2010 Annual Report

West Virginia Governor's Office of Health Enhancement and Lifestyle Planning

Pursuant to the provisions of West Virginia Code §16-29H-4(c), this annual report is submitted to Governor Earl Ray Tomblin and the Legislative Oversight Commission on Health and Human Resources Accountability by the Acting Director of the Governor's Office of Health Enhancement and Lifestyle Planning (GOHELP) for the 12-month period from January 1, 2010, to December 31, 2010, to provide a review of the condition, operation, function and activities of GOHELP.

EXECUTIVE SUMMARY

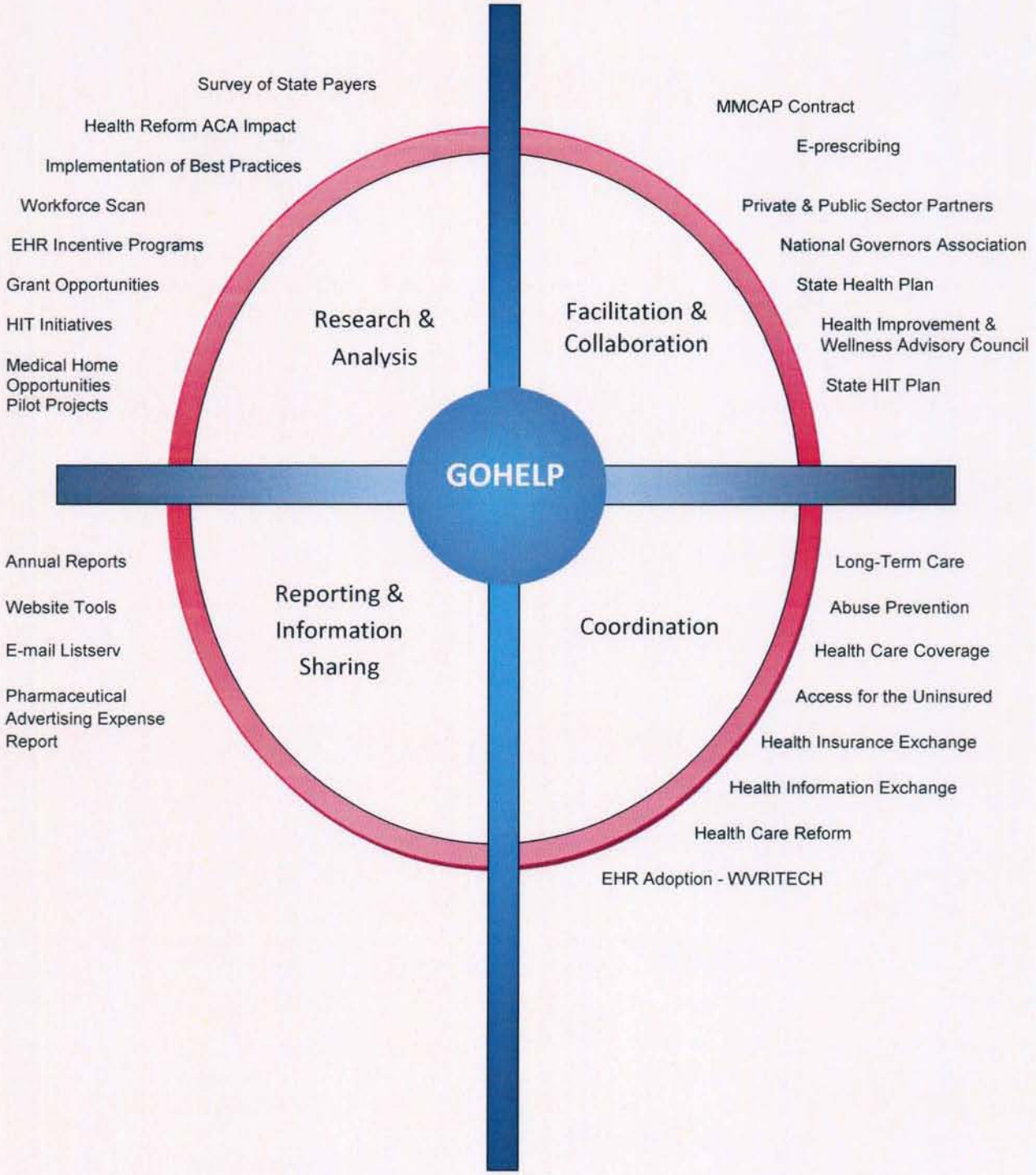
GOHELP was created by Senate Bill 414 during the 2009 regular session. The office began formal operations on September 1, 2009, under the leadership of Acting Director Martha Y. Walker. GOHELP is responsible for coordinating all state health care system reform activities among executive agencies, departments, bureaus and offices. The office is under the direct supervision of the acting director, who is tasked with exercising the duties and powers assigned to the office under West Virginia Code §16-29H-1, et seq. All state agencies having duties regarding the development, improvement and implementation of any aspect of West Virginia's health care system are required to cooperate with GOHELP. In FY2010, GOHELP received a $523,424 appropriation. This funding covered all operational costs of GOHELP, including staffing (i.e., salary and benefits and any contractual costs), technology and communication services, administration (i.e., leased offices and facilities, supplies and other operational costs) and travel expenses. It was originally thought that GOHELP would require a $1.2 million appropriation in order to accomplish the majority of its statutory goals. This original estimate was calculated prior to passage of federal health care reform.

GOHELP's activities are categorized in four key areas:

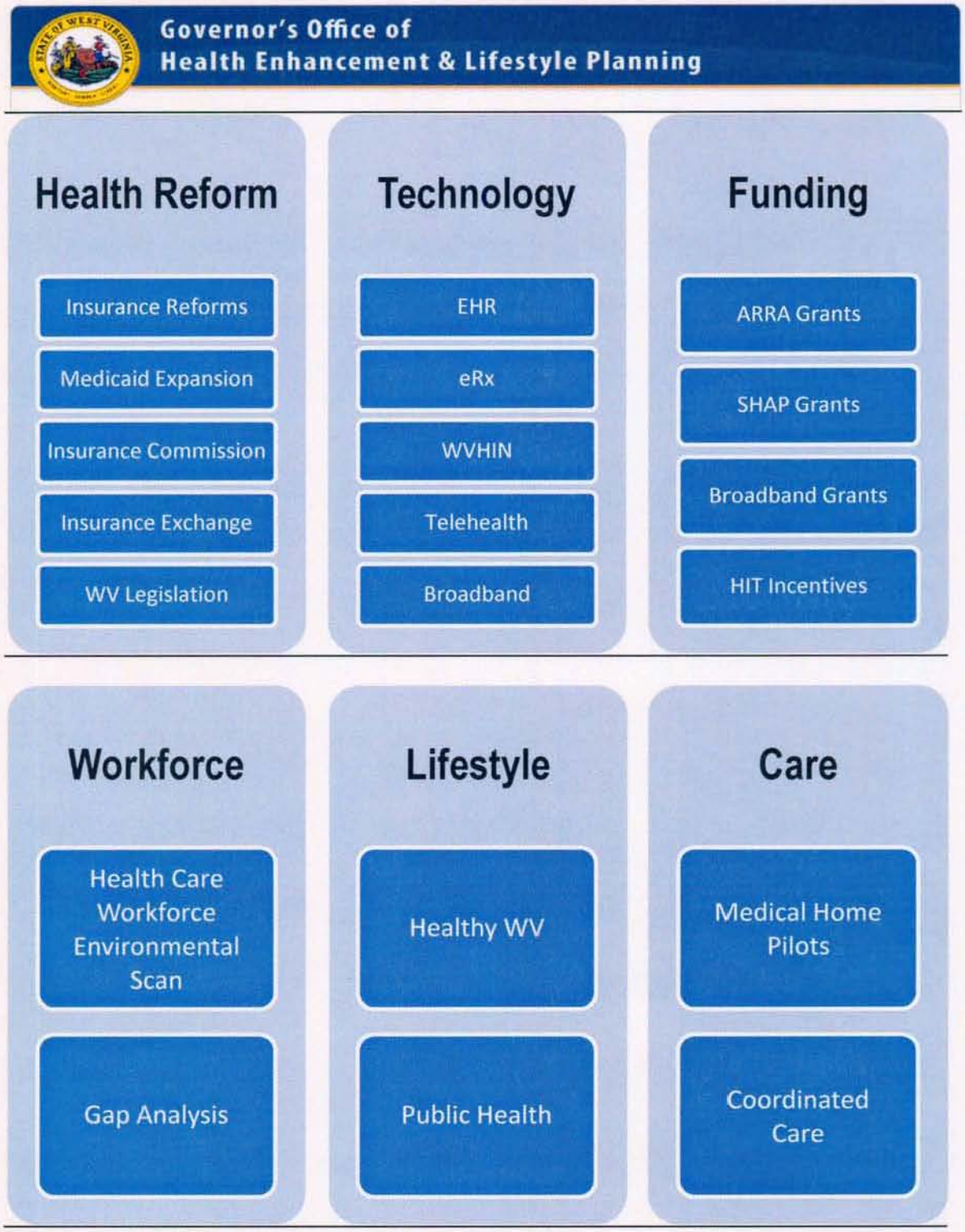
1. Research & Analysis;
2. Facilitation & Collaboration;
3. Reporting & Information Sharing; and
4. Coordination.

