State of West Virginia
Bureau for Medical Services

Health Information Technology
Implementation Advanced Planning Document
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Edward L. Dolly
Deputy Commissioner
Bureau for Medical Services
Processes, Applications, and Methodologies
350 Capitol Street, Room 251
Charleston, WV 25301-3709
ed.l.dolly@wv.gov

Revision History

Version	Delivered Date	Update Reason
1.0	5/6/2011	First draft
2.0	6/9/2011	Revised based on CMS review comments

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1.0 Purpose and Background

This section states the purpose of the Implementation Advance Planning Document (I-APD) and the background behind it. It describes the Bureau's needs, goals, objectives and target for implementing the State of West Virginia's Electronic Health Record (EHR) Provider Incentive Payment program.

1.1 Purpose of the Advance Planning Document

The Bureau for Medical Services (BMS, Bureau) is the single State agency that administers the West Virginia Medicaid program. The State of West Virginia has elected to participate in the Electronic Health Record Provider Incentive Payment Program funded through CMS. This Implementation Advance Planning Document (IAPD) is a request by the Bureau on behalf of the State for enhanced federal financial participation (FFP) from the Centers for Medicare & Medicaid Services (CMS), in accordance with federal regulations. The State Medicaid Health Information Technology Plan (SMHP) was submitted for consideration by CMS on December 23, 2010, and received approval on April 19, 2011.

1.2 Background

On February 17, 2009, President Obama signed the American Recovery and Reinvestment Act (ARRA) of 2009. The Health Information Technology (HIT) provisions of the ARRA are found primarily in Title XIII, Division A, Health Information Technology, and in Title IV of Division B, Medicare and Medicaid Health Information Technology. These titles together are cited as the Health Information Technology for Economic and Clinical Health Act, or the HITECH Act.

The main goal of the HITECH Act is to improve the nation's health care through the adoption of electronic health records (EHRs) and promotion of the meaningful use of EHR via incentive payments. The CMS expects that under Medicare and Medicaid, "meaningful EHR users" would demonstrate each of the following: meaningful use of a certified EHR, the electronic exchange of health information to improve the quality of health care, and reporting on clinical quality and other measures using certified EHR technology. The criteria surrounding

eligibility for provider incentive payments for EHR usage was finalized with the 42 CFR Parts 412, 413, 422 Medicare and Medicaid Programs; Electronic Health Record Incentive
Program; Final Rule on July 1, 2010.

In a letter to Medicaid Directors dated August 17, 2010, CMS provides guidance to State Medicaid agencies regarding implementation of section 4201 of the American Recovery and Reinvestment Act of 2009 (the Recovery Act), Pub. L. 111-5, and our recently published regulations at 42 CFR Part 495, Subpart D. Section 4201, as well as our final regulations, will allow the payment of incentives to eligible professionals (EPs) and eligible hospitals to promote the adoption and meaningful use of certified EHR technology.

The Bureau is responsible for establishing the overall strategic direction and priorities for the West Virginia Medicaid Program. The Bureau is committed to maintaining accountability for the use of resources in a way that ensures access to appropriate, medically necessary, and quality health care services for all members. The Bureau will provide these services in a user-friendly manner to providers and members alike, and focus on the future by providing preventive care programs.

The following goals are incorporated into the Bureau's vision:

1. Streamline administration;
2. Tailor services to meet the needs of enrolled populations;
3. Coordinate care, especially for those with chronic conditions; and
4. Provide members with the opportunity and incentives to maintain and improve their health.

2.0 Statement of Need

This section states the purpose of the Implementation Advance Planning Document (I-APD) and the background behind it. It describes the Bureau's needs, goals, objectives and target for implementing the State of West Virginia's Electronic Health Record (EHR) Provider Incentive Payment program.

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2.1 Statement of Need

The Bureau's SMHP outlines the EHR Provider Incentive Program Design, which will be implemented to achieve adoption and meaningful use of certified EHR throughout the State. The State at this time needs the support necessary to complete the first phase of the State's participation in the development and expansion of the use of EHR. In the first phase, the BMS will apply the system changes that are necessary to support the West Virginia EHR Provider Incentive Payment program, as well as the administrative support necessary for implementation and operation of this program.

Through the input of key stakeholders inside and outside of State government, as outlined in the SMHP and the Health Information Technology Pre-Planning Advanced Planning Document (HIT P-APD), the Bureau determined the need to directly contract the program administration of its West Virginia Provider Incentive Payment Program with its fiscal agent, Molina Medical Services. Subsequently, the Bureau has identified the need to provide, through an updated HIT I-APD, two other core program functions. First, while the Bureau will oversee all program aspects, it will award a vendor through the BMS request for proposal process to perform the West Virginia Provider Incentive Payment program audit function. The Bureau will also need to maintain its direct contract for communication and outreach with the West Virginia Regional Health Information Technology Extension Center (WVRHITEC) to provide continuous education for meeting meaningful use.

The Bureau's SMHP will be updated with changes in policy and process as the program is further defined by CMS, and tools are refined by the Office of the National Coordinator of Health Information Technology (ONC). At a minimum, the SMHP will be updated annually. This HIT I-APD will also be updated to include costs for the Bureau's communication and outreach, auditing, and any other program functions required by CMS and ONC.

2.2 Alternative Considerations

The West Virginia HIT Collaborative has several core Workgroups. The Provider Incentive Program (PIP) Administration workgroup was charged with determining the best solution path for the overall design and implementation of the PIP. This group consisted of key stakeholders from the Department of Health and Human Resources, the Bureau for Medical Services, designated representatives of Care Provider associations, WV Health Care Authority, and GOHELP. After due care and consideration of available options, the workgroup recommended the best direction was to work directly with our current MMIS provider. This decision was primarily based on the following:

- Any Provider Incentive Solution proposed would require extensive file sharing with our current MMIS provider to ensure the accurate eligibility status of the Medicaid provider. The current fiscal agent would have to continually exchange this information with the external party, as well as establish new processes to maintain the integrity of the information in a secure and sustainable manner. This would inherently increase cost for the Provider Incentive Solution Support and introduce additional work to our current Fiscal Agent. These costs would then be in addition to the base amount required to build and host a stand-alone PIP application for the State.

- Provider services, currently provided by Molina as part of the MMIS support staff, are already familiar with the provider population, as well as intrinsic details about the Provider Enrollment and eligibility that would not be readily apparent to an external vendor. This includes details regarding provider enrollment and eligibility and payment capabilities.

- By integrating the MMIS claims data and the PIP uniform data sets for “Meaningful Use Stage, 1” the platform will be ready to accept the Stage 2 “Meaningful Use” requirements for Care Management, Disease Management, and Outcomes Reporting.

- As Molina is already the WV Fiscal Agent with access to MMIS Provider data, by utilizing the Molina PIP solution, we will have the capacity to query and meet the ARRA required Fraud and Abuse Reporting requirements to CMS, the Zone Program Integrity Contracts (ZPICs), and State Medicaid Fraud Units (MFUs).

