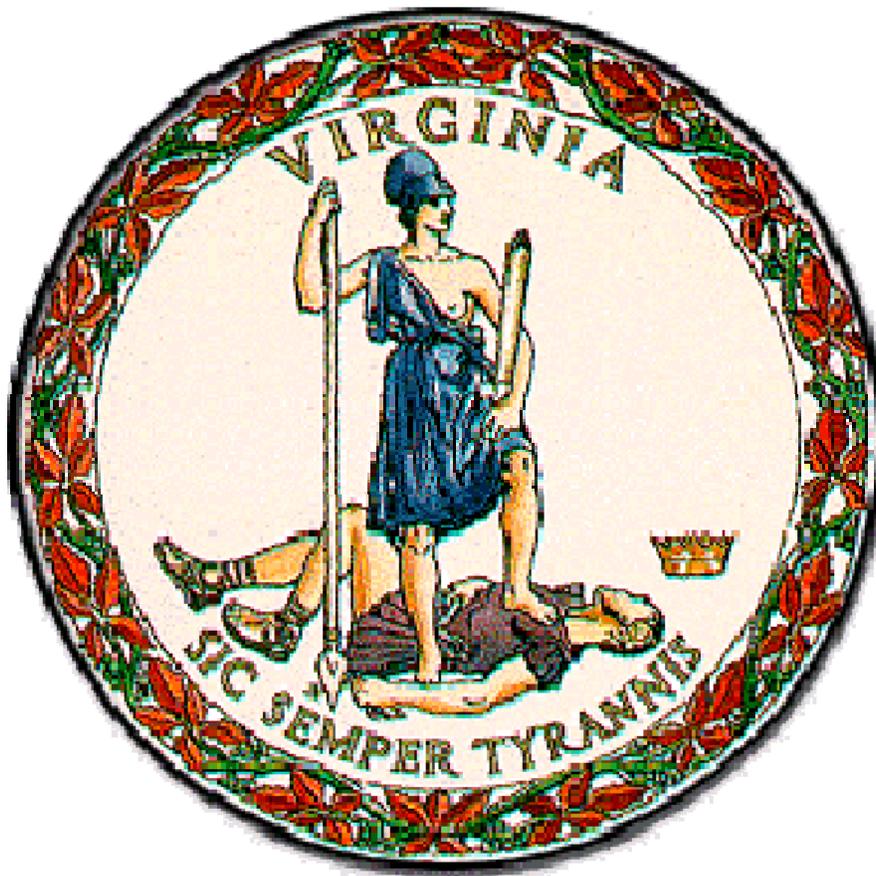


VIRGINIA

State Medicaid Health Information Technology Plan

Version 1.2



Prepared by
The Department of Medical Assistance Services
Commonwealth of Virginia

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Overview

The Commonwealth of Virginia's Department of Medical Assistance Services (DMAS) submits this State Medicaid Health Information Technology Plan (SMHP) in order to provide the Centers for Medicare & Medicaid Services (CMS) with an understanding of the activities DMAS expects to undertake over the next five years as we implement Section 4201 Medicaid provisions of the American Recovery and Reinvestment Act (ARRA).

Specifically this SMHP will focus on how DMAS expects to encourage, administer, and monitor incentive payments to eligible professionals (EP) and hospitals. DMAS' SMHP will lay out a plan to ensure that applicants that demonstrate eligibility receive timely and accurate incentive payments, without duplication. To accomplish these objectives, DMAS will focus on verifying the following key actions from EPs and hospitals: validate that Medicaid patient volume thresholds are met; ensure satisfactory adoption, implementation, and upgrading of Electronic Health Record (EHR) technology; and establish that EHR technology is being Meaningfully Used, in accordance with the definition set forth in 42 CFR Part 495, Subpart D. Additionally the SMHP addresses how DMAS' efforts will fit together with and support broader Health Information Exchange (HIE) efforts in Virginia including the Virginia Health Information Technology Regional Extension Center (VHIT REC), and how best DMAS can align with the Medicare models.

DMAS is planning to procure a multi-state approach for the incentive payment program administration. The details for the requirements of this approach are in Section C, Table 8. As CMS acknowledges, plans generally need to change over time. With this in mind, DMAS expects to keep CMS informed of anticipated changes to activities, scope, or objectives. DMAS will provide annual updates and as-needed updates to CMS as our plan evolves over the next five years.

A. Virginia's "As-Is" HIT Landscape

1. *EHR Adoption Information*

Environmental-Scan

Virginia conducted an environmental scan (e-scan) of providers, Managed Care Organizations (MCO), and hospital systems in spring of 2010. The e-scan targeted all providers in the Commonwealth—not just Medicaid providers. The environmental scan effort began with a review of available e-scans from other states as well as information already available in Virginia. Virginia selected the New Mexico e-scans as a model because they provided a good framework to reach out to all provider types in order to establish a comprehensive “as-is” implementation and readiness baseline.

e-Scan Methodology:

The e-scan was implemented as a paperless, web-based application. Health Information Technology Advisory Commission (HITAC) provided the outreach to all providers by leveraging the industry associations that make up a large part of the Commission membership.

e-Scan Preparation:

DMAS initially adapted the e-scan for Virginia Medicaid needs. Subsequently, comments were solicited from HITAC members to address HIE and VHIT REC aspects, as well as the Secretary of Technology for the broadband questions. Inputs and suggestions resulted in three separate e-scan documents: One document targeted hospitals and their hospital-owned practices; a second targeted MCOs; and a third targeted practices of all types.

The e-scans were implemented by the Virginia Department of Health (VDH) using SurveyGizmo. Joint testing was done by VDH and DMAS. The links to the surveys were posted on <http://www.hits.virginia.gov/>.

E-Scan Conduct:

The industry associations reached out to their membership and the providers had a four calendar-week window in which to complete the survey via the Internet. After the survey period ended on June 7, 2010, the raw survey data was available in three spreadsheets for evaluation by HITAC.

e-Scan Evaluation:

Consistent with previous e-scans, a vast majority (78%) of the 18 hospitals and health systems that responded to the e-Scan reported using Electronic Medical Records (EMR). Most hospitals and health systems report being connected to pharmacies, labs and other hospitals, and about half are connected to other clinics, emergency departments, and digital radiology. A majority of EHRs are implemented in acute care and specialty inpatient units. Hospitals and health systems reported that most of their owned or closely affiliated physician practices have EMR systems that are compatible with the Commonwealth of Virginia Health Information Exchange (COV-HIE) Strategic Plan. Major EMR

functionalities reported include the following: medical history and testing result retrieval consultation reports, clinical documentation, discharge planning, problem lists, and physician order entry. Almost every hospital surveyed reported the intention of seeking funding for an EHR under ARRA, and the hospitals also plan to encourage providers in their network to apply for stimulus incentives under Medicaid or Medicare. Only 11 percent of responding hospitals are actively participating in an HIE; however, more than half plan to connect to an HIE within the next two years.

Unfortunately, neither the MCO nor the provider survey was able to supply meaningful results with the number of responses received. To address this shortcoming, plans are being made to coordinate with the Commonwealth's broadband initiative. This initiative is to undertake a revised provider scan coordinated with the Secretary of Technology to assess both broadband adoption as well as EMR adoption as part of the first phase of implementation of the COV-HIE. This survey is scheduled for implementation in the late summer/early fall 2010. The need for additional e-scans will be periodically determined going forward. DMAS is also planning to contract with VHIT REC to conduct statewide outreach activities and to assist providers in registering for the incentives.

Results for Hospital and Health System Respondents to the e-Scan

EMR Penetration:

- ... 78% implemented in acute care inpatient units
- ... 72% implemented in specialty inpatient units
- ... 56% implemented in sub-acute care units
- ... 67% of owned or closely affiliated physician practices have implemented an EMR system
- ... 61% of the owned and 50% of the affiliated physician practice EMRs are compatible with the health system/hospital's EMR
- ... 50% implemented in home health agency and hospice
- ... 33% implemented in free standing ambulatory surgery facility

Functions (ranked from most to least used):

- ... Medical history (94%)
- ... Medical testing result retrieval consultation reports (94%)
- ... Clinical documentation (83%)
- ... Discharge planning (78%)
- ... Problem lists (67%)
- ... Exchange with sub acute care or other units/facilities (61%)
- ... Physician order entry (50%)

EMR Details:

- ... 78% use an EMR software package
- ... 72% are connected to pharmacies and labs
- ... 67% are connected to other hospitals
- ... 55% are connected to other clinics, and emergency departments
- ... 50% are connected to digital radiology

HIE penetration:

- ... 11% participate in an HIE
- ... 56% plan to provide an HIE within the next 24 months

Patient Portals:

- ... 50% are implementing patient portals

Telemedicine and Telehealth:

- ... Most to least frequently used services: information from home monitoring equipment, providing care to patients, Telepharmacy, and Teleradiology

These results provide specificity about types of EMR/EHRs used in Virginia. The results are not specific to Medicaid providers; they are intended to represent all provider types.

Estimated Hospital Data

Using calculations based on data from Virginia Health Information, DMAS has estimated the following hospital information:

Table 1 Estimated Hospital Data

Hospitals not meeting volume threshold	34
Hospitals meeting volume threshold ¹	52

¹These hospitals are estimated to meet the volume threshold but are not confirmed to be within the allowable CCN range.

Estimated Physician and Nurse Practitioner Data

Using claims and encounters dates from January through March 2009 for visits based on one day of service, DMAS has estimated the following physician and nurse practitioner information:

Table 2 Percent Medicaid Physician Visits of Total Estimated Physician Practice Visits

% Medicaid Visits of Total Estimated¹ Practice Visits:	Number of Pediatricians² (Column %):	Number of Other Physicians (Column %):	Total, All Physicians (Column %)
Medicaid < 20 %	594 (48.38)	8954 (92.38)	9548(87.42)
20-29 %	80 (6.52)	348 (3.59)	428(3.92)
30 % or more	554(45.1)	391(4.03)	945(8.66)
Total	1228 (100.0)	9693 (100.0)	10,921(100.0)

¹ For physicians, Mountain States Group estimates 4800 visits to a physician (family physician) in a year, reduced here to 1200 for selected claims period. Estimate based on American Medical Association and Department of Health and Human Services data.

²DMAS provider enrollment includes neonatologists with pediatricians.

Data Sources: MMIS SAS claims and encounters dates of service January – March 2009, hospital-based visits excluded, and Medicaid-Medicare visits excluded. Mountain States Group “Tools for Estimating Need for Physicians, Market Penetration, Revenue Potential”, not dated.

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Table 3 Physician Practice Size by Physician Specialty

Physician Practice Size:	Pediatricians¹- Practice Count (Column %):	Other Physicians- Practice Count (Column %):	Total Physicians- Practice Count (Column %)
1-5	869 (97.75)	6258 (97.66)	7127(97.67)
6-10	14 (1.57)	91 (1.42)	105(1.44)
11-19	5 (0.56)	29 (0.45)	34(0.47)
20 or more	1 (0.11)	30 (0.47)	31(0.42)
Total	889 (100.0)	6408 (100.0)	7297(100.0)

¹DMAS provider enrollment includes neonatologists with pediatricians.

Data Source: MMIS SAS claims and encounters dates of service January – March 2009, hospital-based visits excluded, and Medicaid-Medicare visits excluded. SAS variable BILL_PROV_NAME used for counting providers regarding practice size, which reflects service provider name in some instances.

Table 4 Percent Medicaid Nurse Practitioner Visits of Total Estimated Nurse Practitioner Practice Visits

% Medicaid Visits of Total Estimated¹ Practice Visits:	Number of Nurse Practitioners (Column %):
Medicaid < 20%	382(88.02)
20-29 %	17 (3.92)
30 % or more	35 (8.06)
Total	434 (100.0)

¹For nurse practitioners, Mountain States Group estimates 3000 visits to a nurse practitioner in a year, reduced here to 750 for selected claims period. Estimate based on American Medical Association and Department of Health and Human Services data.

Data Sources: MMIS SAS claims and encounters dates of service January – March 2009, hospital-based visits excluded, Medicaid-Medicare visits excluded, and nurse practitioner-nurse midwives excluded. Mountain States Group “Tools for Estimating Need for Physicians, Market Penetration, Revenue Potential”, not dated.

Table 5 Nurse Practitioner Practice Size

Nurse Practitioners Practice Size:	Nurse Practitioners- Practice Count (Column %):
1-5	299 (98.68)
6-10	3 (0.99)
20 or more	1 (0.33)
Total	303(100.0)

Data Source: MMIS SAS claims and encounters dates of service January – March 2009, hospital-based visits excluded, Medicaid-Medicare visits excluded, and nurse practitioner-nurse midwives excluded. SAS variable BILL_PROV_NAME used for counting providers regarding practice size, which reflects service provider name in some instances.

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Table 6 Percent Medicaid Visits of Total Estimated Practice Visits for Physicians, Nurse Practitioners & Dentists

% Medicaid Visits of Total Estimated^{1, 2, 3} Practice Visits:	Number of Physicians (Column %)	Number of Nurse Practitioners (Column %)	Number of Dentists (Column %)	Total Physicians, Nurse Practitioners & Dentists (Column %)
Medicaid < 20 percent	9548(87.42)	382(88.02)	824(83.66)	10,754(87.15)
20-29 percent	428 ⁴ (3.92)	17 (3.92)	54(5.48)	499 ⁴ (4.04)
30 percent or more	945(8.66)	35 (8.06)	107(10.86)	1,087(8.81)
Total	10,921(100.0)	434 (100.0)	985(100.0)	12,340(100.0)
Total Physicians, Nurse Practitioners & Dentists Estimated Eligible for HIT Incentives⁵	1025⁴	35	107	1,167

¹ For physicians, Mountain States Group estimates 4800 visits to a physician (family physician) in a year, reduced here to 1200 for selected claims period. Estimate based on American Medical Association and Department of Health and Human Services data. Optometrists are excluded from counts.

² For nurse practitioners, Mountain States Group estimates 3000 visits to a nurse practitioner in a year, reduced here to 750 for selected claims period. Estimate based on American Medical Association and Department of Health and Human Services data.

³ For dentists, an estimate of 1465 dental visits per dentist per quarter based on discussions with the DMAS dental consultant.

⁴ Includes 80 pediatricians who meet the HIT legislation criteria for incentive payments because Medicaid patient visits are 20 percent or more of total practice visits.

⁵ Physicians with the exception of pediatricians, nurse practitioners and dentists must have 30 percent or more Medicaid patient visits of total practice visits.

Data Sources: MMIS SAS claims and encounters dates of service January – March 2009, hospital-based visits excluded, Medicaid-Medicare visits excluded, and nurse practitioner-nurse midwives excluded. Mountain States Group “Tools for Estimating Need for Physicians, Market Penetration, Revenue Potential”, not dated. DMAS dental consultant for total visits per dentist estimate, May 2010.

Table 7 Physician and Nurse Practitioner Practice Size

Combined Physician & Nurse Practitioner Practice Size:	Physician & Nurse Practitioner- Practice Count (Column %):
1-5	7243 (97.62)
6-10	110 (1.48)
11-19	35 (0.47)
20 or more	32 (0.43)
Total	7420 (100.0)

Data Source: First Health SAS claims and encounters dates of service January – March 2009, hospital-based visits excluded, Medicaid-Medicare visits excluded, and nurse practitioner-nurse midwives excluded. SAS variable BILL_PROV_NAME used for counting providers regarding practice size, which reflects service provider name in some instances.

2. Broadband Internet Access

The American Recovery and Reinvestment Act of 2009 (ARRA) directed the National Telecommunications and Information Administration (NTIA), to develop and maintain a comprehensive nationwide inventory map of broadband service capability and availability, and to make the map publicly available via the Internet. NTIA awarded monies to Virginia to collect and verify statewide data about the availability, speed, and location of broadband Internet. This data collection is to be conducted on a semi-annual basis over a two-year period, with the data to be presented in a clear and accessible format to the public, government, and the research community.

The VDH Office of Health IT and Medicaid are partnering with this initiative to conduct an environmental scan of healthcare providers. This scan will assess the availability of the technical infrastructure that is necessary for a deployment of “Meaningful Use” electronic health records. With the vast geography of the Commonwealth, Virginia has many rural areas where broadband capability is at a premium. This partnering will illustrate the areas of the state that require immediate attention to supply healthcare providers with the tools necessary for practice improvement. NTIA will then use the data collected by grantees, in combination with other data sources, to create and publish online the National Broadband Map by February 17, 2011. The map will further educate consumers and businesses about broadband Internet availability, enable broadband Internet providers and investors to make better-informed decisions regarding the use of their private capital for future broadband investment, and inform the decisions of Federal, State, and local policymakers as they work to expand the benefits of broadband to all Americans.