No activity area is more important than the other. Together, these four activity areas assure that the Patient Protection and Affordable Care Act (PPACA) is appropriately implemented. Additionally, GOHELP has adopted a proactive approach to health care; it is continually looking for the latest health care initiatives and opportunities that will increase West Virginia's stature in the areas of health care delivery and technology. Provided on the following four pages are graphics representing the various activities that GOHELP performs, its initiative areas and an organizational chart of the office.

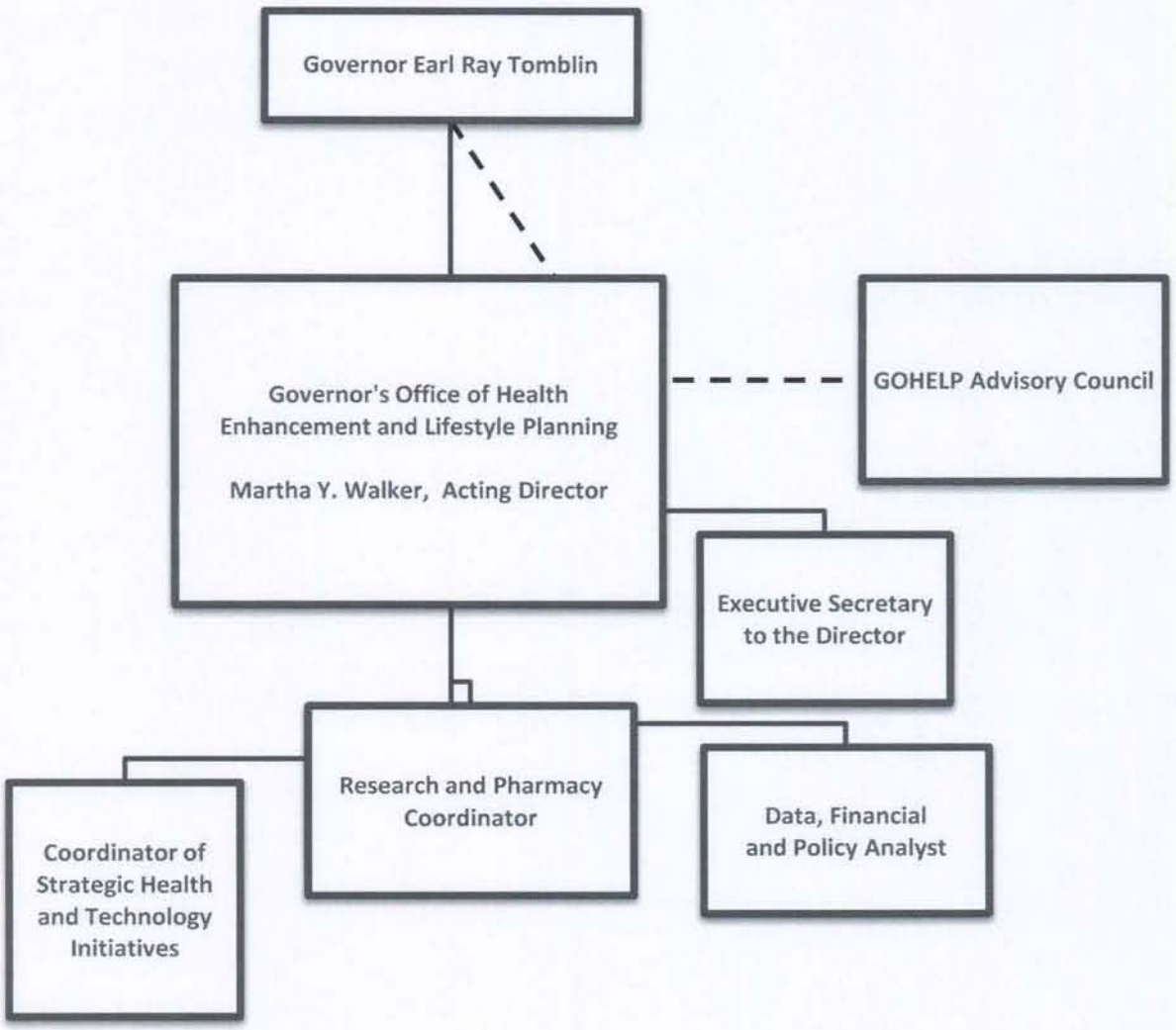
GOHELP CORE ACTIVITIES



GOHELP'S SIX INITIATIVE AREAS



GOHELP ORGANIZATIONAL CHART



To learn more about GOHELP, you can visit our website at www.gohelp.wv.gov.

OVERVIEW

GOHELP's Advisory Council consists of members appointed by the Governor who represent organizations and by statutory members designated in West Virginia Code §16-29H-5. The Advisory Council held six meetings between September 2009 and November 2010. The members of the GOHELP Advisory Council are listed in **Appendix A**, and the meeting agendas are available in **Appendix B**. The Advisory Council assists GOHELP in educating interested parties about the health care delivery system and with dissemination of information to the public.

GOHELP closely follows health care reform discussions at the federal level. Federal health care reform impacts the direction reform efforts take in West Virginia. GOHELP monitors activities in Washington D.C. with relevant constituent state agencies. To facilitate coordination of health care reform, GOHELP has initiated a review of existing state agencies' programs, expenditures and outcomes regarding health care. This review will permit further analysis of the impact of federal health care reform on the state's current health care system. The review will also provide baseline information for the State Health Plan and will be vital in developing GOHELP's five-year strategic plan, which is required by West Virginia Code §16-29H-6.

The passage of the federal PPACA on March 23, 2010, created numerous opportunities and challenges for the state. GOHELP is monitoring the release of federal regulations and timelines, conducting ongoing research on the impact of the Act, providing constituent state agencies and interested/invested parties with the tools necessary to track and assess the reform. GOHELP, in partnership with the agencies responsible for the implementation of PPACA, works diligently to assure execution of the Act's provisions. GOHELP continues to coordinate model development and outcome scenarios for changes in the health care system. Moreover, GOHELP works with other states to identify and promote projects where health care can be improved.

PRESCRIPTION DRUGS

Senate Bill 414 transferred the rule-making authority for monitoring pharmaceutical advertising costs from the Pharmaceutical Cost Management Council (PCMC) to GOHELP. When the PCMC was phased out by GOHELP's start up in September 2009, GOHELP developed and filed an emergency rule with the Secretary of State to guarantee that direct advertising cost reporting continued in the absence of the PCMC. The legislative rule was passed during the 2010 regular session. Title 210, Series 1 of the Code of State Rules governs the reporting of pharmaceutical advertising expenses. The pharmaceutical companies' *2009 Advertising Expense Report* by pharmaceutical companies is included in **Appendix C**.

