knowledge/ technical support	0.00%	0
5	Resistance to change	10.00%	1
6	Other	0.00%	0
	Total		10

**Please explain the barrier(s) that prevent your facility from obtaining or upgrading internet services.**

N/A

**Do you anticipate a change in internet services within the next year?**

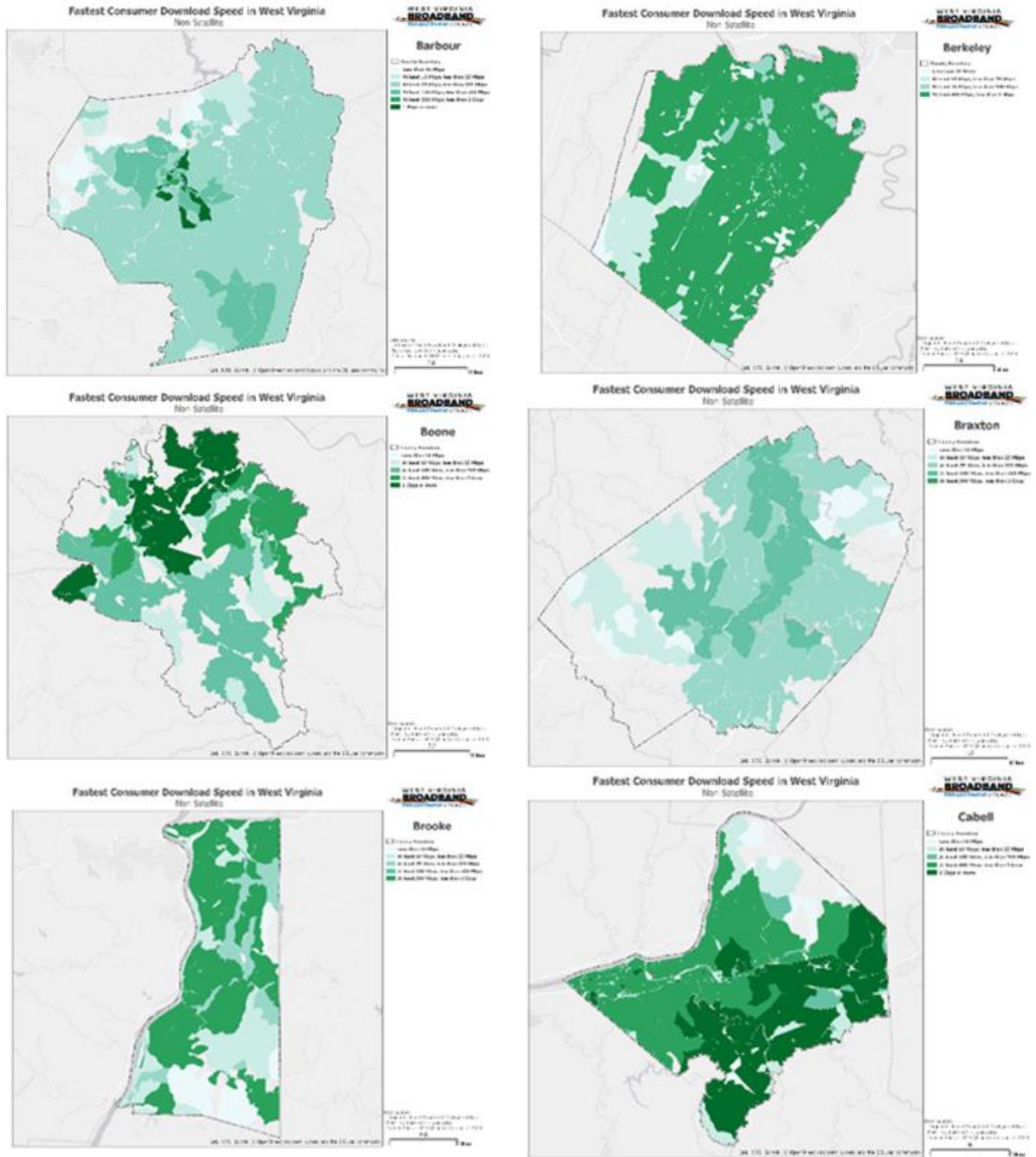
#	Answer	%	Count
1	Yes	20.00%	1
2	No	80.00%	4
	Total		5

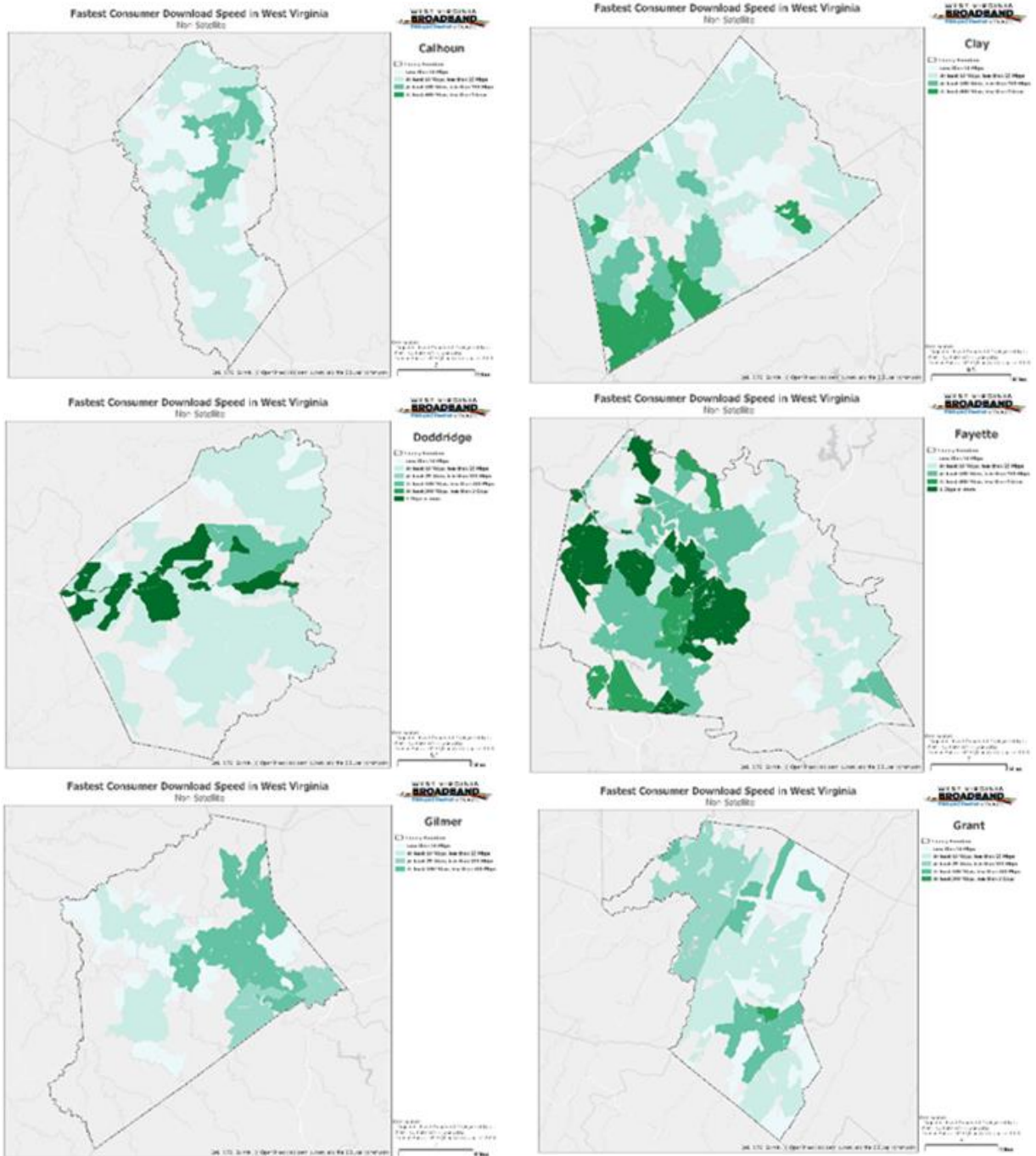
**Do you consider your current internet access a barrier to functioning more efficiently?**

#	Answer	%	Count
1	Definitely yes	40.00%	2
2	Probably yes	0.00%	0
3	Possibly	0.00%	0
4	Probably not	60.00%	3
5	Definitely not	0.00%	0
	Total		5

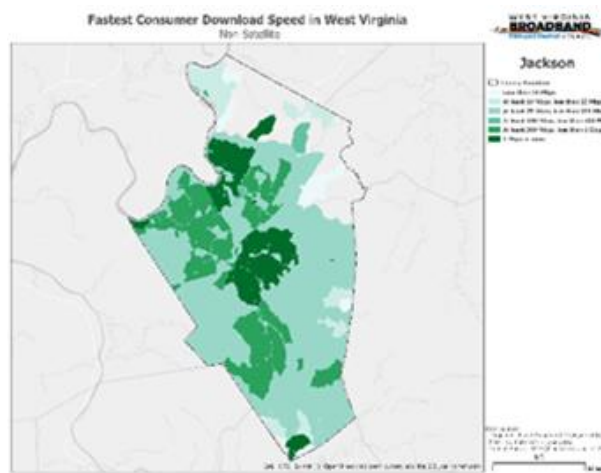
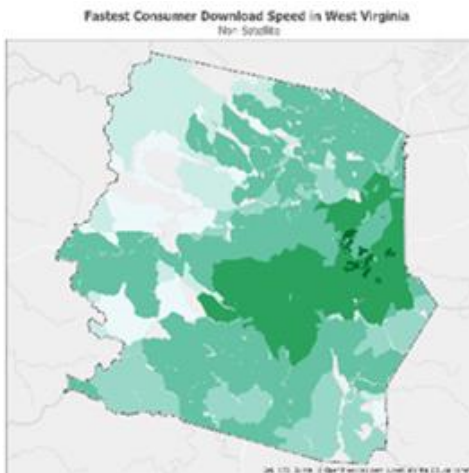
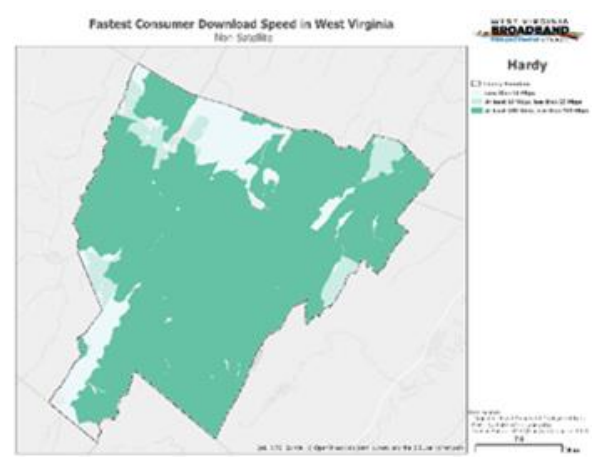
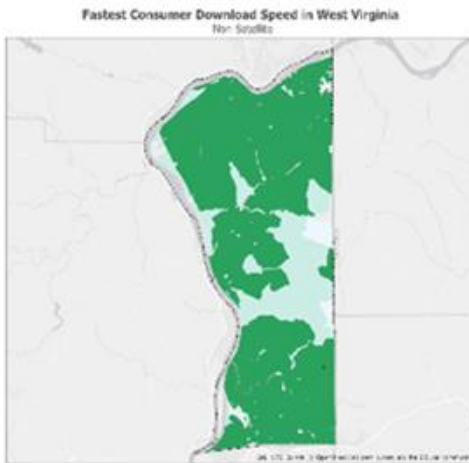
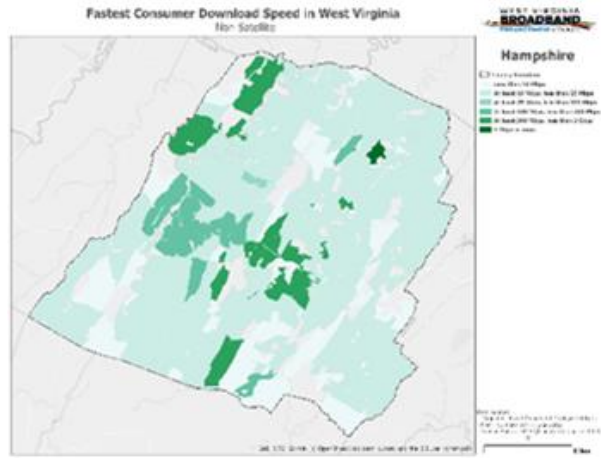
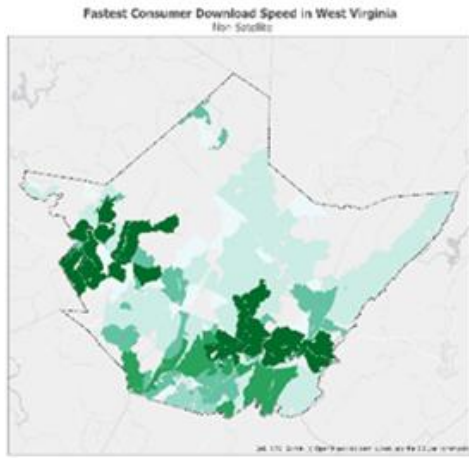
## Appendix C: County Level Broadband Maps

All county broadband maps were created by the WV Broadband Council and can be found at <https://broadband.wv.gov/maps/west-virginia-broadband-fixed-wireline-speeds-by-county/>.





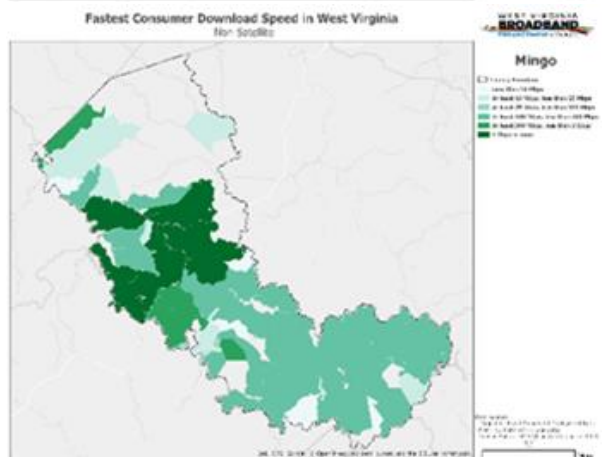
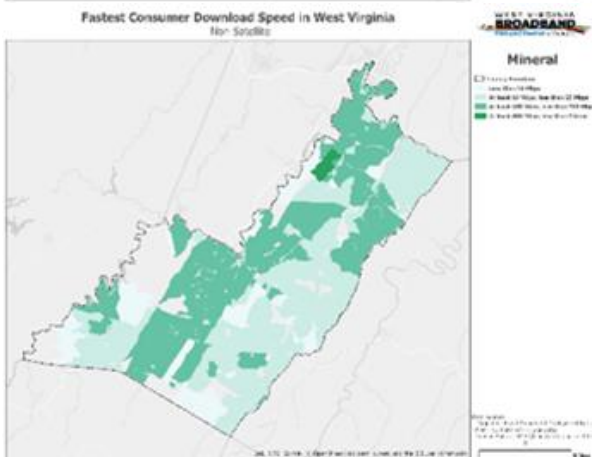
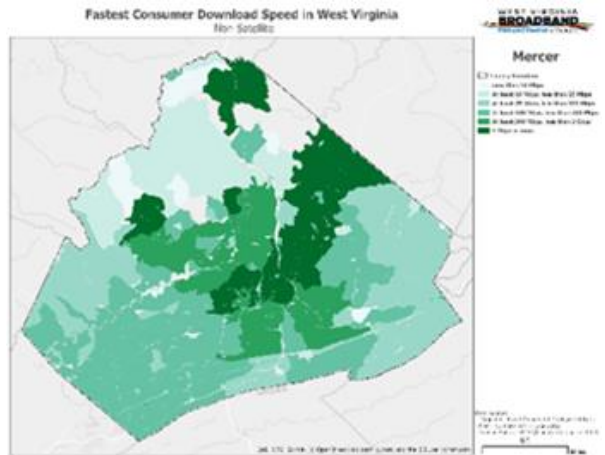
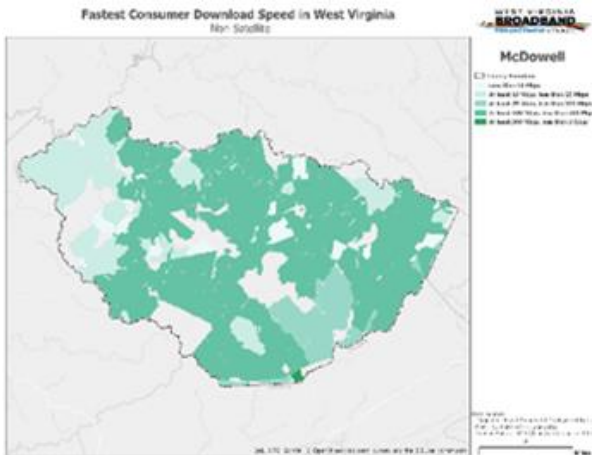
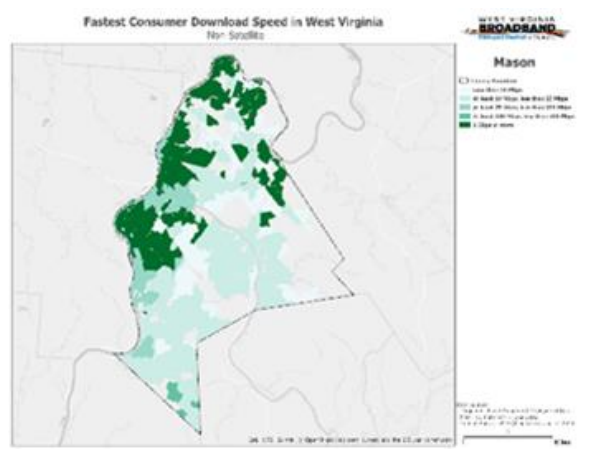
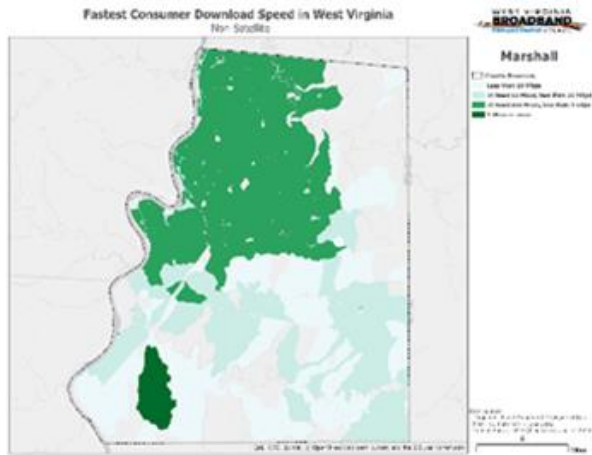