- Molina has already developed a Provider Incentive Payment Solution system for our Louisiana customer to support their current Mainframe system and Provider Portal, and is actively testing this solution with the NLR as a Stage 1 State. Development of this technology was given as a Change Request directly to the Fiscal Agent.

2.3 Cost Benefits Analysis

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

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

3.0 Provider Incentive Payment Program Administration

This section describes the

Bureau's project approach, major tasks/deliverables, constraints, and work plan for implementing the State of West Virginia's Electronic Health Record (EHR) Provider Incentive Payment program.

3.1 Project Summary

Being the State's Medicaid Fiscal Agent, allows Molina to be well suited for this functionality at the State level. Molina MMS has access to provider eligibility, provider type and specialty information, and provider Medicaid claims volume information; all which is needed to verify that the Medicaid provider meets the meaningful user eligibility requirements. The West Virginia Provider Incentive Payment (PIP) program implementation project will consider the following required high-level functionalities:

- NLR Communications including registration, attestation, and payment data communications
- Provider State specific attestation
- Attestation review and approval
- Attestation and provider auditing/reporting regarding incentive payments
- Processing payments to providers

These functions will involve both business and technical modifications, and development to existing business and technical workflows within the State, as mapped in the table below.

MITA Business Area	Alignment to EHR Incentive Program Business Areas	Business/Technical Workflow Impact to be Modeled
Provider Management	Program Registration and Eligibility	Document impact on Provider Enrollment
Operations Management	Payment	Document Provider Payment
Provider Management	Appeals	Provider Help Desk and State involvement
Program Management	Reporting	Attestation Provider Oversight Reporting and CMS reporting
Provider Management	Communication, Education and Outreach	PIP Provider Outreach materials and planning
Program Management	State Oversight	Provider auditing workflows and PIP system requirements

The PIP Implementation project will involve the conduct of several business and technical configuration requirements sessions focusing on the PIP technical solution, as well as impacted business and technical workflows. Information determined during these sessions will be used to configure and install the Molina PIP solution. In addition, these sessions will be used to develop the future State-specific processes needed to administer and oversee West Virginia's PIP program, and to support the adoption of EHR technology among the provider community.

3.2 Project Approach

The West Virginia PIP solution supports real time data interfaces with the National Level Repository, which allows for a provider's attestation materials, eligibility, and payment information. It also permits the receipt of federal files on provider eligibility provider payment, and ONC Certified EHR system status. The system must also interface with the State Claims Processing System to allow for the expedited disbursement of provider incentive payments by the Fiscal Agent. By treating this like any other claims or provider capitation payment, the system can track them and readily report taxable payments to the federal and state governments.

The WV PIP like all West Virginia HIT systems will comply with all Federal, State, Department and Bureau rules, regulations and applicable policies and procedures. This includes complying with all current and future security policies and procedures of DHHR, BMS and the WV Office of Technology which can be found at the following links:

http://www.technology.wv.gov/security/Pages/policies-issued-by-the-cto.aspx

http://www.wvdhhr.org/mis/IT/index.htm

In addition, the system will provide secure web portal access to authorized users. Authorized users are administered using role-based security access, ensuring confidential access to the data at the individual and group security levels. In accordance with WV MMIS contract and industry standard best practices the system will maintain high availability access by utilizing the same procedures for the overall WV MMIS. A disaster recovery site is dedicated with redundant applications and servers to ensure minimal downtime.

WV PIP Required Functionality: There are six major functions required for the HITECH program

1. Registration

   CMS must provide a mechanism for Medicare and Medicaid EPs and hospitals to register for the incentive payment program. The states must intercept and validate this registration for a Medicaid specific payment.

2. Attestation and Qualification

   CMS and states must collect and analyze information from EPs and hospitals to qualify them for the incentive payments. To qualify for payment, EPs and hospitals must demonstrate meaningful use of a certified EHR product, report clinical quality and other measures when CMS is prepared to accept them, and electronically exchange health information. In the first year of the program, CMS anticipates collecting attestations to demonstrate meaningful use. CMS will collect attestations from Medicare participants while states will collect attestations from Medicaid participants. Hospitals successfully attesting for Medicare will be deemed eligible for Medicaid if the hospital is dually eligible.

3. Payment and Settlement

   After qualifying for payment, CMS and States must make incentive payments to hospitals and EPs (or the entities that EPs assigned payment, i.e. Medicare MA Plans, group practices, Medicaid MCOs, and Medicaid Entities promoting adoption of EHR). CMS will pay Medicare participants and states will pay Medicaid participants. CMS will provide funding to states through the grants process.

4. Manage Post Payment Operations

   Post payment, CMS and states will manage an appeals and auditing process. At the time of the publication of this document, CMS was still making policy decisions for appeals and auditing. This document assumes that the appeals function will allow program

participants to dispute qualification and/or payment determinations. This document also assumes that the auditing function will implement pre and post payment controls to prevent and detect fraud, waste, and abuse.

5. Help Desk Service

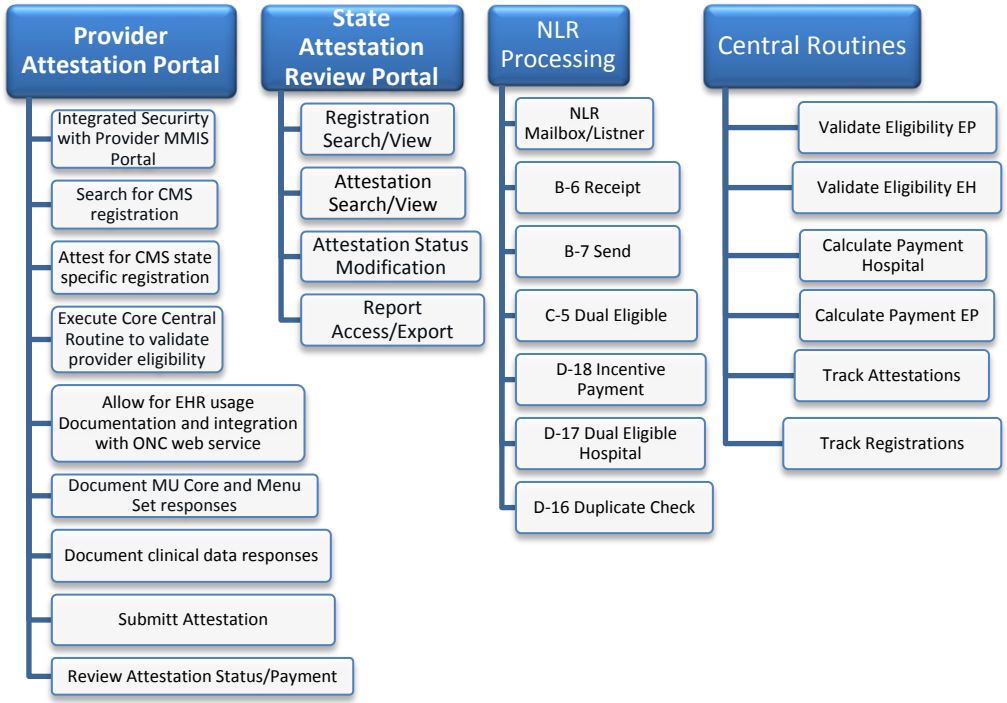
   The HITECH program will need help desk services to answer questions about the basic program rules (e.g., how to meet meaningful use), assist participants with submitting information to register and qualify for the program, and answer questions about actual incentive payments.