GOHELP has the authority to participate in regional and multistate purchasing alliances. PCMC previously joined the Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP). After reviewing this agreement, GOHELP renewed West Virginia's membership in MMCAP. MMCAP is a voluntary, no-cost group purchasing organization operated and managed by the State of Minnesota. MMCAP's mission is to provide the best value in pharmaceuticals and related products for governmental health care facilities. MMCAP membership provides the Department of Health and Human Resources with a purchasing option to lower the cost of pharmaceuticals.

GRANTS

The coordination and monitoring of health care grants is crucial if West Virginia is to successfully transition its health care system into the 21st century. GOHELP has collaborated

with several partners to develop a matrix of federal grant opportunities supporting health care reform and Health Information Technology (HIT) efforts. Available grant opportunities are distributed to likely applicants via the GOHELP Listserv. GOHELP also provides support to applicants by providing background research materials and planning/coordination guidance among grant applicants. If additional funding becomes available, GOHELP sees value in developing a process for tracking and evaluating the impact of all health care-related grant awards in West Virginia. The information gained from this process would be used to make public policy recommendations.

GOHELP coordinates efforts between the Department of Health and Human Resources (DHHR) and the Office of the Insurance Commissioner on the WV Connect Project, which is supported by a Health Resource and Services Administration grant. The grant finances the expansion of access to health care for the uninsured and the development of a health insurance exchange through a virtual network. The project involves the creation of a clinical web portal that will lead to administrative simplification and accelerated payment for services.

HEALTH INFORMATION TECHNOLOGY

HIT will play an important role in the transformation of West Virginia's health care delivery system. To help improve patient outcomes, HIT must be integrated into daily clinical practice at all levels and in all health care settings. Coordinated health care teams, including the medical home model, must utilize HIT effectively to provide optimal, lower cost health care for patients. Implementation of an interoperable HIT system can improve the efficiency and effectiveness of all health care services. Briefly stated, HIT:

- enhances self-management by patients and involvement of patients;
- reduces medical errors;
- streamlines administrative processes; and
- helps contain future health care costs.

The federal government is providing unprecedented incentives for the adoption and use of HIT through the American Recovery and Reinvestment Act (ARRA). Approximately $17 billion has been appropriated federally to provide these incentives under Medicare and Medicaid, so hospitals, physicians and other designated care providers adopt and make "meaningful use" of HIT under defined standards. The estimated financial impact of these incentives for state providers is $150 to $200 million during the next six to 10 years. Most hospitals and many individual health care providers are eligible to receive the incentives.

HIT adoption incentives range from $44,000 for individual providers under Medicare provisions to $63,750 per provider through Medicaid. Eligible hospitals are likely to receive several million dollars from these incentive programs. An explanation of the incentive programs is included in **Appendix D**. It is important to note that mere adoption of HIT is not sufficient to meet incentive requirements. Providers are expected to meet certain obligations for reporting patient outcomes and quality of care indicators in addition to exchanging information electronically with patients and other health care providers. A short glossary of HIT terms is available in **Appendix E.**

GOHELP's role in the HIT arena is to serve as a coordinator of these collective efforts. Managing the transition of health care facilities and providers in the state from paper records to an interconnected HIT system requires extensive teamwork and managerial resources. Furthermore, coordinating the vast array of HIT activities taking place in West Virginia requires

an evolving inventory of initiatives and activities, such as creating a virtual map of the HIT universe and constructing an intersection matrix of funding and needs. The inventory and mapping will allow policymakers to determine where additional resources and investments could be warranted while avoiding duplicate efforts.

GOHELP intends to use the revised *West Virginia Health Information Technology Statewide Strategic Plan*, the executive summary is available in **Appendix F**, to guide and coordinate HIT activities. GOHELP has undertaken a number of efforts aimed at preparing West Virginia for these HIT initiatives. Some of these efforts are:

- Promoting increased collaboration among the West Virginia Health Information Network (WVHIN), Medicaid, Regional Health Information Technology Extension Center, PEIA and other organizations;

- Working with WVHIN, DHHR and several other interested/invested parties on issues surrounding the Health Information Exchange, including discussions concerning financial sustainability, assistance with the Health Information Exchange grant application and privacy policies. WVHIN was awarded a $7.8 million federal grant for the development of a statewide Health Information Exchange.

- GOHELP formed a working group to address problems encountered with the implementation of e-prescribing in West Virginia. Key stakeholders were convened (i.e., representatives from the Board of Pharmacy, SureScripts, WV Academy of Family Physicians, retail pharmacies, pharmacists, claims payers and the State Medical Association) to address issues and potential conflicts with signature requirements and to interpret the statutory requirements and communications among the parties involved. GOHELP also assists in the promotion of e-prescribing projects at the Bureau for Medical Services and presents at the GOHELP Advisory Council meetings.

- GOHELP is an integral member of the Medicaid planning team that is developing a State Medicaid Health Information Technology Plan (SMHP). The SMHP will be a chapter of the overall state plan. Medicaid is responsible for implementing and auditing Electronic Health Records (EHR) incentive payments to eligible providers.

WELLNESS AND HEALTHY LIFESTYLES

GOHELP has conducted a number of meetings and coordinated planning sessions with involved stakeholders, including the WV Office of Healthy Lifestyles, PEIA and the Department of Education to encourage the adoption of wellness and healthy lifestyle programs into schools, medical homes and other entities. Due to staff changes at the Bureau for Public Health (BPH) and the loss of its chairperson, the Healthy Lifestyles Coalition remains inactive. The BPH's Office of Healthy Lifestyles was successful in its federal ARRA grant application for "Communities Putting Prevention to Work." Four and a half million dollars ($4.5 million) will be spent during the next two years through the Mid-Ohio Valley Health Department to promote healthy lifestyles. The initiative includes increasing access to fresh foods and opportunities for physical activity; the Bureau was also awarded approximately $1 million to evaluate the initiative. More information on the program can be found at www.changethefuture.org.

HEALTH CARE PILOT PROJECTS

GOHELP is directed to work with state agencies and interested/invested parties on various health care pilot projects. A number of similar pilot projects to those listed below have been facilitated as part of the Medicaid transformation, such as those by the West Virginia Health Improvement Institute, PEIA and the WV Medical Institute Doctor's Office Quality Initiative funded by the Centers for Medicare & Medicaid Services. GOHELP intends to leverage the experience gained from these prior efforts in the design and implementation of the following pilot projects:

- *Preventative Health Care/Primary Care Medical Home Pilot Projects*: In accordance with West Virginia Code §16-29H-4, GOHELP is mandated to work with the WV Health Care Authority (WVHCA) to ensure that preventive health care pilot projects are implementing a primary-care medical home model. The governing statute indicates that these pilot projects should reflect

  > a program that would allow health clinics and private medical practitioners to provide primary and preventive health services for a prepaid fee, [which] would enable more West Virginians to gain access to affordable health care and to establish a medical home for purposes of receiving primary and preventative healthcare services.

  The pilot projects referenced in the statute were authorized under 2006 legislation and are in the third year of deployment. WVHCA reports that 802 people are enrolled in the Preventative and Primary Care Pilot Project at six sites throughout the state (**see Appendix G**). These sites cover various preventative services for a prepaid fee, and work is underway to expand the pilot projects in accordance with the Health Resources and Services Administration-funded expansion grant.

- *Chronic Care Model Pilot Projects*: This model focuses on smaller physician practices. Primary care providers are required to work with payers and providers to identify various disease states. Through the mutual effort of the primary care provider and the payers and providers, programs will be developed to improve management of agreed upon conditions of the patient. These groups will be comprised of medical directors from the major health care payers and the state payers, along with medical providers and others.

- *Individual Medical Homes Pilot Projects*: These pilot projects will focus on larger physician practices seeking certification from the National Committee on Quality Assurance (Level I certification). The Health Improvement Institute (HII) will conclude a Medical Home Pay for Performance (P4P) pilot project in September 2011. This pilot project was developed by the HII multi-payer workgroup for the purpose of testing the medical home concept in a variety of practice settings. Currently, 24 providers with 18,000 patients are participating in the pilot. The practices collect monthly data on key indicators, focusing on chronic diseases. All of the practices are working toward NCQA recognition. The HII is also sponsoring a Partners in Health Pilot Project, where three large Federally Qualified Health Centers (FQHCs) are working with Charleston Area Medical Center (CAMC) to manage the SSI population.