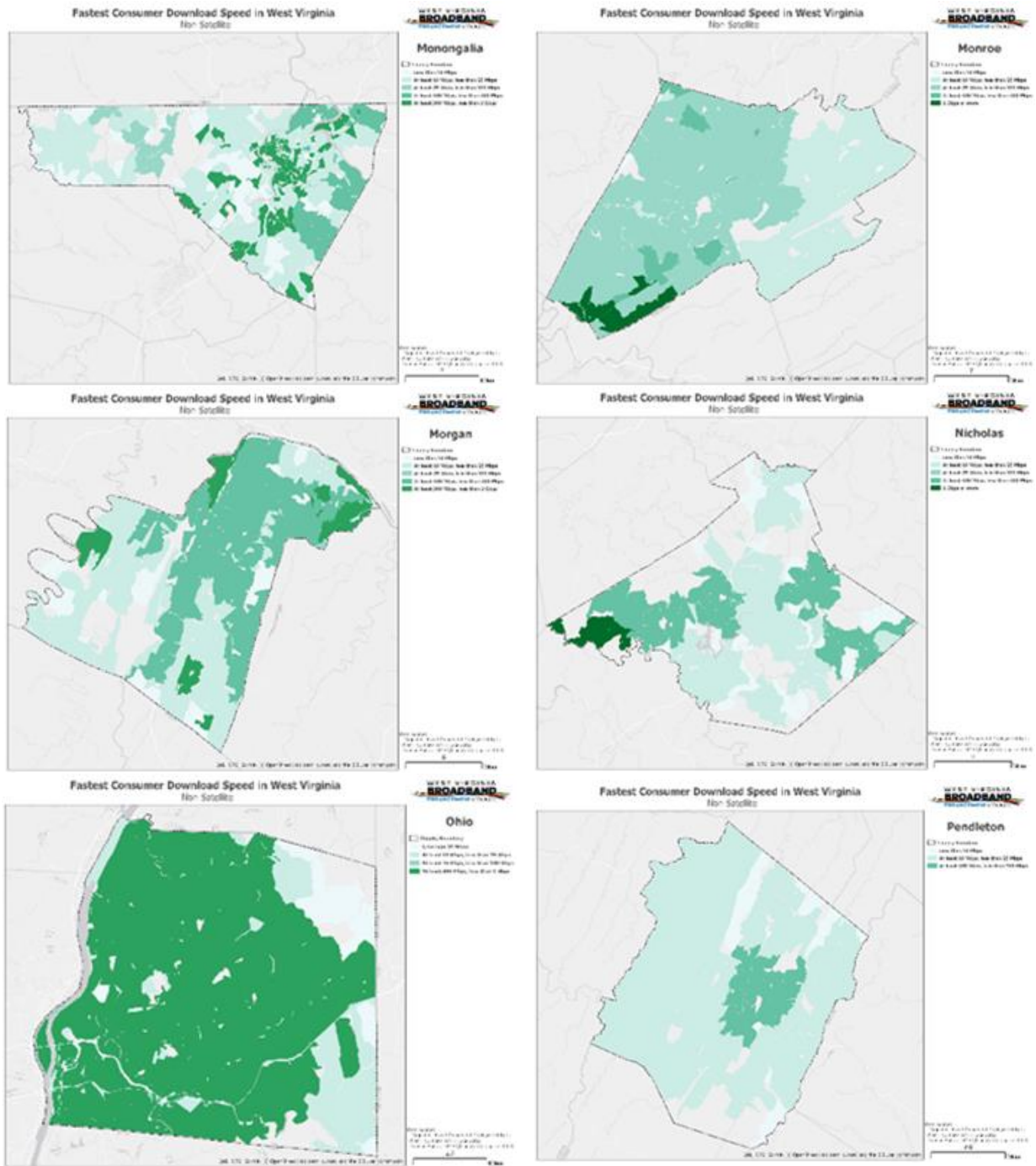




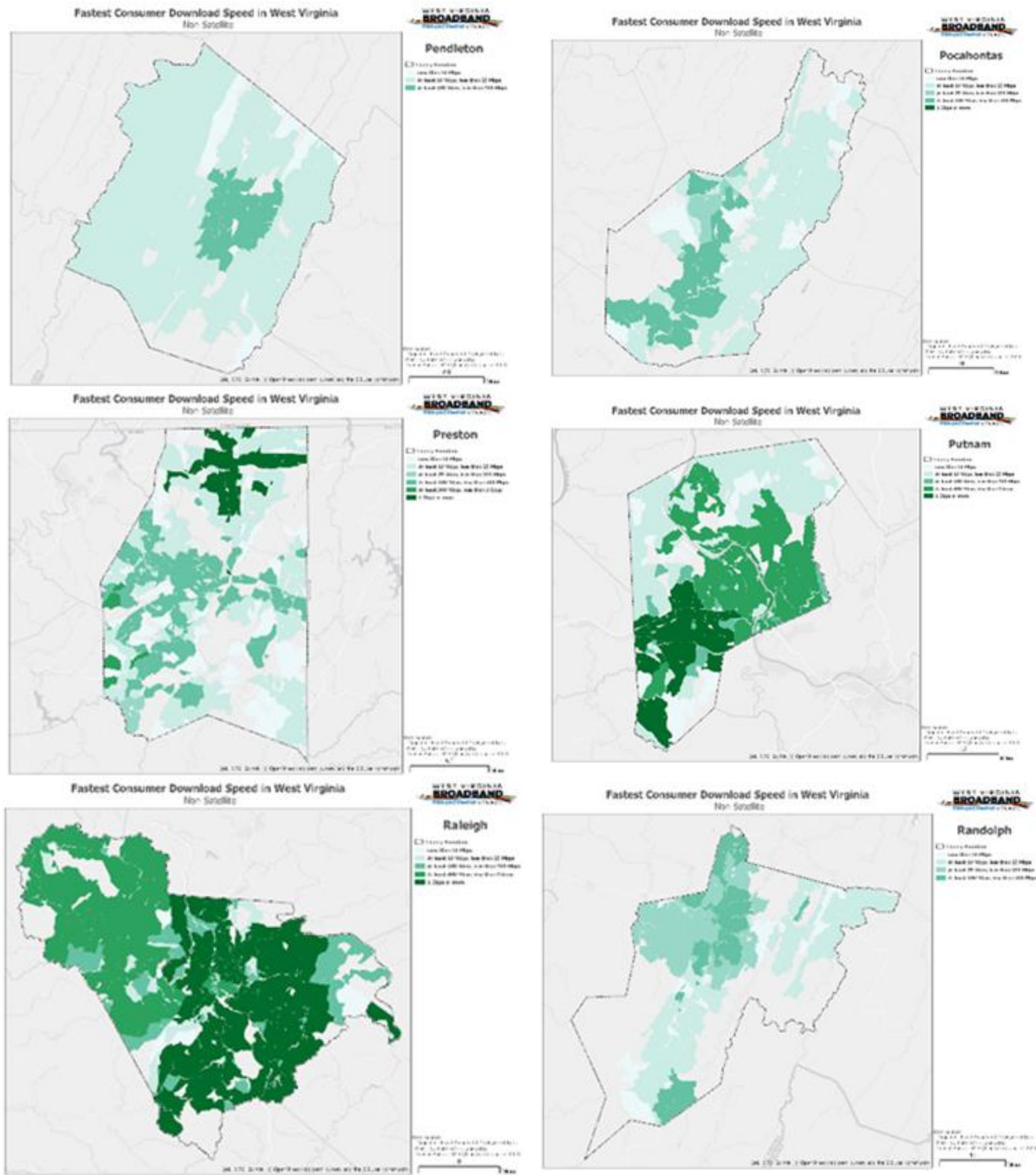


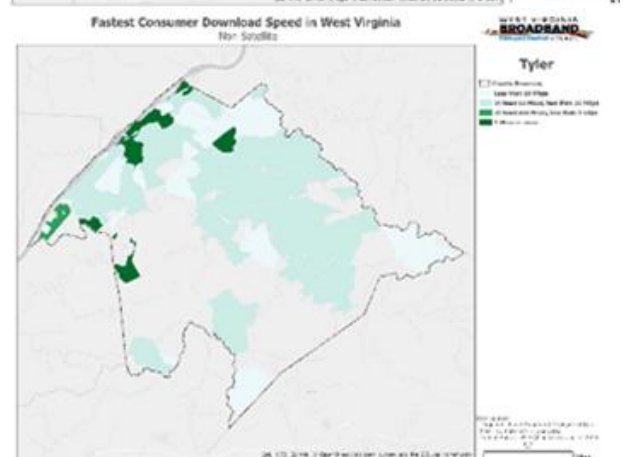
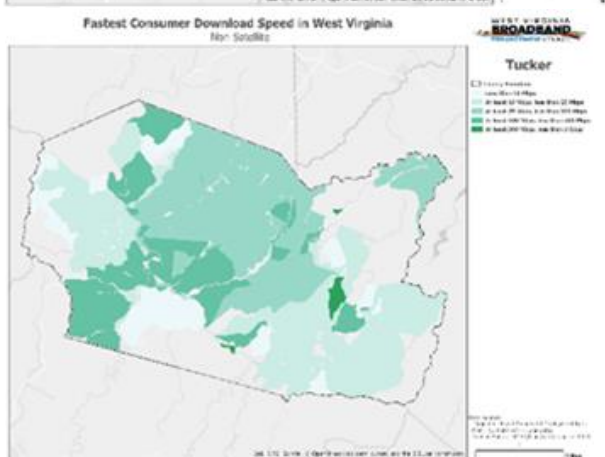
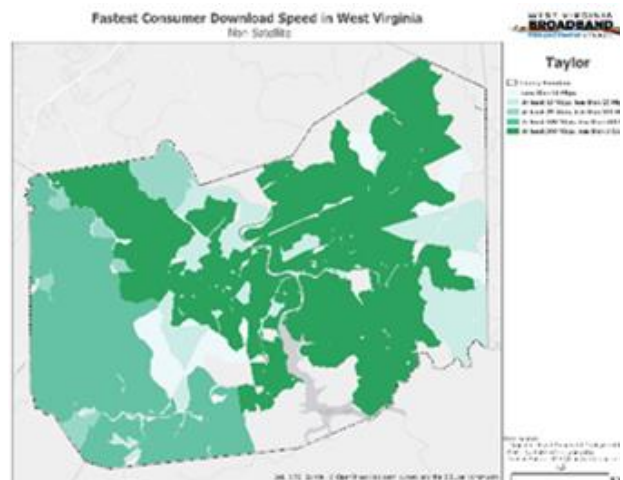
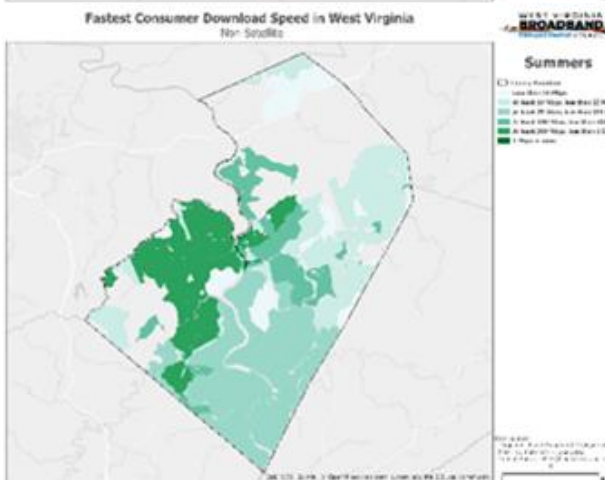
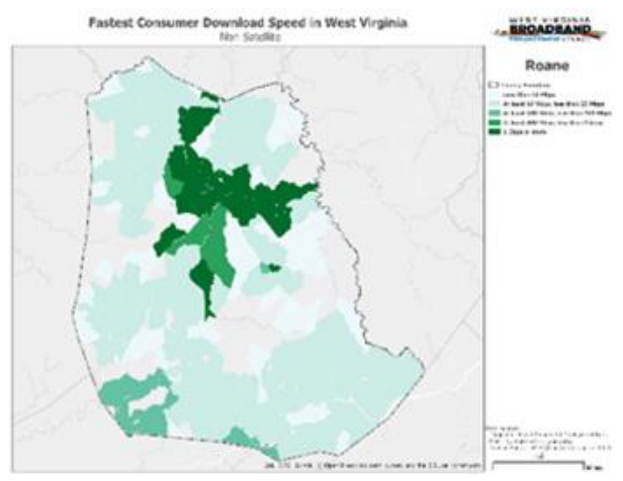
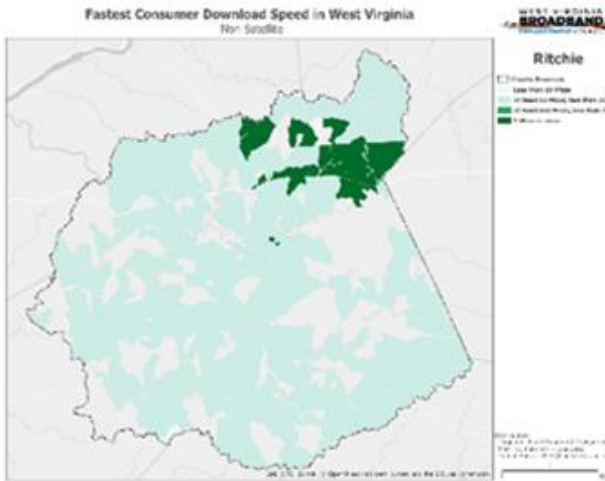


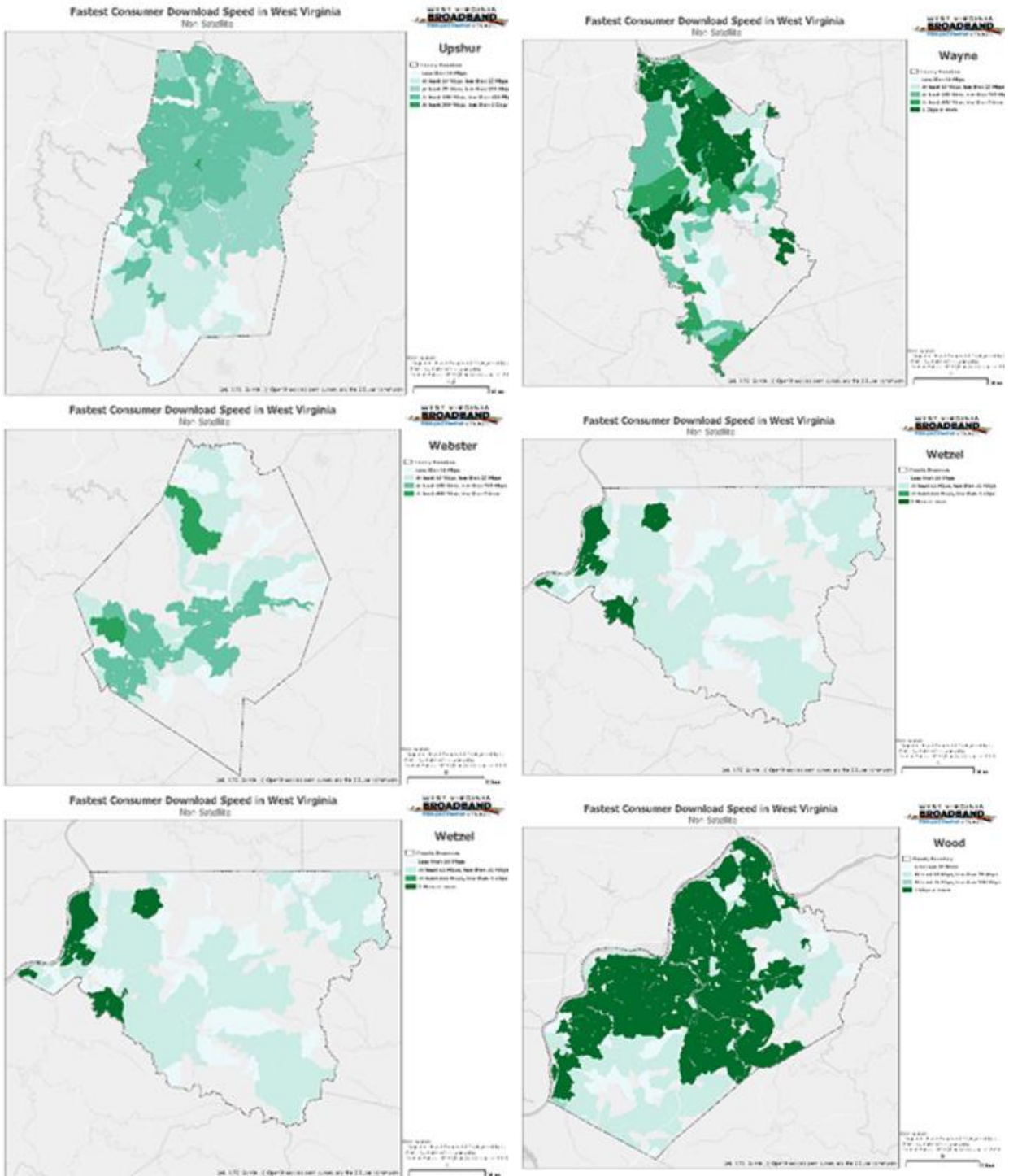


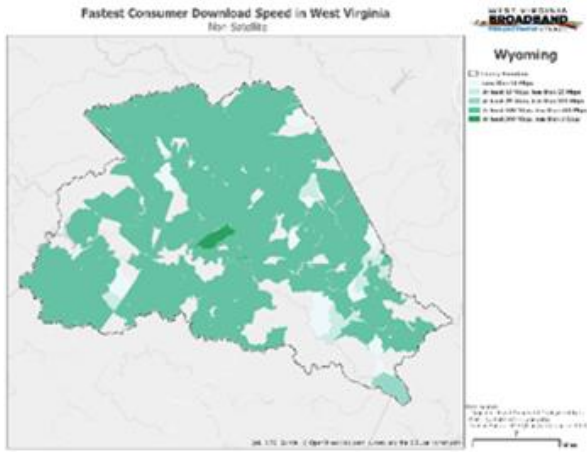














## Appendix D: Stage 1 Meaningful Use Objectives and Measures

Meaningful Use Criteria – Core Set		
EP – Stage 1 Objectives	EH – Stage 1 Objectives	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 EH 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 EH or CAH's inpatient or emergency department have at least one entry or an indication that the patient has no known medication allergies recorded as structured data.
Record and chart changes in vital signs: <ul style="list-style-type: none"> <li>• Height</li> <li>• Weight</li> <li>• Blood Pressure</li> <li>• Calculate and display BMI</li> <li>• Plot and display growth charts for children 2-20 years, including BMI</li> </ul>	Record and chart changes in vital signs: <ul style="list-style-type: none"> <li>• Height</li> <li>• Weight</li> <li>• Blood Pressure</li> <li>• Calculate and display BMI</li> <li>Plot and display growth charts for children 2-20 years, including BMI</li> </ul>	For more than 50% of all unique patients age 2 and over seen by the EP or admitted to EH 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 EH or CAH's inpatient or emergency department have "smoking status" recorded as structured data.

<b>Meaningful Use Criteria – Core Set</b>		
<b>EP – Stage 1 Objectives</b>	<b>EH – Stage 1 Objectives</b>	<b>Stage 1 Measures</b>
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), upon request	More than 50% of all patients of the EP or the inpatient or emergency departments of the EH 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 EH 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	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.

<b>Meaningful Use Criteria – Core Set</b>		
<b>EP – Stage 1 Objectives</b>	<b>EH – Stage 1 Objectives</b>	<b>Stage 1 Measures</b>
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.

<b>Meaningful Use Criteria – Menu Set</b>		
All EH or CAH must meet all 5 of 10 Menu Set MU Criteria		
<b>EP – Stage 1 Objectives</b>	<b>EH – Stage 1 Objectives</b>	<b>Stage 1 Measures</b>
Implement drug-formulary checks	Implement drug-formulary checks	The EP/EH/CAH has enable this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.
	Record advance directives for patients 65 years or older	More than 50% of unique patients 65 years or older admitted to the EH 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 EH 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.


<b>Meaningful Use Criteria – Menu Set</b>		
All EH or CAH must meet all 5 of 10 Menu Set MU Criteria		
<b>EP – Stage 1 Objectives</b>	<b>EH – Stage 1 Objectives</b>	<b>Stage 1 Measures</b>
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, EH, 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 or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.
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 EH’s or CAH’s inpatient emergency department are provided patient-specific education resources.

<b>Meaningful Use Criteria – Menu Set</b>		
All EH or CAH must meet all 5 of 10 Menu Set MU Criteria		
<b>EP – Stage 1 Objectives</b>	<b>EH – Stage 1 Objectives</b>	<b>Stage 1 Measures</b>
The EP, EH, 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, EH, 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, EH, 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.
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.

<b>Meaningful Use Criteria – Menu Set</b> All EH or CAH must meet all 5 of 10 Menu Set MU Criteria		
<b>EP – Stage 1 Objectives</b>	<b>EH – Stage 1 Objectives</b>	<b>Stage 1 Measures</b>
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 E: Eligible Provider Desk Audit Letter Template



STATE OF WEST VIRGINIA  
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

**Bill J. Crouch**  
Cabinet Secretary

**BUREAU FOR MEDICAL SERVICES**  
**Office of Program Integrity**  
350 Capitol Street – Room 251  
Charleston, West Virginia 25301-3712  
Telephone: (304) 558-1700 Fax: (304) 558-4837

**Cynthia E. Beane**  
Commissioner

|

[Current Date]

[Provider's Contact Name]  
[Pay-To-Provider Name]  
[Pay-To-Provider City, State, Zip Code]

BMS Case Number: FAM-XX-XX-XXXXX-XXX  
RE: EP Name, EP NPI

Dear [Provider's Contact Name],

Please be advised that the West Virginia Office of Program Integrity (OPI) intends to perform a desk audit to review documentation supporting the attestation of [EP Name] for **Modified Stage 2 Meaningful Use (MU)** of the Medicaid Electronic Health Record (EHR) Incentive Program. We are auditing Payment Year [#], which covers Calendar Year (CY) (date range), and which was submitted by your organization on (Date of Submission). This submission included a patient volume date range of (Patient Volume Date Range) and a Certified EHR Technology (CEHRT) date range of (EHR Date Range). Please find a copy of your attestation record attached for convenience.

The Centers for Medicare & Medicaid Services (CMS) has set standards that Eligible Professionals (EPs) must meet in order to successfully demonstrate MU and continue receiving incentive payments under the Medicaid EHR Incentive Program. We are responsible for confirming that EPs enrolled in the Incentive Program are using CEHRT in this manner as part of our audit and oversight responsibilities.

To facilitate the desk review, we request you complete the attached questionnaire. The questionnaire is based around general information regarding your practice and the strategy implemented to meet your Modified Stage 2 MU requirements. In addition to providing responses to the questionnaire, you will also need to provide relevant documentation to support your questionnaire responses for the applicable objectives. The following are **examples** of documentation that may support responses in the questionnaire:

- Copies of MU reports (or other documentation) you used to perform your attestation. If based on patient volumes, system-generated reports should be at the patient-level detail and agree, in total, to attested patient volume.
- Supporting documentation to show group patient volume, if attesting as part of a group practice.
- Supporting documentation to show legal or financial commitment in obtaining or using CEHRT and utilization at one clinical location. If multiple locations apply, provide documentation of all applicable locations.