6. Reporting

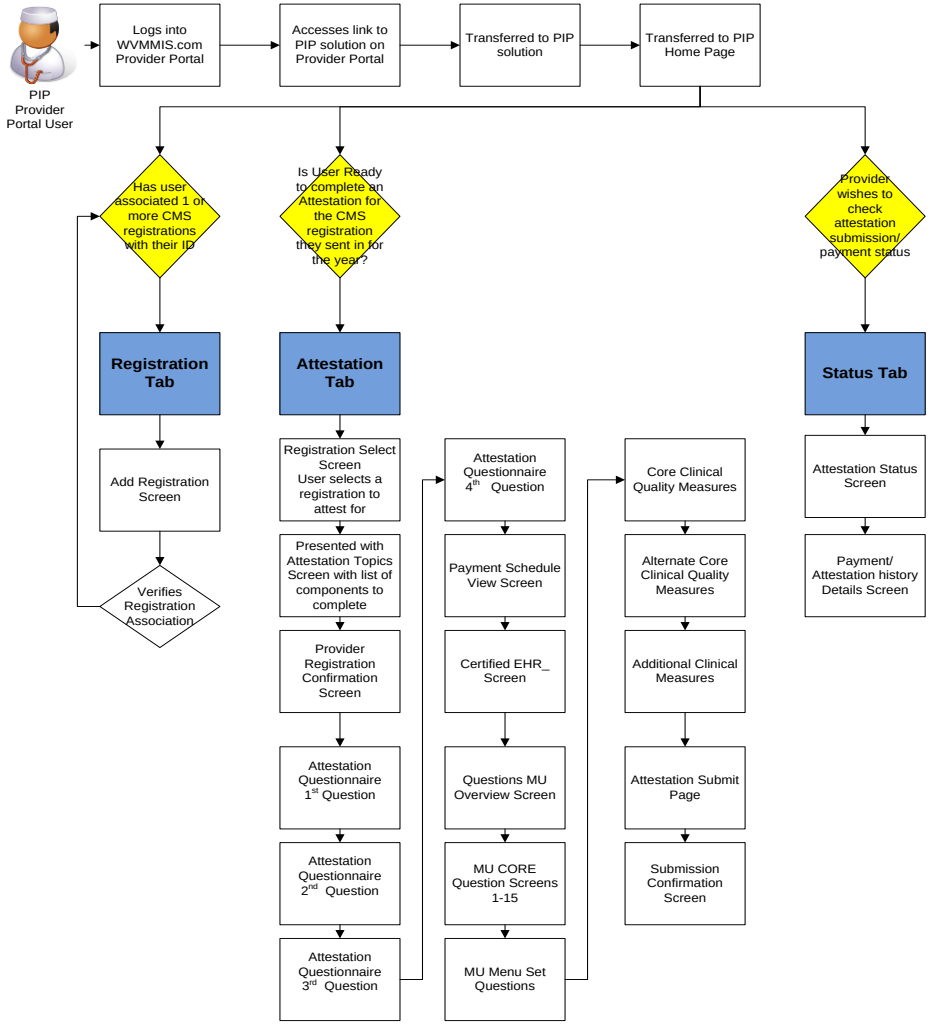
   The Recovery Act requires CMS to post the name and business address of Medicare eligible professionals and hospitals that received incentive payments to a public website. Additionally, CMS will need management reporting to manage the program and report program information to Congress and other stakeholders.

PIP will be designed as a Service Oriented Architecture (SOA) solution to allow for flexibility in its connection capabilities to other portals and the MMIS, permitting it to easily adapt to differences in MMIS solutions among Molina customers. The solution will consist of two front end portals, back end payment calculations and eligibility calculations, NLR transaction handling and processing, interfaces to the MMIS for incentive payment, and provider eligibility calculation. The solution will have active interfaces via stored procedures/services or ETL with the

MMIS solution for the purposes of payment and provider eligibility validation.



The below picture illustrates the provider portal component of PIP solution user interface workflow



The table below outlines the high level PIP solution for West Virginia.

Registration & Attestation	**Provider Registration**
	• **Provider Registration Completion – Communication with NLR on provider eligibility**
	Provider Attestation Portal
	• **Single Sign-On with existing Molina Provider Portal**
	• **Provider Attestation Portal**
	  ○ **Provider Yearly Attestation Form – Stage 1**
	  ○ **Provider Attestation History View – Stage 1**
	  ○ **Provider Attestation Status & Payment Review**

Federal and State Interfaces	Provider Attestation/Registration NLR Integration
	• Interface B-6: NLR – States, Provider Registration Data
	• Interface B-7: States – NLR, Registration Confirmation Data
	• Interface D-16: State – NLR, Duplicate Payment/Exclusion Check
	• Interface D-18: State – NLR, Incentive Payment Data
	
	Molina Health PAS MMIS
	• Provider PIP Solution with
	  ○ Provider Eligibility and Enrollment Data
	  ○ Claims Volume data for providers

Payment and Appeals	Molina Health PAS MMIS • Receive validated Attestation Payment Request File • Create payments and send to providers • Update payment history and CMS payment related reports under Molina management • Route payment information to PIP portal solution for display to providers Provider Services and Call Tracking • Manage Appeals Requests via Provider Services Help Desk and transfer to Medicaid for appeals management
Auditing and Reporting	PIP Solution • Perform Eligibility checking logic • Validate Attestation against ARRA requirements by Provider type and specialty

	• Validate Attestation against ARRA requirements for Attestation response • Record Attestation metrics and make them available for reporting and analysis <u>Reporting – PIP solution</u> • Pended Attestations by date and by pend reason • Denied Attestations by date and by deny reason • Approved Attestations by date • Paid Attestations by date and provider type and specialty • Number of days between Attestation submission and payment • Count and list of EHRs used by Providers attesting • Attestation questions and answers with counts by Provider types
Provider Relations & Outreach	<u>Molina Provider Services Help Desk</u> • Full Provider Help Desk for Provider questions related to Attestation • Provide Attestation educational materials to Molina for Provider Training and Outreach • Educate Help Desk to provide basic PIP support and routing regarding PIP questions • Changes to existing telephony routing for PIP calls • Work with WV RHITEC/State HIE on Provider Outreach • Assist WV Staff with information for audits • Provide training on PIP and the PIP Attestation system with the Provider community

The table below outlines the general, technical, and operational

1.0	General Requirements
1.1	Comply with all Federal, State, Department and Bureau rules, regulations and applicable policies and procedures.
1.2	Ability to maintain accurate and complete audit trails of all processing.
1.3	System shall be able to allow provider to save an unfinished application
1.4	The system shall adhere to BMS Provider Incentive Program workflows as defined by BMS SMHP.
1.5	System shall be internet-based.
1.6	System should be encrypted.
1.7	System shall inform the user of field entry rules when appropriate/necessary.
1.8	System should have “hover” bubbles that explain or give hints to what information goes in what field.
1.9	System shall have interfaces for both BMS and provider user.
1.10	System should allow the provider to print a completion certificate/receipt when they are finished, and a printout of all information they entered for their records.
1.11	System shall have system-generated creation date and modification date timestamps for all entries.
1.12	System shall close to new entries in accordance with CMS requirements.
1.13	System shall be able to serve simultaneous user sessions.
1.14	System shall maintain response time at a minimum of 4 seconds in any user session.
1.15	System shall display Provider pedigree Information at top of screen so that provider is aware that he or she is logged into the system.
1.16	System should allow provider to keep a "profile", or platform, of their pedigree information, that can be updated if some element changes.
1.17	System should utilize e-mail address to send updates to provider based on status events as defined by BMS (ie. completing application process, receipt of appeal, etc.)
1.18	System shall keep a repository or logs of all activity in accordance with BMS records retention policy.