- *Community-Centered Medical Home Pilot Projects*: This approach will link primary care practices with community health teams that could expand the current structure of FQHCs. The community health teams include social and mental health workers, nurse

practitioners, care coordinators and community health workers. These personnel currently provide services in community hospitals, home health agencies and other settings. The pilot projects will facilitate the development of teams to cooperate with the primary care practices and will focus on primary prevention, such as smoking cessation and wellness promotion programs. Furthermore, the primary care practices, in this pilot project, will be expected to manage patients with multiple chronic conditions.

The HII sponsors the Shared Care Coordinator Pilot Project and the Partners in Health Pilot Project. The Shared Care Coordinator Pilot Project was an experiment involving three small private family practice providers who shared a care coordinator. The pilot project is now complete and under evaluation. In the Partners in Health Pilot Project, three large FQHCs are working with CAMC to manage the SSI population. This pilot project tests the sharing of hospital-based resources to improve the outcomes of SSI recipients. A pharmacist, dentist, case manager and dietician all work with patients to improve health outcomes.

In early 2011, the HII will launch the CHIP Quality Demonstration known as the T-CHIC Project. This pilot project is a joint effort with Oregon and Alaska to focus on pediatric quality measures. West Virginia will test the use of shared care coordinators to assist in health improvement. A key focus will be to improve the rate of EPSDT screenings; this pilot project will conclude in 2014.

- *Medical Homes for the Uninsured Pilot Projects:* These pilot projects will focus on medical homes to serve the uninsured and will include various means of providing care to the uninsured with primary and preventative care. With this mechanism, a variety of pilots may be developed that include screening, treatment of chronic disease and other aspects of primary care and prevention services.

  In specific response to the GOHELP mandate, all free clinics were recruited into the Medical Home P4P pilot project. GOHELP is working with DHHR and the Office of the Insurance Commissioner to determine if federal grant funding can be used to assist the clinics further in their efforts to become medical homes.

  The Ebenezer Pilot Project is specific to the uninsured and involves using an electronic tracking tool to improve health care coordination across the continuum of services as patients move in and out of the free clinic environment.

WORKFORCE DEVELOPMENT

In 2010, GOHELP convened a working group of its advisory council and interested parties to address health care workforce issues. GOHELP also initiated a series of meetings with representatives of the Community and Technology College System and the Higher Education Policy Commission to identify training/development needs to support the health system reform efforts and HIT deployment and use objectives of the state. These workforce needs continue to be defined by surveys and research to identify skill gaps required to meet the health care needs of a rapidly changing and aging marketplace. Particular attention will be paid to those skills required to support accelerated adoption and use of HIT and health improvement care teams.

PPACA provided for a National Health Care Workforce Commission to be appointed by the Comptroller General of the United States. The Commission was appointed in September 2010, but remains unfunded, has no staff and has not yet begun its work. GOHELP continues to

communicate with the Government Accountability Office regarding the operations of the Commission and intends to utilize all resources provided by the federal government in the analysis of workforce needs.

FEDERAL FUNDING

GOHELP serves as a resource for information and initiatives aimed at maximizing the value of federal funding opportunities in support of HIT and health reform initiatives. Consistent with the provisions of West Virginia Code §16-29H-6(12)(vii), GOHELP works with constituent state agencies and private sector stakeholders to identify "federal funding to ensure the most efficient and cost-effective means of meeting the state's health information technology objectives."

GOHELP maintains a matrix of these funding opportunities and the programmatic linkage to strategic state health improvement and HIT efforts. GOHELP also convenes periodic meetings of these stakeholders to ensure coordination of efforts by acting as a clearinghouse, assisting parties in identifying the stakeholders that can best meet the objectives of the funding announcements. GOHELP has identified the need for a comprehensive system of tracking and review of all health care related grants operating in the state of West Virginia. Increased information sharing would foster more collaborative work among the numerous state and private sector partners.

APPENDIX A

Members

West Virginia Code §16-29H-5 provides for the creation of the Health Enhancement and Lifestyle Planning Advisory Council as follows:

(a) The Health Enhancement and Lifestyle Planning Advisory Council is hereby created. The advisory council is an independent, self-sustaining council that has the powers and duties specified in this article.

(b) The advisory council is a part-time council whose members perform such duties as specified in this article. The ministerial duties of the advisory council shall be administered and carried out by the Governor's Office of Health Enhancement and Lifestyle Planning.

(c) Each member of the advisory council shall devote the time necessary to carry out the duties and obligations of the office. Those members appointed by the Governor may pursue and engage in another business or occupation or gainful employment that is not in conflict with the duties of the advisory council.

(d) The advisory council is self-sustaining and independent, however, it, its members, the director and employees of the Governor's Office of Health Enhancement and Lifestyle Planning are subject to article nine-a, chapter six of this code and chapters six-b, twenty-nine-a and twenty-nine-b of this code.

(e) The advisory council is comprised of the following governmental officials: The Secretary of the Department of Health and Human Resources, or his or her designee, the Director of the Public Employees Insurance Agency, or his or her designee, the Commissioner of the Office of the Insurance Commissioner, or his or her designee, the Chair of the West Virginia Health Care Authority, or his or her designee and the director of the West Virginia Children's Health Insurance Program or his or her designee. The council shall also consist of the following public members: One public member shall represent an organization of senior citizens with at least ten thousand members within the state, one public member shall represent the West Virginia Academy of Family Physicians, one public member shall represent the West Virginia Chamber of Commerce, one public member shall represent the largest education employee organization in the state, one public member shall represent the largest labor organization in the state, one public interest organization that represents the interests of consumers, one public member shall represent West Virginia Hospital Association, one public member shall represent the West Virginia Medical Association, one public member shall represent the West Virginia Nurse's Association and two ex-officio nonvoting members shall be the Speaker of the House, or his or her designee, and the President of the Senate, or his or her designee.

(f) Public members shall be appointed by the Governor with advice and consent of the Senate. Each public member shall serve for a term of four years. Of the public members of the advisory council first appointed, one shall be appointed for a term ending June 30, 2010, and two each for terms of three and four years. The remainder shall be appointed for the full four year terms as provided in this section. Each public member serves until his or her successor is appointed and has qualified. The Director of the Governor's Office of Health Enhancement and Lifestyle Planning shall serve as chairperson of the advisory council.

Pursuant to the foregoing, Governor Manchin has appointed the following to serve on the GOHELP Council, subject to the terms and provisions of the governing statute:

Martha Y. Walker, Acting Director of GOHELP, Chairperson of Council

Patsy Hardy, Secretary, WV Department of Health and Human Resources

Ted Cheatham, Director, Public Employees Insurance Agency

Jane Cline, Commissioner, WV Insurance Commission

Sonia Chambers, Chairperson, WV Health Care Authority

Sharon Carte, Director, WV Children's Health Insurance Program

Amanda Pasdon, representing WV Chamber of Commerce

Gary Johnson, representing a federally qualified health center
Angela Vance, representing an organization of senior citizens
Denise Campbell, representing the WV Nurses' Association
Dr. David Avery, representing the WV Academy of Family Physicians
Karen Bowling, representing the WV Hospital Association
Dr. Steven Sebert, representing the WV Medical Association
Brandon Tinney, representing the largest labor organization in the state
Ryan Ferns, representing the interest of consumers

Ex-officio non-voting members:
Senator Roman Prezioso, Chairman, Senate Health and Human Resources Committee and Chairman, Legislative Oversight Commission on Health and Human Resources Accountability, by designation of Senate President Earl Ray Tomblin

Delegate Don Perdue, Chairman, House Committee on Health and Human Resources and Chairman, Legislative Oversight Commission on Health and Human Resources Accountability, by designation of House Speaker Richard Thompson