---

Medicaid EHR Incentive Program MU Audit Strategy Toolkit-- Appendix 18: EP MU Stage 2 Post-Payment Desk Audit Questionnaire Rev 08/15 Page 1



[Provider Name]

Case No. FAM-XX-XX-XXXXXX-XXX

[Current Date]

Page 2

- Supporting documentation to show eligibility if claiming to be a Physician Assistant (PA) practicing in a Physician Assistant-led Federally Qualified Health Center (FQHC) or Rural Health Center (RHC), non-hospital-based data, etc. during the attestation.
- EHR or ancillary system reports to support the conclusion that you have met one of the exclusion criteria for a measure.
- Evidence to support your submission of electronic data for the Public Health Reporting measure(s) (immunization registry, syndromic surveillance data, specialized registry reporting) to which you attested. This could include email communication to the agency, contact information for the registry, and/or print screens of the active interface within the EHR.
- Checklist or program used to perform the security risk analysis, written report listing deficiencies as a result of the review, and/or corrective action plan for addressing those deficiencies.
- Evidence supporting the Clinical Quality Measures (CQMs) you reported in your attestation.
- Evidence to support the availability of patients' electronic health information access to which you attested. This could include print screens of the information with dates within the EHR, documentation supporting patient access, etc.
- Print screens, system-generated reports, logs, and/or diagrams from your EHR that illustrate the functionality you describe in the questionnaire provided below.

For your convenience, we have also enclosed the questionnaire on a CD-ROM included. The completed questionnaire and supporting documentation should be submitted via the provided CD-ROM or an encrypted flash drive. Please ensure all sensitive information is properly encrypted before sending. Please submit all information, including your completed questionnaire and supporting documentation, to:

**Samuel W. Stout, Program Specialist, Senior**  
**WV Bureau for Medical Services**  
**Office of Program Integrity**  
**350 Capitol Street, Room 251**  
**Charleston, WV 25301-3710**

The completed desk audit questionnaire and supporting documentation must be submitted utilizing one of the methods described above by **October 29, 2018**. BerryDunn will be available the week of **October 8, 2018** if you would like to request a day and time for a phone call to discuss any questions you may have or to review supporting documentation you plan to submit. Please contact us via email at [dhhrehr@wv.gov](mailto:dhhrehr@wv.gov). Failure to return this information in the time allotted shall result in a pay-hold being placed on your account until the information is completed and returned.

Thank you for your assistance in providing the completed desk audit questionnaire and supporting documentation for the Medicaid EHR Incentive Payment audit. Once the documentation is reviewed, a State representative or contractor will reach out to you regarding next steps. Please note your results will be provided to you upon completion, which could take up to a year. If you have any questions or concerns about the review, the related questionnaire, or the submission process, please email your questions to [dhhrehr@wv.gov](mailto:dhhrehr@wv.gov). As this audit progresses, frequently asked questions (FAQs) will be updated and available at :

- <http://www.dhhr.wv.gov/bms/Provider/EHR/Pages/default.aspx>

As you complete your questionnaire, please ensure Protected Health Information (PHI), as defined within the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that is pertinent to this review

[Provider Name]

Case No. FAM-XX-XX-XXXXXX-XXX

[Current Date]

Page 3

is not used or disclosed in any way that will compromise the privacy, security, or confidentiality of the patient/recipient to whom the information pertains.

Thank you,

Samuel W. Stout  
Program Specialist, Senior  
Office of Program Integrity

SS:pjd  
Attachment

## Appendix F: Eligible Hospital Desk Audit Letter Template



**Bill J. Crouch**  
Cabinet Secretary

**STATE OF WEST VIRGINIA**  
**DEPARTMENT OF HEALTH AND HUMAN RESOURCES**  
**BUREAU FOR MEDICAL SERVICES**  
Office of Program Integrity  
350 Capitol Street – Room 251  
Charleston, West Virginia 25301-3712  
Telephone: (304) 558-1700 Fax: (304) 558-4837

**Cynthia E. Beane**  
Commissioner

[Current Date]

[Hospital's Contact Name]  
[EH Name]  
[EH]City, State, Zip Code]

BMS Case Number: FAM-XX-XX-XXXXXX-XXXX  
RE: EH Name, EH NPI

Dear [Hospital Contact Name],

Please be advised that the West Virginia Office of Program Integrity (OPI) intends to perform a desk audit to review documentation supporting the attestation for eligibility of the Medicaid Electronic Health Record (EHR) Incentive Program. We are auditing Payment Year [#], which covers Fiscal Year (2016) (1/1/2016 – 12/31/2016), and which was submitted by your organization on (submission date). This submission included a patient volume date range of (Patient Volume Date Range) and a Certified Electronic Health Record Technology (CEHRT) date range of (EHR Date Range). Please find a copy of your attestation record attached for convenience. We understand that a payment calculation review is currently being conducted and this review is separate. We will not ask for additional payment calculation support.

The Centers for Medicare & Medicaid Services (CMS) has set standards that Eligible Hospitals (EHs) must meet in order to successfully demonstrate eligibility and effective A/I/U to receive an incentive payment under the Medicaid EHR Incentive Program. We are responsible for confirming that EHs enrolled in the incentive program are eligible and have successfully adopted A/I/U using CEHRT as part of our audit and oversight responsibilities.

To facilitate the desk review, we request you complete the attached questionnaire. This questionnaire is based around general information regarding your practice and the strategy implemented to meet your A/I/U and eligibility requirements. In addition to providing responses to the questionnaire, you will also need to provide relevant documentation to support your questionnaire responses for the applicable objectives. The following are **examples** of documentation that may support responses in the questionnaire:

- System generated reports to show attested Medicaid and total patient volume levels. These reports should be at the patient-level detail and agree, in total, to attested patient volumes
- Supporting documentation to show legal or financial commitment in obtaining or using CEHRT and utilization

[EH Name]  
Case No. FAM-XX-XX-XXXXX-XXX  
[Current Date]

For your convenience, we have also enclosed the questionnaire on a CD-ROM included. The completed questionnaire and supporting documentation should be submitted via the provided CD-ROM or an encrypted flash drive. Please ensure all sensitive information is properly encrypted before sending. Please submit all information, including your completed questionnaire and supporting documentation, to:

**Samuel W. Stout, Program Specialist, Senior**  
**WV Bureau for Medical Services**  
**Office of Program Integrity**  
**350 Capitol Street, Room 251**  
**Charleston, WV 25301-3710**

The completed desk audit questionnaire and supporting documentation must be submitted utilizing one of the methods described above by **October 29, 2018**. BerryDunn will be available the week of **October 8, 2018** if you would like to request a day and time for a phone call to discuss any questions you may have or to review supporting documentation you plan to submit. Please contact us via email at [dhhrehr@wv.gov](mailto:dhhrehr@wv.gov). Failure to return this information in the time allotted shall result in a pay-hold being placed on your account until the information is completed and returned.

Thank you for your assistance in providing the completed desk audit questionnaire and supporting documentation for the Medicaid EHR Incentive Payment audit. Once the documentation is reviewed, a State representative or contractor will reach out to you regarding next steps. Please note your results will be provided to you upon completion, which could take up to a year. If you have any questions or concerns about the review, the related questionnaire, or the submission process, please email your questions to [dhhrehr@wv.gov](mailto:dhhrehr@wv.gov). As this audit progresses, frequently asked questions (FAQs) will be updated and available at :

- <http://www.dhhr.wv.gov/bms/Provider/EHR/Pages/default.aspx>

As you complete your questionnaire, please ensure Protected Health Information (PHI), as defined within the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that is pertinent to this review is not used or disclosed in any way that will compromise the privacy, security, or confidentiality of the patient/recipient to whom the information pertains.

Thank you,

Samuel W. Stout, MPA  
Program Specialist, Senior  
Office of Program Integrity

SS.pjd  
Attachment

## Appendix G: Auditor's Toolkit

This Audit Toolkit was is a part of the 2019 Audit Strategy and created by BerryDunn and the State.

Objective		EH's Responses	Auditor's Comments (For State Use Only)	W/P Reference (For State Use Only)
<b>1. Identification Information</b>	Name:			
	NPI:			
	CCN:			
<b>2. Patient Volume</b>  Percentage Requirement (10% for all Hospitals except Children's Hospitals who do not have a patient volume requirement). Note that patients may only be counted once per day.	<b>Reporting Period</b> (patient volume date range):			
	<b>EP Attestation Numerator</b> (the total number of Medicaid encounters the provider treated in the reporting period):			
	<u>Medicaid Out-of-State (list):</u>			
	<u>West Virginia Medicaid Fee-For-Service (FFS):</u>			
	<u>West Virginia Medicaid Managed Care (MCO):</u>			
	<u>Total Medicaid Encounters:</u>			
	<b>EP Attestation Denominator</b> (the total number of encounters the provider treated in the reporting period):			
	<u>Total Patient Encounters:</u>			

Objective		EH's Responses	Auditor's Comments (For State Use Only)	W/P Reference (For State Use Only)
	Briefly describe the procedures performed to determine patient volume in your practice. Please also explain how patient volume is determined if you are practicing in multiple locations or groups. Please provide documentation to support your response. <i>Examples of acceptable forms of supporting documentation include: EHR/ PM reports, records with signed attestations from a Director/Supervisor, and documentation supporting the patient volume calculations for each practice location.</i>	Procedures:  Supporting documentation provided? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Please provide a patient volume system-generated report in a Microsoft Excel format with a system stamp showing it is generated from within your EHR <b>AND</b> a screenshot of the EHR's system settings.  <b>Please be sure your documentation includes the following: name of patient, date of birth, social security number, insurance type, provider who treated the</b>	Supporting documentation provided? <input type="checkbox"/> Yes <input type="checkbox"/> No		

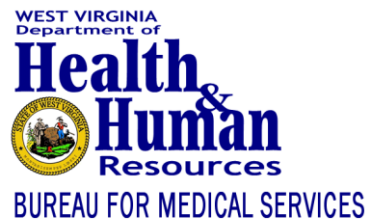
Objective		EH's Responses	Auditor's Comments (For State Use Only)	W/P Reference (For State Use Only)
	patient, date of service, Medicaid ID, and the state in which the visit occurred and was billed.			
<b>3. Hospital Payment Calculation</b>	<b>Total Discharges</b> (for current year, for all historical years used to calculate growth rate, and future calculated discharges based on growth rate):			
	Year 1 (current year used during first payment year):			
	Year 2:			
	Year 3:			
	Year 4:			
	Medicaid Inpatient Bed Days:			
	Medicaid HMO Inpatient Bed Days:			
	Total Inpatient Bed Days:			
	Total Hospital Charges:			
	Total Charity Care Charges:			
	Briefly describe the procedures performed and sources used to determine your payment calculation. For numbers used,			

Objective		EH's Responses	Auditor's Comments (For State Use Only)	W/P Reference (For State Use Only)
	we will need the items noted above.			
	As an attachment to this questionnaire, please provide documentation to support your response above. <i>Examples of acceptable forms of supporting documentation include: EHR/PM reports, records with signed attestations from a Director/Supervisor, and documentation supporting the numbers used.</i>	Supporting documentation provided? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If documentation is not provided, please explain why:			
<b>4. Certified EHR Technology (CEHRT)</b>	What is your CEHRT number?			
	For year being attested to ( <b>2015</b> ), provide details of CEHRT software maker, software version, and documentation showing date of CEHRT implementation.			



Objective		EH's Responses	Auditor's Comments (For State Use Only)	W/P Reference (For State Use Only)
	Please provide documentation showing your legal or financial commitment to the CEHRT. This can include: bill(s) of sale, receipts, contracts, maintenance agreements, licenses, canceled checks, or other documentation.	Supporting documentation provided? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Does your CEHRT meet the 2014 standards?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Is your CEHRT the same one you attested with in prior years?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**State of West Virginia  
Bureau for Medical Services**



**MITA 2018 Health Information Technology (HIT)  
State-Self Assessment  
Companion Report  
Version 0.1**

**Date Prepared:** August 30, 2018 under Contract Agreement CMA #15 \*3

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**Table 1: Revision History**

<b>Version</b>	<b>Delivered Date</b>	<b>Update Reason</b>
0.1	December 10, 2018	Submitted to CMS for review

## Executive Summary

The West Virginia (State and/or WV) Medicaid MITA 3.0 State Self-Assessment (SS-A) Report is updated annually to measure the achievement toward the business goals and objectives for the Medicaid Enterprise in an ongoing, iterative process. This SS-A Annual Update Report includes an assessment of the Health Information Technology (HIT) maturity within the Medicaid Enterprise. This Companion Report examines how West Virginia is continuing their MITA efforts. The SS-A Annual Update Roadmap supports specific State goals for business improvement in Medicaid HIT within the MITA 3.0 Framework consistent with the State Medicaid Health Information Plan (SMHIP). Business process documentation prepared for this Report are documented on the MITA Management Portal (MMP), which the Department of Health and Human Resources (DHHR) will use to monitor project progress, outcomes, and the achievement of target capabilities.

## HIT SS-A Overview

### MITA 3.0 Overview

As part of this year's MITA 3.0 SS-A annual update, the DHHR is endeavoring to conduct a Health Information Technology (HITECH) assessment to increase federal support for optimizing related HITECH programs and systems by aligning Medicaid HIT strategies with the MITA goals and objectives for the State's Medicaid Enterprise. The methodology and approach used for this assessment were consistent with the Centers for Medicare and Medicaid Services (CMS) MITA HITECH toolkit and is tailored to help the State assess its ability to achieve the related solutions identified in the 2016 SS-A Roadmap, which draws upon the strategic goals and objectives defined in the SMHP, the 2017 WV West Virginia Health Information Network Health Information Technology Implementation Advanced Planning Document (HIT-IAPD) and 2018 West Virginia Health Information Network Health Information Technology Implementation Advanced Planning Document Update (HIT-IAPDU), and State Health Information Technology Plan (SHIP).

## HIT Scope Goals and Objectives

The MITA HIT goals and objectives that were identified for the 2017 MITA 3.0 SS-A Annual Update were derived from an alignment between the HIT solutions identified in the 2016 MITA SS-A Roadmap, the 2017 HIT-IAPD and the 2018 HIT-IAPDU, and the strategic HIT initiatives identified in the 2016 SMHP.

## Health IT Landscape

The SMHP is a vision document that includes a current assessment of the State's health IT landscape, a vision of the health IT future in the year 2021, and a roadmap that serves as a strategic pathway to move from the State's "as-is" health IT landscape to the "to-be" health IT vision. The plan has been developed in accordance with guidance provided in the Code of Federal Regulations (CFR): 42 CFR §495.332, as amended by CMS.

The MITA SS-A Roadmap is intended to demonstrate how the implementation of the State’s strategic vision effectively meets MITA goals, objectives, and principles.

In conjunction with the assessment of the “as-is” health IT landscape, the State developed its “to-be” health IT landscape using an inclusive stakeholder-driven planning process that leverages the strategic planning aspects of the completed MITA State SS-A. The MITA SS-A resulted in a MITA Roadmap that guides the Bureau for Medical Services (BMS) in its planning for strategic initiatives. Please refer to the SMHP final document that was approved in January 2017.

To support the achievement of the “to-be” landscape, the BMS SMHP identified 15 specific health IT initiatives. These initiatives are listed in the following table:

**Table 2: BMS SMHP Goals and Initiatives**

ID	West Virginia’s Health IT Initiatives
1	<b>Re-procure Medicaid Enterprise Integrated Eligibility and Enrollment System (IES):</b> The IES Re-procurement project is designed to transform the eligibility system within the DHHR enterprise to provide West Virginians a better eligibility experience, transition the eligibility system from the legacy environment to a modern architecture, and simplify the administration of the technical aspects of the program administrations.
2	<b>Encourage the Meaningful Use (MU) of EHRs (Electronic Health Record):</b> Robust and meaningful data can be shared when EHR systems are deployed. West Virginia will continue to build on the foundation already provided through the Provider Incentive Payment (PIP) Program. Leveraging the EHR post-payment audit process, West Virginia will share lessons learned with providers to accelerate adoption and MU of EHR.
3	<b>Support Reimbursement Methods that Promote the Use of Technology:</b> Aligning the reimbursement system to support health IT adoption in the field can help promote the adoption of health IT. This could include differential payments that support health IT adoption goals.
4	<b>Encourage the Adoption of Telemedicine Technology:</b> Given the geography and demographics in West Virginia, telemedicine has the opportunity to support healthcare in West Virginia in meaningful ways. West Virginia’s Medicaid program already supports reimbursement for telemedicine.
5	<b>Encourage E-Prescribing:</b> E-Prescribing allows physicians to order prescriptions through computers instead of using a paper-based Rx and handwritten signatures, thereby reducing medical errors and duplication of effort and prescriptions. West Virginia will continue to encourage E-Prescribing.
6	<b>Exchange Health Information:</b> West Virginia is committed to acting as an equal partner and continuing the dialogue on determining solutions for efficient, accurate, and secure exchanges of healthcare data between and among providers, consumers, and payers. This may take the form of participating in a national exchange, utilizing a state-based platform, or some combination that best meets HIE needs.
7	<b>Encourage Clinical Messaging:</b> Building on the adoption of EHR, West Virginia will continue to support clinical messaging. Clinical messaging is a leverage point to transition the provider

ID	West Virginia's Health IT Initiatives
	community from paper to electronic transactions and a way to establish data exchange between separate health systems.
8	<b>Coordination and Continuity of Care:</b> BMS is taking action to improve the coordination and continuity of care, especially for those providers who may not have been eligible for the EHR provider incentive payments through PIP, in the form of a Substance Use Disorder (SUD) focused CMS 1115 Waiver that BMS is currently developing.
9	<b>Improve Quality and Value:</b> Quality of care and value is supported by data when data is leveraged for physician analysis, public health, clinical quality measures, and research.
10	<b>Leverage MITA to Enhance Business Processes Throughout BMS:</b> MITA provides a blueprint that West Virginia and other states are using to examine their business priorities, plan future improvements, and acquire technical applications that meet the health IT needs of both the State and Federal partners.
11	<b>Ensure Adoption of Key Standards to Guide HIT in the State:</b> West Virginia plans to work with its Federal partners to help ensure that HIT systems implemented in the state comply with standards adopted at the national level. Additionally, the West Virginia Office of Technology has issued State IT guidelines and standards that will be adhered to as statewide health IT systems are acquired.
12	<b>Establish Security Protocols and Guidelines for Protection and Use of Data:</b> In order to confidentially share information, West Virginia recognizes that it is necessary to have security protocols and guidelines for the protection of that information. To that end, West Virginia will continue to focus on security protocols, leveraging industry standards, such as National Institute of Standards and Technology (NIST) standards.
13	<b>Use Information to Drive Improvement in Key Areas of Need Throughout the State:</b> Having invested heavily in the data infrastructure within the state, West Virginia intends to use that infrastructure to drive improvements in key areas, including access to care and SUD.
14	<b>Reduce/Eliminate Duplication (Including Redundant Systems and Capabilities) Without Detracting From the State's Ability to Serve the Public and Achieve Organizational Goals:</b> Reducing administrative complexity is a key strategy for West Virginia to generate cost savings. West Virginia is actively taking steps to do this, such as leveraging the recently implemented Medicaid Management Information System (MMIS) to support the West Virginia Children's Health Insurance Program (WVCHIP).
15	<b>Leverage Outside Partnerships:</b> West Virginia is committed to working with their Federal and other state partners. These relationships have allowed West Virginia to improve its health IT landscape, while also supporting the goals of its Federal and other partners. West Virginia also seeks to convene a state health IT summit that will further collaboration among health IT stakeholders.
16	<b>Enhance the Role of the State in Driving Technology:</b> The State has the opportunity to drive the use of technology through the establishment of standards that set common expectations for how vendors and third parties interact with the State, especially when the State funding is part of the project.

ID	West Virginia's Health IT Initiatives
17	<p><b>Convene a Health IT Summit:</b> As BMS has taken the lead in advancing technology, there is a desire to promote this work so that healthcare delivery transformation continues to progress. One way this can happen is for the State to convene a health IT summit to facilitate additional collaboration among stakeholders (provider, consumers, and payers) from around West Virginia.</p>

## MITA 3.0 HITECH Assessment Background

### West Virginia MITA State Self-Assessment

#### MITA Assessment of the WV Medicaid Enterprise

Since the West Virginia Medicaid Enterprise was assessed for MITA 3.0 in 2014, the State has complied with the statutory requirement to update the MITA SS-A annually to support State submission of Advanced Planning Documents.

The HIT Assessment will leverage the information from the solutions analysis conducted for the MITA 3.0 SS-A Update Roadmap by identifying HIT capabilities and maturity for the MITA business processes identified in the MITA Roadmap and by CMS in the MITA HITECH Toolkit.

The West Virginia DHHR is using the MITA Framework to:

- Focus DHHR information transformation
- Build common and shared services across the Medicaid Enterprise
- Improve how DHHR operates and delivers care to West Virginians
- Eliminate inefficiencies and reduce costs
- Expand the reach of services

The consistent use of MITA assessment for the Medicaid Enterprise has facilitated an enterprise-driven view for DHHR in assessing business needs, and a service-oriented approach when conducting technology planning. Comprehensive business process information has been formally documented, providing a common view of each business process flow as well as opportunities to identify areas for increased efficiency and effectiveness.

In support of the broader West Virginia DHHR goal of establishing results-based accountability, BMS also identified several benchmarks in the SMHP that will be used to measure the progress toward desired outcomes in maturing the State's health IT landscape. These benchmarks will be used to support the top-priority initiatives identified during the strategic planning process:

- Implement integrated eligibility system (IES)
- Accelerate Adoption and MU of EHR
- Ensure Adoption of Key Standards to Guide HIT in the State
- Use Information to Drive Improvement in Key Areas throughout the State

The SMHP offers a comprehensive overview of the West Virginia Medicaid Enterprise IES and Data Warehouse projects. The execution of these projects will be key milestones for the State that will gain significant strides toward achieving their strategic goals.