1.19	System should include a Links page, displayed to the user before and after sign-on. System will offer a links page to sites explaining the EHR program -- at a minimum, BMS policies and manuals, Center for Medicaid and Medicare Services (CMS), WV BMS page, U.S. Health and Human Services, and so on.
1.20	System shall display a progress bar indicating how much of the process is complete.
1.21	System shall allow provider to resume application from point of exiting the application.
1.22	System shall display contact information for BMS including e-mail address, phone, FAX and mail address.
1.23	System shall provide BMS the ability to monitor provider incentive payment processing through a "user view" capability of the information from the NLR and provider submitted data.
1.24	System shall provide system checks to: • Not issue a duplicate payment, including payment from other states • Not issue a payment to a provider currently sanctioned or excluded from receiving payment as per federal or state law, rules. • Not issue a payment to a deceased provider
1.25	System shall require provider to input Federal Certified EHR Product information in accordance with the Federal EHR program requirements.
1.26	System shall validate Federal Certified EHR Product information in accordance with the Federal EHR program requirements.
1.27	The system shall have the capability to provide ad-hoc, standard and operational reports, as defined by BMS, to support all federal and state reporting requirements.
1.28	System shall send email notification to provider every 15 days reminding provider application will be voided if application is inactive for 60 days.
1.29	System shall void provider application if inactive for 60 days, and send provider email notification informing them application is voided due to 60 day inactivity.
1.30	The system will provide a data extract of all data.
1.31	System shall allow applicant/user to move backward in their application by hitting a "previous screen" button or the Internet Explorer "back" button.
1.32	The system should provide role-based access for authorized users, ensuring confidential access to the data at the individual and group security levels.
1.33	System should display notices about privacy and any applicable federal or state laws governing privacy of content in site.
1.34	System shall post information up front about what information is needed for the provider to complete application.

2.0	
2.1	System should have banner or similar capability enabling messages to providers, with basic attestation instructions/information.
2.2	System shall inherit users from the MMIS portal, via a secure trusted sign on.
2.3	System shall ensure that ALL data fields have been completed by provider before accepting application. System shall generate an "attention" notice to provider and not allow application to be submitted without entering required fields.
2.4	If an application is suspended, system shall generate notifications to contact an applicant, notify them of suspension, identify missing information and provide instructions for re-application or re-attestation.
2.5	The system shall meet all federally defined EHR requirements.
2.6	The system shall have the capability to upload all types of file formats (ie. WORD, TXT, PDF, etc) as defined by BMS.
2.7	System shall allow applications to be entered every year of application (years 1-6).
2.8	System shall pre-populate all data passed from the NLR.
2.9	System shall interface with MMIS to validate the data that has been passed from the NLR.
2.10	System shall produce a notification of rejection and refuse acceptance if data submitted by provider is inconsistent with MMIS records.
2.11	System shall provide a list of inconsistent information.
2.12	System shall direct providers who complete the application section to the attestation section.
3.0	**Provider Registration process, part 2: Provider Attestation Entry**
3.1	System shall have the ability to accept electronic provider attestation.

3.2	Provide a user-friendly menu system that is easily navigated by a non-technical user between the several Attestation assertion areas such as: • attestation yr • provider type • A/I/U • MU criteria numerator/denominator.
3.3	System shall provide a non-editable side by side comparison view of the NLR-submitted data and the MMIS data, to enable user to cross-check for consistency. If any discrepancy exists, the application will be rejected.
3.4	System shall utilize a provider-type crosswalk from NLR to MMIS BMS provider types.
3.5	System shall allow provider to select specialty and validate against data stored in MMIS.
3.6	The system shall allow provider the option to select Year 1 Early Adopter M/U or Year 1 A/I/U.
3.7	The system shall auto-increment up to six (6) years dependent on the provider's selection for Year 1.
3.8	System shall allow attestation in nine (9) sub categories: • Hospital or hospital based provider or not • Whether the provider is an eligible "provider" as defined by the HITECH Act • That the provider has not submitted duplicate registrations (i.e. not registered in another state, not registered for Medicare incentive payments) • Provider has adopted or is in the process of adopting, implementing and upgrading (A/I/U) of certified EHR technology • That the technology adopted by the provider is "certified" according to CMS regulation. • That provider expects to meet MU criteria starting in Year 2. (Year 1 AIU, Year 1 only) That provider meets MU criteria for a 90 day period in Year 1 (Early MU adopters, Year 1 only) • Provider has met all core set MU criteria and 5 core set MU criteria for a 90 day period within the Payment Year. (Year 1 AIU, Year 2 only) • Provider has met all core set MU criteria and 5 core set MU criteria for a 12 month period within the Payment Year. (Year 1 AIU, Year 3 – 6 only; Early MU adopters Year 2-6 only)
3.9	System shall allow provider to select yes or no from a drop-down menu when asked “Did you perform 90% of your services in an inpatient hospital or emergency room hospital setting?"

3.10	For Eligible Professionals, the system must validate the provider is one of the following: i. Physician ii. Pediatrician iii. Nurse Practitioner in. Certified Nurse Mid-wife v. Dentist vi. Physician Assistant in FQHC or RH led by Physician Assistant, where "led" is defined as: 1. A PA is the primary provider in a clinic 2. A PA is a clinical or medical director at a clinical site of practice; or 3. A PA is an owner of an RHC.
3.11	For eligible hospitals, the system shall validate the provider is one of the following: 1. Acute Care Hospital (Defined as having an average length of stay of 25 days or fewer, and with a CCN that falls in the range 0001-0879 pr 1300-1399. Included in the definition are Cancer Hospitals or Critical Access Hospitals) 2. Children's Hospital (Defined as being separately certified as a children's hospital, with a CCN in the 3300-3399 series and predominantly treating individuals under age 21).
3.12	For eligible professionals the system shall allow applicants to attest that they have not submitted duplicate registrations by checking or clicking radio buttons that indicate that they are not: • registered in another states • registered under another NPI • registered in Medicare.
3.13	For eligible hospitals, the system shall allow applicants to attest that they have not submitted duplicate registrations by checking or clicking radio buttons that indicate that they are not: • registered in another state • registered under another NPI.
3.14	System shall allow providers to attest that they have adopted implemented or upgraded EHR technology or that they are in the process of doing so. To do that, the provider must select one of the following choices from a drop-down menu: a. Adoption: an actual purchase/acquisition or installation has occurred. b. Implementation: the provider's certified EHR technology is being used in his or her clinical practice (i.e. staff training or data entry of the patients' demographic data) c. Upgrade: the provider expands the functionality of the certified EHR technology (i.e. addition of clinical decision support or e-prescribing functionality).