APPENDIX B

Governor's Office of Health Enhancement and Lifestyle Planning (GOHELP) Advisory Council Meeting October 21, 2009

A G E N D A

- **Welcome and Opening Remarks**
  Martha Y. Walker
  Acting Director
- **Introductions**
- **Current Business**

☞Expense Reimbursement
Debbie Waller
GOHELP Staff
☞Health Care Reform
Nancy Malecek, Insurance Market Analyst
WV Insurance Commission
☞Pharmacy
Advertising Rule and MMCAP Contract
Shannon Landrum
GOHELP Staff
☞Healthy Lifestyles
Keri Kennedy, Manager
WV Office of Healthy Lifestyles

- **New Business**

☞Five Year Strategic Plan
☞Survey
☞Work Groups
HIT, Wellness, State Plan
☞Future Meeting Schedule

- **Adjournment**

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

Advisory Council Meeting
December 16, 2009
2:00 p.m.
WV Insurance Commission Conference Room

A G E N D A

- Welcome and Introductions
  -Martha Walker, Director
- Review of October 21, 2009 Meeting Notes
  -Martha Walker
- Discussion of the 2007 WV State Health Report "Towards a Healthy WV: A Strategic Vision and Action Plan
  -Martha Walker
- Presentation - Electronic Medical Records
  -Rick Simon, CEO, Tri-County Health Clinic
  -Sarah Chouinard, MD, Chief Medical Advisor of the Community Health Network of WV & Medical Director for Primary Care Systems, Inc.
- Presentation - WV Healthy Lifestyles
  -Keri Kennedy, Manager
  WV Office of Healthy Lifestyles
- Presentation – State Health Plan
  -Sonia Chambers, Chair
  WV Health Care Authority
- Work Groups/Committees
  -Martha Walker
- Future Meeting Schedule
- Other Business/Adjournment

Governor's Office of Health Enhancement and Lifestyle Planning (GOHELP) Advisory Council Meeting July 15, 2010

A G E N D A

- **Welcome and Opening Remarks**
  Martha Y. Walker, Acting Director
- **Impact of Health Reform on Public Members**
  Amanda Pasdon, WV Chamber of Commerce
  Angela Vance, AARP
  Dr. David Avery, WV Academy of Family Physicians
  Gary Johnson, FQHC TBD!!!!!
  Denise Campbell, WV Nurses Association
  Karen Bowling, WV Hospital Association
  Brandon Tinney, AFAT-WV
  Ryan Ferns, Consumer Representative
- **Impact of Health Reform on Statutory Members**
  Jane Cline, WV Insurance Commissioner
  Ted Cheatham, Director, PEIA
  Sharon Carte, WV CHIP
  Sonia Chambers, Chair, WV HCA
  Patsy Hardy, Secretary WVDHHR
- **Discussion/Next Steps**
- **Adjournment**

Governor's Office of Health Enhancement and Lifestyle Planning
Advisory Council Meeting
12:00 PM August 18, 2010

AGENDA

- **Welcome and Opening Remarks** - *Martha Y. Walker, Acting Director*
- **Introductions** – *Martha Walker*
- **Senator Rockefeller's Office** - *Sara Dash*
- **Overview of Health Information Technology Initiatives** – *Chris Clark, GOHELP*
- **Health Information Technology (HIT) Project Updates**
  - **West Virginia Regional HIT Extension Center** - *Larry Malone*
  - **Hospital Electronic Health Record (EHR) Incentives** *Karen Bowling, WVHA*
  - **West Virginia Health Information Network** - *Raul Recary,COO WVHIN*
  - **West Virginia Bureau for Medical Services** - *Nancy Atkins, Commissioner*
    - *MediWeb & WVeScript – Vicki Cunningham, R.Ph.*
    - *State Medicaid HIT Planning*
  - **Public Health Projects**
  - **Statewide Broadband Infrastructure Project** – *Lt. Col. (Ret.) Mike Todorovich*
  - **West Virginia Telehealth Alliance** – *Larry Malone*
  - **Medical Homes, EHRs & PHRs** – *David Campbell*
  - **Health Insurance Portal** – *Jeremiah Samples, WV Insurance Commission*
  - **Funding Sources** – *Chris Clark GOHELP*
- **Impact of Health IT on Other Council Member Organizations**
  - WV Chamber of Commerce, *Amanda Pasdon*
  - AARP, *Angela Vance*
  - WV Academy of Family Physicians, *Dr. David Avery*
  - E.A. Hawse Health Center, *Gary Johnson*
  - WV Nurses Association, *Denise Campbell*
  - AFT-WV
  - WV Medical Association, *Dr. Steven Sebert*
  - West Virginia Insurance Commission, *Jane Cline, Commissioner*

- PEIA, *Ted Cheatham, Director / Gloria Long*
- WV CHIP, *Sharon Carte, Executive Director*
- WV Health Care Authority, *Sonia Chambers, Chair*
- WV Department of Health & Human Resources, *Patsy Hardy, Secretary*

- **Discussion/Next Steps**
- **Other Business**
- **Adjournment**

Governor's Office of Health Enhancement and Lifestyle Planning (GOHELP) Advisory Council
September 17, 2010
12:00 p.m.
OIC Conference Room

A G E N D A

Welcome and Introductions
-Martha Walker, Director

Overview of Health Information Technology Initiatives – Funding Sources
-Chris Clark, GOHELP

MediWeb and E-prescribing Demonstration
-Vicki Cunningham, Bureau for Medical Services

WV Primary Care Association's Reform Plans
-Louise Reese, WV Primary Care Association

Tax Implications of the Affordable Care Act
-Mark Muchow, WV Tax Department

Health Improvement Institute Activities
-Roger Chaufornier, Health Information Institute

Old Business
- E-prescribing meeting summary
- Workforce development workgroup report – Shannon Landrum, GOHELP

New Business

Adjournment

Governor's Office of Health Enhancement and Lifestyle Planning (GOHELP) Advisory Council
November 16, 2010
12:00 p.m.
OIC Conference Room

A G E N D A

Welcome and Introductions
-Martha Walker, Director

Presentation on How Seniors Will be Affected by the New Health Reform
-Marcia Meeks, Director of WV SHIP, Bureau for Senior Services

Presentation on the Status of the Broadband Technology Opportunities Program (BTOP)
-Mike Todorovich, Deputy 33-Continuity, NGWV and a member of the BTOP Grant Implementation Team

Presentation on Accountable Care Organizations
-John Moore, Bowles, Rice, McDavid, Graff & Love LLP

Presentation and Brief Discussion on Legislative Scope of Practice Study
-Nancy Tyler, Counsel for House Health Committee

Chamber of Commerce's Initiatives on Health Reform
-Amanda Pasdon, WV Chamber of Commerce

Overview of HIT and Strategic Plan Contracts

Question and Answer Period

Other Business

Adjournment

APPENDIX C

The West Virginia Governor's Office of Health Enhancement and Lifestyle Planning (GOHELP)

2009 Prescription Drug Advertising Expense Report

SB 414 transferred the rule-making authority for monitoring pharmaceutical drug advertising expenses from the Pharmaceutical Cost Management Council (PCMC) to GOHELP. When the PCMC was terminated with the creation of GOHELP in August 2009, it was necessary for GOHELP to develop and file emergency and legislative rules with the Secretary of State to assure direct advertising cost reporting continued in the absence of the PCMC. The legislature approved the legislative rule in the 2010 regular session. Pharmaceutical advertising cost reporting is now governed by Title 210, Series 1 of the Code of State Rules. The following reporting requirements were eliminated by the GOHELP legislation:

- the amount spent promoting specific drugs;
- the amount of financial support provided to advocacy groups in excess of $10,000; and
- the amount of financial support provided to individual pharmacies.

The GOHELP rule requires reporting entities to provide:

- the total amount spent for advertising and direct promotion in the state; and
- the total number of state prescribers to whom the entity provided financial support of any kind in excess of $100.

Under both the statute (§16-29H-8) and the Legislative Rule (CSR 210-1), only aggregated data may be disclosed to the public.