Additionally Virginia has received several broadband grants to help address the problem. Below is a description of these grants:

- ... The BIT Wireless Broadband Initiative project plans to bring high-speed affordable broadband services to 15 underserved counties and the cities of Emporia and Franklin in South Central Virginia by expanding and enhancing its existing high-speed broadband and voice communications wireless network. The BIT Wireless project intends to offer wireless broadband at speeds of up to 10 Mbps to as many as 100,000 households, 14,800 businesses, and 800 community anchor institutions. In addition, the project will promote broadband adoption by discounting the cost of the equipment necessary to subscribe at home. Grant award: \$18,983,648.
- ... The Middle Mile Expansion for Southern Virginia project proposes to add 465 miles of new fiber to an existing 800-mile fiber network, focused on directly connecting 121 K-12 schools, a majority of which are in unserved and underserved areas of southern Virginia. The expanded fiber network expects to improve connection speeds for these schools from 1.5 Mbps to at least 10 Mbps, with a goal of 100 Mbps. The service area includes 12 counties in Southern Virginia, and includes the cities of Danville, Emporia, and Martinsville near the North Carolina border. Grant award: \$16,044,290.
- ... The Virginia Tech Foundation (VTF) proposes to construct a 110-mile open access fiber-optic network between Blacksburg in Montgomery County to Bedford City in Bedford County in its Allegheny Fiber Project. VTF is partnering with Mid-Atlantic Broadband Cooperative (MBC) to extend the Cooperative's fiber-optic footprint to unserved and underserved communities in the Appalachian region. The resulting network would cross six

counties in Virginia's Appalachian region and provide direct high-speed connections to Virginia Tech's main campus in Blacksburg and the Virginia Tech Carilion School of Medicine in Roanoke. Improved capacity and speed will enhance the ability for both institutions to collaborate on cutting-edge medical and other scientific research with institutions in the United States and abroad. The project proposes network speeds from 10 Gbps to 200 Gbps and could offer point-to-point, private line services ranging from 10Mbps through 10Gbps. Grant award: \$5,540,000.

... Nelson and Page counties also received smaller grants of \$1,826,646 and \$1,648,941 respectively.

3. Federally-Qualified Health Center HIT/EHR Funding

Virginia currently has 25 FQHCs operating in the Commonwealth. In 1994, these FQHCs formed a health center controlled network called Community Care Network of Virginia (CCNV) which provides the vehicle through which Virginia's FQHCs adopt, implement and operate health information technology. As one of the first federally supported networks, CCNV has been implementing Health Resource Services Administration (HRSA) supported HIT initiatives since 1999.

In 2007, the Virginia FQHCs were awarded HRSA funding for High Impact Health Information Technology Electronic Health Record Implementation which supported the network-wide acquisition of a single EMR software application (eClinicalWorks). As of June 2010, 92 percent of Virginia's FQHC providers have adopted and implemented electronic health record applications through the support of this HRSA funded initiative. Additional HRSA Health Information Technology funding was received in 2007 to acquire and deploy innovative technology throughout Virginia's FQHCs. The selected innovative technology will result in patient kiosks with content that will be integrated into the electronic health record.

CCNV has been actively engaged in the development and planning for Virginia's COV-HIE. Its Chief Executive Officer is an appointed member of the Governor's Health Information Technology Advisory Commission and sits on the State Medicaid Agency's Task Force for Health IT. CCNV is a collaborating partner with Virginia's Regional Extension Center grantee, and actively supports the two operating NHINs in Virginia (MedVirginia and CareSpark). CCNV's own strategic agenda includes a significant emphasis on health outcomes improvement and health information exchange. It is anticipated that the FQHCs will connect to the statewide HIE either as a certified HIE or through an existing HIE once the COV-HIE is operating.

4. Veterans Administration and Indian Health Services EHR Use

Veterans Administration hospital-based outpatient clinics or community-based clinical services exist in the following localities in Virginia:

- ... Alexandria (VISN 5)
- ... Hampton Roads, Richmond, Salem (VISN 6)
- ... Bristol, Norton (VISN 9)

The Veterans Administration uses its own version of an electronic health record system called VISTA\CPRS. The VISTA\CPRS system is also used in Veterans Administration Community-Based Outpatient Clinics operated by contractors.

There are no Indian Health Service clinical facilities located in Virginia.

5. HIT/E Engaged Stakeholders

Office of Health IT, The Virginia Department of Health has been designated through executive order as the lead agency for HIT in the Commonwealth, and has established an Office of Health IT. One of the main goals of this office is to use information technology to improve health care quality and efficiency through the authorized and secure electronic exchange and use of health information. This office staffs the HITAC, provides guidance to the Governor on HIT issues, and ensures that the efforts of the Commission are aligned with other HIT initiatives in the Commonwealth.

CareSpark was founded in 2005 as part of an overall strategy to improve health outcomes and to reduce inefficiencies in the delivery of health care in the central Appalachian region of Southwest Virginia and East Tennessee. CareSpark has developed a collaborative multi-stakeholder governance structure and diversified funding mechanisms to support adoption and use of certified electronic systems (electronic health records with e-prescribing and clinical decision support) in clinical settings; connectivity and interoperability through a secure, standards-based network that supports regional and national HIE; aggregation and monitoring of data for the purpose of individual and population health improvement; and alignment of financial incentives for patients, providers and purchasers (employers, public and private health plans). With support from local, state and national leaders, CareSpark's system became operational in fall 2008, and houses records for 300,000 patients served by 125 clinicians who currently use the system. CareSpark is now engaged with CMS to develop and test specifications for physician reporting of quality measures (PQRI) directly from their EHR systems through an HIE/Nationwide Health Information Network (NHIN) gateway in a standardized format, and to receive feedback reports on an interim and final basis verifying their qualifications for receipt of incentives payments for Meaningful Use. This project was initiated in June 2010 and is targeted for completion before the 1st quarter of 2011, allowing for demonstration and publication of standard specifications for use by others across the country.

MedVirginia, LLC, established in 2000, is a provider-owned and governed health information organization based in Richmond. Its organizational purpose is to improve quality, safety and efficiency through the use of HIT. At its core is MedVirginia Solution®, a community-based HIE linking clinical data from physicians, hospitals, labs and pharmacies. In 2006, MedVirginia's HIE became operational, making it among the first "live" HIEs in the U.S. In 2007, MedVirginia was awarded a Health and Human Services (HHS) contract to participate in the NHIN Trial Implementation. In 2008, MedVirginia's CEO, Michael Matthews was named the state's Convener for the CMS EHR Demonstration as well as Senior Advisor to the Governor's Office of Health IT. Last February, MedVirginia became the first and remains the only HIE in production on the NHIN through its partnership with the Social Security Administration to automate the disability determination process.

The Northern Virginia Regional Health Information Organization Inc. (NoVaRHIO) was established in May 2006. NoVaRHIO has broad participation from across northern Virginia including from patient groups, physicians, hospitals and hospital systems, allied health providers, local governments, free clinics, and laboratories, IT system integrators, corporations, pharmacies

and universities. NoVaRHIO's hospital partners include Inova Health System, Virginia Hospital Center, Reston Hospital Center, Sentera Potomac Hospital and Prince William Hospital. NoVaRHIO's first full-scale pilot project towards establishing a comprehensive health information exchange is underway with a goal to provide Inova Alexandria Emergency Department physicians with patient medication history (with patient permission) to help in diagnosis and in determining treatment during times of medical emergency. Collaborators include Inova Health Systems and GE Healthcare and the first phase of the project has been funded by a grant from the Commonwealth of Virginia. NoVaRHIO also is in the process of establishing a standards-based health information framework for automating and providing access to the "File for Life" and personal health records (PHR). With the help of public health officials from across Planning District 8, NoVaRHIO is extending the File for Life effort through community outreach.

The Virginia Health Exchange Network (VHEN) is a collaboration of Virginia health plans, health systems, hospitals and the Commonwealth dedicated to lowering transaction costs and improving the efficiency of administrative systems in health care. VHEN was convened by the Virginia Association of Health Plans, the Virginia Hospital & Healthcare Association and the Governor's Office of HIT, and operates under a charter that began July 1, 2007. Using the CAQH CORE Phase I operating rules for the Health Insurance Portability and Accountability Act (HIPAA) eligibility and benefit transactions, a secure web portal is being developed to connect Virginia's health plans, health systems and state agencies to simplify patient insurance eligibility verification. Health care providers will be able to determine insurance eligibility status, level of benefits and other critical information in real time across multiple health plans, public and private, by using this one portal. Currently, over 90% of health plans in Virginia participate in this initiative. Virginia's providers ultimately will be able to reduce eligibility verification and claims submission requests via phone/fax and query the Medicaid Management Information System (MMIS) to reduce the overall number of self-pay accounts. The network also provides a platform for expansion into other services, including populating health records and financial management. Future plans include identifying a solution to verify patient insurance coverage when it may be unknown or unavailable so that benefits can be accessed more easily. VHEN also will evaluate additional approaches for reducing costs of collection, payment and approvals, and where justified, engage in further defined, collaborative and measured efforts to streamline health care administration in Virginia. Medicare connectivity is also offered through the system. The VHEN Steering Committee conducted a competitive request for proposal (RFP) last year and selected Availity as its first technology partner to achieve the joint health plan and health system objectives outlined above.

CommonwealthRx was launched in 2009 to increase the volume of e-prescribing in Virginia. Its vision is to improve patient safety, quality of care, and cost-effectiveness through e-prescribing and medication management. The goal of CommonwealthRx is to increase the use of electronic prescriptions in Virginia by providing the structure to support purchase and Meaningful Use of e-prescribing (eRx) and offering ongoing technical support to prescribers. It is led by a steering committee of health care executives, pharmacists, prescribers and others who possess a shared vision of Virginia being one of the nation's top e-prescribing states. The structure of Commonwealth Rx will support purchase and Meaningful Use of eRx and there will be ongoing technical support to prescribers. Commonwealth Rx promotes certified EMR technology and identifies providers' readiness for e-prescribing. These goals fit well with the COV-HIE. The integration of Commonwealth Rx efforts into the COV-HIE will allow the implementation of e-

prescribing to its fullest capability and give providers access to pharmacists and experts. The current status of the program is ongoing and MedVirginia is funding the entire program including the website and consultant. MedVirginia plans to continue the program through the year and beyond, but hopes that this statewide grass roots effort can be taken to the next level through COV-HIE to reach its full potential.

Surescripts, with headquarters in Virginia, has been a long-standing advocate for the advancement of e-prescribing in the Commonwealth and is an active member of CommonwealthRx. Surescripts operates the country's largest e-prescribing network. The Surescripts network connects prescribers to all of the nation's major chain pharmacies (e.g., Walgreens, CVS/pharmacy, Rite Aid, Wal-Mart), many of the nation's leading payers and pharmacy benefits managers (PBMs) such as Aetna, CVS Caremark, Express Scripts, Medco, Wellpoint, as well as over 10,000 independent pharmacies nationwide. In Virginia, over 85 percent of pharmacies (1,214) are connected to prescribers via Surescripts. Surescripts provides key performance metrics for tracking medication management in Virginia. Examples include: 3.49 percent of prescriptions are electronic and 1.7M requests for prescription benefits were submitted, with a response rate of 72 percent. Data provided at www.surescripts.com indicates that as of 2008, Virginia ranks 12th in the nation with about 86 percent of total community pharmacies in the state activated for e-prescribing, an increase of 11 percent from the previous year.

Advanced Healthcare Directive Registry, a program that will be supported as a reporting service by the COV-HIE's technical infrastructure. The goals of this program parallel those of the COV-HIE. During the 2008 Session of the Virginia General Assembly, legislation was passed that required VDH to establish an Advance Healthcare Directive Registry for its citizens. This legislation also contained provisions that would allow VDH to seek contributions, grants, or incorporate user fees into the program in order to fund the activity. After significant research on suggested business models, VDH chose to follow the guidelines of the Public-Private Educational Facilities and Infrastructure Act of 2002 that allows state agencies a mechanism for reviewing creative project proposals from vendors. In 2009 VDH awarded the creation and maintenance of the Advance Healthcare Directive Registry to a partnership of two corporations, Unival and Microsoft. This partnership will allow citizens the ability to submit their directive by paper or electronic formats at no charge. It will also facilitate the issuance of access credentials to the citizen. An additional utility will be provided that will allow the citizen to designate what individuals they would like to have immediate access and then facilitate communication with those individuals to notify them of the directive's availability. The directives will be stored within the dynamic Customer Relationship Management (CRM) platform of Microsoft and will therefore be available to provide interoperability with the COV-HIE in the near term.

Virginia Health Information (VHI) developed a pilot exchange system to collect laboratory data and other clinical data from hospitals utilizing the international system of Logical Observation Identifiers Names and Codes (LOINC®); used in transmission of HL7 messages. This information comes from hospitals representing approximately 50 percent of Virginia's 870,000 plus discharges per year and represents over 15 million distinct tests and test results. VHI has worked with hospitals to convert internal lab test schema to LOINC® codes for electronic reporting.

Virginia Telehealth Network (VTN) reaches out to all healthcare stakeholders. It is very wide in scope; the applications can range from basic to complex. These services include telephone, email or use of the Internet; remote screening, monitoring and diagnostic consultation; digital imaging and distance learning. An advancing technical infrastructure is required to enable optimal distribution of electronic information and services between consumers and clinicians¹. The Telehealth providers in Virginia are CareSpark, NoVaRHIO, Inova Health System, University of Virginia (UVA) Office of Telemedicine, Virginia Commonwealth University (VCU) Health System Clinical Telemedicine, Northern Neck Middle Peninsula Telehealth Consortium, Southwest Virginia Community Health Systems, and Edward Via Virginia College of Osteopathic Medicine². All of these providers are or have the potential to be HIEs that will connect to the COV-HIE.

The Office of Telemedicine at the University of Virginia Medical Center connects providers to consumers who are geographically remote. This office enables UVA health professionals to reach out to all the citizens of the Commonwealth. The 60 site network uses advanced computer applications and broadband telecommunications technologies to securely bring UVA specialists to rural communities that may not have access to specialty care. With two way interactive video, a consumer can see and talk to the doctor in Charlottesville, and not have to leave their community. This service is available 24/7 and provides emergency response for several critical clinical scenarios such as stroke. The UVA Telemedicine Network is also utilized to provide professional education classes to providers and health education classes for consumers. UVA's initiative to grant access to specialists by the rural communities matches the COV- HIE's vision to empower providers to make good decisions based on the coordination of care.

Health Information Technology Advisory Commission, Virginia took an important step towards the development and implementation of a comprehensive plan for HIT when Governor Mark Warner established the Governor's Task Force on Information Technology in Health Care in 2005. Governor Kaine continued and expanded Virginia's commitment to advancing HIT in the Commonwealth when he issued Executive Order 29 in 2006, creating the Governor's HIT Council. When the Order expired, the council continued on a voluntary basis as the Health Information Technology Interoperability Advisory Committee (HITIAC). HITIAC was created by Executive Order 95 in 2009, and was charged with ensuring broad stakeholder engagement and providing guidance to the Governor on the most effective use of American Recovery and Reinvestment Act (ARRA) funds designated for HIT. HITIAC is chaired by the Secretary of Health and Human Resources (HHR) and enlists a broad range of stakeholders including hospital and insurance executives, physicians, Medicaid Director, and HIE and privacy experts. HITIAC was formed to encourage public-private partnerships to increase adoption of electronic health records for physicians in the Commonwealth; provide healthcare stakeholder input to build trust in, and support for a statewide approach to HIE; ensure that an effective model for HIE governance and accountability is in place; examine and define an integrated approach with DMAS and VDH to enable information exchange; support monitoring of provider participation in HIE as required to qualify for Medicaid Meaningful Use incentives; develop and/or update privacy and security requirements for HIE within and across state borders; encourage and integrate the proliferation of telemedicine activities to support the Virginia healthcare

¹ Source: <http://ehealthvirginia.org/whatistelehealth2.html>, retrieved May 24, 2010.

² Source: <http://ehealthvirginia.org/telehealthproviders.html>, retrieved May 25, 2010.

improvement goals; monitor and support the activities of the VHIT REC; and examine other health related issues as appropriate.

Health Information Technology Standards Advisory Committee (HITSAC) advises state government on the approval of nationally recognized technical and data standards for HIT systems or software pursuant to subdivision 6 of § 2.2-2458 in the Code of Virginia. Four HITSAC members are appointed to the HITAC, and HITAC incorporated the guidance of HITSAC in the development of strategic and operation plans for COV-HIE. HITSAC's guiding principles are to (1) develop a blueprint for (HIE) and identify steps to achieving that vision; (2) focus on data requirements for both patient health purposes and public health purposes (research); (3) ensure data is available where it needs to be for the patient, while protecting the patient's privacy and wishes; (4) recognize standards, like EMR and EHR are a utility of HIT, not a competitive advantage; (5) focus on interoperability as a critical success factor; (6) develop and manage close relationships with the federal healthcare initiatives; (7) adopt standards instead of creating new ones; and (8) insure standards have been validated prior to adoption. HITSAC will specify the data and communications standards for the Medicaid Information Technology Architecture (MITA) to-be information architecture, and eventually, the data and communications standards specified will be broadly adopted for data exchange across the Commonwealth state agencies. The design will also allow for configurability from state to state.