#### MITA 3.0 SS-A 2016 Roadmap – HIT Assessment Opportunity Areas

The 2016 MITA SS-A Annual Update Roadmap illustrates the State strategy for business improvements that will mature the Medicaid enterprise within the next five years. The MITA



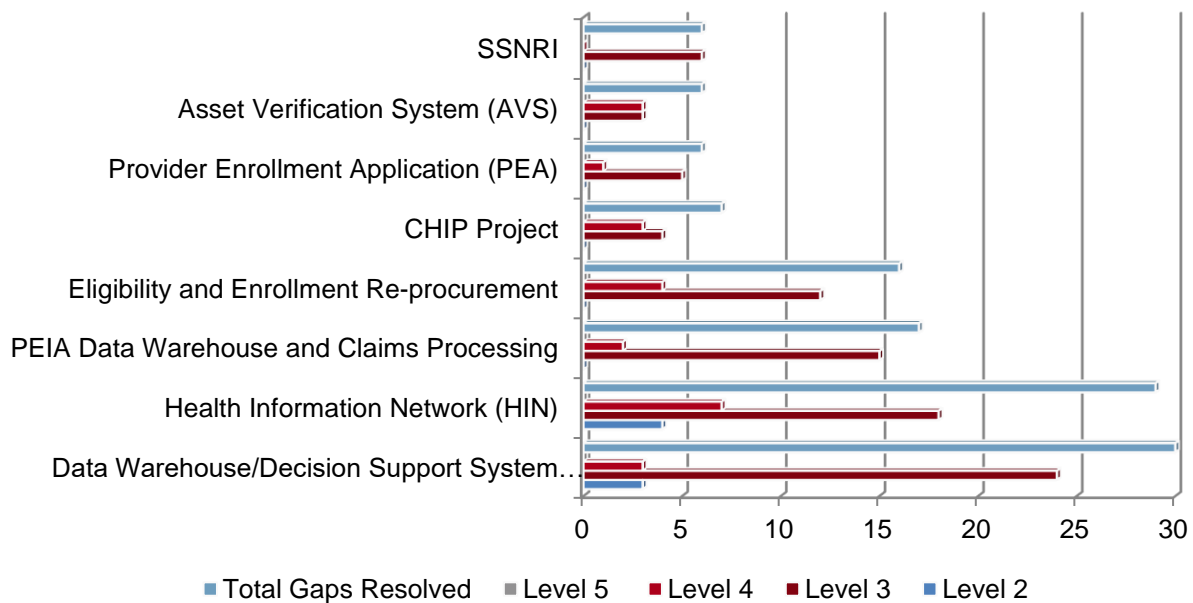
develops the strategic approach through three key areas of analysis from which a sequencing plan is developed consistent with the outcomes measures and priorities of the state.

The analysis conducted includes:

- Transition Strategy
- Gap Analysis
- Solution Analysis
- Transition Analysis

The solution analysis sequencing plan from the 2016 MITA 3.0 Roadmap was assessed for maturity in the context of the SMHP.

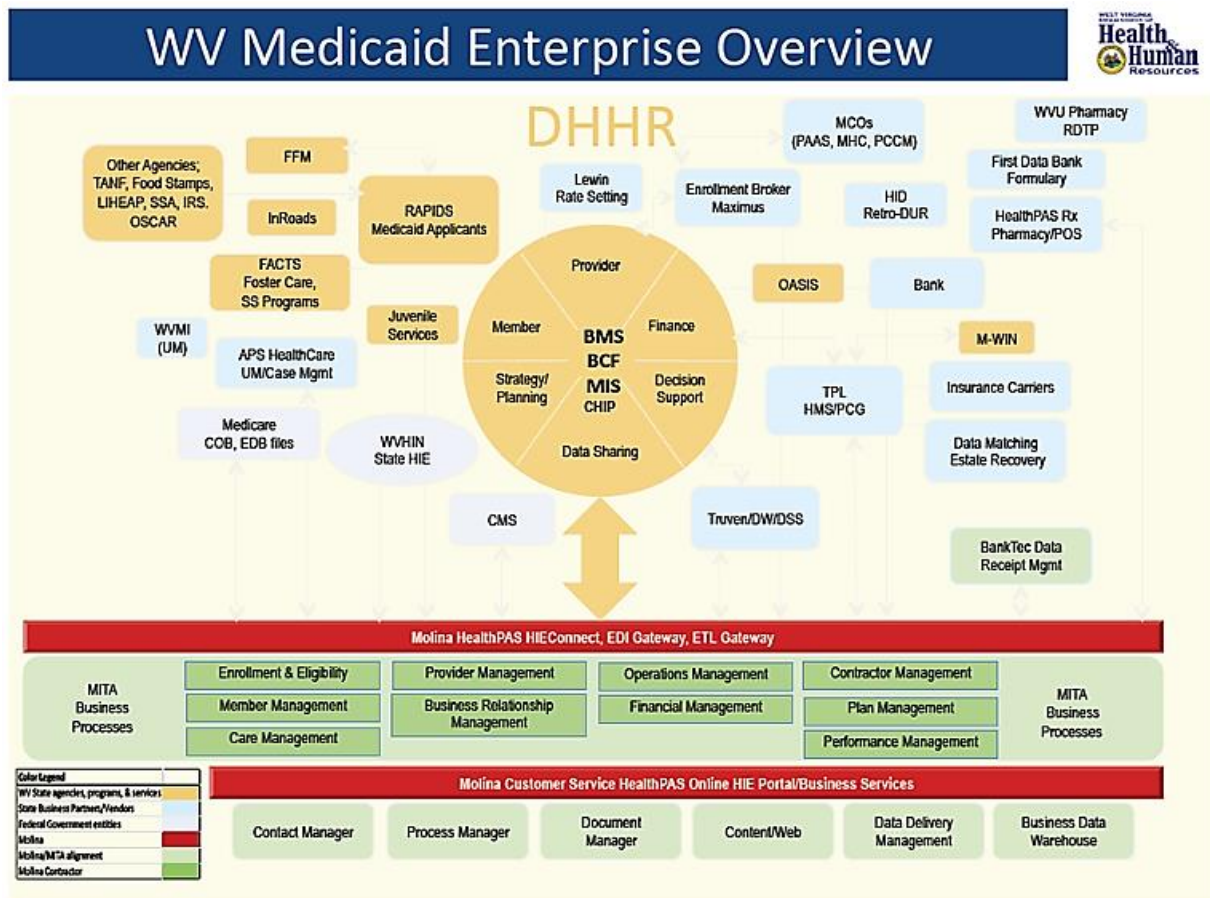
**Figure 0.1: 2016 MITA SS-A Solution Analysis**



## Medicaid Enterprise - MITA 3.0

The agencies and systems that make up the WV Medicaid enterprise are detailed in the MITA SS-A Report. The diagram in Figure 2 illustrates an overview of the WV Medicaid Enterprise.

**Figure 0.2: WV Medicaid Enterprise**



## Background of HIT in West Virginia

BMS partnered with the WV HIT Collaborative and many other stakeholders across the WV health IT landscape to review existing documentation, conduct research, and gather information required to update the baseline assessment of West Virginia’s health IT environment that was first completed in 2011. The SMHP describes current health IT activities in detail.

In addition, DHHR has HIT-IAPDs approved by CMS through 2018 that were used in this assessment of objectives and progress toward outcomes for WV HIT projects identified in these documents and the MITA 3.0 SS-A.

## WV MITA HIT Approach and Methodology

The HITECH HIT assessment teams will use the HITECH Supplement to the MITA SS-A Companion Guide for tailored guidance on performing a MITA 3.0 SS-A on HITECH systems. The Supplement is designed to be used alongside the MITA 3.0 SS-A Companion Guide to determine the “as-is” and “to-be” maturity of HITECH systems.

For HITECH systems, CMS encourages a minimum “to-be” MITA Maturity of Level 4 to support MU capabilities. The process for achieving MITA Maturity Levels 4 or 5 begins with a MITA SS-A on HITECH systems. The Supplemental Guide for a MITA SS-A provides tailored guidance to assist State Medicaid Agencies (SMAs) in performing a MITA 3.0 SS-A on SMA systems supporting EHR Incentive Program and HITECH infrastructure systems. Performing a MITA SS-A on the EHR Incentive Program and HITECH infrastructure systems is to assist SMA in aligning systems development activities to help ensure MITA compliance.

The output of a MITA SS-A defines a “to-be” state of system maturity. For the State’s EHR Incentive Program and HITECH infrastructure systems, a minimum MITA Maturity of Level 4 is recommended to support seamless communication and integration between the SMA and federal agencies.

A MITA assessment of the EHR Incentive Program and HITECH infrastructure systems is limited to determination of “as-is” and “to-be” system maturity. Since an SS-A of the WV EHR Incentive Program and HITECH infrastructure systems is on a limited scope of systems, data, and business processes, much of the business process modeling activities and MITA transformation efforts performed in a full MMIS assessment are not required. For an SMA’s EHR Incentive Program and HITECH infrastructure, the MITA assessment of business processes will be limited to the eight MITA business areas of Business Relationship Management, Care Management, Financial Management, Plan Management, Provider Management, Eligibility and Enrollment Management, Member Management, and Performance Management. Assessment of the Member Management business area is dependent on the release of MITA 3.0 enhancements, which include descriptions and details of corresponding business processes when they are finalized by CMS.

The HITECH assessment leverages the MITA 3.0 SS-A artifacts to tailor the MITA Business Architecture, Information Architecture, or Technical Architecture capability as defined in the respective MITA Capability Matrix. The assessment will document N/A (not applicable) capabilities or architectures and provide justification where appropriate.

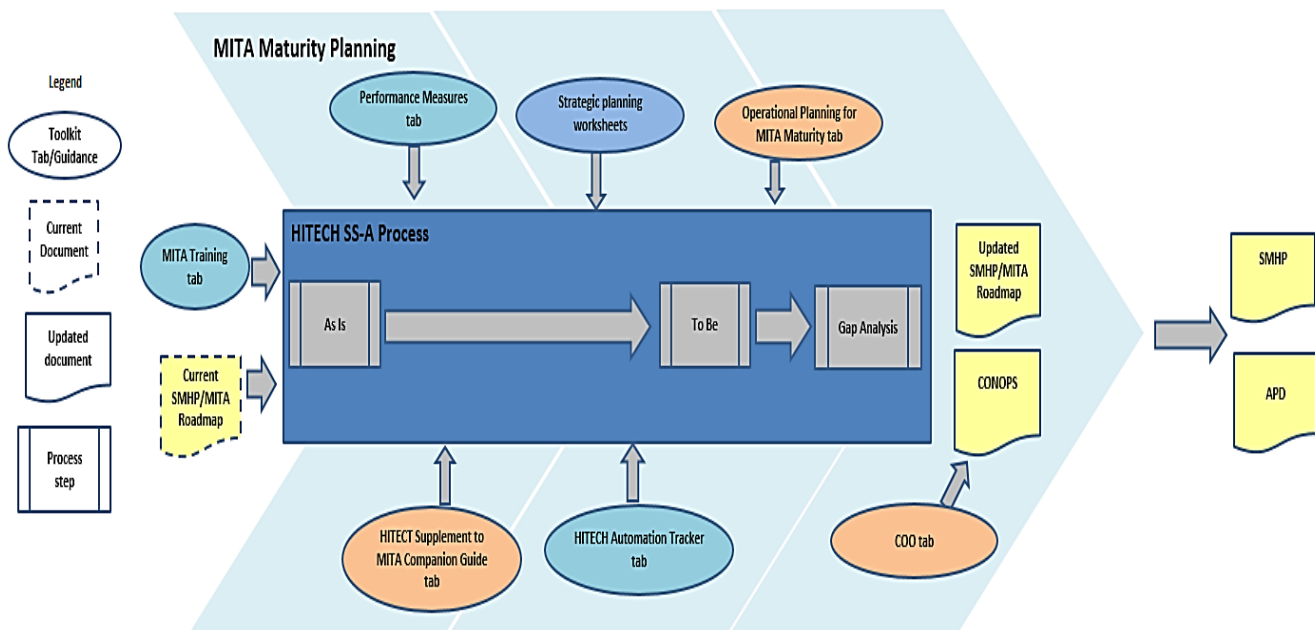
The following section illustrates the process steps as defined in the MITA HITECH toolkit that the BerryDunn team will execute in assisting the State.

## MITA HITECH Maturity Planning Overview

To promote effective operational planning for HITECH systems, business leads from each Business Area validate that planning activities align with the MITA Framework. Since HIT is dispersed throughout the various business areas, the WV HITECH Steering Committee is made

up of the WV Medicaid Enterprise business process owners. The MITA Maturity Planning Diagram was used in the SMHP to define the steps in the planning process for maturing HITECH systems and make recommendations based on the state goals and objectives in the MITA HITECH Roadmap. The workflow diagram in Figure 3 describes the process used by the HIT Assessment team in conducting this assessment consistent with the guidance provided in the CMS MITA HITECH Toolkit.

**Figure 0.3: Workflow Diagram**



The following definitions correspond with the process steps identified in the workflow diagram:

**Business Improvement Case Studies** – Examples of how BMS can use HITECH capabilities to achieve business and strategic goals and direct discussions of State HIT systems development

**MITA 3.0 Roadmap** – BMS’ five-year plan for increasing the Electronic Health Record (EHR) Incentive Program’s and HITECH infrastructure systems’ MITA Maturity level. See the 2016 MITA SS-A Roadmap\*

**Supplemental Guide to MITA SS-A Companion Guide** – Tailored guidance to assist BMS in performing a MITA 3.0 SS-A on the State EHR Incentive Program and HITECH infrastructure systems, if applicable

**Concept of Operations (COO)** – COO for planned HITECH business operations, processes, and systems, including stakeholder and information interactions

**Operational Plan for MITA Maturity** – Guide for BMS on achieving MITA Business Architecture (BA), Information Architecture (IA), and Technical Architecture (TA) Maturity Levels 4 or 5 for its HITECH IT solutions

**Gap Analysis** – Comparison of the “as-is” and “to-be” MITA Maturity Levels for BMS’ EHR Incentive Program and HITECH infrastructure systems

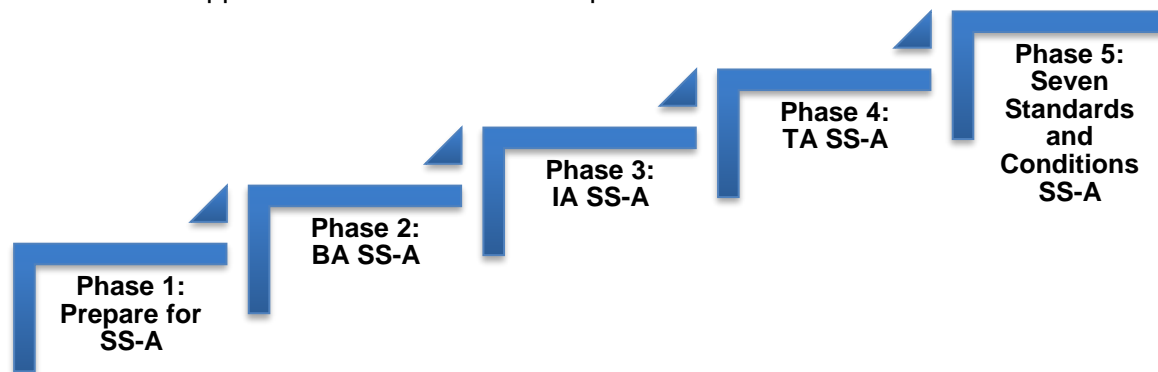
**SMHP** – Provides information in State plans for HITECH implementation; West Virginia’s SMHP may require updating and renewing with MU

**Advance Planning Document (APD)** – APDs are required for several federally funded HIT initiatives; the State should regularly refer to this document while implementing EHR Incentive Program and HITECH infrastructure systems. The State can refer to these plans to understand the implementation plans and timeline for other HIT systems.

## Project Influencers

To promote effective operational planning for HITECH systems, this assessment ensures that planning activities align with the MITA framework. State business area owners should encourage staff assigned to MITA alignment activities to review the following material prior to performing a MITA SS-A on HITECH systems.

The HITECH supplement identifies five SS-A phases:



**Approach Part 1** – The BerryDunn team will Implement Phase 1 first. The additional four phases can be implemented in parallel or in sequence, depending on the State’s resource and time constraints.

**Approach Part 2** – Within each phase, the BerryDunn team will implement the identified tasks in sequential order.

## Project Influencers

Project influencers for this project are defined as a person or group, who, while not directly related to exchanging health data or providing financial or programmatic support, have significance influence in one or more factors regarding exchanging health data in West Virginia.

- National efforts can directly impact WV’s strategic vision regarding electronic exchange of health data.
- CMS guidance on the availability of enhanced 90/10 funds to implement HIT in support of addressing the use of opioids.

- State legislative efforts such as the recent Substance Use Disorder (SUD) Waiver can also impact the amount of data exchanged and health outcomes of the patients involved.
- The WV 2017 MITA SS-A Update.

## Assumptions

Project assumptions are defined as events or circumstances that are expected to happen during the course of a project's life-cycle. Assumptions that would affect data exchanges opportunities identified in this document would be:

- On-going federal support of specific data exchange and interoperability projects such as promoting interoperability, CMS innovation projects, and opioid crisis funding.
- Continued viability of key West Virginia stakeholder's in HIT such as West Virginia Health Information Network (WVHIN).

## Constraints

A constraint is defined as any restriction that defines data exchange limitation.

Provider capabilities and commitment to exchanging data electronically are limitations that will affect the amount of data exchanged. Costs, EHR / vendor issues, and general understanding of the benefits are examples of reasons why providers choose not to exchange data or are not able to exchange data.

## Dependencies

The strategic relationship between the MITA SS-A Roadmap and the SMHP is key to the outcome of this MITA HITECH Assessment. As well the continued viability and expansion of data sharing through the roll out of the MMIS modules, expanded use of EHR technology by Medicaid providers, and the statewide participation in the WVHIN.

## Risks

The latest changes to the EHR Incentive Program effective October 2018 known as "Promoting Interoperability" can impact electronic reporting of data to the State Public Health Department's syndromic surveillance, electronic lab reporting, and immunizations. The relationship between the Public Health Department and other systems in the Medicaid Enterprise is key to achieving accuracy, modularity, leverage, access, and utility that interoperability seeks to achieve.

Eligible hospitals can choose to send data to national registries and state registries and these registries may or may not be established data sources in the Medicaid Enterprise.

## Issues

Information related to WVHIN was captured from their website. WVHIN's current roadmap and strategic plan were not made available at the time this document was developed.

## Project Documentation



- Project Artifacts – This MITA 2017 SS-A Update HIT Assessment Companion Report is the only document produced as an artifact of the MITA HITECH Assessment.
- MITA MMP – The MMP manages all MITA SS-A documentation and artifacts including this report and supporting documentation.

## WV HIT Concept of Operations

The CMS HITECH toolkit provides State HIT MITA assessment teams with an outline for creating a MITA COO for a HITECH system. The WV MITA COO describes how the State plans to deploy and operate the set of HITECH business processes, systems, and stakeholder interaction to achieve the HIT objectives defined by the State. The WV HIT COO for planned HITECH business operations, processes, and systems, includes these components:

- Vision for the Medicaid Enterprise
- Stakeholders
- Information and Data
- Drivers and Enablers
- As-Is Operations
- To-Be Environment
- Business Improvements

## HIT Vision for the Medicaid Enterprise

In addition to the DHHR annual strategic planning initiatives, the 2016 MITA 3.0 SS-A Annual Update established the strategic direction for the HIT outcomes and solutions that will achieve these outcomes in the MITA Roadmap. The MITA Roadmap is updated annually to continually reset and adjust its strategic direction as needed to achieve the desired outcomes in business process, information, and technology capability maturity. The strategic planning is done in alignment with the DHHR Strategic Plan, SHIP, and the CMS Seven Standards and Conditions. Additionally, the WV HIT Collaborative, through a State Innovation Model grant, developed the WV State Health System Innovation Plan (WV SHSIP), which helped inform the current planning process. Incorporation of these existing planning documents allows BMS to develop a vision for the future of health IT that supports the overall health goals of the State as they apply to the Medicaid program. The vision described in Section 4.0 of this document is derived from these planning activities. The Health IT Roadmap is presented in Section 5.0 of this document.

## HIT Stakeholders

The MITA 3.0 SS-A 2016 Annual Update Report identified numerous Key Stakeholders and their Data Exchanges. Also identified were Detailed DHHR Stakeholders. As data exchange becomes more prevalent, the list of WV BMS HIT stakeholders will become more refined.