The West Virginia Governor's Office of Health Enhancement and Lifestyle Planning (GOHELP)

2009 Prescription Drug Advertising Expense Report

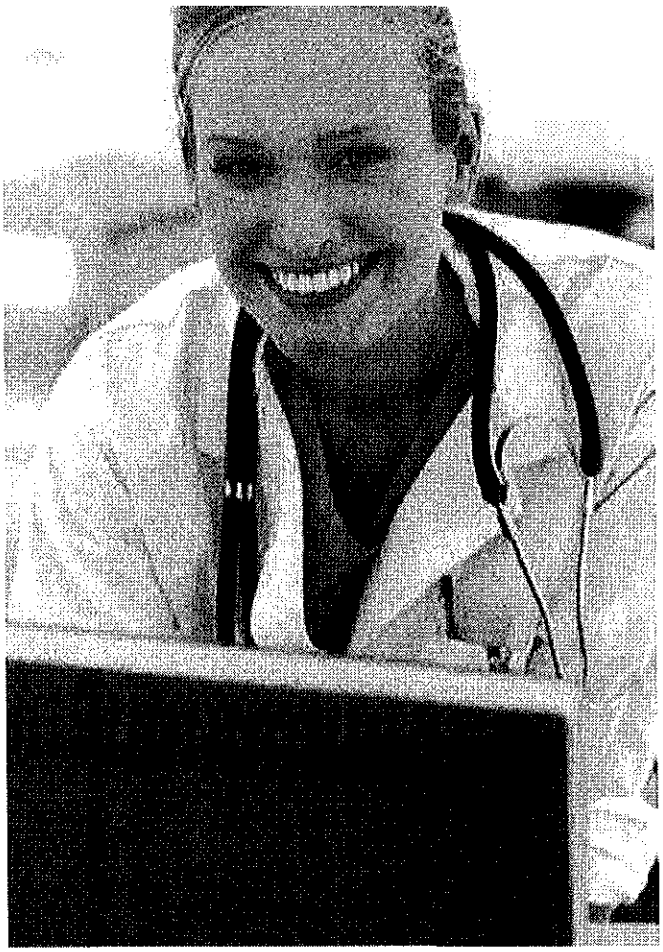
Aggregated Data

135 manufacturers and labelers filed reports under the Legislative Rule. This is an increase over both 2007 and 2008, when 111 and 126 companies respectively reported to the Pharmaceutical Cost Management Council.

Companies reported a total amount spent for advertising and direct promotion of prescription drugs to consumers, prescribers, pharmacies and advocacy groups for the 2009 reporting period of $28,661,957.00. This figure has dropped from $33 million in the prior reporting period. $7.7 million of the 2009 total was spent on direct-to-consumer advertising. $21 million was spent on direct promotion to consumers, prescribers, pharmacies and patient support or advocacy groups. 96% of expenditures were in amounts less than $2500. No discretionary disclosures were reported.

2010 advertising expense reports are to be submitted to the Governor's Office of Health Enhancement and Lifestyle Planning no later than April 1, 2011.

APPENDIX D



Medicare Electronic Health Record Incentive Program for Eligible Professionals

The American Recovery and Reinvestment Act (Recovery Act) of 2009 provides for incentive payments for Medicare eligible professionals (EPs) who are meaningful users of certified electronic health record (EHR) technology. Section 1848(o)(5)(C) as added by the Recovery Act section 4101 defines the term eligible professional to mean a physician as defined in section 1861(r), which includes the following five types of professionals: doctor of medicine or osteopathy, a doctor of oral surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. These professionals are eligible for incentive payments for the "meaningful use" of certified EHR technology, if all program requirements are met. Hospital-based EPs are not eligible to participate in the EHR incentive program. An EP is considered to be hospital-based if the EP furnishes 90 percent of his or her services in a hospital inpatient or emergency room setting.

EPs may not receive EHR incentive payments from both the Medicare and Medicaid programs in the same year. In the event an EP qualifies for EHR incentive payments from both the Medicare and Medicaid programs, the EP must elect to receive payments from only one program. After an EP qualifies for an EHR incentive payment under one program but before 2015, an EP may switch between the Medicare and Medicaid programs one time. Upon switching programs, the EP will be placed in the payment year the EP would have been in had the EP not switched programs. For example, if an EP decides to switch after attesting to meaningful use of certified EHR technology for a Medicare Fee-for-Service (FFS) incentive payment for the second payment year, then the EP would be in the third payment year for purposes of the Medicaid incentive payments.

Participation in Other CMS Incentive Programs

An EP who participates in the Medicare EHR incentive program may also participate in the Physician Quality Reporting System. However, if an EP elects to receive an EHR incentive payment through the Medicare Program, the EP is not eligible to receive an incentive payment through the Electronic Prescribing (eRx) incentive program. On the contrary, EPs who receive an EHR payment through the Medicaid Program are eligible to also receive an incentive payment through the eRx incentive program provided they meet all the requirements of the eRx program.

Fee-for-Service Medicare Incentive Payment

Incentive Payment - Calculation

Under FFS Medicare, the payment incentive amount, subject to an annual limit, is equal to 75 percent of an EP's Medicare physician fee schedule allowed charges submitted not later than 2 months after the end of the calendar year. This means that, for 2011, the EHR incentive payment for an EP would be, subject to an annual limit, equal to 75 percent of the EP's Medicare physician fee schedule allowed charges for CY 2011, based on claims for services performed by the EP from January 1, 2011 through December 31, 2011, and submitted to the EP's Medicare contractor (MAC/carrier) no later than February 29, 2012.

Incentive Payment - Time Frame

EPs can begin receiving incentive payments in any calendar year (CY) from 2011 to 2014. EPs may receive Medicare incentive payments for up to five years, depending on the year in which the EP first becomes a meaningful user of certified EHR technology.

Medicare EPs who successfully demonstrate meaningful use and receive a Medicare EHR incentive payment in the first or second year of the incentive program (2011 or 2012) may qualify to receive payments for the full five years. However, Medicare EPs who first successfully demonstrate meaningful use for 2013 can only receive incentive payments for four years and will receive less than the maximum possible incentive payment. Accordingly EPs who start participating in 2014 can only receive incentive payments for three years and will also receive less than the maximum

incentive payment possible. An EP who first successfully demonstrates meaningful use of certified EHR technology for 2015 will not qualify for any Medicare EHR incentive payments. In addition, starting in 2015, an EP who does not successfully demonstrate meaningful use of certified EHR technology use will be subject to reduced physician fee schedule payments.

Medicare EHR incentive payments will be made on a rolling basis after CMS has ascertained that the EP met meaningful use for the reporting period and the EP has met the maximum allowable charges threshold. In the event that the EP does not meet the maximum allowed charges threshold by the end of the calendar year, payment will be made following the deadline to submit claims for the period.

Incentive Program - Annual Limits

EPs who successfully demonstrate meaningful use of certified EHR technology during the relevant EHR reporting period may be eligible for an incentive payment amount, subject to an annual limit, equal to 75 percent of the EP's Medicare allowed charges submitted not later than two months after the end of the calendar year. Table 1 illustrates the maximum incentive payments an EP can receive by year and the total incentive payments possible if an EP successfully demonstrates meaningful use and qualifies for an incentive payment each year. As shown, the total amount of the incentive payment an EP can receive is dependent in part on the year in which the EP successfully demonstrates meaningful use.

Table 1: Maximum Incentive Payments Based on the First CY in Which an EP Participates in the Program

Calendar Year	*Maximum Incentive Payments Based on the First CY in Which an EP Participates in the Program*			
	2011	**2012**	**2013**	**2014**
2011	$18,000			
2012	$12,000	$18,000		
2013	$8,000	$12,000	$15,000	
2014	$4,000	$8,000	$12,000	$12,000
2015	$2,000	$4,000	$8,000	$8,000
2016		$2,000	$4,000	$4,000
Total	***$44,000***	***$44,000***	***$39,000***	***$24,000***

Health Professional Shortage Area

Section 1848(o)(1)(B)(iv) of the Act provides that the amount of the annual EHR incentive payment limit for each payment year be increased by 10 percent for EPs who predominantly furnish more than 50 percent of services in an area that is designated by the Secretary (under section 332(a)(1)(A) of the PHS Act) as a geographic health professional shortage area (HPSA). CMS will use the frequency of services provided over a one-year period from January 1 to December 31 rather than allowed charges to determine if an EP qualifies for an HPSA bonus. EPs who predominantly furnish services in an HPSA who do not accrue the maximum allowed charges will be paid according to the statutory formula at 75 percent of the allowed charges.