6. DMAS HIT/E Relationships with Outside Entities

With respect to the exchange of administrative data, the Commonwealth has the VHEN, a privately-run collaboration of Virginia health plans, health systems, hospitals and the state dedicated to lowering transaction costs and improving the efficiency of administrative systems in health care. VHEN and the Commonwealth have the shared goals of standardizing and streamlining administrative transactions and lowering costs and improving service quality. Using the CAQH CORE Phase I operating rules for HIPAA eligibility and benefit transactions, a secure web portal is being developed to connect Virginia's health plans, health systems and state agencies to simplify patient insurance eligibility verification. Health care providers will be able to determine insurance eligibility status, level of benefits and other critical information in real time across multiple health plans, public and private, by using this one portal. Virginia's providers ultimately will be able to reduce eligibility verification and claims submission requests via phone/fax and query the MMIS to reduce the overall number of self-pay accounts.

7. HIE Presence in Virginia

There are three HIEs in operation in Virginia: MedVirginia covers central Virginia as well as Tidewater; CareSpark covers southwest Virginia and eastern Tennessee; and NoVaRHIO covers northern Virginia.

MedVirginia is involved in driving technology adoption at free clinics. To date four free clinics have the following capabilities:

- ... New registration and scheduling systems;
- ... Can receive automated results from all participating data suppliers, including Bon Secours Richmond Health System;
- ... Connected to area specialists and hospitals via a secure clinical messaging system;
- ... Have access to an automated and standardized system for eligibility screening, results of which are available to all specialists and hospitals at time of referral;

- ... Will be provided e-prescribing capabilities, with connectivity to 175 community pharmacies as well as the CrossOver free clinic pharmacy; and
- ... Have "EMR lite" capabilities, including clinical documentation infrastructure for capturing medications, allergies, problem lists, immunizations, and vital signs.

In the Appalachian region of Virginia, CareSpark has developed a collaborative multi-stakeholder not-for-profit governance structure and diversified funding mechanisms to support:

- ... Adoption and use of certified electronic systems (electronic medical records with e-prescribing and clinical decision support) in clinical settings;
- ... Connectivity and interoperability through a secure, standards-based network that supports health information exchange regionally and nationally;
- ... Aggregation and monitoring of data for the purpose of individual and population health improvement; and
- ... Alignment of financial incentives for patients, providers and purchasers (employers, public and private health plans).

With support from local, state and national leaders, CareSpark's system became operational in fall 2008, and houses records for 175,000 patients served by 100 clinicians who currently use the system. Use is projected to grow to nearly 500 clinicians serving nearly 2,000,000 patients by the end of 2009, including those with records in Virginia's Immunization Registry

The NoVaRHIO works to enhance the health status of those who live or work in Northern Virginia and the quality of their health care by facilitating secure, reliable and timely access to and exchange of accurate electronic and other health records. A critical and significant part of this important community initiative is maintaining and enhancing the privacy and security of health information.

Incorporated in August of 2007, NoVaRHIO, a Virginia not for profit organization, was chaired by William Hazel, MD. It serves an area approximating the boundaries of Planning District 8. Participants include: area physicians, nursing and allied health care providers, hospitals, consumer advocacy groups, service group members, behavioral health providers, business leaders, pharmacy representatives, laboratory representatives, information technology providers, academic faculty, public health officials, elected officials, public sector leaders and long term care providers. George Mason University has facilitated this process by providing encouragement and assistance in planning and implementation. Jane Woods, State Health Policy & Community Development Liaison, Associate at George Mason and Professor J.P. Auffret, School of Management have been instrumental in coordinating this effort.

8. Role of MMIS in HIT/HIE Environment

The MMIS in the current HIT environment will be used for incentive payment and administration of provider incentive funding. The MMIS will have future participation in the VHEN payer portal, tentatively targeted for the fall of 2010.

9. Facilitation of HIE & EHR Adoption

The communications plan is a joint coordination effort between the VHIT REC, COV-HIE, and Medicaid. Medicaid is in a supporting role; The VHIT REC and COV-HIE efforts are the primary outreach vehicles. The VHIT REC is in direct contact (phone/email) with the small provider groups. Also, VHIT REC and COV-HIE representatives have been working on the SMHP project team for coordination purposes.

Virginia Health Quality Center, the Quality Improvement Organization's (QIO) contractor to CMS, is also contracted to serve as Virginia's Regional Extension Center for Health Information Technology. The mission of the VHIT REC is to provide comprehensive, low-cost technical assistance to make it easier for the Commonwealth's priority primary care providers (PPCPs) to adopt electronic health records (EHRs), integrate them into the patient care process, and attain Meaningful Use. VHIT REC will assist in two areas: new EHR implementations and existing EHR implementations, both with the goal of attaining Meaningful Use. VHIT's target is to bring 2,285 PPCPs to Meaningful Use of EHR within two years. VHIT has hired its initial staff and begun the awareness and physician enrollment campaign. In these stages of outreach, VHIT is addressing both individual providers, provider groups, and numerous statewide medical organizations. Regional EHR solution partner "kick-off" meetings are being held around the state in June/July 2010 as well as webinars, exhibits, and other venues for campaign material distribution. VHIT is providing a choice of three EHR solution partners (Allscripts, MDLand, and Athena Health) with well negotiated group pricing discounts, and assistance with training and implementation. Currently VHIT is developing a continuum of services to assist physician practices in achieving Meaningful Use. In the early phase of a provider going "live", several aspects of Meaningful Use will be pursued, including electronic prescribing and clinical data reporting. Virginia providers will benefit from VHIT REC services even after the initial EHR go-live as VHIT staff will continue to work with them to ensure they achieve full Meaningful Use of their EHR systems.

DMAS will expand the scope of VHIT REC to offer the same level of services to the other types of eligible professionals and hospitals not already being served.

10. DMAS Relationship with Virginia HIT Coordinator

The Medicaid, HIE, and VHIT REC entities participate in each other's efforts to ensure coordinated planning. The Virginia Medicaid Director is a voting member of HITAC; the SMHP project manager is participating on the HIE committees and working closely with the Office of the National Coordinator for Health Information Technology (ONC) coordinator. DMAS is also participating in ONC sponsored events. The ONC coordinator's office is being used as the project office for the SMHP effort (project oversight) and the VDH Office of Health IT participates on the SMHP project at the executive level.

11. Other Activities that May Affect the EHR Incentive Program

None.

12. State Law or Regulation impact on EHR Incentives

No significant changes in Virginia laws or regulations have been identified that would impact our EHR incentive payment program. HITAC held several public meetings; there were no requests for changes to legislation in the public sessions.

13. HIT/HIE Activities Across State Borders

CareSpark operates its HIE in both Tennessee and Virginia. Also there are Medicaid patients who see providers across D.C., Northern Virginia, and Maryland. It will be important that Virginia, Washington DC, West Virginia, Tennessee, North Carolina, and Maryland ensure interoperability of their HIEs.

14. Immunization Registry Interoperability with Public Health Surveillance

Hewlett-Packard/Electronic Data Systems Corp. (EDS) manages the Virginia Immunization Registry using the Wisconsin registry platform. During H1N1, the Virginia Department of Health required any organization that received H1N1 vaccine from VDH to record the administration of the vaccine into its VIIS registry. This included organizations using the user interface or data exchange. The data exchange accepted both flat file format and the HL7 2.3.1. There was a 500 percent increase in providers' submissions. The Virginia Department of Health is working to retain as many physicians as possible. Major pharmacies, including a large grocery chain, cooperated in the program with direct data feeds. VDH is the major source of these records but also receives feeds from major health systems and direct data entry from providers. The major health systems send aggregate data on a monthly feed.

To qualify for meaningful use, an organization must submit data via HL7 2.3.1 or HL7 2.5.1. VDH is currently working to be able to accept data via HL7 2.5.1. VDH will still accept data through the user interface or a flat file data exchange, but those methods will not suffice for meaningful use.

15. HIT-related Transformation and CHIPRA Grant Status

DMAS does not have a Medicaid Transformation Grant or a Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) grant.

B. Virginia's "To-Be" Landscape

1. HIT/HIE Goals & Objectives

DMAS' specific HIT/HIE goals, objectives, measures, targets and baselines are outlined in Table 9. They are broken into the following four main goals with their supporting objectives:

... Goal 1 is to encourage Medicaid providers to adopt, implement, or upgrade to certified EMR technology. The following objectives fall under Goal 1:

- × Objective 1.1: Encourage Medicaid providers to take first steps towards adoption by phasing out paper-based claims; while this will not lead to Meaningful Use, it will help encourage adoption for later stages of Meaningful Use as well as provide more timely payments and reduction in administrative expense.
- × Objective 1.2: Encourage Medicaid providers to adopt, implement, or upgrade by leveraging and expanding the current Virginia HIT Regional Extension Center scope of efforts for outreach, education, and technical support in Virginia. DMAS partnered with VHIT REC to outline the tasks VHIT REC will perform in its expanded role. These tasks are described in detail in the draft contract.
- × Objective 1.3: The Medicare program will reduce rates paid to EP and eligible hospital (EH) providers who are not able to demonstrate Meaningful Use by 2015 as a negative incentive to participate. Reevaluate possible methods of requiring Meaningful Use compliance for Virginia Medicaid EP & EH providers to better align with Medicare efforts in 2015.

... Goal 2 is to obtain a multi-state solution for incentive program administration. The following objectives fall under Goal 2:

- × Objective 2.1: Obtain a service solution (technical, business services, policies & procedures) from a vendor that is already supporting one or more state's incentive program(s). This is what DMAS is calling a "multi-state" solution.
- × Objective 2.2: Use existing DMAS tools and methods to support audit and oversight requirements.

... Goal 3 is to support implementation and sustainability of the COV-HIE. The following objectives fall under Goal 3:

- × Objective 3.1: Provide financial support to the COV-HIE. The COV-HIE financial sustainability model is based on subscriptions that are paid for by the COV-HIE certified HIEs as well as payers. There will be a weight applied to the subscription fees based on a to-be defined sizing criteria such as covered lives/bed capacity, etc. Medicaid will need to provide for its share of financial support to the COV-HIE. Precise information on the HIE subscription fees will not be known until the planned HIE procurement cycle is complete. Federal funding for this has not been requested yet and will only be requested if the other large payers in Virginia agree to contribute.
- × Objective 3.2: Provide financial support to the COV-HIE State Government Gateway that is necessary to achieve stage 2-plus Meaningful Use.

... Goal 4 is to leverage MITA

- × Objective 4.1: Establish the COV State government gateway that allows COV-HIE access to State government assets such as immunization registry, syndromic surveillance, and state labs.
- × Objective 4.2: From the updated MITA State Self Assessment (SS-A) transition plan, initiate projects to develop the required Service Oriented Architecture (SOA) based services needed by the COV-HIE Care Management business area.
- × Objective 4.3: For the SOA services that are identified, establish harmonized standards.
- × Objective 4.4: Leverage MITA infrastructure for Medicaid expansion.
- × Objective 4.5: Leverage MITA infrastructure for health insurance exchange.

DMAS' target is to enroll 20 percent of its eligible providers in HIT/E efforts. Based on our analysis of the number of qualifying providers, we estimate this target to be approximately 2000 providers.

2. IT System Infrastructure

HITAC evaluated several approaches to the technical infrastructure of the COV-HIE. These included consideration of federated, hybrid, and centralized architectural data models. In a centralized architecture, the HIE maintains a Master Patient Index (MPI), but a Record Locator Service (RLS) may not be necessary since the data is hosted on an HIE database. In a federated architecture, data is retained on a source system. This architecture supports requests for data to the HIE, patient identification, a query for the HIE RLS, the ability to assemble the data, and then respond to the initial request. HITAC chose a hybrid architecture, whereby providers of health care services shall provide and maintain the patient clinical data and communicate with COV-HIE with the use of edge (staging) servers that are separate from the providers' electronic medical transaction systems. In addition health care provider's clinical patient data shall be transmitted to COV-HIE using the edge servers in the CCD format or HL7 as currently endorsed by Health Information Technology Standards Panel (HITSP). Finally, the COV-HIE shall follow the HITSP interoperability specifications to determine duration of data storage.

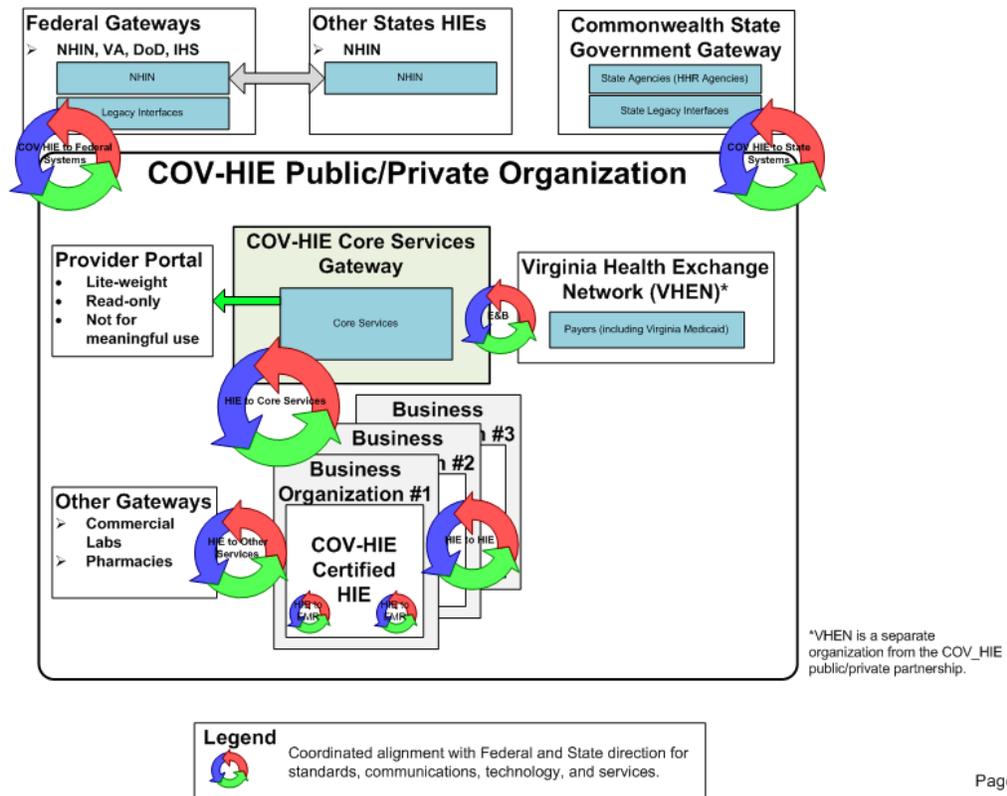
The COV-HIE shall support the connectivity requirements of the NHIN and provide connectivity to the NHIN for providers and certified HIEs in the Commonwealth of Virginia. Figure A depicts the envisioned COV-HIE Technical Architecture. The technical architecture is aligned with Federal and Virginia direction for technology utilizing MITA Technical Infrastructure Standards. It contains the following major components:

- ... Control, oversight, audit, and accreditation requirements are controlled by a public/private partnership;
- ... The primary telecommunication connection is the Internet;
- ... A COV-HIE Core Services Gateway that offers state-wide services to certified HIEs exclusively. In addition, the services offered are those that make sense from a state-wide perspective rather than the regional aspects of the certified HIEs;
- ... A Virginia-certified HIE and its clients and services form a conceptual business organization. Each of the HIE client provider's meaningfully use certified EMR system(s). Each provider owns and is responsible for providing required information via an edge server for access by the HIE as well as meeting the service level agreements for disaster recovery, backup and retention, hours of availability, and performance requirements. Information ownership is maintained by the originating provider and it is not copied or replicated by the COV-HIE

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- Core Services Gateway. The individual HIEs may offer value-added hosting services for edge servers to their clients; however, that is not a required service;
- ... Each COV-HIE certified HIE may interact with other Virginia-certified HIEs as well as the COV-HIE Core Services Gateway;
- ... VHEN is an administration (payer) portal that includes Virginia Medicaid. Services include member registry and claims processing. Payer medical professional staff may access the clinical information in order to perform necessary functions on behalf of their members such as service authorizations (medical reviews to determine need) and appeals;
- ... A Commonwealth State Government Gateway provides access to state services (immunization registry, state reporting etc.). Any existing interactive/batch interfaces will continue to be supported during the transition to SOA technology and near real-time processing capabilities; and
- ... A conceptual Federal Gateway is used to represent information sharing via the NHIN and other Federal partners and other States.