**Table 3: WV BMS HIT Stakeholders and Major Data Exchanges**

Key Stakeholder	Major Data Exchanges
<p><b>Providers</b> – Providers of services including pharmacists, hospitals, case managers, and home and community-based caregivers serving the Medicaid population. Includes services that are rendered by other state agencies such as WV Children’s Health Insurance Program (WVCHIP) and the Bureau for Behavioral Health and Health Facilities (BBHFF).</p>	<ul style="list-style-type: none"> <li>• Providers submit enrollment applications via the Provider portal.</li> <li>• Providers submit claims for reimbursement electronically using Health Insurance Portability and Accountability Act (HIPAA) standard transactions and paper.</li> <li>• Medicaid responds to providers electronically or via the Provider portal.</li> <li>• Paper is still used to exchange some information with providers.</li> <li>• Providers receive electronic payments via Electronic Funds Transfer (EFT).</li> </ul>
<p><b>Managed Care Organizations (MCOs)</b> – Organizations who contract with the State to provide Medicaid recipients with a defined set of services. Current MCOs are The Health Plan (THP), Unicare, West Virginia Family Health, and Aetna Better Health.</p>	<ul style="list-style-type: none"> <li>• The Medicaid Enterprise sends enrollment data to MCOs electronically using the X12N 834 standard transaction and a supplemental file.</li> <li>• X12N 834 transactions are sent to MCOs monthly.</li> <li>• X12N 820 transactions are sent to MCOs weekly.</li> <li>• MCOs submit encounter data to Medicaid using the X12N 837 standard transactions.</li> <li>• MCOs submit encounter data no later than 90 days after the end of the quarter in which the encounters occurred.</li> </ul>
<p><b>Beneficiaries</b> – West Virginia residents who apply for or who receive Medicaid Enterprise benefits.</p>	<ul style="list-style-type: none"> <li>• Applicants submit applications by phone, fax, mail, or enter directly through the Health Insurance Marketplace or WV inROADS.</li> <li>• Beneficiaries submit eligibility verifications in electronic and paper format.</li> <li>• Beneficiaries receive multiple notices regarding eligibility from the Medicaid Enterprise and the MCO.</li> </ul>
<p><b>CMS</b> – A branch of the U.S. Department of Health and Human Services (HHS). CMS is the federal agency that administers Medicare, Medicaid, and CHIP. CMS provides information for health professionals, regional governments, and consumers.</p>	<ul style="list-style-type: none"> <li>• Medicaid Enterprise submits invoices and Transformed Medicaid Statistical Information System (T-MSIS) reports via an interface.</li> <li>• Medicaid Enterprise electronically submits CMS budget reports using the Medicaid Budget and Expenditure System/State Children’s Health Insurance Program Budget and Expenditure System (MBES/CBES).</li> </ul>
<p><b>Other Payers</b> – Other benefit programs with liability to cover medical costs for Medicaid recipients. Includes private insurers.</p>	<ul style="list-style-type: none"> <li>• Benefit information is exchanged prospectively.</li> </ul>



Key Stakeholder	Major Data Exchanges
<p><b>Other Agencies</b> – State, local, and federal agencies that exchange information with Medicaid (e.g., WVCHIP, BBHFF, Medicare, IRS, Treasury, and Department of Finance and Accounting).</p>	<ul style="list-style-type: none"> <li>Medicaid Enterprise responds to requests for information from the state legislature, governor, other state agencies, CMS, other federal agencies, and the public by manually accessing data from multiple sources using different media, connectivity, format, and data content.</li> </ul>
<p><b>Newly Identified Key Stakeholders</b></p>	
<p><b>Mental / Behavioral Health Providers</b> - the integration of physical and behavioral health care can improve quality and decrease costs, especially for Medicaid beneficiaries with complex health care needs<sup>1</sup>.</p>	<p>Integration of physical and behavioral health models that data exchange / interoperability can support:</p> <ul style="list-style-type: none"> <li>Managed care</li> <li>Enhanced Care / Case Management</li> <li>Patient Centered Medical Home</li> <li>Health homes</li> <li>ACOs</li> </ul>
<p><b>Opioid Crisis Response Collaborators</b> The Opioid Crisis Response Act of 2018 (S. 2680), puts a premium on leveraging information technology such as electronic health records, telemedicine and Prescription Drug Monitoring Programs (PDMPs). Though SAMSHA Part 2 rules restricts the way substance abuse data can be exchanged, there are numerous opportunities to use health data and information technologies to address the Opioid Crisis.</p>	<ul style="list-style-type: none"> <li>Utilizing syndromic surveillance / hospital discharge data to identify and analyze opioid related events in hospital emergency departments.</li> <li>WVHIN's WV CSAPP Query and Encounter Notification service in the case of an opioid related medical emergency.</li> <li>Establishment of a WV Opioid and Heroin Data Center where relevant data sets can be analyzed to develop and evaluate strategies. Stakeholder data sets could include DHHR (syndromic surveillance / hospital discharge data), WVHIN (clinical / encounter data), law enforcement (overdose data), and WV CSAPP (controlled substance prescription data).</li> </ul>
<p><b>CMS Innovation Projects</b> The CMS Innovation Center supports testing various payment and service delivery models that aim to achieve better care for patients, better health for our communities, and lower costs through health care system improvement. Many of the innovation projects can be enhanced with</p>	<p>Active CMS Innovation Projects that could benefit from data exchange / interoperability:</p> <ul style="list-style-type: none"> <li>Transforming Clinical Practice Initiative</li> <li>Accountable Health Communities Model</li> <li>Million Hearts®: Cardiovascular Disease Risk Reduction Model</li> <li>Strong Start for Mothers and Newborns</li> </ul>

<sup>1</sup> *Assessing Changes to Medicaid Managed Care Regulations: Facilitating Integration of Physical and Behavioral Health Care*, Commonwealth Fund, Elizabeth Edwards, October 24, 2017.

Key Stakeholder	Major Data Exchanges
<p>the exchange / use of health care data. Current West Virginia CMS Innovation projects can potentially benefit by exchanging / using health care data</p>	<ul style="list-style-type: none"> <li>• Oncology Care Model</li> </ul>
<p><b>Accountable Care Organizations (ACOs) -</b> States are increasingly turning to Medicaid ACOs to improve patient outcomes and control costs by shifting accountability for risk and quality to providers.<sup>2</sup> Nationally, the number of ACOs has steadily increased. ACOs have shown they can play a vital role for West Virginia providers in the transition from fee-for-service to a value-based reimbursement model. The goal of coordinated care is to ensure that patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. ACOs can use data analytics to identify gaps in a patient’s care and coordinate resources to address patient’s needs in a timelier manner.</p>	<p>Identified ACOs in West Virginia include:</p> <ul style="list-style-type: none"> <li>• Aledade</li> <li>• ACO West Virginia</li> <li>• National Rural Accountable Care Consortium</li> <li>• MHC Accountable Care Organization</li> <li>• Loudon Medical Group ACO</li> <li>• BetterCARE Partners</li> </ul>
<p><b>Providers – Supporting Transitions of Care</b> Transition of Care (transferring a patient from one care setting (e.g., a hospital, nursing facility, primary care physician, long-term care, home health care, or specialist care) to another. Breakdowns in these processes, as well as the ineffective handoff of information between care providers, can lead to poor transitions and miscommunication among providers. This, in turn, can cause confusion regarding treatment plans, duplicative testing, discrepancies in medications, and missed physician follow-up, ultimately leading to fragmented care and patient dissatisfaction<sup>3</sup>. Exchanging health data in a timely manner can mitigate many of the problems.</p>	<ul style="list-style-type: none"> <li>• Exchanging clinical encounter data with other providers. Examples would include using WVHIN to query for patient level data; using Direct Secure Messaging and exchanging CCDs, querying WVSIS for a current immunizations status.</li> <li>• Utilizing WVHIN’s Encounter Notifications – “real time” alerts informing Case / Care managers upon specific events such as admission or discharge.</li> </ul>

<sup>2</sup> Medicaid Accountable Care Organization Programs: State Profiles, Jim Lloyd, Rob Houston, and Tricia McGinnis, Center for Health Care Strategies, October 2015.

<sup>3</sup> *Improving Transitions of Care, Findings and Considerations of the “Vision of the National Transitions of Care Coalition”*, National Transitions of Care Coalition, September 2010

DHHR maintains a detailed list of stakeholders that is reflected in Table 4.

**Table 4: Detailed DHHR Stakeholders**

Detailed DHHR Stakeholders
The Department of Health and Human Resources (DHHR)
The Bureau for Medical Services (BMS) <ul style="list-style-type: none"> <li>• Medical Fraud</li> <li>• Legal</li> <li>• Grants Management</li> </ul>
Office of Management Information Systems (MIS)
Medicaid Management Information System (MMIS)
Our Advanced Solution with Integrated Systems (OASIS)
West Virginia Children’s Health Insurance Program (WVCHIP)
Online Support Collection and Reporting (OSCAR)
West Virginia Office of Technology (WVOT)
IBM Watson Health (formerly Truven) Data Warehouse/Decision Support System (DW/DSS)
Molina Healthcare (Fiscal Agent)
Optum (Recipient Automated Payment Information and Data System (RAPIDS)/Eligibility System)
Families and Children Tracking System (FACTS)
Center for Medicare and Medicaid Services (CMS)
Public Employees Insurance Agency (PEIA)
Bureau for Behavioral Health and Health Facilities (BBHFF)
West Virginia (WV) Board of Education
Managed Care Organizations (MCOs) <ul style="list-style-type: none"> <li>• Unicare</li> <li>• The Health Plan (THP)</li> <li>• West Virginia Family Health</li> <li>• Aetna Better Health</li> </ul>
WV County Offices
WV Public Health Departments
Health Management Systems (HMS)
Goold Health Systems (GHS)
Health Information Designs (HID)

Detailed DHHR Stakeholders
COBA (Medicaid file for dual eligible)
West Virginia Medical Institute (WVMI)
Health Check
U.S. Department of Health and Human Services, Office of the Inspector General (OIG)
West Virginia University (WVU)
West Virginia Board of Pharmacy
WV Law Enforcement Agencies
Office of the State Medical Examiner

As DHHR continues to outline their Information Architecture and data exchange / interoperability expands within the state, other stakeholders will continue to be identified and tracked in the present and in the future. Additionally, stakeholder information will continue to be identified and tracked as the enterprise matures through the implementation of the IES, Asset Verification System (AVS), All Payer Claim Database (APCD), DW/DSS, and Recovery Audit Contractor (RAC) projects.

### HIT Information and Data

State interoperability initiatives such as the WVHIN public health reporting, and telemedicine State initiatives to expand electronic exchange of health information vary in scope. The end result is the collection and dissemination / use of the data to achieve public health objectives, meet MU criteria and provide solutions to West Virginia providers to exchange / use health data efficiently.

The State envisions the implementation of a robust DW/DSS to effectively manage and uses data across the Medicaid Enterprise. The DW/DSS is currently used to run standard management and administrative reports (MAR), surveillance and utilization review (SUR) reports, and ad hoc queries to respond to requests for information.

Between December 2011 and September 2014, BMS conducted design, development, and implementation (DDI) activities for a more robust DW/DSS solution that would also support HIT goals and objectives. The deployment of the completed DW/DSS in the fall of 2014 significantly enhanced the State's reporting capabilities in the following areas:

- Enhanced reporting
- More efficient and effective performance monitoring
- Improved data access, analysis, and reporting to support decision-making
- Enhanced integration with other entities to further reduce the potential for redundancy of services and payment

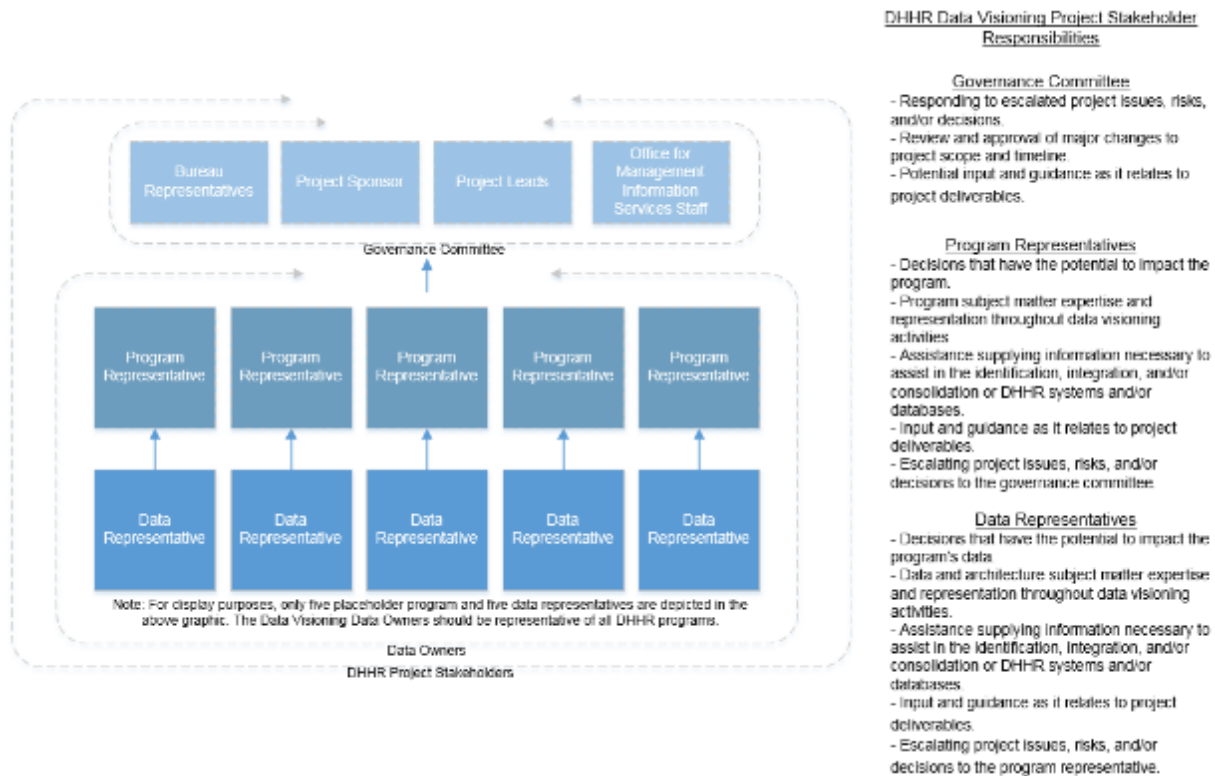
- Improved access and integration of clinical and encounter data with reconciled claims and payment data
- Providing other covered entities with online access to appropriate data
- Leveraging the DW/DSS to support WVCHIP decision making with an embedded WVU data analyst
- Reports used by BMS, vendors, and other State entities executed from a single reconciled data store and the results will be consistent
- MMIS claims data, eligibility data, encounter data, and reference data stored in a single location, allowing easy access for program and operations management and decision-making
- Improved tools and training for data analysis to improve healthcare decision-making

In 2018, DHHR initiated data visioning activities to further facilitate the integration of data sources with the DW/DSS. The project will develop a request for proposals (RFP) and procure a new DW/DSS.

The following are goals of the Data Visioning Project. The goals will be further defined within the Data Source Integration Roadmap:

- **Enterprise Integration and Modernization:** To create and maintain a modernized and comprehensive health information database for the Department's use in promoting quality and cost-effective care.
- **Increased Shared Use:** To maximize, promote, and improve the use and reuse of State resources across the enterprise, while minimizing unnecessary duplicity of DHHR information databases.
- **Improved Analytics and Reporting Capability:** To enhance and achieve user's confidence in the DHHR health data analytic capabilities, reporting, and services.
- **Long-Term Stability, Performance, and Use:** To enhance DHHR's health information database, analytic capabilities, and associated infrastructure to help ensure the long-term stability and performance.
- **Common Governance Structure:** To standardize the governance, management approach, and integrated change control processes that govern DHHR data management enterprise.

**Figure 4: Data Visioning Project Stakeholders**



## HIT Drivers and Enablers

The need for health information exchange (HIE) in Medicaid is driven by a broad array of state and national supported by federal initiatives. Technical capacity for providers and other healthcare stakeholders is required to conduct the exchange of health information efficiently and accurately and the HITECH Act began this effort in earnest in 2009. The 2016 WV SMHP reported the Office of National Coordinator (ONC) recorded significant progress in West Virginia’s health IT landscape:

- 76% percent of West Virginia office-based physicians (i.e., MD and DO) have adopted a certified EHR. This is slightly above the national average of 74%.
- More than 80% of the office-based primary care providers—and more than 70% of non-primary care office-based providers—in West Virginia report adoption of a certified EHR.
- More than 71% of office-based physicians in West Virginia practices of 10 or fewer physicians report adoption of a certified EHR.
- As of the end of 2015, approximately 53% of West Virginia office-based physicians have demonstrated MU of certified health IT in the CMS EHR incentive program—slightly below the national average of 56%.

Though additional effort is required to increase WV’s HIE capacity, the progress West Virginia has made lays the foundation for increased health information exchange between West Virginia providers and other health care stakeholders within the State.

There are multiple initiatives in West Virginia that now are driving the electronic exchange of health information. The section below describes a few of the more significant initiatives:

### **Meaningful Use (MU) (Promoting Interoperability)**

The CMS incentive program continues to be a primary driver to deploy Certified EHR Technology (CEHRT) and HIT to facilitate the exchange of health information between providers and healthcare stakeholders. The latest rule change includes removing certain measures that do not emphasize interoperability and the electronic exchange of health information. The rule change adds measures that increase the electronic exchange of data to include the Query of PDMP which will be optional in CY 2019 and required beginning in CY 2020.

### **DirectTrust Capacity**

The capability to “push” data between providers and Health Care organizations (HCOs) is growing steadily. DirectTrust reported a 26% increase in the number of direct exchange transactions in the second quarter of 2018 (compared to the same period in 2017) and a 23% increase in the number of health care organizations served by DirectTrust health information service providers (HISPs)<sup>4</sup>.

### **Accountable Care Organizations (ACOs)**

Exchanging health information to increase patient outcomes and lower costs will continue to be a priority for ACOs. Opportunities for ACO infrastructure support continue to increase with support from CMS for such organizations under Medicaid waivers, demonstrations, and innovation projects. States can leverage the experience of other states through these mechanisms with enhanced funding support from CMS.

### **Payment Reform**

Initiatives to transition from a fee-for-service model to a value-based care system continue to emerge in Medicaid nationally. The ability to coordinate care to meet new payment reform requirements will require exchanging health information in a timely manner amongst WV providers and with other healthcare organizations. CMS has continued to demonstrate support for Medicaid payment reform initiatives and in particular leveraging the experience of other states with desirable outcomes resulting from innovation projects that CMS has supported previously.

### **WVHIN**

The WVHIN can play a key role in furthering the exchange of health information and promoting interoperability within the State of West Virginia. Since its inception in 2010, WVHIN has grown in the number of participants, the amount of clinical data collected, and its data exchange /

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<sup>4</sup> *Direct Exchange Transactions Increased 26 Percent in Q2 2018*, Direct Trust, Aug 2, 2018.



interoperability capabilities. Current participants from the WVHIN website updated August 14, 2018:

- 42 hospitals are connected to WVHIN
  - 42 are sending public health data
  - 38 are sending ADT (seven in testing)
  - 24 are sending both ADT and clinical data (any combination of lab results, radiology reports, transcribe reports, and CCDs)
  - Hospitals sending ADT and/or clinical data account for 72% coverage the licensed beds in the WV
- 23 ambulatory organizations are sending clinical data
- 8 post-acute organizations
- 4 external HIEs

### **Encounter Notifications Services**

WVHIN also has key services that can drive additional participation in WVHIN and increase the exchange / use of data. Services such as Encounter Notifications, the Controlled Substance Automated Prescription Program (CSAPP) query capability, and the Advanced Directives Registry all provide additional value to providers to participate and support efforts that share / use data. Opioid crisis efforts will drive the use of the WVHIN to query the CSAPP. Encounter Notifications provides timely information to the health care community regarding admissions and discharges that support reduction of hospital readmissions and transitions of care. Strategies surrounding these specific tools can be used to increase the WVHIN usage and facilitate the exchange of healthcare data.

### **WVHIN Roadmap**

#### **West Virginia Telemedicine Efforts**

In March of 2016, HB 4463 was signed into law, implementing a variety of telemedicine practice standards and remote prescribing rules. In April 2017, HB 2509 was also signed into law, regulating the practice of telemedicine in the State of West Virginia. Telemedicine technologies allow real-time communication between the member at the originating site and a practitioner at the distant site. Providing the remote practitioner access to consolidated health data from sources such as WVHIN can further telemedicine efficiencies in West Virginia and increases health outcomes in both the primary and mental / behavioral health areas.



### **Opioid crisis-related activities and Integration between primary health and mental / behavioral health providers**

In October 2017, the opioid crisis was officially declared a public health emergency. Since then, resources have been allocated to states to address the emergency with more expected to be available. The crisis is complex and multi-faceted requiring cooperation between different agencies such as law enforcement, mental health, public health, the health care community, and political entities.

In 2016, West Virginia had the highest rate of opioid-related overdose deaths in the United States—a rate of 43.4 deaths per 100,000—and up from a low 1.8 deaths per 100,000 in 1999. The number of overdose deaths peaked at 733 deaths in 2016 with the majority of deaths attributed to synthetic opioids and heroin. Since 2010, deaths related to synthetic opioid deaths quadrupled from 102 to 435 deaths and deaths related to heroin rose from 28 to 235 deaths.

Planning efforts to combat the Opioid crisis in West Virginia include data-driven plans and solutions. Efforts will include data from different sources (e.g., law enforcement data related to overdoses, controlled substance prescription data (WV CSAPP), public health, Emergency Management Systems (EMS), primary health data (WVHIN), and others). Understanding local opioid prescribing patterns, opioid overdose rates and the potential to predict who may be at increased risk for chronic opioid use is critical to the solution. Collecting, analyzing, and sharing these data will allow for the development of data-driven solutions and associated evaluation plans.