Table 2 shows the maximum incentive payments for EPs who qualify for the higher HPSA limit.

Table 2: Maximum Incentive Payments for an EP Who Qualifies for an HPSA Bonus Payment Based on the First CY in Which the EP Participates in the Program

Calendar Year	*Maximum Incentive Payments for an EP Who Qualifies for an HPSA Bonus Payment Based on the First CY in Which the EP Participates in the Program*			
	2011	**2012**	**2013**	**2014**
2011	$19,800			
2012	$13,200	$19,800		
2013	$8,800	$13,200	$16,500	
2014	$4,400	$8,800	$13,200	$13,200
2015	$2,200	$4,400	$8,800	$8,800
2016		$2,200	$4,400	$4,400
Total	***$48,400*** ***($4,400 increase)***	***$48,400*** ***($4,400 increase)***	***$42,900*** ***($3,900 increase)***	***$26,400*** ***($2,400 increase)***

Payment Adjustments Beginning in 2015

If an EP does not successfully demonstrate meaningful use of certified EHR technology, the EP's Medicare physician fee schedule amount for covered professional services will be adjusted by the applicable payment adjustment specified in the Recovery Act beginning in 2015. The payment adjustments will be as follows:

- 2015—99 percent of Medicare physician fee schedule covered amount
- 2016—98 percent of Medicare physician fee schedule covered amount
- 2017 and each subsequent year—97 percent of Medicare physician fee schedule covered amount

If it is determined that for 2018 and subsequent years that less than 75 percent of EPs are meaningful users then the payment adjustment will change by one percentage point each year until the payment adjustment reaches 95 percent.

The Recovery Act allows for a hardship exception, which, if applicable, could exempt certain EPs from the payment adjustment. The exemption is subject to annual renewal, but in no case will a hardship exemption be given for more than five years. ***Note: More information on payment adjustments and the requirements to qualify for a hardship exemption will be provided in future rulemaking prior to the 2015 effective date.***

Medicare Advantage (MA) Incentive Payments

Section 1853(l)(1) of the Act, as added by the Recovery Act, also provides for incentive payments to qualifying MA organizations (MAO) for their affiliated EPs who are meaningful users of certified EHR technology. Specifically an MA EP as defined by section 1853(l)(2) of the Act, as added by the Recovery Act must either:

- Furnish, on average, at least 20 hours/week of patient-care services and be employed by the qualifying MAO

  or
- Be employed by, or be a partner of, an entity that through contract with the qualifying MAO furnishes at least 80 percent of the entity's Medicare patient care services to enrollees of the qualifying MAO

If an MA EP meets these guidelines and the MAO can attest that the MA EP is a meaningful user of certified EHR technology the MAO can receive an incentive payment in accordance with Table 3. Similar to the Medicare FFS incentive program MA organizations are not eligible for incentive payments for hospital based EPs.

Table 3: Maximum Incentive Payments Based on the First CY in Which the MAO EP Participates in the Program

Calendar Year	*Maximum Incentive Payments Based on the First CY in Which the MAO EP Participates in the Program*			
	2011	**2012**	**2013**	**2014**
2011	$18,000			
2012	$12,000	$18,000		
2013	$8,000	$12,000	$15,000	
2014	$4,000	$8,000	$12,000	$12,000
2015	$2,000	$4,000	$8,000	$8,000
2016		$2,000	$4,000	$4,000
Total	***$44,000***	***$44,000***	***$39,000***	***$24,000***

Section 1853(l)(3)(B) of the Act, as added by the Recovery Act, specifically states that duplicate payments may not be made for EPs eligible for both the FFS incentive payment and the MA incentive payment. Section 1853(l)(3)(B)(i) says that if an EP is eligible to receive an incentive payment from both the Medicare FFS and MA programs, the Medicare

FFS payment will be made first but only if it is for the maximum amount due for that payment year. Therefore, before a payment can be made to a qualifying MAO for an EP, CMS will determine if that EP has already been paid the maximum for that year through the Medicare FFS Program. If the EP received the maximum incentive payment available for that payment year from the Medicare FFS Program then the MAO would not be eligible to receive an MA incentive payment for that EP for that payment year.

If, however, the EP did not receive the maximum possible incentive payment possible for the payment year, then the MAO will receive the incentive payment solely through the MA incentive program. Payment solely under the MA program for EPs who qualify for incentive payments under both FFS and MA, but who did not earn the maximum bonus under FFS, is required by section 1853(l)(3)(B)(ll) of the Act.

Additional Resources

For more information on the EHR incentive program, see ***http://www.cms.gov/EHRIncentivePrograms/*** on the CMS website.

ICN# 903695 (November 2010)