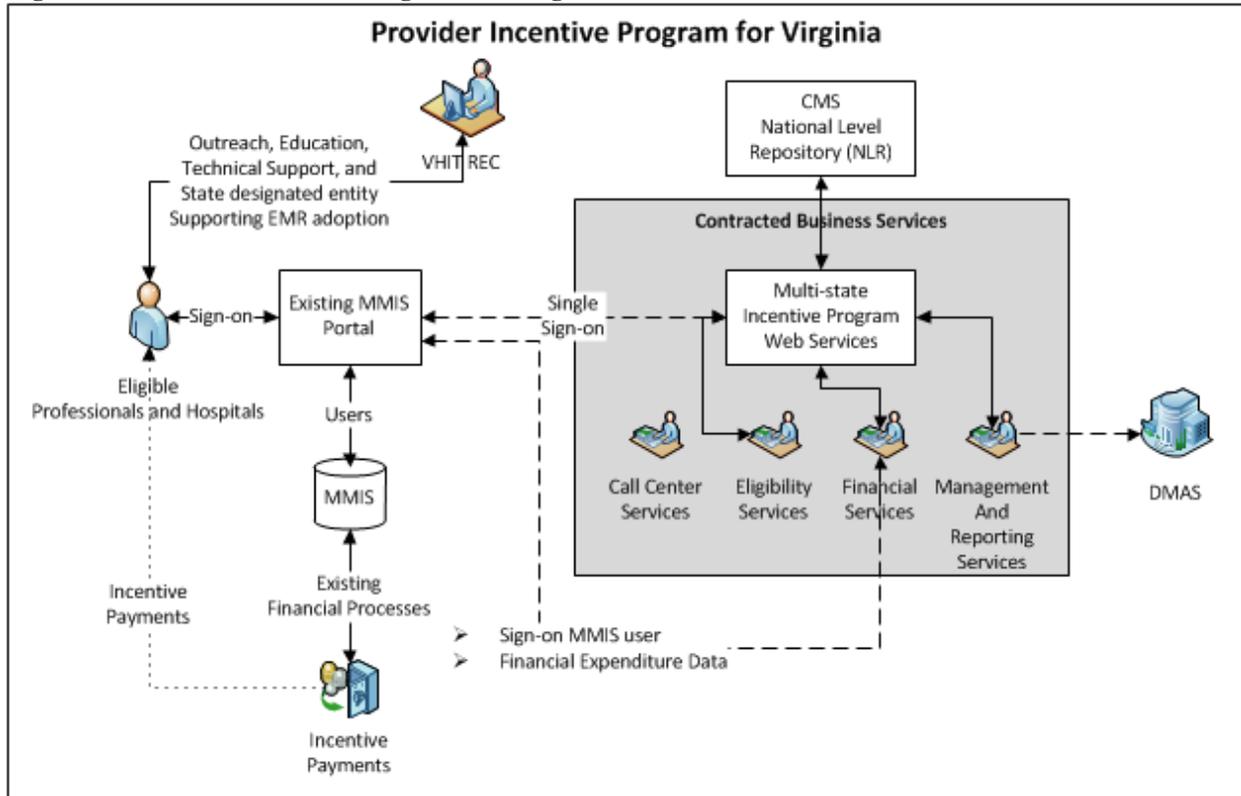
Figure A To-Be Technical Architecture
To-Be Conceptual Architecture



3. Medicaid Provider Interface with EHR Incentive System

For Virginia, a multi-state solution will be procured that Virginia providers will interface with as shown in Figure B, Provider Incentive Program for Virginia. The providers will use the existing Medicaid portal to access the EHR incentive system. Incentive payments will be made from existing functionality in the MMIS.

Figure B Provider Incentive Program for Virginia



4. HIE Governance Structure

The contracted non-profit corporation that forms the COV-HIE Governance Body will constitute its board of directors as it deems appropriate; however, the COV-HIE Governance Body will be required by contract to include COV-HIE stakeholder participation both on the board of directors and any working committees for the COV-HIE. In addition, the Commissioner of Health, or designee, the Coordinator of the Office of Health IT, and the state Medicaid Director shall be voting board members.

An Executive Director of the HIE will be appointed or contracted by the board to ensure that all appropriate work functions of the HIE (vendor managed operations as well as the working committees and management, control and outreach functions of the COV- HIE) are properly filled either by volunteers or by contract. The Executive Director reports directly to the board.

The COV-HIE Governance Body is expected to develop a succession plan for its board of directors consistent with the mission and vision of the COV-HIE (i.e. including multi-stakeholder involvement) past the contracted timeframe with VDH (4 years) when the COV-HIE is expected to be financially self-sustaining.

The COV-HIE Governance Body is expected to act in a manner that assures transparency and accountability to the fullest extent possible, including regular communications with constituents, stakeholders and participants, via online, print and briefings for state leaders and others charged with oversight for the funded activities.

Governance for the COV-HIE must reflect the interests of the varied stakeholders that will participate, due to the following facts:

- ... Virginia providers will receive ARRA incentive funding for becoming Meaningful Users of certified EHRs.
- ... The COV-HIE will provide a subset of services that providers need to become Meaningful Users.
- ... The COV-HIE will assist in improving the quality and efficiency of healthcare delivered to Virginians.
- ... There will be multiple stakeholders that benefit from the services provided by the COV-HIE, including consumers and patients.

As a result, the following principles have been adopted that relate to governance of the COV-HIE:

1. The COV-HIE Governance Body will be responsible for accountability and transparency to all stakeholders for COV-HIE activities to both public and private interests and make available performance metrics.
2. The COV-HIE Governance Body will be an ongoing body that has clearly defined rules for representation and order of succession for representation.
3. The COV-HIE Governance Body will have a process for addressing new state and national legislation and guidance and will manage communication with state legislators and other stakeholders.
4. The COV-HIE should NOT be fully publicly funded and will include both public and private sector participation.
5. The COV-HIE will leverage existing HIE activities within the Commonwealth and provide a certified HIE for areas not currently served.
6. Participation in the COV-HIE will be voluntary, not mandatory.
7. The COV-HIE Governance Body will coordinate interstate HIE activities and adjudicate issue resolution with other COV- HIE governance bodies.

The approach taken by the Commonwealth to set up the Governance Body for the COV-HIE is primarily meant to establish a governance structure as quickly as possible while still supporting the principles of governance described above. To ensure that the Commonwealth is presented with the full array of potential governance options, the plan calls for moving ahead this fall with an RFP process to be managed by the Office of Health IT within VDH, with input from the HITAC.

The Virginia Department of Health will contract with the successful respondent (once final approval of the Commonwealth's HIE strategic and operational plan is received) to serve as the COV-HIE Governance Body. The contracted Governance Body must have the ability to meet the vision, mission and requirements of the COV-HIE as laid out in the strategic and operational plans.

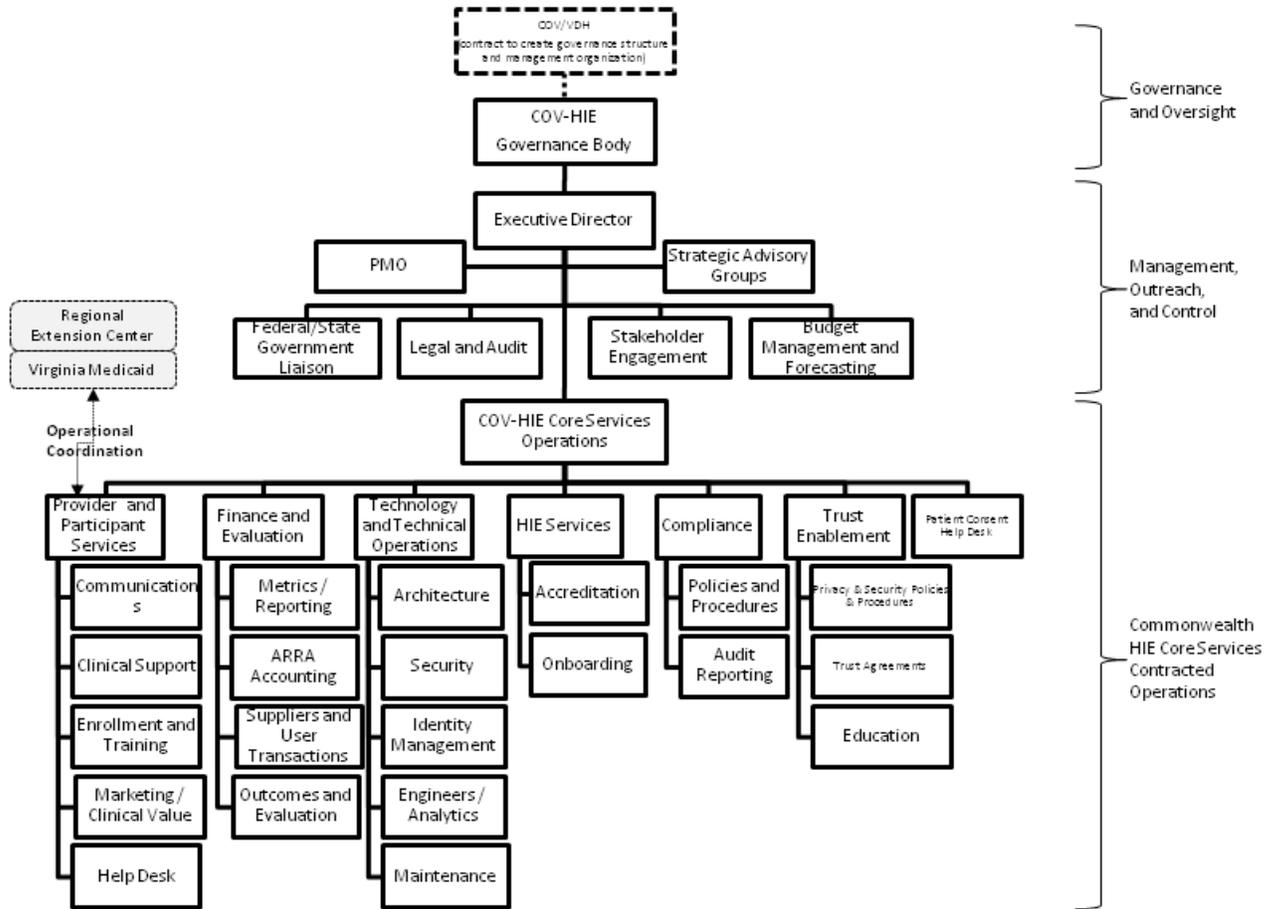
Virginia State Medicaid Health Information Technology Plan

The contract between VDH and the COV-HIE Governance Body will specify that the Governance Body will perform the following functions for the COV-HIE:

1. Develop and enforce Commonwealth standards (aligned with national standards), policies and agreements for HIEs that apply both to public and private sector entities;
2. Develop, administer and maintain a certification process for HIE program and service providers to ensure compliance with Commonwealth of Virginia HIE standards, policies and agreements;
3. Authorize HIE program and service providers after the certification process is complete to connect to the COV-HIE network;
4. Coordinate integration and use of the COV-HIE amongst other public and private sector health IT related projects within the Commonwealth (i.e. Virginia HIT Regional Extension Center, VHEN, etc);
5. Recommend policy changes as necessary to Commonwealth executive, legislative and judicial branches;
6. Determine acceptable uses for the COV-HIE such as consumer care and public health reporting;
7. Work with national and regional interstate governance bodies yet to be constituted to represent the Commonwealth and resolve issues of standards harmonization, interstate/national policy, technical interoperability, and applicable current and future federal and state regulations;
8. Institute mechanisms for key stakeholder groups (consumers & healthcare consumers, healthcare providers, healthcare purchasers, healthcare policymakers, etc.) to provide feedback on COV-HIE policies, procedures, and operations;
9. Maintain and publicly disclose appropriate metrics at regularly determined open public meetings;
10. Contract with other vendors to provide necessary additional services to build, maintain and operate the COV-HIE as laid out in the COV-HIE strategic and operational plans;
11. Enforce accountability with vendors contracted to the COV-HIE for meeting designated service metrics and impose penalties as contractually appropriate;
12. Determine how the COV-HIE will be represented in dispute resolution;
13. Manage and maintain financial sustainability for the COV-HIE by determining and pursuing appropriate funding sources and ensuring continuation of the COV-HIE past the end of ARRA funding; and
14. Maintain financial and operational accountability to VDH for the duration of the contract period.

All Commonwealth state agencies that interact with health data will be required to participate in the COV-HIE. The method of enforcing this participation from state agencies will need to be determined by the Commonwealth and is not in the jurisdiction of the COV-HIE Governance Body. The State HIT Coordinator, Commissioner of Health and other designated entities to be determined by the Commonwealth will be members of the COV-HIE Governance Body representing state interests in the COV-HIE. The State HIT Coordinator also acts as the contracting officer for the COV-HIE Governance Body for their activities under contract.

Figure C Virginia HIE Organizational Chart



5. Provider Adoption Encouragement

In the next 12 months DMAS and other stakeholders are planning a coordinated provider outreach and education program through the COV-HIE, VHIT REC, and Medicaid. Virginia's adoption strategy will be to partner with the VHIT REC for provider outreach, education, and technical support. The VHIT REC will be the direct line to providers. DMAS is also planning a sunset date for accepting paper claims; this will include a comprehensive communication plan to ensure that providers have ample time to prepare for this conversion to electronic-only claims. This conversion will be communicated to providers through Medicaid Memos, the Internet, and various other resources.

6. FQHCs with HRSA HIT/EHR Funding

As previously described the CCNV is one of the oldest operating and "mature" health center controlled networks in the country, which has had the advantage of HRSA funding for EMR adoption and implementation since 1999. As of June 2010, of the 25 FQHCs operating in the Commonwealth, all but 2 FQHCs have adopted and implemented EHR with funding support from HRSA, which equates to approximately a 92 percent adoption rate among the nearly 350 providers delivering care in an FQHC site in the Commonwealth. It is anticipated that those FQHCs (n=2) that have not adopted EHR will work with the VHIT REC in the selection and adoption of an EHR.

7. Technical Assistance for Medicaid Providers

DMAS will expand the scope of VHIT REC to extend its services to all potentially Eligible professional types and hospitals (EP & EH) not already served by VHIT REC. After contract execution, a provider outreach plan will be produced by VHIT REC and approved by DMAS.

8. Unique Needs Population

Virginia's plan for addressing the needs of underserved and vulnerable populations in the state is described below:

Person Centered Goals and Objectives and Shared Decision-Making:

The Commonwealth has made a strong commitment to making its publicly funded long-term care (LTC) programs more person-centered by increasing participants' choice and control over their services and providing more global assurance that person-centered practices infuse the system. Virginia has included self direction in its home and community-based services (HCBS) waiver program since 1997, preceded by the Department of Rehabilitative Services (DRS) personal assistance program. Currently, Virginia offers self-directed personal care and other services in the following HCBS waivers: Elderly and Disabled with Consumer Direction (EDCD), Individual and Family Developmental Disabilities Support (DD), Mental Retardation (MR/ID), and HIV/AIDS. In Virginia's self-directed program, participants employ and schedule their own attendants and develop their care plans with the assistance of a service facilitator. Participants use a fiscal agent contracted with DMAS to handle administrative processes related to employment and payment of attendants. DMAS' program gives participants the option of using a combination of agency-directed and consumer-directed services. As of March 2009, 5,183 individuals were using consumer-directed services, the majority of whom were in the EDCD waiver.

Coordination of Care Across Multiple Service Providers, Funding Sources, Settings, and Patient Conditions:

Virginia's Medicaid program is making efforts to expand the use of integrated acute and LTC in the Commonwealth. Virginia has six programs based on the Program of All-Inclusive Care for the Elderly (PACE) model, one of which is among the first rural PACE sites in the U.S. (operated by Mountain Empire Older Citizens in Big Stone Gap, Virginia). There are nearly 300 people participating in Virginia's PACE programs. DMAS also obtained waiver approval from CMS to operate the Virginia Acute and Long-Term Care Integration program. This program would manage acute and LTC services for dual-eligibles and participants in Virginia's EDCD waiver and was to be piloted July 2009 in the Tidewater area; however, the project is on hold due to funding constraints.

Universal Design to Ensure Access by People with Disabilities and Older Americans:

DMAS does not have a specific universal design program; however, DMAS covers necessary environmental modifications for individuals who participate in home and community-based waiver programs.

Institutional Discharge Planning and Diversion Activities that are Tied to Community Based Service Availability:

Virginia's Money Follows the Person (MFP) Demonstration is designed to enhance and strengthen Virginia's system of long-term services and supports to provide individuals the opportunity to transition from long-term care institutions into the community. Virginia's MFP Demonstration also supports the implementation of the Olmstead decision and complements the efforts of the recently awarded Systems Transformation Grant that aims to improve the infrastructure for community-based long-term support services. On May 14, 2007, Virginia received notice of an award.

Virginia's MFP Demonstration goals include:

Goal 1 Rebalancing Virginia's long-term support system, giving individuals more informed choices and options about where they live and receive services;

Goal 2 Transitioning individuals from institutions (Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), nursing facilities (NF), and long stay hospitals (LSH)) who want to live in the community; and

Goal 3 Promoting quality care through long-term support services that are person-centered, appropriate, and needs-based, and by ensuring continual improvement is made through a quality management strategy for HCBS settings and institutions.

To date, Virginia's MFP Demonstration has accomplished the following:

- ... Included transition funding (lifetime \$5,000 limit) within five HCBS waivers;
- ... Incorporated additional services including assistive technology, environmental modifications, and transition services into existing HCBS waivers;
- ... Created a new provider class, Transition Coordinator Agencies, for the Elderly and Disabled with Consumer Direction Waiver to assist in moving individuals out of institutions;

- ... Developed a community living supplement and supplemental home modification assistance (including payment of rent during the home modification period) through a partnership with the Virginia Department of Housing and Community Development; and
- ... Established a cadre of stakeholders that will sustain the efforts of the demonstration beyond the life of the demonstration.