### **WV HIT Improvement Opportunities**

CMS supports these efforts using funding mechanisms such as the 90-10/75-25 match funds. The recent State Medicaid Director's (SMD's) letter SMD # 18-006 (<https://www.medicaid.gov/federal-policy-guidance/downloads/smd18006.pdf>) provides an opportunity for states to use CMS funds to create HIT infrastructure in support of the opioid crisis. Specific interoperability efforts are identified in SMD # 18-006 that support the exchange and use of health data to include:

- enhanced PDMP (WV CSAPP) interoperability;
- data analytics and public health reporting;
- technologies for coordinating / increasing access to care; and
- enhanced Statewide interoperability in general.

Matched funds may be used to enhance BMS' DW/DSS by increasing clinical / encounter data reported, including new data sources such as mental / behavioral health and emergency management system data and developing enhanced reporting solutions such as opioid-related dashboards.

A specific use case regarding this SMD letter involves foster children. The opioid crisis effects families beyond the individual who is addicted. In West Virginia, about 80% of the children in foster care come from homes with substance abuse<sup>5</sup>. WVHIN's encounter notification service (ENS) can provide real-time alerts to the DHHR Child Protective Services case / care managers for foster children who have been admitted or discharged from an emergency department.

### Opioid-related Lawsuits

Subsequent to the opioid crisis are the myriad of lawsuits that are and will be filed against opioid manufacturers and distributors. The state of West Virginia and multiple local government entities have already filed multiple lawsuits against opioid companies since 2016. Similar to the funds received from the 'big tobacco' lawsuit settlements in the late 1990s, funds can be used by the opioid settlements to create programs and HIT solutions to help address the crisis. West Virginia has shown lawsuits against opioid companies can be financial viable with a successful suit against Purdue Pharma in 2004 resulting in a \$10M settlement in the state of West Virginia's favor. The funds West Virginia received were used to finance community-based drug abuse and diversion programs, law enforcement initiatives, and medical programs on drug abuse for providers.

### SUD Demonstration Waiver

In October 2017, the Medicaid 1115 Waiver was awarded to DHHR by CMS to improve care and health outcomes by expanding services for those with a substance use disorder diagnosis. The Waiver allows BMS the opportunity to test innovative policy and delivery approaches to reform systems of care for individuals with SUD in West Virginia.

The goals of the SUD demonstration waiver are to improve quality of care and population health outcomes for Medicaid enrollees with SUD issues; increase enrollee access to, and utilization of, appropriate SUD treatment services based on American Society of Addiction Medicine (ASAM) criteria; decrease utilization of high-cost emergency department and hospital services by enrollees with a SUD; and improve care coordination and care transition for Medicaid enrollees with SUD issues.

Utilizing the SUD Demonstration Waiver, BMS started providing the following services in January 2018:

- **Screening, Brief Intervention, and Referral to Treatment (SBIRT):** West Virginia will implement statewide use of the widely-accepted SBIRT screening tool to identify SUD treatment needs among the Medicaid population.

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<sup>5</sup> Side effects: Opioid crisis creating child welfare crisis in W. Va., Andrea Lannom, The Register-Herald, May 24, 2018

- **Methadone treatment and administration:** The State will add Medicaid coverage of methadone as a withdrawal management strategy, as well as the administration and monitoring of the medication, and related counseling services.
- **Naloxone Distribution Initiative:** West Virginia will design and implement a Statewide initiative to make Naloxone (Narcan®) widely available and increase awareness of the benefits of Naloxone in reversing the effects of an overdose.

An example of an HIT solution available to BMS that could directly support SUD services would be WVHIN's ENS that would provide "real-time" alerts to SUD providers or BMS case manager information about patients presenting at emergency departments connected to WVHIN.

### **Data Center Activities in support of Opioid Efforts**

The use of data to target prevention and treatment efforts as well as identifying fraud and abuse are CMS' high level objectives. Many funding opportunities are requiring data analytics using data sources from organizations such as law enforcement, emergency management systems, public health, health community, and PDMP. Results generated from these analytics would include dashboards, predictive analysis, and evaluation support. Interagency collaboration to establish the data centers and associated governance is daunting at the least. However, DHHR could leverage existing resources such as BMS' DW/DSS to support these efforts.

## **HIT As-Is Operations, To-Be Environment, Business Improvements**

This assessment of the As-Is and To-Be business, information, and technical architectures for the HITECH MITA business processes can be found in Section 6 below.

### **HIT Assessment Results**

#### **Business Architecture Assessment Overview**

The MITA Business areas and processes were assessed for MITA maturity within the HITECH environment within the As-Is and To-Be environments of the Medicaid Enterprise. The maturity results for these HITECH processes are consistent with the findings for these same processes as assessed for the maturity of their broader business role within the MITA Framework for the WV Medicaid enterprise as assessed in the MITA 2017 SS-A Annual Update.

##### **6.1.1 Business Relationship (BR)**

- BR01 Establish Business Relationship

#### **Business Architecture Maturity Assessment**

This process has not matured in the past year as business process improvement solutions for this area have not been fully implemented resulting in maturity. The continued development of the relationship and ultimately data sharing agreements with WVHIN will likely improve business capability and greatly broaden the network of data sharing agreements within and across the Medicaid Enterprise.

**Table 5: BR Business Area – Maturity Level Profile (Business Architecture)**

Business Relationship Management Business Area Maturity Level Profile - Business Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
BR01 - Establish Business Relationship			As-Is	To-Be	

**Information Architecture Maturity Assessment**

**Table 6: BR Business Area – Maturity Level Profile (Information Architecture)**

Business Relationship Management Business Area Maturity Level Profile – Information Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
BR01 - Establish Business Relationship		As-Is		To-Be	

**Technical Architecture Maturity Assessment**

**Table 7: BR Business Area – Maturity Level Profile (Technical Architecture)**

Business Relationship Management Maturity Level Profile – Technical Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
BR01 - Establish Business Relationship		As-Is		To-Be	

**6.1.2 Care Management (CM)**

All nine of the Care Management (CM) business processes were identified for HIT business improvements:

- CM01 Establish Case
- CM02 Manage Case Information
- CM03 Manage Population Health Outreach
- CM04 Manage Registry
- CM05 Perform Screening and Assessment
- CM06 Manage Treatment Plan and Outcomes
- CM07 Authorize Referral
- CM08 Authorize Service
- CM09 Authorize Treatment Plan

**Business Architecture Maturity Assessment**

All processes in the Care Management (CM) business area were assessed for HITECH Maturity. Most processes are expected to mature with the implementation of the Care

Management module in Health PAS. This module has not yet been implemented. Requirements for the use of Electronic Health Records and data sharing by MCOs. The Medicaid program has begun data visualization for CM04 Manage Registry through the use of HIEConnect, which is powered by CareEvolution HIEBus™ which permits sharing Immunization registry data with authorized EHRs but not as of yet for other registries or processes in the CM business area. The SMA does not currently have an HIE implemented.

### **Information and Data**

Member Enrollment is shared by a roster provided via secure File Transfer Protocol or electronic media by the enrollment broker. No electronic records or health data is shared. The MCO contracts do not require the use of or data sharing with electronic health records or networks.

The MMIS care management module has not yet been implemented and data sharing from EHRs and the WVHIN has not been established. This process requires the use of member records and management of information medium varies by program. MCO contracts do not require the use of EHRs or network data sharing for information management. This process requires the use of member records and management of information medium varies by program. MCO contracts do not require the use of EHRs or network data sharing for information management.

The use of health information technology has not yet been implemented for Manage Population Health Outreach process analytics and activities.

HIEConnect, which is powered by CareEvolution HIEBus™ permits sharing Immunization registry data with authorized EHRs.

Once the State initiates and finalizes the case management process, Health PAS is prepared to support the State in managing Manage Treatment Plan and Outcomes, Authorization of services, referrals, and treatment plans.

Molina acknowledges that BMS does not wish to implement this process at this time. Each MCO maintains clinical and health-related data electronically and securely through their own systems.

The SMA does not currently have an HIE implemented. When claims are submitted through the Point of Sale (POS) system, requests for selected non-preferred drugs are automatically processed in an automated Prior Authorization (PA) module.

### **Table 8: CM Business Area – Maturity Level Profile (Business Architecture)**

Care Management Business Area					
Maturity Level Profile – Business Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
CM01 Establish Case		As-Is		To-Be	
CM02 Manage Case Information			As-Is	To-Be	
CM03 Manage Population Health Outreach			As-Is	To-Be	
CM04 Manage Registry		As-Is		To-Be	
CM05 Perform Screening and Assessment		As-Is		To-Be	
CM06 Manage Treatment Plan and Outcomes		As-Is		To-Be	
CM07 Authorize Referral		As-Is		To-Be	
CM08 Authorize Service		As-Is		To-Be	
CM09 Authorize Treatment Plan			As-Is	To-Be	

### Information Architecture Maturity Assessment

HIEConnect, which is powered by CareEvolution HIEBus™ permits sharing Immunization registry data with authorized EHRs.

**Table 9: CM Business Area – Maturity Level Profile (Information Architecture)**

Care Management Business Area					
Maturity Level Profile – Information Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
CM01 Establish Case			As-Is	To-Be	
CM02 Manage Case Information			As-Is	To-Be	
CM03 Manage Population Health Outreach			As-Is	To-Be	
CM04 Manage Registry			As-Is	To-Be	
CM05 Perform Screening and Assessment			As-Is	To-Be	
CM06 Manage Treatment Plan and Outcomes			As-Is	To-Be	
CM07 Authorize Referral			As-Is	To-Be	
CM08 Authorize Service			As-Is	To-Be	

Care Management Business Area					
Maturity Level Profile – Information Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
CM09 Authorize Treatment Plan			As-Is	To-Be	

### Technical Architecture Maturity Assessment

HIEConnect, which is powered by CareEvolution HIEBus™ permits sharing immunization registry data with authorized EHRs.

**Table 10: CM Business Area – Maturity Level Profile (Technical Architecture)**

Care Management Business Area					
Maturity Level Profile – Technical Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
CM01 Establish Case			As-Is	To-Be	
CM02 Manage Case Information			As-Is	To-Be	
CM03 Manage Population Health Outreach			As-Is	To-Be	
CM04 Manage Registry				As-Is To-Be	
CM05 Perform Screening and Assessment			As-Is	To-Be	
CM06 Manage Treatment Plan and Outcomes			As-Is	To-Be	
CM07 Authorize Referral			As-Is	To-Be	
CM08 Authorize Service			As-Is	To-Be	
CM09 Authorize Treatment Plan			As-Is	To-Be	

### 6.1.3 Eligibility and Enrollment Management (EE)

- EE 06 Enroll Provider

#### Business Architecture Maturity Assessment

At the time of this assessment there are no health information technology requirements for enrollment of Medicaid providers and no plans for this process to incorporate the use of networks for this business purposes within the Medicaid Enterprise were identified. However, the general strategy development of EE06 within the enterprise does mature the process to

Level 4 and the increased use of health information technologies would be required to achieve this level.

**Table 11: EE Business Area – Maturity Level Profile (Business Architecture)**

Eligibility and Enrollment Business Area Maturity Level Profile – Business Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
EE06 Enroll Provider		As-Is		To-Be	

### Information Architecture Maturity Assessment

**Table 12: EE Business Area – Maturity Level Profile (Information Architecture)**

Eligibility and Enrollment Business Area Maturity Level Profile – Information Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
EE06 Enroll Provider			As-Is	To-Be	

### Technical Architecture Maturity Assessment

**Table 13: EE Business Area – Maturity Level Profile (Technical Architecture)**

Eligibility and Enrollment Business Area Maturity Level Profile – Technical Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
EE06 Enroll Provider			As-Is	To-Be	

### 6.1.4 Financial Management (FM)

The following processes from the FM Business Area were assessed for HITECH Maturity.

- FM01 Manage Provider Recoupment
- FM12 Manage Incentive Payment
- FM18 Manage Fund
- FM19 Generate Financial Report

### Business Architecture Maturity Assessment

These processes assessed were determined to have achieved maturity in the past year due to the implementation and roll-out of Oasis.



**Table 14: FM Business Area – Maturity Level Matrix (Business Architecture)**

Financial Management Business Area Maturity Level Profile – Business Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
FM01 Manage Provider Recoupment		As-Is	To-Be		
FM12 Manage Incentive Payment				As-Is	To-Be
FM18 Manage Fund			As-Is	To-Be	
FM19 Generate Financial Report			As-Is	To-Be	

**Information Architecture Maturity Assessment**

**Table 15: FM Business Area – Maturity Level Profile (Information Architecture)**

Financial Management Business Area Maturity Level Profile – Information Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
FM01 Manage Provider Recoupment		As-Is	To-Be		
FM12 Manage Incentive Payment			As-Is	To-Be	
FM18 Manage Fund			As-Is	To-Be	
FM19 Generate Financial Report			As-Is	To-Be	

**Technical Architecture Maturity Assessment**

**Table 16: FM Business Area – Maturity Level Profile – (Technical Architecture)**

Financial Management Business Area Maturity Level Profile – Technical Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
FM01 Manage Provider Recoupment		As-Is		To-Be	
FM12 Manage Incentive Payment				As-Is To-Be	

Financial Management Business Area Maturity Level Profile – Technical Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
FM18 Manage Fund				As-Is To-Be	
FM19 Generate Financial Report				As-Is To-Be	

### 6.1.5 Operations Management (OM)

- OM04 Submit Electronic Attachment

#### Business Architecture Maturity Assessment

This process currently meets industry standards and regulatory requirements. It does not yet make use of health information networks local, statewide, or nationally to support the process.

**Table 17: OM Business Area – Maturity Level Profile (Business Architecture)**

Operations Management Business Area Maturity Level Profile – Business Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
OM04 Submit Electronic Attachment		As-Is	To-Be		

#### Information Architecture Maturity Assessment

**Table 18: OM Business Area – Maturity Level Profile (Information Architecture)**

Operations Management Business Area Maturity Level Profile – Information Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
OM04 Submit Electronic Attachment		As-Is	To-Be		

#### Technical Architecture Maturity Assessment

**Table 19: OM Business Area – Maturity Level Profile (Technical Architecture)**

Operations Management Maturity Level Profile – Technical Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
OM04 - Submit Electronic Attachment			As-Is	To-Be	

### 6.1.6 Performance Management (PE)

The following processes from the PE Business Area were assessed for HITECH Maturity.

- PE01 Identify Utilization Anomalies
- PE02 Establish Compliance Incident
- PE03 Manage Compliance Incident Information
- PE05 Prepare REOMB

### Business Architecture Maturity Assessment

The processes in the PE business area generally do not make use of health information technology available to improve business process outcomes with the exception of PE01 which has improved with some limited access to a broader data set from the MCOs and the use of encounter data that is now available through the MMIS. PE 02 and 03 continue to rely on manual processes to gather information although electronic data is increasingly available for PE02. PE05 is an automated process but algorithms that are used for random distribution do not rely on data from health information networks.

**Table 20: PE Business Area – Maturity Level Profile (Business Architecture)**

Performance Management Business Area					
Maturity Level Profile - Business Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
PE01 Identify Utilization Anomalies			As-Is To-Be		
PE02 Establish Compliance Incident			As-Is To-Be		
PE03 Manage Compliance Incident Information		As-Is	To-Be		
PE05 Prepare REOMB		As-Is	To-Be		

### Information Architecture Maturity Assessment

**Table 21: PE Business Area – Maturity Level Profile (Information Architecture)**

Performance Management Business Area					
Maturity Level Profile - Information Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
PE01 Identify Utilization Anomalies		As-Is	To-Be		
PE02 Establish Compliance Incident		As-Is	To-Be		

Performance Management Business Area Maturity Level Profile - Information Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
PE03 Manage Compliance Incident Information		As-Is	To-Be		
PE05 Prepare REOMB		As-Is	To-Be		

### Technical Architecture Maturity Assessment

**Table 22: PE Business Area – Maturity Level Profile (Technical Architecture)**

Performance Management Business Area Maturity Level Profile - Technical Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
PE01 Identify Utilization Anomalies				As-Is To-Be	
PE02 Establish Compliance Incident			As-Is	To-Be	
PE03 Manage Compliance Incident Information		As-Is		To-Be	
PE05 Prepare REOMB		As-Is			To-Be

### 6.1.7 Plan Management (PL)

The following processes from the PL Business Area were assessed for HITECH Maturity.

- PL01 Develop Agency Goals and Objectives
- PL03 Maintain State Plan

### Business Architecture Maturity Assessment

The Business Processes in the PL Business Area remain largely manual and do not make use of health information technologies to support the process to the extent that is available and may in the future.

**Table 23: PL Management Business Area – Maturity Level Profile (Business Architecture)**

Plan Management Business Area Maturity Level Profile - Business Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
PL01 - Develop Agency Goals and Objectives			As-Is	To-Be	
PL03 - Maintain State Plan		As-Is		To-Be	

### Information Architecture Maturity Assessment

**Table 24: PL Management Business Area – Maturity Level Matrix (Information Architecture)**

Plan Management Business Area Maturity Level Profile - Information Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
PL01 - Develop Agency Goals and Objectives		As-Is		To-Be	
PL03 - Maintain State Plan		As-Is		To-Be	

### Technical Architecture Maturity Assessment

**Table 25: PL Management Business Area – Maturity Level Matrix (Technical Architecture)**

Plan Management Business Area Maturity Level Profile – Technical Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
PL01 - Develop Agency Goals and Objectives			As-Is	To-Be	
PL03 - Maintain State Plan		As-Is		To-Be	

### 6.1.8 Provider Management (PM)

The following processes from the PM Business Area were assessed for HITECH Maturity.

- PM01 Manage Provider Information
- PM02 Manage Provider Communication
- PM03 Perform Provider Outreach

### Business Architecture Maturity Assessment

The processes in the PM business area that were assessed are not as of yet making use of health information technologies to improve process capabilities.

**Table 26: PM Business Area – Maturity Level Profile (Business Architecture)**

Provider Management Business Area Maturity Level Profile- Business Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
PM01 Manage Provider Information		As-Is		To-Be	
PM02 Manage Provider Communication		As-Is		To-Be	
PM03 Perform Provider Outreach			As-Is	To-Be	

### Information Architecture Maturity Assessment

Table 27: PM Business Area – Maturity Level Profile (Information Architecture)

Provider Management Business Area Maturity Level Profile – Information Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
PM01 Manage Provider Information		As-Is		To-Be	
PM02 Manage Provider Communication		As-Is		To-Be	
PM03 Perform Provider Outreach		As-Is		To-Be	

### Technical Architecture Maturity Assessment

Table 28: PM Business Area – Maturity Level Profile (Technical Architecture)

Provider Management Business Area Maturity Level Profile – Technical Architecture					
Business Process	Level 1	Level 2	Level 3	Level 4	Level 5
PM01 Manage Provider Information			As-Is	To-Be	
PM02 Manage Provider Communication			As-Is	To-Be	
PM03 Perform Provider Outreach			As-Is	To-Be	



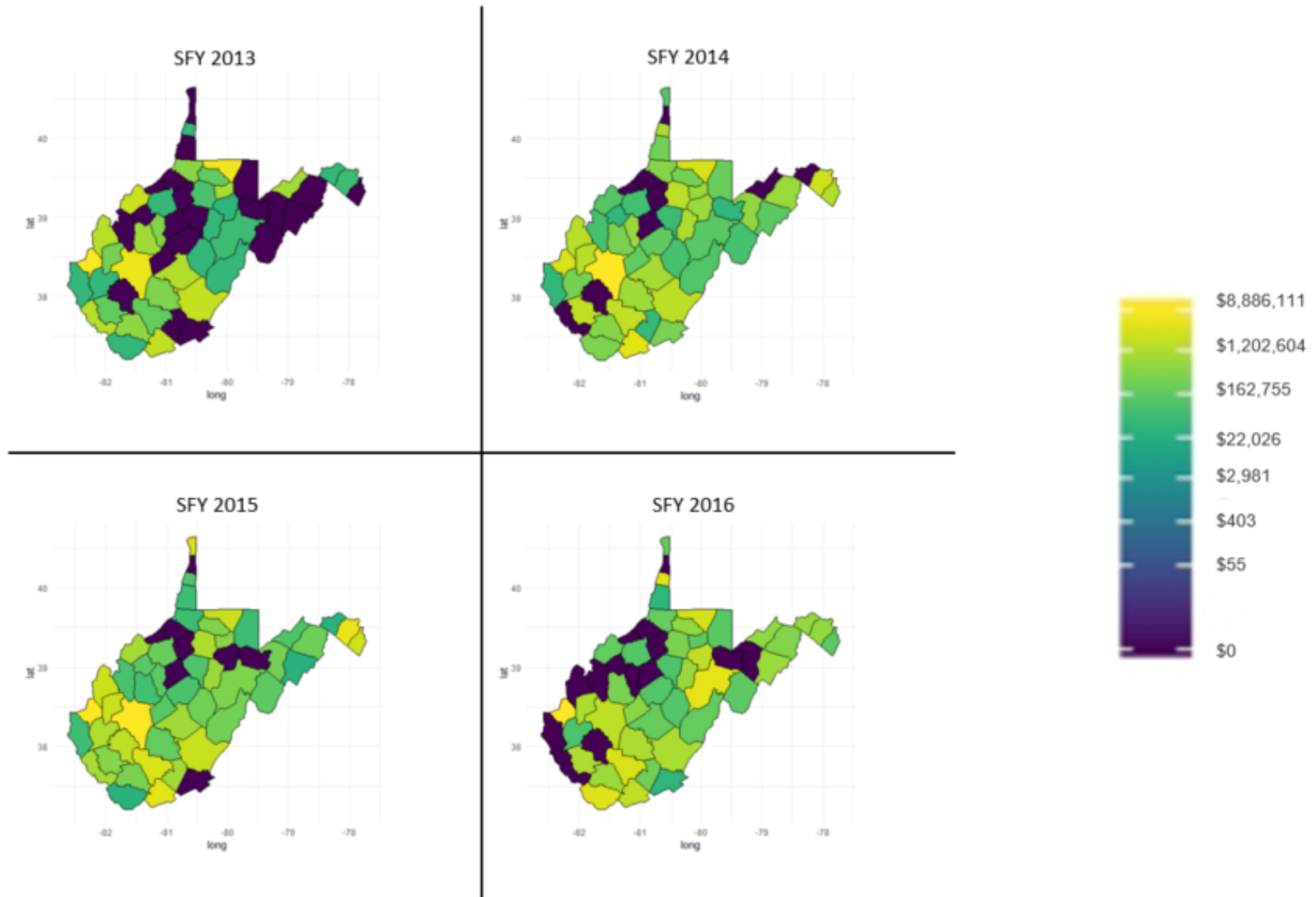
## Appendix A: HIT Business Architecture Ownership