3.15	System shall allow providers to demonstrate that they have met all core set meaningful use (MU) criteria and 5 core set MU criteria for a 90 day period in Year 1 as early adopters. To do this, System shall: • Indicate a start and end date of 90-day period used • Provide entry screens where the provider may enter numerator and denominator amounts for each measurement • Automatically calculate the provider MU measurement objective results based on numerator and denominator inputs • Generate a rejection notification and refuse acceptance if measurement results fail • Provide a screen area for provider to upload MU reports supporting measurement data. • Accepts upload of supporting documentation for M/U (ie. WORD, TXT, PDF) as defined by BMS.
3.16	System shall allow providers to demonstrate that they have met all core set meaningful use (MU) criteria and 5 core set MU criteria for a 90 day period in Year 2 for Year 1 adopters. To do this, System shall: -Indicate a start and end date of 90-day period used ·Provide entry screens where the provider may enter numerator and denominator amounts for each measurement corresponding with tables 13 and 14 in SMHP section 5.3.6. ·Automatically calculate the provider MU measurement objective results based on numerator and denominator inputs ·Generate a rejection notification and refuse acceptance if measurement results fail ·Provide a screen area for provider to upload MU reports supporting measurement data. - Accepts upload of supporting documentation for M/U (ie. WORD, TXT, PDF) as defined by BMS.
3.17	System shall allow providers to demonstrate that they have met all core set MU criteria and 5 core set MU criteria for a 12 month period within the Payment Year for Year 3-6 (Year 1 AIU) or Year 2-6 (Early MU adopters). To do this, System shall: ·Provide entry screens where the provider may enter numerator and denominator amounts for each measurement corresponding with tables 13 and 14 in SMHP section 5.3.6. ·Automatically calculate the provider MU measurement objective results based on numerator and denominator inputs ·Generate a rejection notification and refuse acceptance if measurement results fail ·Provide a screen area for provider to upload MU reports supporting measurement data.

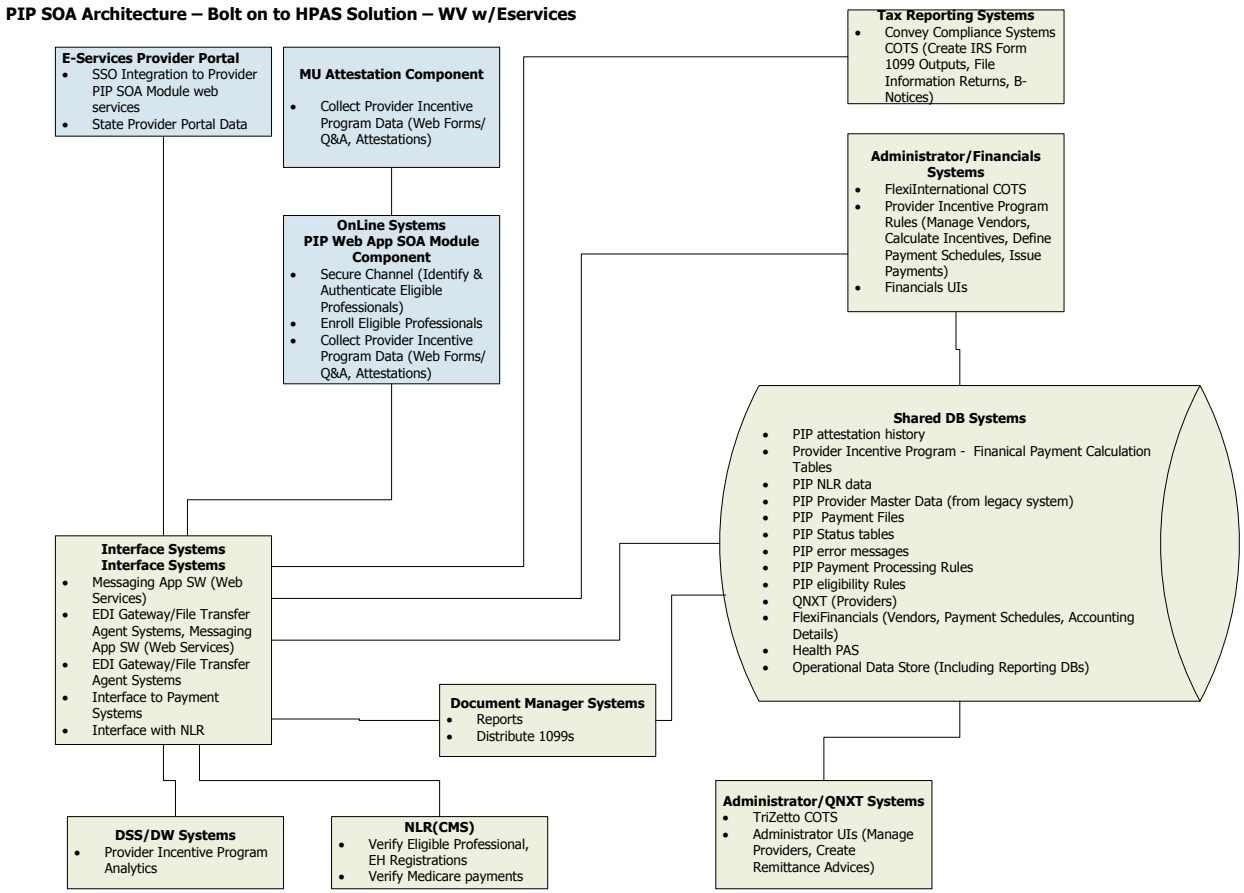
3.18	For eligible professionals not practicing at an FQHC or RH, the following drop-down menu choices must be available: Physicians (including Pediatricians seeking full incentive payment) – 30% Medicaid patient encounters Pediatricians (seeking alternative incentive payment)– 20% Medicaid patient encounters Dentists – 30% Medicaid patient encounters Certified Nurse Midwives – 30% Medicaid patient encounters Nurse Practitioner – 30% Medicaid patient encounters. Indicate start and end date of 90-day period used.
3.19	For eligible professionals practicing at an FQHC or RH, the following drop-down menu choices shall be available: • Physicians Assistants practicing at an FQHC or RHC led by a Physician Assistant – 30% needy individual encounters • EPs other than Physician Assistants practicing at an FQHC or RHC – 30% needy individual encounters. • Indicate start and end date of 90-day period used.
3.20	For eligible hospitals, the following drop-down menu choices shall be available: • Acute Care Hospital (includes critical access and cancer hospitals) – 10% Medicaid patient encounters • Children's Hospital – No threshold. • Indicate start and end date of 90-day period used.
3.21	The system shall provide definitions related to attestation. Specifically, "encounter" and, "needy individuals" will be defined for the purposes of attestation.
3.22	The system shall provide a calculation entry screen for the provider to enter "numerator" (Medicaid, CHIP, uncompensated care and other needy) and "denominator" (total patient encounters) fields for a 90-day period.
3.23	The system shall display patient volume percentage and notify the provider if the percentage meets the threshold for EHR incentive payments.
3.24	At completion of attestation, the system shall: • calculate the incentive payment • provide a notification of acceptance or rejection of the application and attestation • generate a printable application and attestation • generate a message that the eligibility review process can be initiated for the accepted application and attestation.