Virginia will build on its success in multi-level reform, stakeholder commitment, legislative and executive support, and statewide system transformation planning efforts to ensure the success of the Demonstration. The prior accomplishments of current Real Choice Systems Change and Virginia Board for People with Disabilities grants' activities have been integrated into the MFP Demonstration to create a solid framework to maximize outcomes. The MFP Demonstration will move Virginia closer to a rebalanced long-term support system that promotes choice, quality, and flexibility.

Using the MITA architecture, EHRs will be able to interoperate with Virginia Department of Health and the Virginia Department of Consolidated Laboratories via the COV-HIE to achieve meaningful use. This will allow clinicians via their certified EHRs to access both patient records, state health information, and Virginia's Master Data Management (person and vendor information). In addition, the automation of the MITA Member Management business area processes (determine member eligibility, enroll member, and disenroll member) allows those services to be accessed from the citizen/client centric portal now under development as well as the health benefit exchange, now in its planning phase. This will allow Virginians to be able to access services in many cases without the need for manual intervention by State staff. In effect, this can turn any provider's office with internet connectivity into an extension of a state enrollment office to enroll a patient into a medical insurance plan (commercial, Medicaid, SCHIP) via the Health Benefits Exchange or via the citizen-centric portal. Further, the planned connection of vital statistics registry (birth and death) to the SOA technical infrastructure allows for birth and death events to be sent to subscribers for real-time notification. In the case of a birth, it could trigger an automated enrollment of the child under the parent's health plan. In the case of a death, it could trigger the disenrollment process.

9. HIT Grant Leveraging for EHR Incentive Program

Coordinated planning for Medicaid (SMHP), Virginia COV-HIE (HIE Cooperative Agreement), VHIT REC, and broadband will help leverage efforts. In addition, DMAS will contract with VHIT REC to extend its services to all types of Eligible Professions and Hospitals not already served under the ONC REC cooperative agreement. VHIT REC services are planned to be offered to all Medicaid eligible hospitals should they require VHIT REC services.

DMAS will pay a subscription fee to the COV-HIE to help sustain operations and allow reporting back to DMAS on utilization statistics for Medicaid providers. The EHR vendors can choose to become certified COV-HIE or partner with an organization that is a certified COV-HIE. These EHR vendors will fund the COV-HIE subscription fee either directly as a certified COV-HIE or indirectly as a customer of a certified COV-HIE.

10. State Legislation Outlook Relative to EHR Incentive Program

Virginia COV-HIE will use an opt-in model without restrictions. This method is in compliance with Federal and Virginia law as advised by the HITAC Legal and Policy committee. At this time, no changes to State law are anticipated; however, information exchange with other states that may use a different model may be problematic. Virginia legislative representation on the COV-HIE governing board is planned.

This model assumes that no patient data is automatically available for electronic exchange through the HIE without active patient expression of desire to participate. Patient information is either all in or all out.

Advantages for providers:

- ... Lowest liability associated with data disclosure to or through the HIE;
- ... Complete data received through the HIE, including special categories of data (substance abuse, HIV, mental health) which cannot be exchanged through a notice model or an opt-out model without additional consents and authorizations;
- ... Same level of patient education required for opt-in and opt-out;
- ... Based on research about existing HIEs, opt-in participation rates can be very high;
- ... Increased trust in the relationship with patients; and
- ... There may be technical mechanisms to permit “break-the-glass” access to data to enable emergency data access for patients who do not opt in.

Advantages for patients:

- ... Increased trust in the healthcare system and their providers;
- ... Ability to authorize exchange of all their data at the same time; and
- ... There may be technical mechanisms to permit “break-the-glass” access to data for those who do not opt in.

Advantages for the HIE:

- ... Reduced complexity and cost if HIE later decides to change participation model (switching from opt-in to opt-out requires no work; switching from opt-out to opt-in requires obtaining agreement from every person whose data is in the exchange);
- ... Compliance with current Virginia and Federal laws regarding disclosure of special categories of data (substance abuse, HIV, mental health); and
- ... Based on research about existing HIEs, opt-in participation rates can be very high.

11. Other Issues

The unrestricted Opt-in Patient Participation model could cause problems when sharing data across multi-state borders where a different patient participation model is used. It is hoped that the barriers between opt-in/out models can be overcome by the NHIN DURSA. DMAS would recommend that the Federal government support an interoperability arrangement that would address this potential issue.

C. Virginia’s Administration & Oversight of the EHR Incentive Payment Program

Overview

Virginia will contract a multi-state provider incentive program solution (refer to Figure B). The Contractor will provide incentive program administrative services, as well as the necessary web tools for supporting the program. Specific process details will depend on the workflow the Contractor is using and what data is needed from DMAS to support the workflow. Adequate oversight of the program will be conducted by the DMAS Contract Monitor. DMAS expects that the procured solution will meet the requirements outlined in Table 8.

Table 8 Requirements for the Medicaid EHR Incentive Payment Program Procurement

GENERAL REQUIREMENT	
Procure a business service that provides a multi-state solution for the Medicaid EHR Incentive Payment Program under CMS Final Rule for Meaningful Use of EHR 42 CFR Part 495, Subpart D (the Act). This solution will include infrastructure management, a provider portal, and interfaces to the MMIS and the CMS National Level Repository (NLR). This solution must be capable of the following technical and business functions:	
TECHNICAL REQUIREMENTS	
Eligibility	
1	Interface with the NLR to receive enrollment data and to communicate eligibility determinations back to the NLR.
2	Check that EPs are properly licensed, non-sanctioned, and non-hospital based in accordance with the Act.
3	Capture and maintain attestations for patient volume thresholds; adopt, implement, or upgrade; and Meaningful Use in accordance with the Act.
4	Verify that an eligible hospital’s CCN and verify it is in the allowable range in accordance with the Act.
5	Capture and maintain attestations that hospitals have an average length of stay of 25 days or less.
6	Capture state-requested supporting information from the provider (optional document attachments)
Monitoring and Validation	
7	Require and capture each applying provider’s NPI.
8	Require and capture each applying provider’s TIN.
9	Import claims from the MMIS.
10	Provide service level agreement monitoring and reporting.
11	Track incentive payments.
Payments	
12	Provide payment calculation as defined in the Act for EPs and eligible hospitals.
13	Calculate payments that are not paid at amounts higher than 85 percent of the net average allowable cost of certified EHR technology and the yearly maximum allowable payment thresholds.
14	Interface with the NLR in accordance with the Act to ensure that an EP or eligible hospital that collects an EHR payment incentive has collected an incentive payment from only one state even if the provider is licensed to practice in multiple

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	States.
15	Interface with the NLR in accordance with the Act to ensure there is no duplication of Medicare and Medicaid incentive payments to EPs.
16	Calculate yearly payments according to provider participation year.
17	Ensure payments are made for no more than a total of 6 years; that no EP or eligible hospital begins receiving payments after 2016; that incentive payments cease after 2021; that an eligible hospital does not receive incentive payments after FY2016 unless the hospital received an incentive payment in the prior fiscal year; and that incentive payments for hospitals are disbursed over three-year period.
18	Capture and maintain payment information, including designated assignees as allowable under the Act.
19	Utilize national data standards for health data exchange and open standards for technical solutions as they become available.
20	Ensure secure data exchange using SSL in compliance with HIPAA and other requirements included in ARRA.
21	Track and process incentive payments to providers in a timely and predictable manner. The vendor will be given appropriate level of secure access to the MMIS through the Medicaid portal that is accessible from the Internet as well as access to all the required State systems necessary to perform the services.
Fraud/Abuse and Appeals	
22	Provide on-demand data to support fraud or abuse investigations.
23	Provide on-demand data to support audit requests.
24	Provide on-demand data to support reconsideration or appeal requests.
BUSINESS REQUIREMENTS	
Eligibility	
1	Ensure that each EP and eligible hospital meets all provider enrollment eligibility criteria upon enrollment and re-enrollment to the Medicaid EHR payment incentive program. This will be accomplished using a combination of the following: (1) model after Medicare, as applicable; (2) leverage the contracted business solution; and (3) utilize available claims and/or encounters and other information such as hospital cost reports.
2	Ensure patient volume is consistent with the criteria in §495.304 and §495.306 for each EP who practices in a FQHC or Rural Health Clinic (RHC) and for each Medicaid EP who is a physician, pediatrician, nurse practitioner, certified nurse midwife, dentist or optometrist. This will be accomplished using a combination of the following: (1) model after Medicare, as applicable; (2) leverage the contracted business solution; and (3) utilize available claims and/or encounters and other information such as hospital cost reports.
3	Ensure that the EP or eligible hospital is a provider who meets patient volume consistent with the criteria in §495.304 and §495.306. This will be accomplished using a combination of the following: (1) model after Medicare, as applicable; (2) leverage the contracted business solution; and (3) utilize available claims and/or encounters and other information such as hospital cost reports.
4	Ensure that each EP is not hospital based in accordance with the Act. This will be accomplished using a combination of the following: (1) model after Medicare, as applicable; (2) leverage the contracted business solution; and (3) utilize available claims and/or encounters and other information such as hospital cost reports.

5	Ensure that a hospital eligible for incentive payments has demonstrated an average length of stay of 25 days or less. This will be accomplished using a combination of the following: (1) model after Medicare, as applicable; (2) leverage the contracted business solution; and (3) utilize available claims and/or encounters and other information such as hospital cost reports.
Monitoring and Validation	
6	Review claims extracts and other available data to verify attestations, such as information from VHIT REC.
7	Monitor the compliance of providers coming into the program with different requirements depending upon their participation year.
8	Provide operational procedures for all contracted areas.
Payments	
9	Monitor that incentives are paid, without deduction or rebate, directly to an EP or eligible hospital or to an employee or facility to which such provider has assigned payments. Investigate whether a relationship between an EP and its designated payee is valid.
10	Through interaction with the NLR, monitor that no duplicate payments are made.
11	Monitor that payment calculations are accurate.
12	Monitor that entities promoting the adoption of certified EHR technology do not retain more than 5% of such payments for costs not related to EHR technology.
Fraud/Abuse and Appeals	
13	Monitor fraud and abuse through interaction with the NLR.
Communication and Outreach	
14	Provide a call center for enrollment, validation, and incentive questions.

1. Verification of Non-Sanctioned, Properly Licensed/Qualified Providers

DMAS currently captures ownership information for all providers on the disclosure form that is included in all of the provider enrollment applications. This information is reviewed against the HHS-OIG List of Excluded Individuals/Entities (LEIE) website before enrollment.

Ownership information is not currently captured in the MMIS, but a monthly LEIE report is in production, and is reviewed against our active provider database to check for active enrollment of any excluded providers.

The Contractor will verify that providers are not sanctioned and are properly licensed/qualified providers in Virginia. Details of how DMAS will implement this requirement for the EHR incentive program will not be known precisely until a contractor is selected.

2. Verification of Hospital-Based EPs

Verification that EPs are not hospital-based will mainly be accomplished through attestation. If EPs are already a Medicaid provider, Virginia can verify business relationships via the NPI in the MMIS. Once a contract is signed, implementation details will be available.

3. Verification of Attestations

To verify the overall content of provider attestation, the contractor will check to ensure attestations are properly completed. Improperly completed attestations, will be communicated back to the submitter via phone, mail, or email. Verification of the validity and accuracy of attestations will be done in part through claims review from the MMIS as well as other provider record review. Further, Virginia will hope to model its verification efforts after the Medicare model once details are released to the states. Once a contract is signed, implementation details will be available.

4. Communication to Providers Regarding Eligibility and Payments, etc.

A variety of methods will be used for the initial outreach: DMAS, REC, and industry associations will work to explain the SMHP for Virginia. The incentive program web page is another outreach vehicle. The VHIT REC will handle the bulk of the outreach and education efforts. The Contractor will communicate with the providers (phone, email, mail and/or attendance at industry/provider events) regarding eligibility and payments.

5. Patient Volume Calculation Method

The providers may choose either patient volume formulas in the final rule. For Virginia providers that see both Fee-for-Service (FFS) and Managed Care patients, the FFS visits should be considered as encounters and included in the MCO patient population.

When calculating patient volume for verification needs, the Contractor will rely partially on attestations (and their optional supporting documentation) but may also attempt to ensure the attestation is reasonable by Virginia Medicaid and CHIP claims verification, using industry metrics for the denominator; as well as verification of volume against provider peers. Once a contract is signed, implementation details will be available.

6a. Data Sources for Patient Volume Verification

The Contractor will use a number of sources to verify patient volume for EPs and acute care hospitals. These sources may include the following:

- ... For EPs, the Contractor can use SAS MMIS data to determine the estimated percentage of Medicaid visits a provider sees in a year. Use of the Mountain States Group estimate of 4800 visits to a physician (family physician) in a year could be used as a denominator. The estimate is based on American Medical Association and Department of Health and Human Services data.
- ... For acute care hospitals, the contractor may calculate volume based on data from Virginia Health Information.
- ... Virginia dentist and community health center provider data can be used for dentists and community health centers. Also Community Care Network of Virginia, a statewide primary care provider network and health care management company, can be used as a resource.

7a. Verification that EPs at FQHC/RHCs Meet Requirements

The Contractor can use the CCNV to determine the EPs that practice predominately in FQHC/RHCs. CCNV is a state-wide primary care provider network and health care management company. It has 358 health care professionals that provide primary care access to medically

underserved, uninsured, and insured populations at 90 delivery sites within Virginia's rural and urban communities. Once a contract is signed, implementation details will be available.

6b. Verification of Adopt, Implement, and Upgrade of EHR Technology

Virginia will rely on attestation to verify that providers have met the requirements for adopt, implement, upgrade. Virginia may also request submittal of a contract/agreement as applicable with the attestation; we will verify that what has been contracted for is a certified EHR as defined on the ONC CHPL website and is integrated with a Virginia COV-HIE certified HIE. VHIT REC can also be of great assistance to providers in this process.

7b. Verification of Meaningful Use in Second Participation Year

Verification of Meaningful Use for a provider's second year will depend somewhat on when they started the process. Meaningful use can be verified in a variety of ways:

- ... Studying MMIS data;
- ... Verifying a shift from paper claims to electronic claims;
- ... Verifying required Quality of Care (QoC) reporting;
- ... Reviewing outside sources including utilization metrics from Virginia COV-HIE and other data from Virginia COV-HIE (provider registry) showing which certified HIE a provider uses; and
- ... Reporting made to the Virginia Department of Health.

8. Proposed Changes to Meaningful Use Definition

Virginia will propose no changes to the Meaningful Use definition.

9. Verification of Use of Certified EHR Technology

Virginia will verify providers' use of certified EHRs in the following way: (1) VHIT REC reporting on Medicaid providers using certified EHR technology; (2) As part of the HIE accreditation process, Virginia COV-HIE will require the use of COTS products that meet ONC certification requirements. Virginia will check the CMS EHR certification number at the ONC Certified HIT Product List (CHPL) to verify that providers are using an EHR that has been tested and certified under the Temporary Certification Program maintained by the ONC. A list of these products as well as providers by certified HIE will be available from Virginia COV-HIE.

10. Collection of Meaningful Use Data, Including Clinical Quality Measures

Data will be collected from various sources (see 7b above).

11. Alignment of Data Collection and Analysis with Clinical Quality Measures Data

Virginia will collect Meaningful Use data, including, but not limited to, reporting of clinical quality measures, required by the Final Rule. DMAS will not require any additional reporting, for instance for CHIPRA; However, providers will still be required to respond to requests from DMAS and its contractors, such as the external quality review organization and managed care organizations for medical records, regardless of the format (paper or electronic).

12. IT, Fiscal, and Communication Systems Used to Implement the EHR Incentive Program

To implement the EHR incentive program, Virginia will contract with a vendor offering a multi-state solution for provider incentive program administration. The financial payments and reporting will be handled through existing MMIS capabilities (add pay function). Refer to Figure B.

13. Necessary IT Changes for EHR Incentive Program

Virginia will work with the successful bidder to provide a multi-state provider administration solution adapted for Virginia. The multi-state solution is viewed as a Commercial Off-the-Shelf (COTS) packaged solution so there will not be significant customizations required.

14. IT Timeframe for Systems Modifications

Figure D depicts the Virginia HIT Roadmap timeline; it anticipates provider eligibility operations commencing in September 2011 and incentive payments beginning in October 2011.