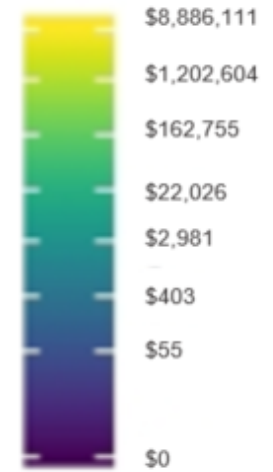
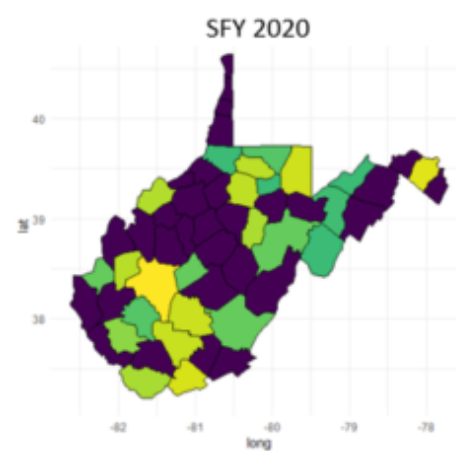
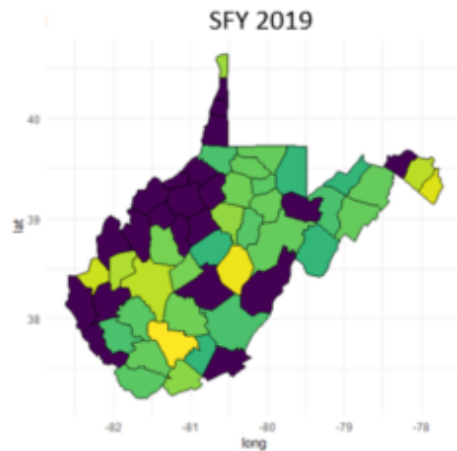
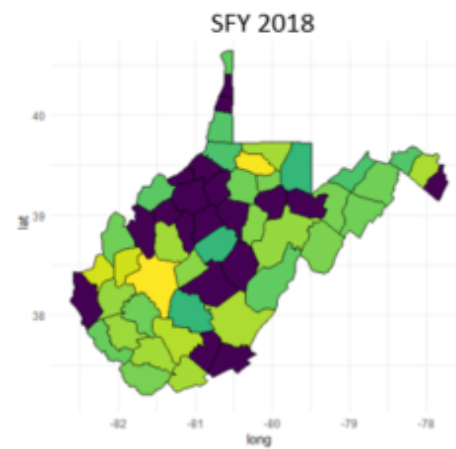
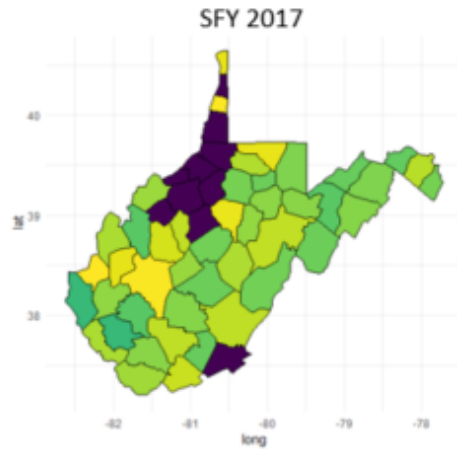
Business Area	BA Owner	Business Category	BC Owner	MITA Business Process	MBP Owner
Business Relationship Management (BR)	Cindy Beane	Standards Management	Sarah Young	BR01 Establish Business Relationship	Cynthia Shelton / Brandon Lewis
Care Management (CM)	Cindy Beane	Case Management	Sarah Young	CM04 Manage Registry	Sarah Young
Eligibility and Enrollment Management (EE)	Sarah Young	Provider Enrollment	Sarah Young	EE06 Enroll Provider	Cynthia Shelton
Financial Management (FM)	Tony Atkins	Accounts Payable Management	Tony Atkins	FM12 Manage Incentive Payment	Tony Atkins
		Fiscal Management	Tony Atkins / Jon Cain	FM18 Manage Fund	Tony Atkins / Jon Cain
				FM19 Generate Financial Report	Tony Atkins
Performance Management (PE)	Tony Atkins	Compliance Management	Tony Atkins	PE01 Identify Utilization Anomalies	Tony Atkins
Plan Management (PL)	Cindy Beane	Plan Administration	Cindy Beane	PL01 Develop Agency Goals and Objectives	Cindy Beane
				PL03 Maintain State Plan *	Ryan Sims
Provider Management (PM)	Cindy Beane	Provider Information Management	Sarah Young	PM01 Manage Provider Information	Cynthia Shelton
		Provider Support	Sarah Young	PM02 Manage Provider Communication	Cynthia Shelton
				PM03 Perform Provider Outreach	



Business Area	BA Owner	Business Category	BC Owner	MITA Business Process	MBP Owner
				PM07 Manage Provider Grievance and Appeal	Ryan Sims
Member Management (ME)	Cindy Beane / Jon Cain	Member Information Management	Mike Ebert	<i>ME01 Manage Member Information *deferred – to be released in 3/2018 for public comment*</i>	Brandon Lewis
		Member Support	Jon Cain / Sarah Young	<i>ME02 Manage Applicant and Member Communication *deferred – to be released in 3/2018 for public comment*</i>	Brandon Lewis / Cynthia Shelton

# Appendix I: Incentive Program Annual Payment Maps





## Appendix J: SMHP v3.6 Survey Results

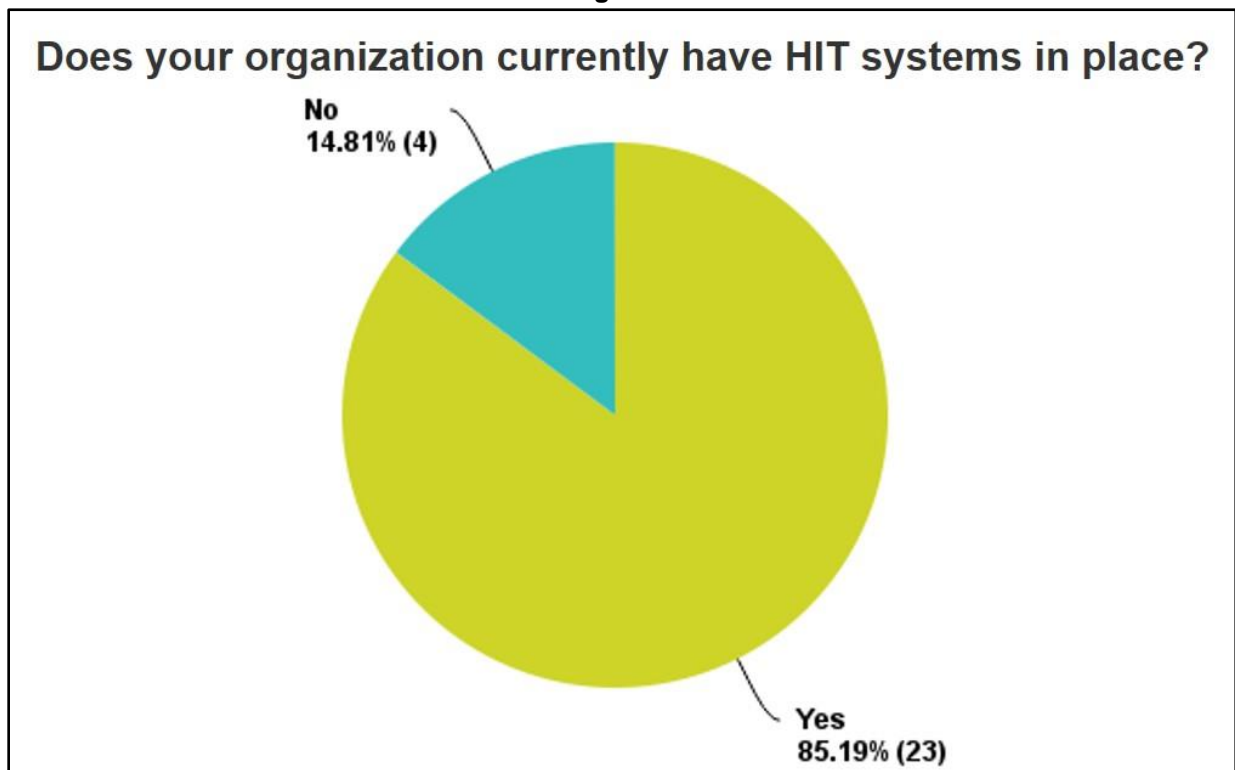
The following section is taken from the SMHP version 3.6.

### 3.4 Survey Responses

The following section provides an overview of the responses obtained from the survey.

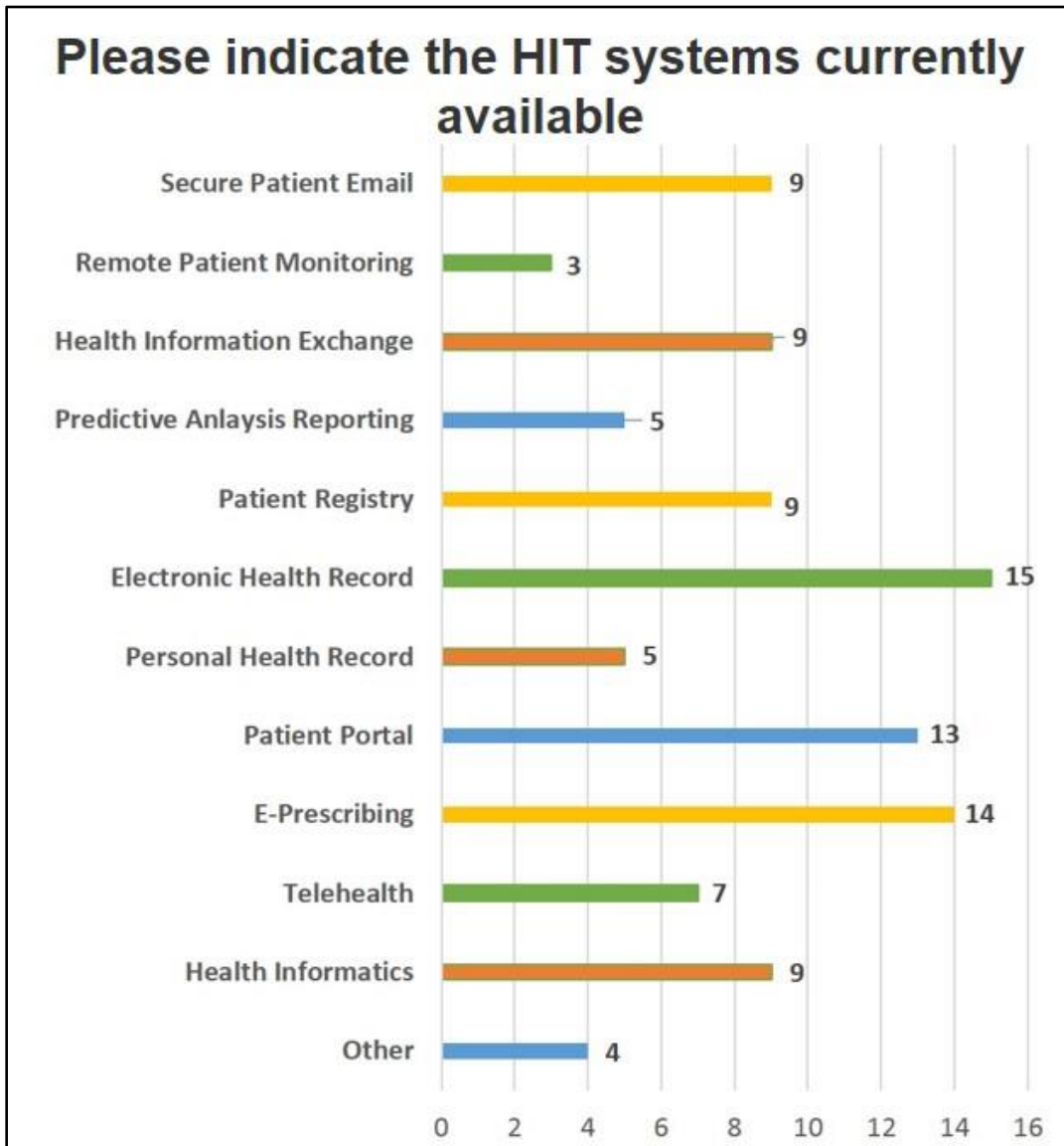
1. Figure 1 shows that more than 85% of the responding organizations have health IT systems in place. These systems are described in Table 4: Current and Planned Health IT Systems. By contrast, in 2011 only 40% of survey respondents indicated they had health IT systems.

Figure 1



2. Figure 2 shows the types of health IT systems that respondents have within their organizations. Twenty-one answered to this question. Among the respondents, the most common health IT technologies deployed were EHRs, E-prescribing, and Patient Portals. Most of the listed technologies were available in 2011 when the initial survey was completed. However, as evidenced in Figure 1, a greater number of respondents have health IT systems in place.

Figure 2

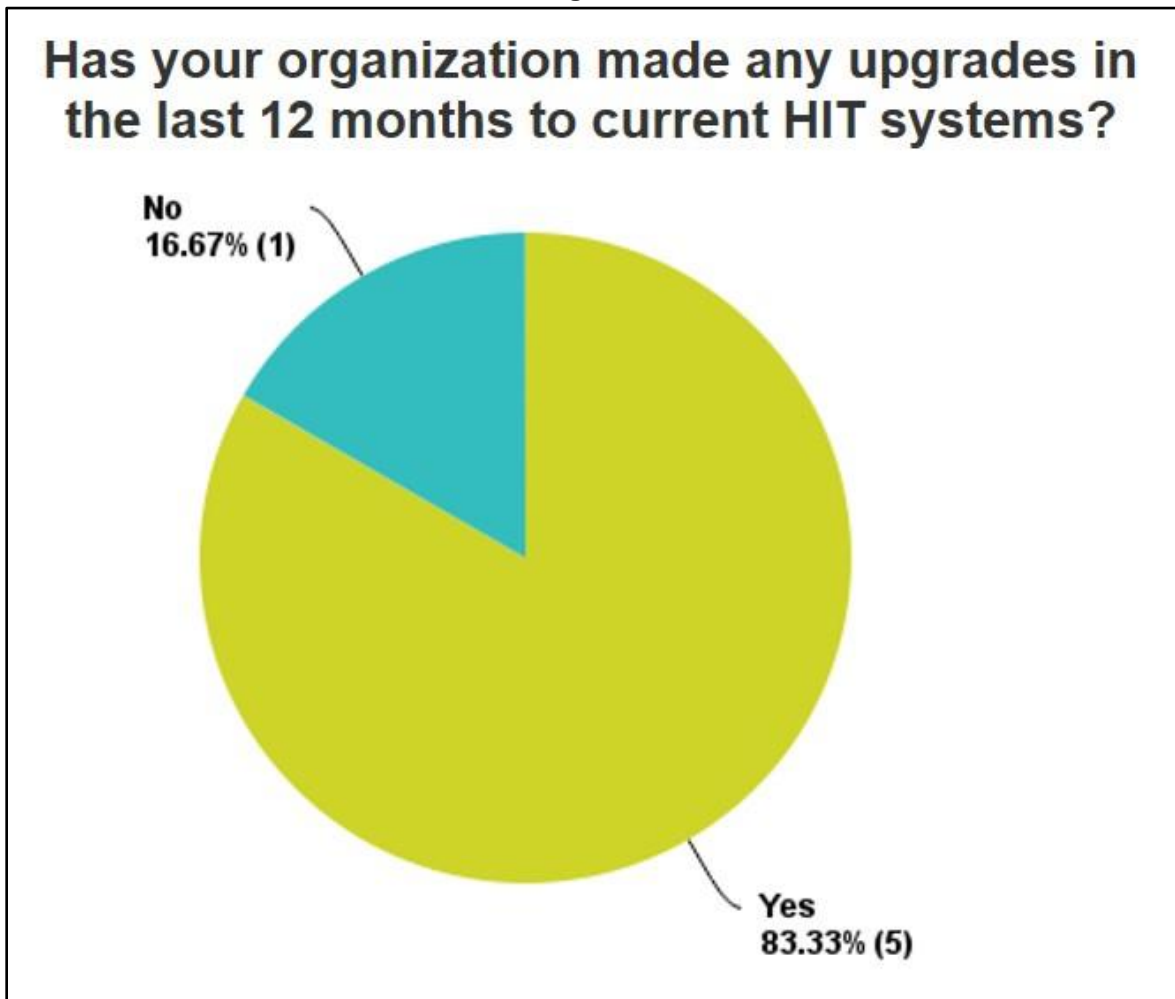


Respondents who marked “Other” listed the following technologies in their responses (among others that were omitted for lack of clarity or relevance):

- Disease Surveillance for reportable diseases: West Virginia Electronic Disease Surveillance System (WVEDSS), Tuberculosis (TB), Sexually-Transmitted Disease (STD), HIV
- Electronic Birth Registration
- State and Territorial Exchange of Vital Events (STEVE)
- Electronic Verification of Vital Events (EVVE)
- Remote look-up and ordering of birth certificates by Child Protective Services (CPS)

- Child Support, and Children and Families workers
  - Public Health Registries, including Cancer, Immunizations, BioSense, Birth, Death, etc., and Electronic Laboratory Reporting
3. Figure 3 shows that, of the six who responded to the question related to health IT system upgrades in the past year, more than 80% indicated that their organization completed an upgrade. In 2011, only 30% of organizations surveyed indicated they had completed an upgrade to their health IT systems in the prior year.

Figure 3

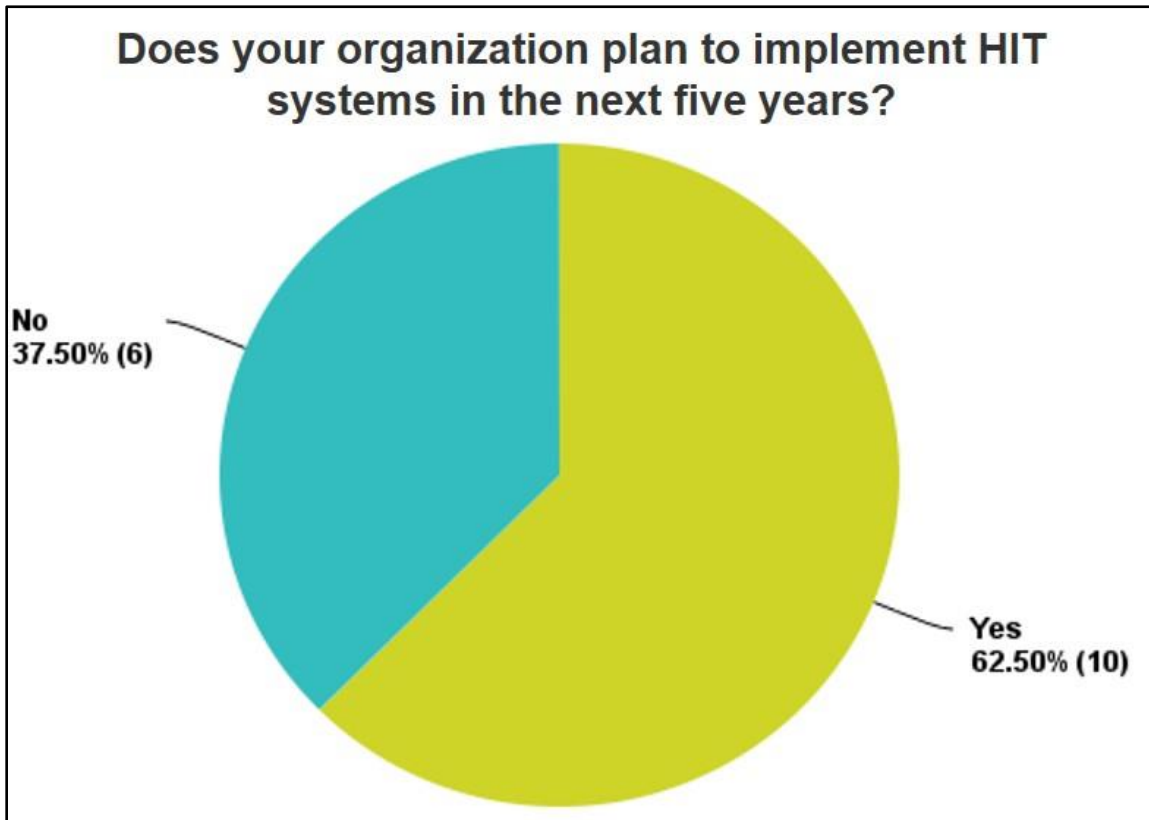


The one respondent who indicated “No” to this question attributed the response to “Procurement issues and delays outside our work unit.”