4.0	Verify Eligibility
4.1	System shall verify that information submitted in application is consistent with information on file in MMIS for the NPI provided.
4.2	System shall verify that applicant is properly licensed based on query of MMIS.
4.3	System shall verify that applicant is not sanctioned based on query of exclusions database.
4.4	System shall query claims data in MMIS to determine the EP is not hospital-based.
4.5	System shall be designed to kick out an administrative warning to BMS when place of service codes on claims are more than 50% hospital codes.
4.6	System shall validate that claim history, extracted from the MMIS, is within an acceptable variance as defined by BMS when compared with the application.
4.7	If not within acceptable variance, the application will be rejected.
4.8	System shall accept variance thresholds.
4.9	The system shall query the NLR to verify that the Eligible Professional is not registered for Medicare or Medicaid incentives in another state.
4.10	The system shall query the NLR to verify that the Eligible Hospitals are not registered in another state.
4.11	The system shall query MMIS to ensure that the provider has a single application with BMS.
4.12	The system shall auto-generate, via e-mail notification and, direct mailing, a denial form and appeal form to the provider if the provider does not meet eligibility requirements.
4.13	System shall verify that the applicant is not deceased, based on a death certificate query.
5.0	**Verify Program Compliance - Pre-Payment**
5.1	The system shall be designed to recalculate incentive payments based upon eligibility status, A/I/U, and/or MU requirements.
5.2	System shall ensure that no A/I/U payment is issued after December 31, 2016.
5.3	System shall ensure that no MU payment is issued after December 31, 2021.

5.4	System should present the entire set of clinical questions for provider or hospital to record numerators/denominators for Core and Menu Set MU Criteria.
5.5	System shall generate a record of pre-payment program compliance verification.
5.6	The system shall generate a weekly report indicating payment processing can be initiated.
5.7	The system shall verify provider is not on pay hold.
6.0	**Process Payment**
6.1	The system shall again verify that the EP is not registered for Medicare incentives or with another state for Medicaid incentive payments.
6.2	The system shall again verify that the EH is not registered in another state.
6.3	The system shall verify that the provider has a single application with BMS by query of MMIS
6.4	The system shall notify provider upon completion of application that the provider has two (2) days to review and submit changes to initial application. Upon 2 days from date of completion of eligibility portion of application, system shall lock so that application cannot be changed.
6.5	The system shall generate a report indicating all eligible incentive payments.
6.6	All reports generated from the system must be stored in Cypress.
6.7	The system shall notify the NLR that the payment has been disbursed.
6.8	The system shall have a reconciliation process prior to payment data being sent to the NLR.
7.0	**Provider Attestation Review**
7.1	System should allow the provider to view its previously-completed attestations.
7.2	System should allow the provider to review their attestation submissions after completion, reprint questions and follow up on payment status.
7.3	System should allow the provider to view the selected attestation's details.
7.4	System should allow Provider to review their identifying and payment information for each attestation submitted.
7.5	System should allow Provider to review the clinical questionnaire information for each attestation submitted.
7.6	System should allow Provider to run select reports, and print their entire attestation and its disposition.
7.7	The system should enable Provider to access attestation documents and links to attestation resources.

3.3 Systems Integration Architecture

The drawing below depicts how each system will connect.



3.4 Phases and Major Tasks/Deliverables

The following grid represents the major tasks of the PIP project plan as it relates to the provider incentive payment technical and business solution. Detailed descriptions of the involved business process changes and the technical tasks involved in the implementation are included in the table below.

Phase	Major Task / Deliverable	Description
Requirements of Configuration Analysis	This phase will review the impact of required PIP changes to current WV provider impacted MITA business areas and determine the configuration changes needed to proceed with PIP implementation. During this phase the business requirements for the configuration of the Molina PIP solution will also be determined to begin configuration of the PIP solution and its interfaces for WV.	
	Configuration Requirements Session: *Provider Incentive Payment Specifics*	Discussion and documentation of the impact to business and technical processes for the following areas: • Payment • Reporting/Auditing • Provider Enrollment/Portal usage • Payment Provider Auditing/ Outreach • Attestation Auditing
	Deliverable: *Configuration Requirements Document* ***Delivery Date:*** *May 13, 2011*	Summary of all requirement session decisions regarding PIP configuration requirements.
Business and System Design	This phase is to design and document the configuration of the PIP system, including business and technical workflows, to be implemented.	
	Validate As-Is and To-Be	Document and validate the As-Is Business Workflows and

	Business Workflows	the To-Be Business Workflows, which will be based on the configuration requirements gathered.
	Design and Document Payment Processing Technical Workflow	Creation and Review of As-Is – To-Be design/configuration rules and workflow for Provider Incentive Payment.
	Design and Document PIP Configuration and Integration Technical Workflow	Document all agreed upon business requirements for Molina PIP solution configuration and payment processing including: provider eligibility and auditing steps, PIP portal configuration and web template (skin) and technical payment and interface specifications.
	Design and Document PIP Reporting Technical Workflow	Document all agreed upon reporting changes.
	Support Development of WV's Health Information Technology Implementation Advance Planning Document	Supply necessary design documentation and technical workflows needed for the State to complete and submit its State Medicaid IAPD for CMS approval.
	Deliverables: • PIP Business Impact Process Models ***Delivery Date:*** June 30, 2011 • PIP System Configuration Design Document ***Delivery Date:*** June 11, 2011	Documentation of the workflow changes and technical workflow and process changes that are decided during the Design meetings described above.
Configuration, Development and Installation	This phase involves the configuration of the PIP solution and any site specific development work. It also includes training users on the new process and system.	
	Support the Update to WV	Supply necessary information to implement modifications of

	Provider Policies	local policies due to required changes of the PIP mandate.
	Develop PIP solution interface and local configuration	Set up of configurable features within local solution
	Install PIP Solution	Installation of Molina PIP solution, configuration and local limited customization
	Train local users on PIP "To Be" Process Changes	Completion of Local PIP training classes - Processes
	Train local users on PIP Solution	Completion of Local PIP training classes – Technical Solution
	Finalize PIP Operational Staffing Model	Completion of Staff Analysis based on modified business processes
	Develop PIP Reports; Apply production reporting changes to CMS/local impacted reports	Completion of report changes
System Integration Testing & User Acceptance Testing	This phase verifies that the system works and satisfies the user requirements through system integration testing and user acceptance testing.	
	PIP Local Integration Testing	Conduct of PIP solution local integration testing
	PIP Provider Outreach Training	Conduct PIP Educational campaign
	PIP Provider Auditing Training/ PIP Provider and Help Desk Support Process Change Education	Conduct of PIP Attestation auditing, helpdesk and appeals training
	PIP NLR Testing	Conduct of technical testing with NLR and CMS (certified systems WSDL)