15. Timeframe for Test Readiness with the NLR

Virginia will be obtaining a Multi-state solution that should have been tested with the NLR for one or more States. If any additional testing is needed for Virginia, it will occur in the Jun-Aug 2011 timeframe. Figure D below depicts the SMHP timeline, including the following key events:

- ... The launch of the Virginia provider incentive program enrollment is targeted for January 2011 after CMS approval of the SMHP, Implementation Advanced Planning Document (I-APD), and procurement documents.
- ... A Medicaid Memo is targeted to be sent to the providers to explain the plan for the incentive program. In addition, Virginia has established a web page where information is posted: http://dmasva.dmas.virginia.gov/Content_pgs/pr-arra.aspx. As indicated on the web page, an email address exists to obtain more information on the incentive program: (ARRA-Medicaid-Incentives@dmas.virginia.gov).
- ... The RFP procurement process will result in a Contractor that provides both the services and a viable technical solution that is used by multiple states for the incentive program. Once this solution is deployed in September 2011, Virginia will have the capability to interface with the NLR, accept attestations, and enroll providers as well as supporting appeals. The capability to make incentive payments is targeted to start October 2011.
 - × Use of a multi-state service and technical solution will help to ensure the controls are in place to determine the right incentive payment amount. The Contractor's staff will use the existing capabilities in the MMIS to make the correct incentive payments to the correct providers.
 - × The DMAS audit function will ensure the controls are adequate and being applied correctly.
 - × DMAS will provide a brief written update on the launch criteria before incentive payments are issued.

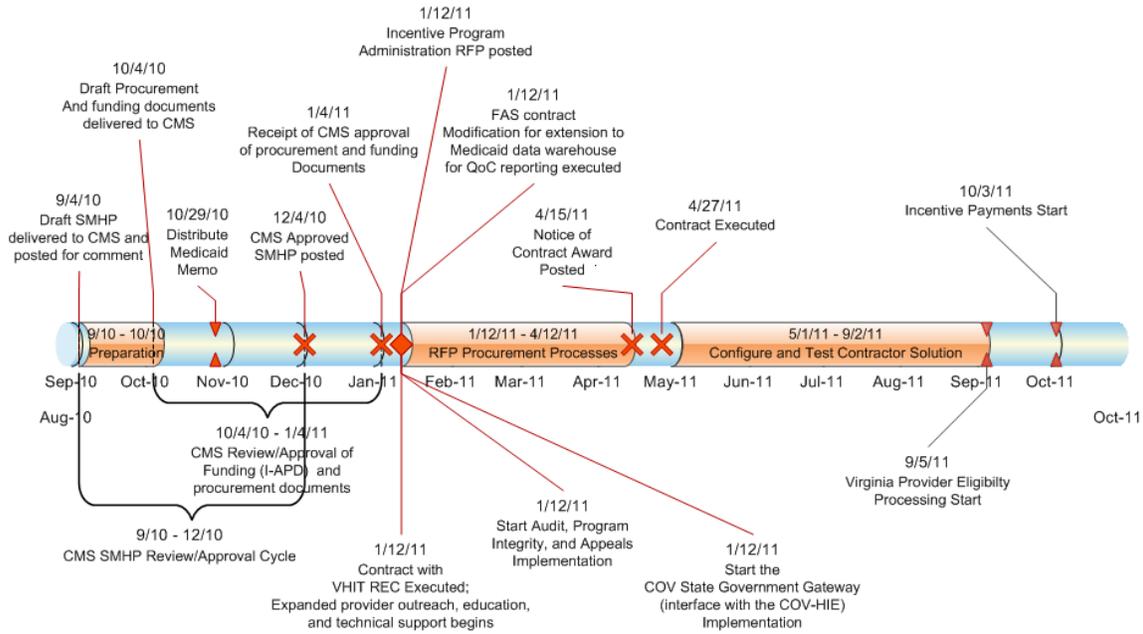
Once a contract is signed, implementation details will be available.

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Figure D Virginia HIT Roadmap Timeline

State Medicaid HIT Plan (SMHP)

Virginia HIT Roadmap Timeline



16. Plan for Accepting Registration Data from NLR

Virginia will be obtaining a Multi-state solution that should have been tested with the NLR for one or more States using file transfer methods acceptable to CMS.

17. Website for Provider Enrollment and Program Information

Virginia has posted a web site with general information. This will be expanded as the incentive program moves forward (http://dmasva.dmas.virginia.gov/Content_pgs/pr-arra.aspx).

18. MMIS Modifications and MMIS I-APD

Few modifications to the MMIS are anticipated. One identified modification is the need for an output file of financial expenditures sent to the incentive program administration contractor. A draft HIT I-APD will be submitted to the CMS Regional Office just after the SMHP.

19. Call Centers/Help Desk Support for Incentive Program Questions

A call center will be provided by the Contractor. The incentive program contractor will provide this service using the same call center used to support their other state client(s). Scripts will be prepared for call center staff on when to connect a provider to the VHIT REC call center once the contracts are executed.

It should be noted that the VHIT REC is a strategic partner, and they will have message centers to answer technical as well as incentive program questions for EPs and EHs. The existing VHIT REC call center will be the primary call center for technical support and assistance for providers with the incentive program. Scripts will be prepared for call center staff on when to connect a provider to the Contractor's call center once the contracts are executed.

20. Provider Appeal Process Relative to the Incentive Program

Virginia's provider appeal process for incentive payments, provider eligibility determinations, and demonstration of efforts to adopt, implement, or upgrade and Meaningful Use is described below:

The following procedures will be available to all non-state operated applicants and participants (referred to herein as "appellant or appellants") when the Agency takes action involving an Agency exercise of discretion.

1. If an Appellant chooses to challenge an Agency action, a request for reconsideration must be submitted. The request for reconsideration and all supporting documentation must be submitted within 30 days of the receipt of the written notification of Agency action that is sought to be challenged and must be delivered to the attention of the appropriate Agency division that took said action at the following address:

Program Operations Division
Department of Medical Assistance Services
600 East Broad Street,
Richmond, Virginia 23219

2. The Program Operations Division will review the documentation submitted and issue a written decision regarding the Appellant's request for reconsideration.
3. If the challenged action is upheld as a result of the reconsideration decision, the Appellant may appeal the reconsideration decision. An appellant may appeal the reconsideration decision by filing a written notice for a first-level appeal with the Virginia Appeals Division within 30 days of the receipt of the adverse decision. The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, 11th Floor
Richmond, VA 23219

The first-level appeal process will proceed in accordance with the Code of Virginia §32.1-325.1, the Virginia Administrative Process Act (APA) Code of Virginia, §2.2-4019, as well as the Virginia Administrative Code 12 VAC 30-20-500 et. seq. A first-level appeal decision shall issue within 180 days of the Agency's receipt of the Appellant's written request for appeal.

4. If the Appellant is dissatisfied with the first-level appeal decision, the Appellant may file a written notice for a second-level appeal, which includes a full administrative evidentiary hearing under the Virginia APA, Code of Virginia, § 2.2-4000 et seq. The notice for a second-level appeal must be filed within 30 days of receipt of the first-level appeal decision. The notice for second-level appeal is considered filed when it is date stamped by the Virginia Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, 11th Floor
Richmond, VA 23219

The normal business hours of Virginia are from 8:00 a.m. through 5:00 p.m. on dates when Virginia is open for business. Documents received after 5:00 p.m. on the deadline date shall be untimely.

All such formal administrative appeals of Agency actions shall be heard in accordance with Virginia APA, Code of Virginia, § 2.2-4000 et seq., the State Plan for Medical Assistance provided in the Code of Virginia § 32.1-325, and the Agency regulations governing the Agency appeal process as set forth in the Virginia Administrative Code at 12 VAC 30-20-500 et. seq.

5. If the Appellant is dissatisfied with the second-level appeal decision, the Appellant may file an appeal with the appropriate county circuit court, in accordance with the Virginia APA, Code of Virginia, §2.2-4000 et. seq. and the Virginia Rules of Court.

6. An appellant may appeal an Agency action when such action involves an act of discretion on the part of the Agency.
7. An appellant may not appeal to the Agency the rules, regulations, criteria or incentive rates established by Federal and/or State law for eligibility or continued participation in the program.

21. *Process for Separate Accounting of HITECH Provisions and MMIS FFP*

To assure that all Federal funding, for both the 100 percent incentive payments, and the 90 percent HIT Administrative match are accounted separately for the Health Information Technology for Economic and Clinical Health Act (HITECH) provisions, a separate account has been established for the ARRA provider incentive program. Separate project codes with this account will be used to keep ARRA project expenses separate (planning, technical, operations, and incentive payments, etc.).

22a. *Anticipated Frequency for EHR Incentive Payments*

The program administrative contractor may have a different frequency; however, Virginia anticipates making EHR incentive payments on a weekly frequency. An aging report will be used by the Contractor to plan/track future payments once the initial payment is made.

22b. *Direct Payments to Provider or Assignee without Deduction or Rebate*

The program administration contractor will have an existing process; however, Virginia anticipates requiring as a term of payment that incentive payments are made directly to the provider (or an employer or facility to which the provider has assigned payments) without any deduction or rebate. The relationship between the EP and designated payee will be investigated to ensure there is a valid relationship. If the provider is a qualified Medicaid provider, the current billing relationship will be known.

23. *Payments to Entity Promoting Adoption of Certified EHR Technology*

The program administration contractor will have an existing process. It is anticipated that the provider will be required to identify which certified EHR products are selected and which Virginia certified HIE is being used. In addition to checking the ONC CHPL, the Contractor will check the Virginia certified HIE to ensure HIE supports the designated EHR products. In the case of the VHIT REC, it will be offering software as a service (reseller) and as the state designated entity (SDE) promoting the adoption of certified EHRs, it is an eligible assignee of incentive payments. VHIT REC will use any assigned provider incentives to pay the seat licensing fees to the EHR vendor on behalf of the EP. The VHIT REC technical support payments are distinctly different from the EHR licensing fees and are made based on two milestones: Completion of Adopt, Implement, and Upgrade (AIU) which is 75 percent of the fixed technical support payment per EP and 25 percent for the subsequent demonstration of meaningful use. Use of any assigned incentive payments to VHIT REC will be accounted for separately by VHIT REC and subject to DMAS and CMS audit. The Virginia provider will need to select a certified EHR vendor(s) that can integrate (interface) with a Virginia certified HIE to connect to the Virginia COV-HIE core services gateway. Additional information may be

required from the organization receiving the payment to show the breakdown of costs for the individual provider to ensure 95 percent is going for valid EHR/HIT expenses.

24. *Incentive Payments Disbursed Through Medicaid Managed Care Plans at Allowable Capitation Rate per CFR Part 438.6*

No incentive funds will be disbursed through MCOs in Virginia. Incentive payments to EPs and EHs under contract with MCOs will be disbursed in the same way as payments for Fee-for-Service EPs and EHs.

25. *Hospital Calculations and EP Incentive Payments Made Consistent with Statute and Regulation*

The program administration contractor will have an existing process; however, it is anticipated that the formula required by Final Rule will be automated. A user will enter the variables and the formula will calculate the amount. An output report will show the breakdown of the payment. Once a contract is signed, calculation details will be available.

26. *Existing Virginia Partners' Role in EHR Incentive Payment Implementation*

Virginia plans to procure the use of a multi-state tool for program administration services. We assume the required calculations and support would be integrated into this tool as well as the interfaces with the NLR. The fiscal agent will support interfaces between the MMIS and that tool. The MMIS will be used "as is" to handle the financial payment, tracking, and reporting. Virginia will also contract with VHIT REC to extend their services to the other types of EPs and EHs that are not targeted under the ONC REC cooperative agreement.

27. *Virginia Assumptions*

The timeline is depicted in Figure D.

Virginia is making the following assumptions:

1. ONC strategic and operational plans are approved without major change.
2. One or more multi-state vendors bid for Virginia in early January 2011.
3. NLR testing will have been completed by the multi-state vendor.
4. The multi-state solution can be used by Virginia without significant change.
5. SMHP and I-APDs are approved in a timely manner (within 60 calendar days).
6. Federal sources will provide communication materials/fact sheets for the state to use for outreach.
7. An ONC certification process has been defined and EHR vendors become certified.
8. Virginia COV-HIE core services gateway is established and one or more Certified HIEs are in operation.
9. Broadband is available in most areas in Virginia in the near future.
10. Providers will see value in using EHR and COV-HIE Certified EMR.
11. Costs will not be prohibitive for providers. DMAS is trying to minimize collective costs with the COV-HIE and through the VHIT REC negotiated discounts with EHR vendors. Virginia has been working on broadband initiatives for some time but there is still considerable "white-space" throughout rural counties in Virginia. DMAS will get a better idea of the scope of broadband availability once the REC pursues outreach and education to the providers after the contract is executed.

D. Virginia's Audit Strategy

Overview

The following outlines Virginia's HIT audit strategy, objective, and related procedures for the Provider Incentive Program. The primary audit objective is to ensure that State and Federal funds expended in association with the Provider Incentive Program business process are spent appropriately and accounted for in a transparent manner. Virginia has assessed the level of risk for this business process as moderate (over 200 points but not exceeding 275).

The Virginia Internal Audit (IA) and the Virginia Program Integrity Division will utilize the following tools and data sources to concurrently assess the validity of the incentive payments:

- ... The MMIS;
- ... Listings of presently certified, commercially available HIT systems and their websites;
- ... Data gathered from the Virginia E-Scan process;
- ... SAS;
- ... Audit Control Language;
- ... Excel;
- ... EP and hospital enrollment data from the NLR;
- ... EP and hospital attestations regarding demonstration of adoption, implementation or upgrade of HIT capability;
- ... Data from the administrative and audit modules of EP and hospital-operated certified, commercial HIT systems. Review of this reporting will assist in the verification of Meaningful Use as well as provide evidence that the EP or hospital has implemented (adopted or upgraded) a specific system, justifying payment;
- ... On-site EP and hospital visits directed to verification of Provider Incentive Payment provider attestations;
- ... Hospital and HMO lists of associated providers;
- ... Attestations and other data regarding providers originating from the VHIT REC;
- ... All the Medicaid claims for the past year of each EP and hospitals requesting an incentive payment will be assembled into a data base, available for analysis;
- ... As much review of the process as possible will be conducted on an automated basis through the analysis of existing, currently available or pre-requested data series. We will try to minimize the impact of our review on all auditees;
- ... Recipient EP and hospital documentation evidencing allowable expenditures on adopt, implement and upgrade of 85% of the incentive payment, prior to any payment by the State Medicaid Agency; and
- ... Virginia Internal Audit (IA) will assemble the following concurrent tests of the payments associated with the Provider Incentive business process. The tests will utilize data from the sources enumerated above and will be performed during every year of operation of the incentive program. Some tests can be simultaneously performed on the same provider since they will entail only the machine analysis of data.

- **Test 1 - Verification of Eligibility**

- Review of data from NLR, query of MMIS, and review of provider attestation from the applications, including the following:

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- × Verification of licensure, non-sanctioned status: performed for each applicant provider, query of Virginia Health Professions for EP's who are not Medicaid providers but who are practicing in Virginia;
 - × Verification of non-hospital based status through EP attestation. A sample of EP applicants will be drawn for verification of affiliation by Program Integrity; and
 - × A sample of EP and hospital attestations will be drawn for detailed verification by Program Integrity and by Internal Audit.
- **Test 2 - Verification of Volume Percentage Requirement**
- × Review of provider attestations as to required volume of Medicaid recipients or service to medically needy then, including either/or:
 - a) Confirmation of volume from employing entity (if in group practice) - sample basis; or
 - b) Verification of volume by Program Integrity (or contractor) during on-site visit - sample basis.
- Once a contract is signed, implementation details will be available.
- **Test 3 - Verification of Meaningful Use & Expenditure Percentage Cost Reporting - Payment Justification**
- × For each progressive level of Meaningful Use, IA will take a sample of applicant providers who have received during the calendar quarter any payment. This sample will be used for the following purposes:
 - 1) Determine which certified HIT vendor system the applicant is using;
 - 2) Request of the applicant system administrative and control reports demonstrating the level of use specified in the Federal standard;
 - 3) Review the reports; and
 - 4) Determine compliance or non-compliance with the level of required Meaningful Use for the payment year.

Each Recipient EP and hospital applying for incentive payment will be required to furnish Virginia IA documentation evidencing allowable expenditures on adopt, implement and upgrade of 85 percent of all incentive payments, prior to each annual payment by Virginia.

In performing this testing, Virginia IA will use whatever additional data sources are available to it as data series against which to compare and extend data reported in the recipient applicant's audit and control reports. These sources include Virginia MMIS claims data, vendor descriptions of the capabilities of their marketed systems, data from HIEs, pharmacy hubs, immunization registries, public health surveillance databases, VHIT REC and any other relevant information available to us.

1. *Virginia Methods to Identify Suspected Fraud and Abuse*

Suspected fraud or abuse may be detected at any point in an audit or review process. Every fraud is an irregularity but every irregularity is not a fraud. Virginia's system of concurrent testing is designed to detect irregularities along the entire continuum of abuse as close to their original point of incidence as possible, thereby minimizing their financial impact.

Tests 1-3 will be repeated with fresh samples, on a quarterly basis, during the entire life of the incentive project. What this means is that, depending upon the level where the provider is in the incentive program, s/he will be subject to all the test(s) appropriate for that level. For example, a provider may be tested on the level of Meaningful Use at several points in the process and then finally reviewed prior to receipt of the last payment. Any irregularities identified during the testing process, which cannot be satisfactorily resolved, will be fully documented and turned over to the Virginia Attorney General for investigation and potential prosecution.