4. Figure 4 shows that more than 60 % of respondents indicate that their organization has plans to implement health IT systems within the next five years. This is an increase from

the 40% of 2011 respondents who indicated an upgrade was planned “in the near future.”

Figure 4



5. As identified in the survey responses, Table 4 below provides an overview of the current health IT systems, recent upgrades to systems, and planned system implementations. The current table shows selected responses.

Table 4: Current and Planned Health IT Systems

Respondent	Current Health IT Systems	Upgrades in Last 12 Months	Implementations in Next Five Years
BMS (three respondents)	<ul style="list-style-type: none"> <li>• Patient Portal</li> <li>• E-prescribing</li> <li>• Telehealth</li> <li>• Health Information Exchange (HIE)</li> <li>• EHR</li> <li>• Health Informatics (MMIS—Molina; Data Warehouse—Truven)</li> </ul>	<ul style="list-style-type: none"> <li>• Pharmacy claims processing system was upgraded from the 4.7 version to the 5.0 version</li> <li>• E-Prescribing was upgraded accordingly</li> <li>• Major upgrade of Medical/Dental claims processing,</li> </ul>	<ul style="list-style-type: none"> <li>• New Eligibility and Enrollment system</li> </ul>

Respondent	Current Health IT Systems	Upgrades in Last 12 Months	Implementations in Next Five Years
		provider enrollment, International Classification of Diseases, Revision 10 (ICD-10)	
BPH Health Statistics Center	<ul style="list-style-type: none"> <li>Health Informatics (12+ databases on birth, death, abortion, fetal death, marriage, divorce, and several other data sets)</li> <li>Electronic Birth Registration</li> <li>STEVE</li> <li>EVVE</li> <li>Remote look-up and ordering of birth certificates by CPS, Child Support, and Children and Families workers</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>	<ul style="list-style-type: none"> <li>New Commercial Off-the-Shelf (COTS) electronic death, birth, and front and back office systems for all vital events in West Virginia</li> <li>Upgrades to interstate exchange data systems</li> </ul>
BPH Office of Epidemiology and Prevention Services	<ul style="list-style-type: none"> <li>WV Immunization Registry—WV Statewide Immunization Information System (WVSIIS)</li> <li>West Virginia My Immunization Record (WV MyIR) (a portal for people to retrieve their immunization history)</li> <li>Disease Surveillance Systems for reportable diseases: WVEDSS, TB, STD, HIV</li> </ul>	<ul style="list-style-type: none"> <li>WVSIIS is being updated for stage 3 MU</li> <li>WVEDSS is also being updated for stage 3 MU, with new message mapping guides</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>
DHHR-OMIS (two respondents)	<ul style="list-style-type: none"> <li>Health Informatics</li> <li>HIE</li> <li>Predictive analysis reporting</li> <li>EHR</li> <li>Public Health Registries               <ul style="list-style-type: none"> <li>Cancer</li> <li>Immunizations</li> <li>BioSense</li> </ul> </li> </ul>	No response	No response



Respondent	Current Health IT Systems	Upgrades in Last 12 Months	Implementations in Next Five Years
	<ul style="list-style-type: none"> <li>○ Birth</li> <li>○ Death</li> <li>● Electronic Laboratory Reporting</li> </ul>		
WVDOC	<ul style="list-style-type: none"> <li>● Indicated health IT systems are in place, but did not specify</li> </ul>	No response	No response

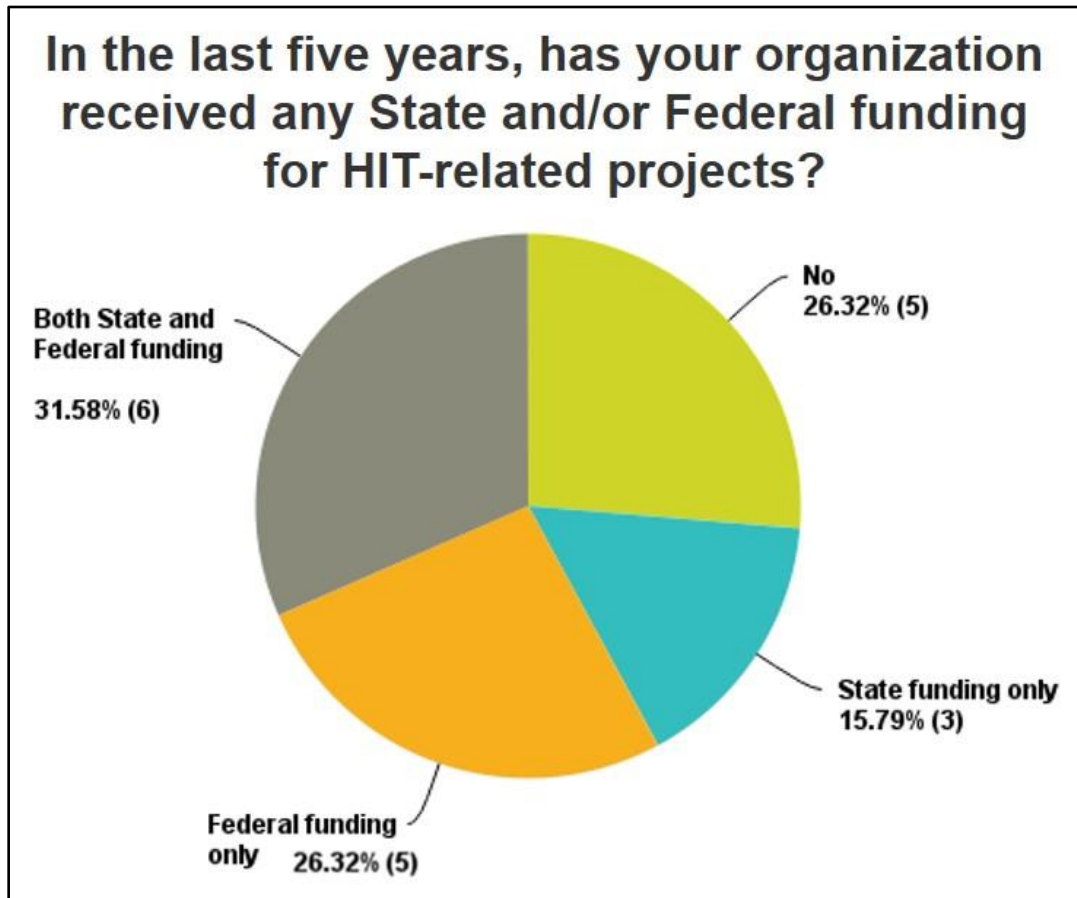
6. Of the respondents who answered the question related to working with other health groups, 100% indicated that their organization collaborates with at least one other health organization. Each respondent provided additional information. Selected responses are described in Table 5 below. In 2011, only 75% of respondents indicated they had collaborative efforts with other health organizations.

**Table 5: Collaborations with Other Health Organizations**

Respondent Organization	Collaborative Partners and Additional Detail
BMS (two respondents)	<ul style="list-style-type: none"> <li>● WV Medicaid processes medical claims for the WV Children’s Health Insurance Program (WVCHIP), and also for the AIDS Drug Assistance Program (ADAP).</li> <li>● Contracted for services: Molina (fiscal agent), Truven (data warehouse)</li> </ul>
BPH—Health Statistics Center	<ul style="list-style-type: none"> <li>● Medicaid—matching birth data, Health Care Authority—requests for data on Neonatal Abstinence Syndrome (NAS), certain causes of death, etc., and all death data from WV Consolidated Public Retirement Board (CPRB), PEIA, and BMS</li> </ul>
BPH—Office of Epidemiology and Prevention Services	<ul style="list-style-type: none"> <li>● The Centers for Disease Control and Prevention (CDC), WVHIN, WV Immunization Network (WIN), Local Health, healthcare providers, etc.</li> <li>● All these partners are necessary to continue our day-to-day disease surveillance and prevention.</li> </ul>

7. Figure 5 provides information related to funding for health IT–related projects in the past five years. Although the question in the 2011 survey did not ask respondents to specify the source(s) of health IT funding, 63% indicated receiving financial support from the State and/or federal governments. In 2016, approximately 76% received State and/or federal health IT funding.

Figure 5

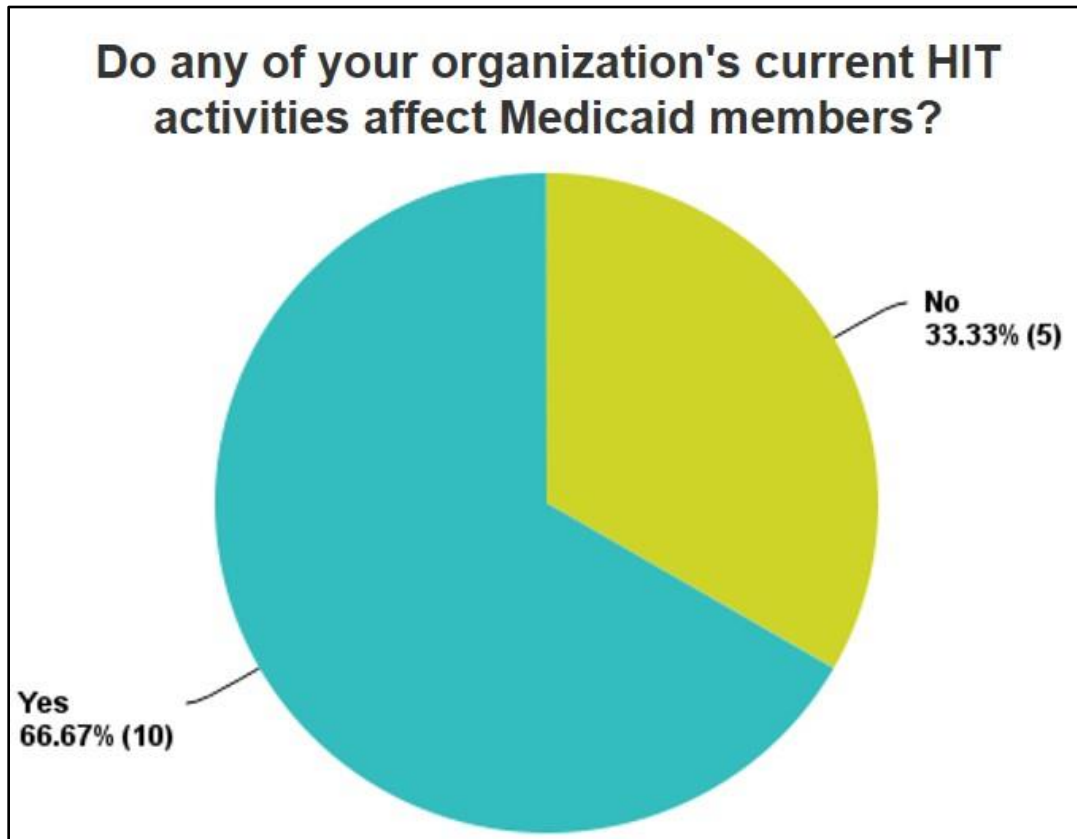


One respondent that indicated receiving State funds only specified how the funding will be used. This entity indicates they will use allocated state funds to hire a firm to co-design new systems requirements, study existing operations, and develop a request for proposals (RFP) for COTS systems. The funds will also be used to support a portion of the COTS system procurement.

Several other organizations provided information about how the funding is (or was) earmarked. For example, the Office of Epidemiology and Prevention Services will use the funds to “increase our ability to track and prevent disease outbreaks and to help and assist providers in meeting MU.”

8. Figure 6 provides information about health IT activities in relation to West Virginia’s Medicaid population. Of the 15 responses received to this question, two-thirds indicated their organization’s health IT activities affect Medicaid members. By contrast, in 2011, just over one-third of the respondents indicated that their health IT activities affected Medicaid members.

Figure 6



Agencies that answered in the affirmative offered additional information indicating that their health IT activities affect Medicaid members in a variety of way. For example, BMS indicated that their activities affect claims processing for Medicaid members.

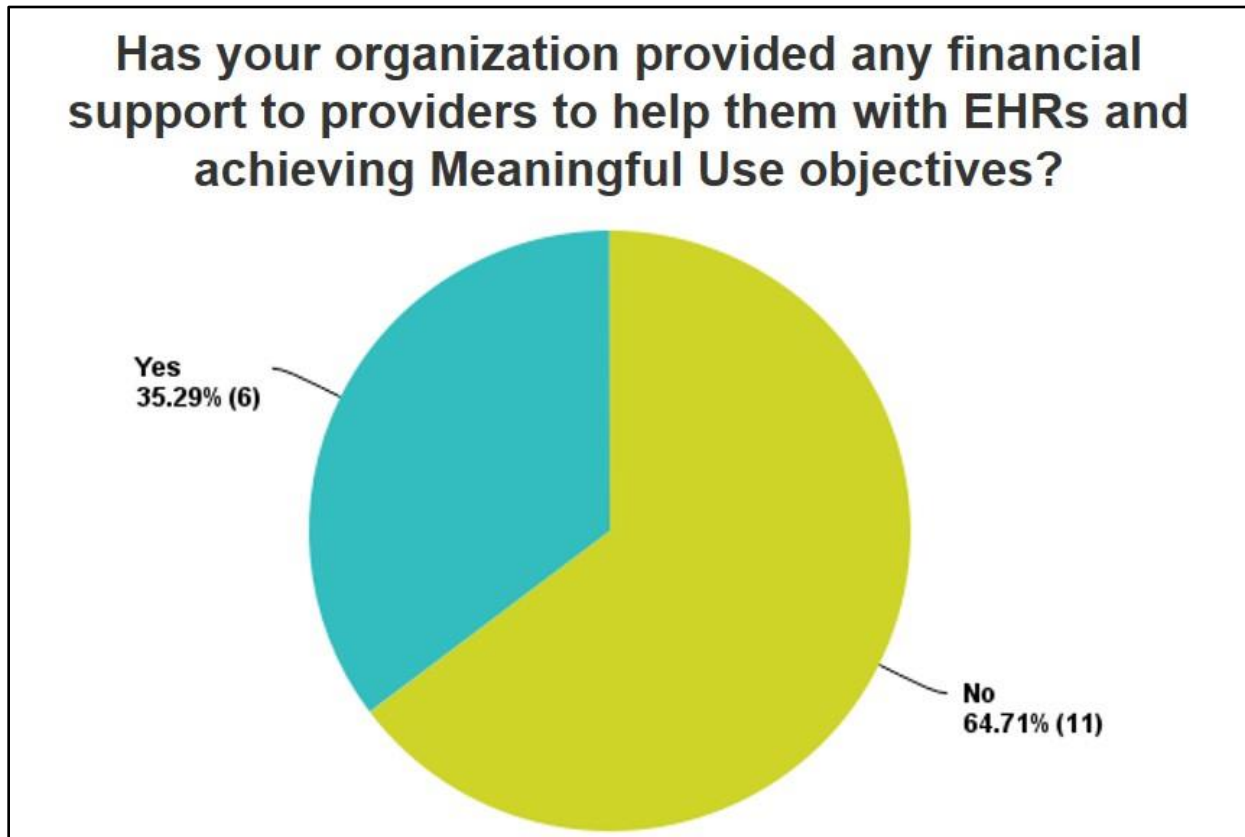
9. Eight of those surveyed responded that their organization works with the provider community. Table 6 below documents the organizations of selected respondents, how each works with the provider community, and the channels they employ for reaching providers. This is parallel to the findings in the 2011 survey, where eight respondents indicated providing outreach to providers.

**Table 6: Outreach to the Provider Community**

<b>Respondent Organization</b>	<b>Outreach to the Provider Community</b>	<b>Channels Used to Reach Providers</b>
BMS	<ul style="list-style-type: none"> <li>• Holds provider workshops twice yearly.</li> </ul>	<ul style="list-style-type: none"> <li>• E-mail</li> <li>• Fax blasts</li> <li>• Messages on remittance banners</li> </ul>
BPH—Health Statistics Center	<ul style="list-style-type: none"> <li>• Annual Reports and Custom Data runs for both Birth, Death, and Behavioral Risk Factor Surveillance Survey (BRFSS) information at the county or city level.</li> </ul>	<ul style="list-style-type: none"> <li>• Through the Perinatal Partnership in regards to NAS</li> <li>• Debundling and paying for intrauterine devices (IUDs) to prevent further unwanted pregnancies</li> </ul>
BPH—Office of Epidemiology and Prevention Services	<ul style="list-style-type: none"> <li>• Through the WIN and through outreach programs in our office, provide updated information on vaccines, education on outbreaks, and tools to assist in tracking and prevention of disease occurrence in West Virginia.</li> </ul>	<ul style="list-style-type: none"> <li>• The WIN</li> <li>• The State HIE</li> <li>• Internal stakeholder communication, including website information</li> </ul>

10. Figure 7 shows the number of organizations who have provided financial support to providers to help them with EHRs and achieving MU objectives. The majority of those responding to this question (65%) indicated their organization had not given financial support to providers for the purpose of implementing EHRs or achieving MU. In 2011, only 13% of respondents indicated providing financial support to providers for meeting MU objectives. This percentage has nearly tripled for the 2016 assessment.

Figure 7



Four of the organizations that answered in the affirmative provided details as to what that support entailed. For example, the Office of Epidemiology and Prevention Services indicated that they are working on a project funded by the CDC to implement bi-directional interfaces for some providers.

11. Respondents were asked to rank what they saw as the biggest challenge for health IT in West Virginia. Sixteen at least partially responded to this question, and their answers are listed below:

- Of the 14 who ranked “Reporting Requirements”, five rated it as the top challenge, and six said it was the second-greatest challenge for health IT.
- Four of 15 respondents selected “Solution Interoperability” as the second-biggest challenge for health IT.
- Seven of the 16 respondents indicated that “Data Governance” is the third biggest challenge for health IT in WV.
- Six of 16 respondents indicated “Provider Training” is the fourth-greatest challenge for health IT.
- Five of 10 respondents selected “Other” as the fifth biggest challenge for health IT. The “Other” responses include:

- Understanding health analytics and how to apply data to Quality Improvement (QI)
- Telehealth education
- Obtaining useable data
- Willingness of providers to implement EHR in their practices
- Transition from quantity to quality reimbursement models.

Please note that this question was not included in the 2011 assessment.

12. Twelve respondents answered the question, “What areas offer the biggest opportunity for HIT expansion in West Virginia?” The responses provided are shown below:

- We need a universal translator...Continue to work with folks from ONC and CDC on interstate data exchange, ELR (Electronic Laboratory Reporting) forwarding, and electronic case reporting.
- Data exchange to improve regular and emergency care
- Interoperability
- Telehealth (2)
- Training and integration
- Predictive analytics
- Telehealth/telemedicine/remote monitoring
- Prescription drug abuse and emergency room (ER) visits for overutilization of care; Health Information sharing for referral purposes.
- Expanded use of project ECHO to bring specialist knowledge to primary care clinicians, use of social media messaging, including in school-based health, expanded use of patient registries. Developing primary care research opportunities.
- Interfacing with additional hospitals/specialists
- Patient record sharing

Please note that this question was not included in the 2011 assessment.

13. Twelve respondents answered the question, “If there is one way that HIT could be used or implemented differently to improve health outcomes for West Virginia’s Medicaid patients, what would it be?” Their answers are below:

- It needs to be relied on more and the data needs to be used to help guide program decisions.
- Improve services and decrease unintended pregnancies.
- Better understanding complex care patients, their social determinants of health, and informing way of intervening to help achieve the triple aim among those individuals and their families.
- Cut down on costly travel using telehealth

- Prevention process on screenings
- Demonstrating measurable improvement in health outcomes.
- Expanded bandwidth/better Wi-Fi access to patients
- Overutilization of multiple PCPs and ER visits
- Telehealth, or just more funding for HIT activities to have them implemented
- Project ECHO expansion for community health centers (CHCs) and school-based health clinics (SBHCs)
- Improve email access to the Medicaid patients, provide additional education about the importance of health care, and improve access of electronic health information between agencies for better coordination of care.
- For those of us with high-end EHRs, we have the systems in place. It appears that you are ignoring the social determinants affecting health outcomes. HIT systems don't address demographic and social factors specific to Medicaid recipients. You don't address over-utilizers of their Medicaid benefits, nor do you address provider mills whose objective is volume.

Please note that this question was not included in the 2011 assessment.

14. Three respondents answered the question, "If there is one way that HIT could be used or differently implemented to improve health outcomes of West Virginia's privately insured population, what would it be?" Their responses are below:

- It needs to be relied on more and the data needs to be used to help guide program decisions.
- Remote monitoring.
- Demonstrating measurable improvement in health outcomes.

Please note that this question was not included in the 2011 assessment.

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