		• Interface B-6: NLR – States, Provider Registration Data • Interface B-7: States – NLR, Registration Confirmation Data • Interface D-16: State – NLR, Duplicate Payment/Exclusion Check • Interface D-18: State – NLR, Incentive Payment Data
	Deliverable: UAT Testing and Test Results Document ***Delivery Date:*** July 20, 2011	Conduct UAT testing with customer. UAT test cases and results of above system and NLR testing for review by the State.
Implementation	This phase ensures system is ready for implementation and that providers are notified of required information.	
	Place PIP Notifications on Provider Portal	Notification of agreed upon go live date for payments for State providers
	Deliverable: Provider Outreach Plan and Materials ***Delivery Date:*** June 16, 2011	Training materials and Provider Outreach materials for state review and approval
	Conduct PIP ORT Testing	
	Conduct PIP Outreach Field Sessions	Training Materials and Training Meetings with providers
	PIP Implementation	

3.5 Work Plan

The work plan below includes the major phases that are required to deliver the Provider Incentive Payment solution and their planned start and finish dates.

Major Phase	Start Date	Finish Date
Design/Development/Configuration	1/25/11	5/27/11
System Integration Testing	5/30/11	6/22/11
User Acceptance Testing	6/23/11	7/13/11
User Training	6/23/11	7/1/11
Production/Go Live	7/5/11	7/20/11

3.6 Assumption, Constraints, and Dependencies

3.6.1 Assumptions

To begin implementation of the Medicaid EHR Incentive Program with 90% federal matching funds, the State must develop and acquire CMS approval on the following:

- ✓ Health Information Technology Planning Advance Planning Document (HIT PAPD) – A plan of action that requests federal matching funds and approval to accomplish the planning necessary for a state agency to determine the need for and plan the acquisition of HIT equipment, services, or both.
- ✓ Health Information Technology Implementation Advance Planning Document (HIT IAPD) – A plan of action that requests federal matching funds and approval to acquire and implement the proposed SMHP services, equipment, or both.

- ✓ State Medicaid Health Information Technology Plan (SMHP) – A document that describes the State's current and future Health IT activities in support of, as well as the path between, the Medicaid EHR Incentive Program. The SMHP is the deliverable resulting from the HIT PAPD. The SMHP will be reviewed and approved before implementation funds are authorized under the IAPD.

3.6.2 Constraints

The table below outlines the high level constraints and their associated key dates West Virginia faces with implementing the PIP program.

Key Date	Constraints
July 3, 2011	Last day for eligible hospitals to begin their 90-day reporting period to demonstrate meaningful use for the Medicare EHR Incentive Program.
July 20, 2011	West Virginia Provider Incentive Payment program launches.
September 30, 2011	Last day of the federal fiscal year (FY). Reporting year ends for eligible hospitals and CAHs.
October 1, 2011	Last day for eligible professionals to begin their 90-day reporting period for calendar year 2011 for the Medicare EHR Incentive Program.

November 30, 2011	Last day for eligible hospitals and critical access hospitals to register and attest to receive an Incentive Payment for Federal FY 2011.
December 31, 2011	Reporting year ends for eligible professionals. • February completion of project tasks by all parties • Completion of the NLR on its projected timeframe of May 2011 for payment checking at the national level. • NLR testing with the local site is completed. **Note:** NLR *interface* testing was completed successfully March 11, 2011.
February 29, 2012	Last day for eligible professionals to register and attest to receive an Incentive Payment for calendar year (CY) 2011.

3.6.3 Dependencies

- CMS continued distribution of PIP NLR technical specifications updates to the State
- State completion of required documents for CMS approval
- Timely review, approval, and program launch

4.0 Personnel Resource Statement

This section provides the required Personnel Resource statement.

Ed Dolly is the Deputy Commissioner of the Division of Processes, Applications, and Methodologies. He has a background in Information Technology and will serve as the Bureau's Project Sponsor. He will also provide subject matter expertise related to systems design, development, and implementation.

Tina Bailes is the Deputy Commissioner of the Division of Finance and Administration who is responsible for planning and managing the Bureau's financial resources.

Jon Cain is the Project Manager for the Division of Processes, Applications, and Methodologies. He has over ten years of information technology experience in system design, development, and implementation and has over six years of experience in project management. He will serve as the Bureau's Project Officer.

Pat Miller is the MMIS Director of Operations for the Division of Processes, Applications, and Methodologies. She has been with the Bureau for fifteen years and has served in her current position of MMIS Director since 1995.

Stacie Haynes-Legg is the Director of the Office of Budgeting and Accounting Services. She is a certified public accountant with over ten years of various accounting experience in West Virginia State government.

Andrew Mullens is the Budget Manager for the Office of Budgeting and Accounting Services. He has over eleven years of accounting experience in state government.

Ken McCale is an account auditor. He is a certified public accountant with over twenty five years of accounting experience.

Additionally, Business Area, Process Owners, and contracted staff will provide subject area expertise throughout the project, as needed. The anticipated allocation of key State staff is provided in the table below.

Name	Position	Estimated Allocation
Ed Dolly	Deputy Commissioner of the Division of Processes, Applications, and Methodologies	Approximately 10% - 30%
Tina Bailes	Deputy Commissioner of the Division of Finance and Administration	Approximately 10% - 30%
Jon Cain	Project Manager for the Division of Processes, Applications, and Methodologies	Approximately 15% - 30%
Pat Miller	Director of MMIS Operations for the Division of Processes, Applications, and Methodologies	Approximately 5% - 15%
Stacie Haynes-Legg	Director of the Office of Budgeting and Accounting Services for the Division of Finance and Administration	Approximately 5% - 15%
Andrew Mullens	Budget Manager for the Office of Budgeting and Accounting Services	Approximately 5% - 15%
Ken McCale	Account Auditor for the Office of Budgeting and Accounting Services	Approximately 5% - 15%

5.0 Assurances

The section describes the required regulatory assurances and state compliance.

The State of West Virginia, Bureau for Medical Services, ensures that this procurement will be carried out in a manner that is compliant with the applicable requirements put forth in the Code of Federal Regulations (CFR), the State Medicaid Manual (SMM), and the State Medicaid Director Letter dated December 4, 1995.

Requirement	Citation(s)	Compliant	
		Yes	No
➢ Procurement Standards (Competition/Sole Source)	45 CFR Part 95.613	✓	
	45 CFR Part 74	✓	
	45 CFR Part 92.36	✓	
	SMM Section 11267	✓	
	SMD Letter of Dec. 4, 1995	✓	
➢ Access to Records	45 CFR Part 95.615 & 95.617	✓	
	SMM Section 11267	✓	
➢ Software Ownership	42 CFR Part 431.300	✓	
➢ Federal Licenses	42 CFR Part 433.112(b)(5) – (9)	✓	
➢ Information Safeguarding	42 CFR Part 164	✓	
➢ HIPAA Compliance		✓	
➢ Progress Reports	SMM Section 11267	✓	

6.0 Summary of Estimated Costs

The request for financial participation will be summarized by project in this section.