2. *Virginia Tracking of Total Overpayment Dollar Amounts*

All identified overpayments will be scheduled and their status tracked and reported to upper management as outstanding audit findings in the Department's Internal Control Evaluation System (ICE) until final resolution. Once a contract is signed, implementation details will be available.

3. *Virginia Actions When Fraud and Abuse is Detected*

All suspected instances of fraud or abuse detected by either Virginia IA Division or Virginia Program Integrity Division will be fully investigated by Virginia Program Integrity Division. Such reviews usually involve field visits and feature a full integrity review. If, following the review, a finding of probable fraud is documented, the results of the review are forwarded to the Medicaid Fraud Unit of the Office of Virginia's Attorney General for further investigation and possible prosecution. In some cases, depending on the magnitude of the suspected abuse or the character of the suspected offense, Virginia notifies the Virginia Auditor of Public Accounts and the State Police.

4. *Leverage of Existing Data Sources to Verify Meaningful Use*

Virginia will require recipient applicants to provide it with audit and control reports demonstrating Meaningful Use from the certified HIT systems they are using. These reports will be reviewed and, using whatever supporting/confirming data available to us, verified to the extent possible. For example, fee for service claims of all types submitted to Virginia for payment can be compared with claims processed by the MMIS.

5. *Sampling in the Audit Strategy*

Virginia will use sampling extensively. Depending upon the size of the recipient universe, Virginia, for some tests, may also use its extensive library of existing concurrent testing routines to look at the entire applicant universe. The samples employed by Virginia to support our concurrent testing are drawn from the component tools bundled with Audit Control Language (ALS) and SAS and will be sufficient to provide 95 percent confidence that the outcome of sample testing is representative of the total population over the total time period tested. Once a contract is signed, implementation details will be available.

6. *Reduction of Provider Burden and Maintenance of Oversight Process*

Our bias is to perform as much of the required integrity work apart from the provider as possible. We will be requesting that the provider furnish us with administrative and control reports from his or her certified HIT system, but apart from that we will be leveraging the MMIS, data from VHIT REC and our existing concurrent testing library to perform the required work. There will be some Program Integrity on-site work but we will try, to the extent possible, to schedule such visits to correspond to routine, regularly scheduled PI reviews.

7. *Virginia Program Integrity Operations*

Virginia maintains both a Division of Internal Audit and a Division of Program Integrity. Both divisions will be involved in reviewing and testing the incentive payment effort as outlined above. Internal Audit will be performing data analysis and conducting concurrent tests. Program Integrity staff will be performing such field work as is required by the tests.

E. Virginia's HIT Roadmap

1. "As-is" Today and Five-Year "To-be"

Figure E As-Is Conceptual Architecture

As-Is Conceptual Architecture

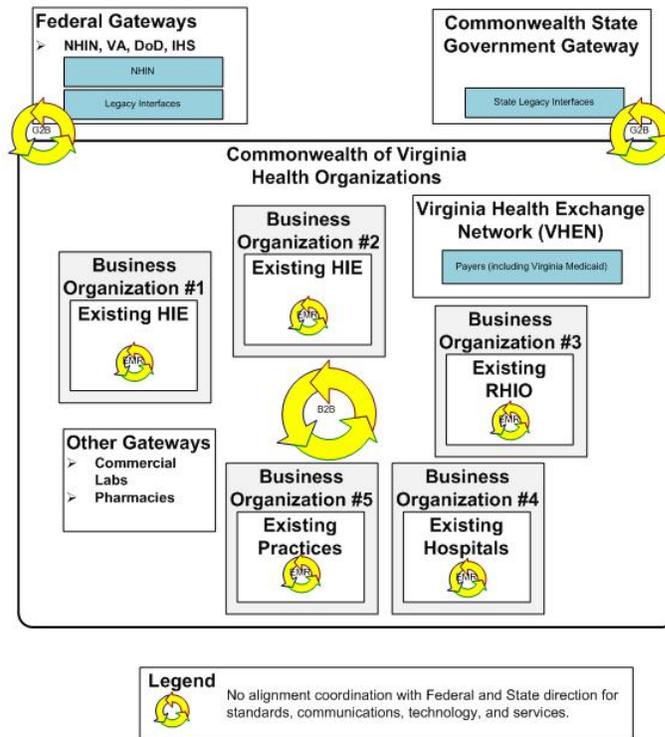


Figure F below depicts the envisioned COV-HIE Conceptual Architecture. The guiding principles for the architecture were:

- ... Do not compete with private sector;
- ... Leverage existing HIT within Virginia; and
- ... Cost efficiency.

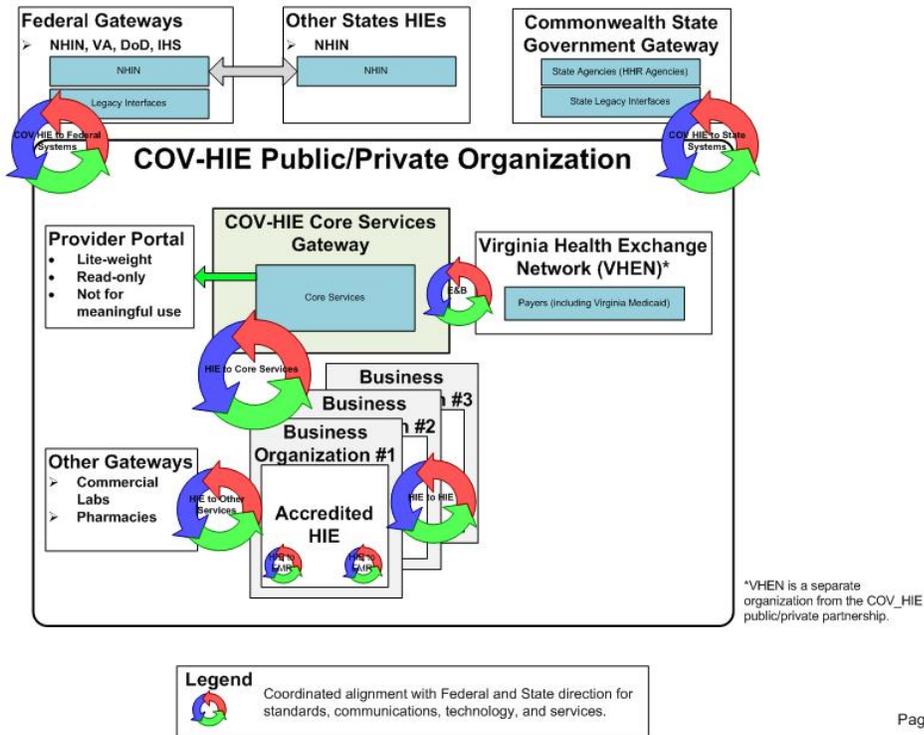
Accordingly, the key features of the selected architecture include:

- ... Establishing COV-HIE as a public/private non-profit organization. COV-HIE will contract for the COV-HIE Core Services Operations;
- ... State-wide alignment with State and Federal direction for standards, communications, technology, and technology services to facility information sharing and semantic interoperability;
- ... Use of a network of networks concept to leverage existing HIT and allow for multiple COV-HIE Certified HIEs;
- ... A COV-HIE Core Services Gateway has been identified that offers core state-wide services exclusively to Certified HIEs. Core state-wide services will not be available directly to providers, patients, or to the public; and

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... Creation of a Certification program for Virginia HIEs that identifies harmonized standards, communications, technology, and technology services for interfacing with COV-HIE Core Services, other Commonwealth certified HIEs, as well as the Commonwealth State Government gateway. Certification, once earned, implies that the organization becomes an accepted trading partner and can interface with other COV-HIE Certified HIEs as well as state and federal government systems and networks in a standard and semantically meaningful way. It also implies the basic service packages made to providers are the same so providers can compare listed prices for HIE basic service packages. COV-HIE and COV-HIE Certified HIEs are also free to offer value-added services and features to their clients and stakeholders beyond the basic required service packages.

Figure F To-Be Conceptual Architecture
To-Be Conceptual Architecture



The COV is planning to leverage MITA as part of a broader effort to reorient essential state services to a citizen-centric paradigm to prepare for the future. The effort will start with a HHR secretariat-wide MITA SS-A to align business strategy and direction. Based on the resulting updates to the MITA Transition plan, additional projects will start to transform targeted MITA business areas toward MITA's concept of operation for citizen-centric services. Other State programs will seek support from their applicable Federal partners to follow the MITA initiatives and begin their own transformation to SOA, standards, and a citizen-centric paradigm.

For Medicaid, these efforts target avoiding cost increases in administrative and operational support that would be necessary for an expansion of Medicaid under the Health Reform Act; However, for the COV-HIE, it will establish broad standards-based capabilities to coordinate and orchestrate future patient services as well as share and exchange health-related information between provider networks and the Commonwealth that is far beyond current capabilities.

The key to the business and technical transformation is standards. The SOA technology components are based on industry standards. Information standards used on the COV SOA are paramount; accordingly, the HITSAC charter will be expanded to harmonize industry standards for the HHR agencies just as it did for the HIE. This harmonization will ensure future capabilities to exchange information between the COV-HIE Federal and State government systems.

2. Virginia's Expectation for EHR Adoption over Time

Table 9 Goals & Objectives: The HIT Road Map

Goal 1: Encourage Medicaid providers to adopt, implement, or upgrade to certified EMR technology			
Objective 1.1: Encourage Medicaid providers to take first step towards adoption by phasing out use of paper-based claims; while this will not lead to Meaningful Use, it will help encourage adoption for Meaningful Use stage 2 as well as provide more timely payments and reduction in administrative expense.			
Strategies	Measures	Target	Baseline
Deploy Medicaid Claims Direct Data Entry (DDE) capability as soon as possible with provider outreach & training.	Medicaid providers can use claims DDE & EFT capabilities.	Capability deployed in CY2010 & training available to providers.	Claims DDE was not deployed with the Medicaid portal in June 2010.
Communicate phase out plan to Medicaid Providers.	Communicate phase-out plan to Medicaid Providers.	Communicate strategy & phase out plan to Medicaid providers in CY2010.	No plan exists in June 2010.
Using an ordered list of paper claim submitters by volume, work with the providers to shift to using claims DDE and Electronic Fund Transfer (EFT) capability.	Reduction in number of providers submitting paper claims.	CY2011: 40% reduction of paper claims. CY2012: 35% reduction of paper claims. CY2013: 25% reduction of paper claims. (This is the last year for paper claims).	CY2010 (end of year) list of paper claims submitters.
Objective 1.2: Encourage Medicaid providers to adopt, implement, or upgrade by leveraging and expanding the current VHIT REC scope of efforts for outreach, education, and technical support in Virginia			
Strategies	Measures	Target	Baseline
Extend outreach and education to all potential Medicaid Providers (EP & EH) that VHIT REC does not already serve under the ONC grant.	Extend outreach and education to all potential Medicaid Providers (EP & EH).	Outreach and education activities for all potential EP & EH Medicaid providers begin CY2011 by VHIT REC.	List of active potential EP & EH Medicaid providers provided by DMAS for CY2010.
Communicate plan to Medicaid Providers.	Communicate plan to Medicaid Providers.	Communicate plan to Medicaid providers in CY2010.	No plan exists in June 2010.
Extend technical support to all potential Medicaid Providers (EP & EH) that VHIT REC does not already serve under the ONC grant.	Extend technical support to all Medicaid Providers (EP & EH).	Technical support activities for all potential EP & EH Medicaid providers begin CY2011 by VHIT REC.	List of active potential EP & EH Medicaid providers provided by DMAS for CY2010.
Extend incentive program education & support to all potential Medicaid Providers (EP & EH).	Extend incentive program education & support to all potential Medicaid Providers (EP & EH).	Provide coordinated incentive program education and outreach activities by CMS, DMAS, & VHIT REC for all potential EP & EH Medicaid providers.	List of active potential EP & EH Medicaid providers provided by DMAS for CY2010.

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Strategies	Measures	Target	Baseline
Establish adopt, implement, & upgrade targets.	Establish adopt, implement, & upgrade targets for potential Medicaid Providers (EP & EH) target population.	For Virginia, there are approximately 10K providers that have the correct type and specialties. Using the same ONC REC goal of 20% adoption, the target has been established as 2,000 Medicaid providers that adopt, implement, and upgrade and meaningfully use certified HIT. The target does not include those Physicians already identified under the ONC REC grant. It should be noted that of the 10K potentially eligible providers, only about 2K will qualify based on Medicaid volume. Therefore, this target likely represents 100% of the providers qualified for the incentive (less the physicians addressed under the ONC REC grant). See Table 9.1 below.	List of active potential EP & EH Medicaid providers provided by DMAS for CY2010.

Table 9.1 Adopt, Implement, and Upgrade Targets for Potential Medicaid Providers

Target: 2000 (20% of 10,000)	Potential Eligible Providers	Cumulative Total
2011 @ 20%	400	400
2012 @ 30% of remaining	480	880
2013 @ 45% of remaining	504	1,384
2014 Complete remaining	616	2,000

Establish VHIT REC as the designated entity promoting adoption of certified EMR technology.	Establish VHIT REC as the designated entity promoting adoption of certified EMR technology. <i>This service allows a provider to assign their incentive to VHIT REC to administer on their behalf. This may be of particular interest to those providers that take advantage of VHIT REC technical support and the EMR solutions.</i>	EPs & EHs can assign their incentive payments to VHIT REC to administer on their behalf.	List of active potential EP & EH Medicaid providers provided by DMAS for CY2010.
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Objective 1.3: The Medicare program will reduce rates paid to EP and EH providers who are not able to demonstrate Meaningful Use by 2015 as a negative incentive to participate. Reevaluate possible methods of requiring Meaningful Use compliance for Virginia Medicaid EP & EH to better align with Medicare efforts in CY2015.			
Strategies	Measures	Target	Baseline
Communicate to Medicaid Providers (EP & EH) of the importance of Meaningful Use.	Communicate to Medicaid Providers (EP & EH) of the importance of Meaningful Use and the possibility there may be negative incentives determined in CY2015.	Communicate strategy to Medicaid providers in CY2010.	No plan exists in June 2010.
Reevaluate the need and strategy for penalties, contract modifications, and other methods for requiring compliance for EPs & EHs in CY2015. Depending on adoption statistics from CY2014, additional action may not be warranted.	Reevaluate the need and strategy for penalties, contract modifications, and other methods for requiring compliance for EPs & EHs in 2015.	VHIT REC adoption targets met by end of year 2014.	VHIT REC report end of year 2014.
Goal 2 Obtain a multi-state solution for incentive program administration			
Objective 2.1: Obtain a multi-state incentive program administration solution for Virginia			
Strategies	Measures	Target	Baseline
Survey all available procurement options & define a procurement plan.	Define a procurement plan.	Select procurement methods & define plan.	State Medicaid HIT Plan.
Objective 2.2: Use existing tools and methods to support audit and oversight requirements			
Strategies	Measures	Target	Baseline
Use existing tools & methods to support audit needs as is done for current Medical assistance programs.	Perform audit of the provider incentive program.	10% of the estimated program population to be audited annually.	Current Audit program schedule for other programs.
Use existing program integrity processes & procedures to provide oversight when site visits are conducted as is done for current Medical assistance programs.	Perform site visit & inspect provider incentive program information.	2% of the estimated program population to be audited annually with site visits only as necessary or for fraud/abuse investigation.	Current Program Integrity site review schedule.

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Goal 3 Support implementation and sustainability of the COV-HIE			
Objective 3.1: Provide financial support to the COV-HIE. The COV-HIE financial sustainability model is based on subscriptions that are paid for by COV-HIE certified HIEs as well as payers. There will be a weight applied to the subscription fees based on to-be defined sizing criteria such as covered lives/bed capacity etc. Medicaid will need to provide for its share of financial support to the COV-HIE and the COV State Government Gateway.			
Strategies	Measures	Target	Baseline
Medicaid Director to participate on the COV-HIE governance board(s).	Medicaid director is a contract required member on COV-HIE governance boards(s).	Board member of any temporary and permanent governance board(s) for the COV-HIE.	COV-HIE Strategic and Operational Plans.
Fund the subscription fee for Medicaid's share.	Fund subscription fees as required to meet COV-HIE financial sustainability goals.	Fund Medicaid share of the COV-HIE.	COV-HIE Strategic and Operational Plans.
Leverage the COV-HIE for reporting and data transport/exchange.	Leverage the COV-HIE for reporting and data transport/exchange.	As the COV-HIE begins operations as per plan, obtain Medicaid-specific measurements of utilization by Medicaid providers. Identify those Medicaid providers that are not participating and coordinate action plans with VHIT REC.	List of active potential EP & EH Medicaid providers provided by DMAS and list of providers from the COV-HIE provider registry.
Objective 3.2: Provide financial support to the COV-HIE State Government Gateway that is necessary to achieve stage 2+ Meaningful Use.			
Strategies	Measures	Target	Baseline
Fund Medicaid's share of MITA technical infrastructure.	Medicaid agency is a required member on COV governance boards(s).	Board member of any temporary and permanent governance board(s) for the state government gateway.	... 2010 MITA and COV-HIE Strategic and Operational Plans; ... MITA SS-A; ... MITA Transformation Plan; and ... COV-HIE Strategic & Operational Plan.

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Goal 4 Leverage MITA			
Objective 4.1: Establish the COV State government gateway that allows COV-HIE access to State government assets such as immunization registry; syndromic surveillance; and state labs.			
Strategies	Measures	Target	Baseline
Leverage MITA to establish the required COV State Government gateway by updating the 2007 MITA State Self-Assessment.	Perform a MITA SS-A to align business and technology efforts for the Care Management business area.	Update the 2007 SS-A and MITA Transition Plan.	2007 MITA SS-A deliverables.
Objective 4.2: From the updated MITA SS-A transition plan, initiate projects to develop the required SOA based services needed by the COV-HIE Care Management business area.			
Strategies	Measures	Target	Baseline
From the SS-A Business Capability Matrix, a list of SOA services are identified, prioritized, and used as input into the updated MITA Transition Plan.	Required SOA Services identified.	Identify priority SOA services for supporting Meaningful Use.	2010 SS-A Business Capability Matrix (BCM) update – prioritized services list.
Objective 4.3: For the SOA services that are identified, establish harmonized standards.			
Strategies	Measures	Target	Baseline
Leverage the existing HITSAC to establish the required COV MITA Information Architecture Standards.	Identify standards for the business and technical services.	All needed SOA services have identified Information standards.	2010 SS-A BCM update – prioritized services list.
Objective 4.4: Leverage MITA infrastructure for Medicaid expansion.			
Objective 4.5: Leverage MITA infrastructure for health insurance exchange.			

3. Annual Benchmarks for Goals

Table 10 Annual Benchmarks for Goals

Objective 1.1: Encourage Medicaid providers to take first step towards adoption by phasing out use of paper-based claims. While this will not lead to Meaningful Use, it will help encourage adoption for Meaningful Use stage 2 as well as provide more timely payments and reduction in administrative expense.					
2010	2011	2012	2013	2014	2015
Deploy Medicaid Claims Direct Data Entry (DDE) capability in CY2010. <i>(Update: Claims DDE was not deployed with the Medicaid portal in June 2010).</i>					
Communicate strategy & paper claim phase out plan to Medicaid providers in CY2010. <i>(Update: No plan exists in June 2010).</i>					
DMAS creates list of paper claim submitters.	40% reduction in paper claims.	35% reduction in paper claims.	25% reduction in paper claims.		
Objective 1.2: Encourage Medicaid providers to adopt, implement, or upgrade by leveraging and expanding the current VHIT REC scope of efforts for outreach, education, and technical support in Virginia.					
2010	2011	2012	2013	2014	2015
DMAS provides VHIT REC with list of active potential EP & EH Medicaid providers in order to extend outreach & education to providers not served under ONC grant.	VHIT REC extends outreach & education to potential EPs not addressed under ONC grant.				
Communicate plan to providers <i>(Update: no plan exists in June 2010).</i>					
DMAS provides VHIT REC with list of active potential EP & EH Medicaid providers in order to extend technical support to providers not served under ONC grant.	VHIT REC extends technical support to potential EPs not addressed under ONC grant.				
	20% of estimated EPs, (400) adopt, implement & upgrade certified EHRs. See Table 9.1.	30% of remaining estimated EPs (480) adopt, implement & upgrade certified EHRs. See Table 9.1.	45% of remaining estimated EPs (504) adopt, implement & upgrade certified EHRs. See Table 9.1.	Remaining estimated EPs (616) adopt, implement & upgrade certified EHRs. See Table 9.1.	

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Objective 1.3: The Medicare program will reduce rates paid to EP and EH providers who are not able to demonstrate Meaningful Use by 2015 as a negative incentive to participate. Reevaluate possible methods of requiring Meaningful Use compliance for Virginia Medicaid EP & EH to better align with Medicare efforts in CY2015.					
2010	2011	2012	2013	2014	2015
Communicate the importance of Meaningful Use to Medicaid providers & the possibility of negative incentives in CY2015.				Review VHIT REC adoption statistics.	Reevaluate the need & strategy for penalties, contract modifications, & other methods for requiring compliance.

4. Annual Benchmarks for Audit and Oversight Activities

Table 11 Annual Benchmarks for Audit & Oversight

Objective 2.2.1: Use existing tools and methods to support audit and oversight requirements.					
CY 2010	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015
Prepare audit program for VHIT REC contract compliance on-site review.	Perform VHIT REC vendor on-site review to ensure contract compliance.				
	Prepare audit program for provider incentive program eligibility audits.	Perform verification of eligibility audits.	Perform verification of eligibility audits.	Perform verification of eligibility audits.	Perform verification of eligibility audits.
	Prepare audit program for provider incentive program patient volume audits.	Perform volume percentage requirement audits.	Perform volume percentage requirement audits.	Perform volume percentage requirement audits.	Perform volume percentage requirement audits.
	Prepare audit program for audits of Meaningful Use and Annual Incentive Payment.	Perform verification of Meaningful Use and Annual Incentive Payment audits.	Perform verification of Meaningful Use and Annual Incentive Payment audits.	Perform verification of Meaningful Use and Annual Incentive Payment audits.	Perform verification of Meaningful Use and Annual Incentive Payment audits.
	Audit Percentage Estimates: (NOTE: Where applicable, automated audit techniques will be used to review 100% of program population).	10% (40) of the estimated program population to be audited.	10% (45) of the estimated program population to be audited.	10% (55) of the estimated program population to be audited.	10% (60) of the estimated program population to be audited.

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Objective: 2.2.2 Perform site visit and inspect provider incentive program information.					
CY 2010	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015
Prepare check sheets of provider incentive program information for inclusion with routine Program Integrity Division site visits.	Prepare audit programs and check sheets for site visit and inspection of provider incentive program information.	Perform on-site verification of incentive program information during the course of routine Program Integrity Division reviews.	Perform on-site verification of incentive program information during the course of routine Program Integrity Division reviews.	Perform on-site verification of incentive program information during the course of routine Program Integrity Division reviews.	Perform on-site verification of incentive program information during the course of routine Program Integrity Division reviews.
	Site Visit / Inspection Percentage Estimates:	2% (8) of the estimated program population to be audited. Site visits only as necessary or for fraud/abuse investigation.	2% (9) of the estimated program population to be audited with site visits only as necessary or for fraud/abuse investigation.	2% (11) of the estimated program population to be audited with site visits only as necessary or for fraud/abuse investigation.	2% (12) of the estimated program population to be audited with site visits only as necessary or for fraud/abuse investigation.

5. Leveraging MITA

MITA is national framework supporting improved systems development and health care management for the Medicaid enterprise. The MITA technical architecture standards is the basis of the of the technical architecture standards for COV-HIE. The proposed technical architecture for the COV-HIE is a SOA-based framework. The envisioned Commonwealth State Government Gateway is based on the MITA technical architecture standard, and existing Virginia system assets will need to exchange information with the COV-HIE using SOA technology in the future.

Virginia is planning to leverage MITA as part of a broader effort to reorient essential state services to a citizen-centric paradigm. The effort will start with an HHR secretariat-wide MITA SS-A to align business strategy and direction. Based on the resulting updates to the MITA Transition plan, additional projects will start to transform the MITA Care Management and Member Management business area towards MITA’s concept of operation for citizen-centric services. Other State programs will seek support from their applicable Federal partners to follow the MITA initiatives and begin their own transformation to SOA, standards, and a citizen-centric paradigm. The key to the business and technical transformation Virginia wants to achieve is based on standards. The SOA technology components are based on industry standards. Information standards used on the COV SOA are paramount; accordingly, HITSAC will be chartered to harmonize industry standards for the HHR Agencies just as it did for the COV-HIE. This harmonization will ensure future capabilities to exchange information throughout the delivery of care and within State and Federal governments.

Virginia Medicaid participates as part of the VHEN organization (payer portal) available to all Virginia providers for eligibility (member registry) and for claims payments that includes coordination of benefits (COB). These functions are handled within the Virginia Medicaid Enterprise (MMIS is one component in the enterprise) by registering VHEN both as an eligibility

vendor and a claims clearinghouse. In addition, the Medicaid QoC reports will be sent via COV-HIE Services Operations to the to-be Commonwealth SOA-based interface for the QoC repository. Finally, Virginia Medicaid will be a client of the COV-HIE using a light-weight EMR for professional medical staff needs (service authorizations and appeals) as well as one source of Medicaid provider Meaningful Use statistics.

For Medicaid, these efforts are also targeted to avoid significant increases in administrative and operational support that would be necessary for an expansion of Medicaid under the Health Reform act. For the COV-HIE, it will establish broad standards-based capabilities to coordinate and orchestrate future consumer services as well as share and exchange health related information between provider networks and the Commonwealth that is far beyond current capabilities. Finally, the information technology can be leveraged for the Virginia Health Insurance Exchange to be created under the Affordable Care Act.

Glossary

ACRONYM	NAME	DESCRIPTION
ACA	Affordable Care Act of 2010 “Health Reform”	In March 2010, Congress passed and the President signed into law the Affordable Care Act, which puts in place health insurance reforms that will hold insurance companies more accountable, lower health care costs, guarantee more health care choices, and enhance the quality of health care for all Americans.
ARRA	American Recovery and Reinvestment Act	Recovery Act has three immediate goals: <ul style="list-style-type: none"> • Create new jobs and save existing ones • Spur economic activity and invest in long-term growth • Foster unprecedented levels of accountability and transparency in government spending The Recovery Act intends to achieve those goals by: <ul style="list-style-type: none"> • Providing \$288 billion in tax cuts and benefits for millions of working families and businesses • Increasing federal funds for education and health care as well as entitlement programs (such as extending unemployment benefits) by \$224 billion • Making \$275 billion available for federal contracts, grants and loans • Requiring recipients of Recovery funds to report quarterly on how they are using the money. All the data is posted on Recovery.gov so the public can track the Recovery funds.
CAQH	Council for Affordable Quality Healthcare	An unprecedented nonprofit alliance of health plans and trade associations, is a catalyst for industry collaboration on initiatives that simplify healthcare administration
CCD	Continuity of Care Document	The Continuity of Care Document (CCD) is built using HL7 Clinical Document Architecture (CDA) elements and contains data that is defined by the ASTM Continuity of Care Record (CCR). It is used to share summary information about the patient within the broader context of the personal health record.
CCR	Continuity of Care Record	A standard specification being developed jointly by ASTM International, the Massachusetts Medical Society (MMS), the Health Information Management and Systems Society (HIMSS), and the American Academy of Family Physicians (AAFP).
CMS	Centers for Medicare and Medicaid Services	A federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (CHIP), and Health Insurance Portability standards (HIPAA).

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COB	Coordination of Benefits	Coordination of benefits is a practice which is used to ensure that insurance claims are not paid multiple times when someone is insured under multiple insurance plans.
Consumer	Consumer	Any actual or potential recipient of health care, such as a patient in a hospital, a client in a community mental health center, or a member of a prepaid health maintenance organization.
COV-HIE	Commonwealth of Virginia Health Information Exchange	A services gateway to be created under contract from VDH to a non-profit Governance Body and various technology and services vendors to serve the health information exchange needs of all stakeholders in the Commonwealth of Virginia. COV-HIE is a temporary name, the contracted Governance Body will define official name and branding for the network.
CRM	Customer Relationship Management	An information industry term for methodologies, software, and usually Internet capabilities that help an enterprise manage customer relationships in an organized way.
DMAS	Department of Medical Assistance Services	DMAS is the agency that administers Medicaid and the State Children's Health Insurance Program (CHIP) in Virginia.
E-scan	Environmental Scan	Process of gathering, analyzing, and dispensing information for tactical or strategic purposes.
EHR	Electronic Health Record	A longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting, including patient demographics, progress notes, problem lists, vital signs, past medical history, review of systems, immunizations, laboratory data, radiology reports, and other components of medical records.
EMR	Electronic Medical Record	A computerized legal medical record created in an organization that delivers care, such as a hospital and doctor's surgery.
ESB	Enterprise Service Bus	Consists of a software architecture construct which provides fundamental services for complex architectures via an event-driven and standards-based messaging-engine (the bus).
FQHC	Federally Qualified Health Centers	Public and private non-profit health care organizations that meet certain criteria under the Medicare and Medicaid Programs (respectively, Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act and receive funds under the Health Center Program (Section 330 of the Public Health Service Act).

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HL7	HL7	The 7th level of the International Organization for Standardization (ISO) seven-layer communications model for Open Systems Interconnection (OSI) - the application level. The application level interfaces directly to and performs common application services for the application processes.
HIE	Health Information Exchange	The mobilization of healthcare information electronically across organizations within a region, community or hospital system.
HIT I-APD	Health Information Technology Implementation Advance Planning Document	Plan of action that requests Federal matching funds and approval to acquire and implement the proposed SMHP services, equipment, or both.
HITAC	Health Information Technology Advisory Commission	Consists of members appointed by the chair in consultation with the Secretary of Technology and represents broad stakeholder engagement in health information technology and exchange.
HITECH	Health Information Technology for Economic and Clinical Health Act	Federal Act that amends Public Health Service Act by adding a number of funding opportunities to advance health information technology. The Act seeks to improve American health care delivery and patient care through an unprecedented investment in health information technology.
HITSAC	Health Information Technology Standards Advisory Committee	Advises the Information Technology Investment Board (ITIB) on the approval of nationally recognized technical and data standards for HIT systems or software.
HITSP	Health Information Technology Standards Panel	Serve as a cooperative partnership between the public and private sectors for the purpose of achieving a widely accepted and useful set of standards specifically to enable and support widespread interoperability among healthcare software applications, as they will interact in a local, regional and national health information network for the United States.
HRSA	Health Resources and Services Administration	Is the primary Federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable.
LOINC	Logical Observation Identifiers Names and Codes	Facilitate the exchange and pooling of clinical results for clinical care, outcomes management, and research by providing a set of universal codes and names to identify laboratory and other clinical observations.
MITA	Medicaid Information Technology Architecture	A national framework supporting improved systems development and health care management for the Medicaid enterprise.

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MMIS	Medicaid Management Information System	An integrated group of procedures and computer processing operations (subsystems) developed at the general design level to meet principal objectives.
MPI	Master Patient Index	The MPI system is characterized by a structured format that permits instantaneous access to medical patient records and eliminates all paper medical records, allowing accurate, quick documentation and retrieval of patients' visits.
NHIN	Nationwide Health Information Network	Set of standards, services and policies that enable secure health information exchange over the Internet.
NLR	National Level Repository	Used to track incentive payments to health care providers that adopt electronic health records and modernize their computer systems.
NTIA	National Telecommunications and Information Administration	An agency in the U.S. Department of Commerce that serves as the executive branch agency principally responsible for advising the President on telecommunications and information policies.
PPCP	Priority Primary Care Provider	Defined in the Virginia HIT Regional Extension Center contract with ONC as providers practicing internal medicine, family practice, Ob/Gyn and pediatrics in groups of 10 or fewer, unless they serve uninsured/underinsured patients.
QIO	Quality Improvement Organizations	Improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries.
QoC	Quality of Care	Metric typically associated with measuring patient outcomes, positive or negative. Can be gathered for purely statistical analyses or as part of a program of continuous improvement in healthcare provider or payer organizations.
RFP	Request for Proposal	"Official" statement to vendors about the services you require.
RLS	Record Locator Service	Holds information authorized by the patient about where authorized information can be found, but not the actual information the records may contain.
SDE	State Designated Entity	In reference to the contractual relationship between a state and ONCHIT for the funding grants for statewide health information exchange, when a state abdicates contractual control of the funding and statewide health information exchange to a third party, typically an existing Health Information Exchange within the state. The Commonwealth of Virginia does NOT have an SDE. The responsible agency to ONCHIT for the duration of grant funding being received for statewide health information exchange is the Virginia Department of Health.
SLA	Service Level Agreement	A part of a service contract where the level of service is formally defined.

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SMHP	State Medicaid HIT Plan	A plan describing how a state's Medicaid Services agency intends to implement and promote Health IT, especially in light of meaningful use requirements as defined by CMS.
SOA	Service Oriented Architecture	A flexible set of design principles used during the phases of systems development and integration.
SS-A	State Self-Assessment	The process by which a state performs an assessment of health IT maturity in both the public and private sector within its borders. Can also be referred to as an environmental scan.
SSL	Security Socket Layer	Cryptographic protocols that provide security for communications over networks such as the Internet.
VDH	Virginia Department of Health	The Commonwealth of Virginia's Health Department.
VHEN	Virginia Health Exchange Network	A collaboration of Virginia health plans and systems dedicated to lowering administrative costs in healthcare convened by the Virginia Association of Health Plans (VAHP), The Virginia Hospital and Healthcare Association (VHHA), and the Governor's Office of Health IT.
VHIT REC	Virginia HIT Regional Extension Center	The organization offering technical assistance, guidance and information on best practices to support and accelerate health care providers' efforts to become meaningful users of electronic health records (EHRs) in Virginia.