The Bureau has conducted initial planning to identify products and services, timeline, and resource needs. This planning provided the basis for the estimates included in the summary of estimated costs. The HIT P-APD costs were based on activities identified prior to project initiation. At this point in time the Bureau no longer has the need to fund the Medicaid Medical Director and Multi State Collaborative Workgroup Dues activities that were proposed in the HIT P-APD. Therefore funds for those activities will not be required. The final cost for the remaining HIT P-APD will be provided at the end of the HIT P-APD project end date of June 30th 2011.

Proposed HIT P-APD Activities	Proposed Costs	Spent-to-Date
State Personnel Participation	$285,348	$0
Project Management Services	$349,140	$196,680
IT Management Specialist	$90,100	$0
Technical SME: WVHIN/HCA	$142,314	$38,610
Medicaid Medical Director	$15,577	$0
Provider Outreach and Education	$83,985	$0
Hardware, Software, Facilities	$25,000	$0
Training Conferences	$42,000	$2,642
Multi State Collaborative Workgroup Dues	$8,000	$0
Misc. (Postage, Printing, etc…)	$2,000	$0
Travel	$6,500	$16
Total	$1,049,964	$237,948

Proposed Bureau Participation Costs for DDI

The Bureau is requesting enhanced funding for implementation of the West Virginia EHR Provider Incentive Payment program solution as follows:

The BMS Project Team will be comprised of seven individuals from various units within the Bureau. The BMS Deputy Commissioner for the Division of Processes, Applications, and Methodologies will serve as the Project Sponsor. The Project Manager for the Division of Finance and Administration will serve as the Project Officer. Five additional BMS personnel have been identified as members of the Project Team for the West Virginia Provider Incentive Payment program.

The following assumptions apply to the BMS Project Team cost estimates, and have been reviewed and deemed reasonable by the BMS Project Team. BMS allocation to the West Virginia Initiatives is estimated as follows:

Deputy Commissioner for the Division of Processes, Applications, and Methodologies	Approximately 10% - 30%
Deputy Commissioner for the Division of Finance and Administration	Approximately 10% - 30%
Project Manager for the Division of Processes, Applications, and Methodologies	Approximately 15% - 30%
Director of MMIS Operations for Processes, Applications, and Methodologies	Approximately 5% - 15%
Director of the Office of Budgeting and Accounting Services	Approximately 5% - 15%
Budget Manager for the Office of Budgeting and Accounting Services	Approximately 5% - 15%
Account Auditor for the Office of Budgeting and Accounting Services	Approximately 5% - 15%

- It is assumed that BMS Business Area and Process Owners will be involved as needed to provide subject matter expertise, and participate in decision making in the outlined projects.

- BMS staff costs are estimated as the "sum of Salary and Benefits x Number of Project Days x Allocation to Project" calculated for each individual expected to participate in the project.

Assumptions:

1. The program will begin in July, 2011, and will include only one quarter in FFY 2011.
2. The program will end in December, 2021.
3. Anticipated EP EHR adoption rates are based on information gathered in an environmental scan conducted by the West Virginia HIT Collaborative. Although the environmental scan defined a baseline rate of EHR usage among providers and their interest in applying for West Virginia's PIP program, it is not considered a sound statistical survey instrument.
4. The West Virginia Medicaid program engages over 23,537 unduplicated; an estimated 4,800 EP's indicated interest in the Medicaid incentive payment program. There are an estimated 1,945 (approximately 40% of those planning participation) providers estimated to be eligible and receive Medicaid incentive payments over the course of the program period.
5. The West Virginia BMS plans to disseminate payments to eligible hospitals over a three year period from the point the hospital becomes eligible. Hospitals will receive 50% of their payment in the first year, 40% in the second year, and 10% in the third year. This payment structure is most favorable to encourage adoption by small, rural hospitals, and ensures rapid incorporation of EHR systems.
6. The estimates do not include potential eligible providers based outside of West Virginia

DDI and Operations	FA	State	TOTAL AMOUNT	%	FFP AMOUNT	%	STATE AMOUNT
INITIATION, SYSTEMS ANALYSIS AND DESIGN							
State Operations / Technical Staff		$67,130					
Fiscal Agent	$277,932						
SYSTEMS DEVELOPMENT, TESTING & IMPLEMENTATION							
State Operations / Technical Staff		$33,565					
Fiscal Agent	$713,402						
FULL SYSTEM IMPLEMENTATION/CLOSEOUT							
State Operations / Technical Staff		$11,188					
Fiscal Agent	$22,294						
Operation Costs							
State Operations / Technical Staff		$0					
Fiscal Agent	$2,684,345						
90/10 TOTAL	**$3,697,973**	**$111,883**	**$3,809,856**	**90%**	**$3,428,870**	**10%**	**$380,986**
Hardware and Hardware Maintenance							
State Operations / Technical Staff		$0					
Fiscal Agent Participation	$37,270						
75/25 TOTAL	**$37,270**		**$37,270**	**75%**	**$27,953**	**25%**	**$9,318**
Training Costs							
State Operations / Technical Staff		$1,178					
Fiscal Agent Participation	$40,872						
Other Operational Costs							
State Operations / Technical Staff		$4,711					
Fiscal Agent Participation	$154,545		$42,050				
50/50 TOTAL	**$195,417**	**$5,889**	**$201,306**	**50%**	**$100,653**	**50%**	**$100,653**
PROJECT TOTAL	**$3,930,660**	**$117,772**	**$4,048,432**		**$3,557,476**		**$490,956**

Proposed Incentive Payment Amounts

	FFY 2011	*FFY 2012*	*FFY 2012*	*FFY 2012*	*FFY 2012*	*FFY 2013*	*FFY 2013*	*FFY 2013*
	9/30/2011	**12/31/2011**	**3/31/2012**	**6/30/2012**	**9/30/2012**	**12/31/2012**	**3/31/2013**	**6/30/2013**
Eligible Professionals (full)	6,869,062.50	2,289,687.50	2,445,875.00	2,445,875.00	2,445,875.00	2,445,875.00	2,962,250.00	2,962,250.00
Pediatricians (partial)	276,256.50	92,085.50	97,045.25	97,045.25	97,045.25	97,045.25	121,130.00	121,130.00
Critical Access Hospitals	1,540,880.00	693,396.00	693,396.00	693,396.00	693,396.00	616,352.00	616,352.00	616,352.00
PPS (Acute Care Hospitals)	4,787,091.00	2,154,190.95	2,154,190.95	2,154,190.95	2,154,190.95	2,127,596.00	2,127,596.00	2,127,596.00
Total	13,473,290.00	5,229,359.95	5,390,507.20	5,390,507.20	5,390,507.20	5,286,868.25	5,827,328.00	5,827,328.00

* ***Estimated Incentive Payments based on Federal Fiscal Year***