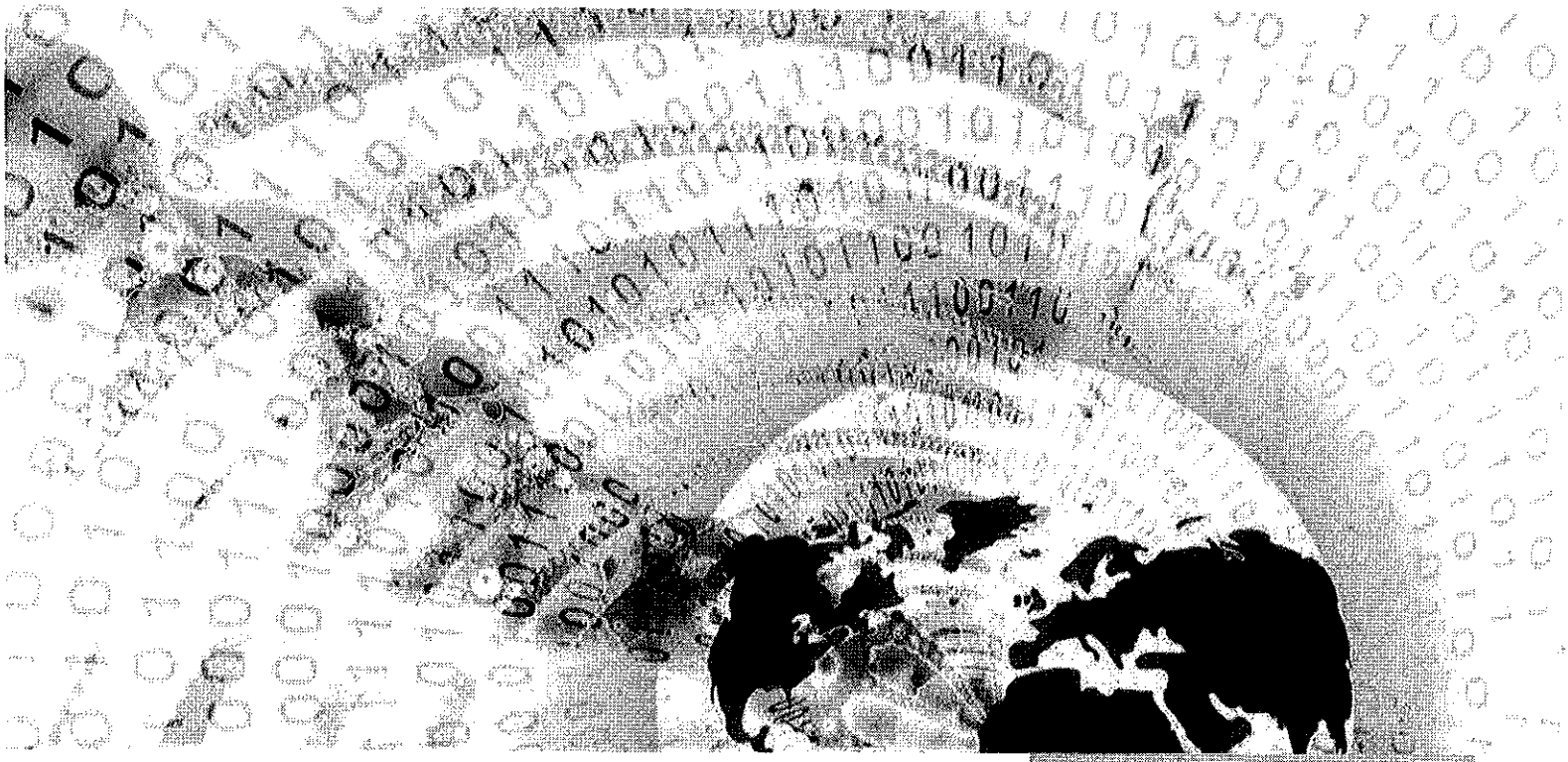
APPENDIX E

Health Information Technology Terms

AHRQ	Agency for Health Quality and Research.
ANSI	American National Standards Institute
ARRA	American Recovery & Reinvestment Act
BTOP	Broadband Technology Program
BIP	Broadband Initiatives Program
CAHs	Critical Access Hospitals
CCD	Continuity of Care Document
CCHIT	Certification Commission for Health Information Technology
CPOE	Computerized Physician Order Entry
EHR	Electronic Health Record
EMR	Electronic Medical Record
HII	Health Improvement Institute.
HIMSS	Health Information Management and Systems Society
HL7	Health Level 7 (accreditation standard for clinical and administrative data)
HIT	Health Information Technology
HITECH Act	Health Information Technology for Economic and Clinical Health Act
HITSP	Health Information Technology Standards Panel
HIE	Health Information Exchange
HIN	Health Information Network
HIO	Health Information Organization
HISPC	Health Information Security and Privacy Collaboration
HRSA	Health Resources and Services Administration
IDN	Integrated Delivery Network
MITA	Medicaid Information Technology Architecture
NIST	National Institute of Standards and Technology
NHIN	Nationwide Health Information Network
ONC	Office of the National Coordinator
PHR	Personal Health Record
PMR	Personal Medical Record
PMS	Practice Management System
RHCPP	Rural Health Care Pilot Program
RHIO	Regional Health Information Organization
RHITEC	Regional Health Information Technology Extension Center (also known as REC)
RPMS	Resource and Patient Management System
SDEs	State Designated Entities
SHAP	State Health Access Program
SOA	Service Oriented Architecture
VistA	Veteran's Health Information System and Technology Architecture
WVTA	West Virginia Telehealth Alliance
WVHIN	West Virginia Health Information Network
WVMI	West Virginia Medical Institute

APPENDIX F

West Virginia
Health Information Technology Statewide Strategic Plan



September 2009

Contributing Organizations:

Marshall University
Shepherd University
West Virginia University
WV Academy of Family Practice
WV Academy of Pediatrics
WV Bureau for Medical Services
WV Department of Health and Human Resources
WV Governor's Office of Information Technology
WV Health Care Authority
WV Health Improvement Institute
WV Health Information Network
West Virginia Medical Foundation
WV State Medical Association
WV School of Osteopathic Medicine
WV Telehealth Alliance

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Dear West Virginians,

The health and well -being of all West Virginians is a priority for the state. The health and burden of illness in our community affects all aspects of our lives. Health affects our productivity that in turn influences our tax base. Health drives the health care costs that the state has to incur. Most important, health affects you and your quality of life.

Unfortunately, West Virginia continues to rank in the bottom ten states in the nation in overall health status of its population. We know how to deliver and improve health care. In West Virginia, some of our doctors and hospitals rank in the top 1% nationally. The rise in Diabetes is one of our major concerns across our citizens. One in three people are at risk for Diabetes in West Virginia. The science exists for how to prevent Diabetes. If we have good doctors and hospitals why can't we bridge this gap between what we know and what we do? One of the primary reasons is the management of health information and communication.

Think about your most recent visit to your doctor or hospital. You were asked to show proof of your health insurance coverage, and asked a series of questions about your family medical history; medications and allergies; your emergency contact information; and asked to verify your address and phone number. How many times have you been asked the same information? What happens if you are in another part of the state and need urgent care? Is that same information available for the care team to help streamline your visit? Have you ever had a medical test and the results are not available when you next need care and you have to have the test repeated? Why are there so many medication errors in health care?

The common thread behind these questions and issues is how our health care system manages and communicates information. This document sets forth a vision for bridging this gap. We intend to leap forward as a state from our bottom ten status to being a top- tier state in terms of health of its population. By aligning resources and the hard work of all those supporting health care in West Virginia we can bridge this gap. As we connect professionals, families and communities, and work together to improve the health status of all West Virginians we should all benefit from the rewards from a high quality of life. Join us on this voyage and play your role in helping us become the healthiest state in the nation because we are the health information technology state.

Sincerely yours,

Martha Y. Walker

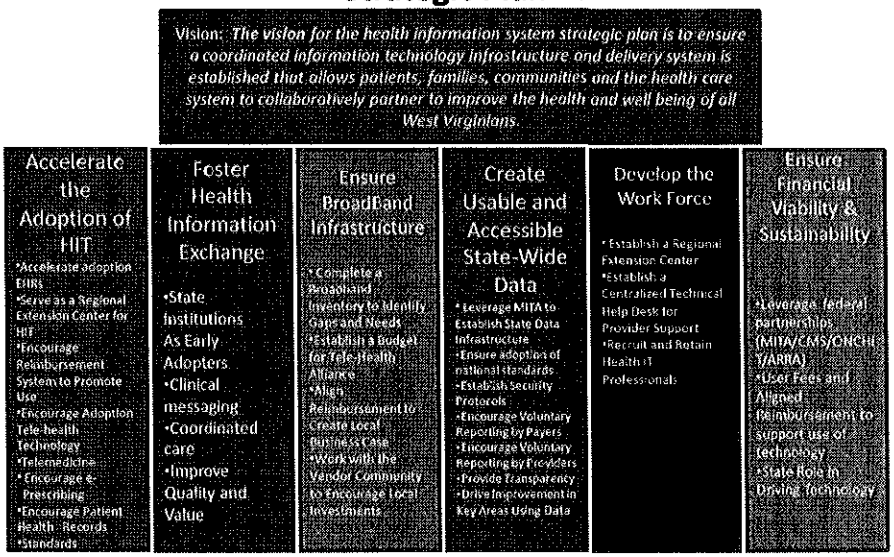
Interim GOHELP Director

Executive Summary

This strategic plan sets forth a vision for the state of West Virginia relative to health information technology. The plan was developed by a work group of stakeholders from the health care system. The plan is being circulated for wide comment and feedback. Comments will be incorporated with the final plan.

A summary of the plan is presented below:

West Virginia State Health Information Technology Strategic Plan



The plan provides insight into the plethora of activities in West Virginia that have focused on health information technology. In many areas, the state has been a leader and early adopter of use of health information technology. Also in many areas, the state faces substantial challenges overcoming its rural environment and economic forces affecting the health care system. Even more daunting are the health care issues facing the population.

A vision is offered in this plan for West Virginia where health information technology plays a critical role in bridging the gaps to access and quality of service for the purpose of improving the health and well- being of all West Virginians.

Six core strategic drivers are presented. These include:

- **Accelerating the Adoption of Health Information Technology:** Six priorities are outlined. All focus on accelerating the adoption of electronic medical records (EMR) and related health information technologies by the provider community. The priorities recognize the need for a well -coordinated effort to ensure that providers are informed purchasers of technology and that their investments translate into meaningful use in daily work.

- **Fostering Health Information Exchange:** In order for the benefits of use of technology to be fully realized there needs to be an efficient, affordable and reliable exchange of information. This plan incorporates the work of the West Virginia Health Information Network, ensuring that a viable and robust exchange supports the flow of information across the health care system.

- **Ensuring Broadband Infrastructure is Available to Support Technology:** The rural geography of West Virginia, coupled with the population dispersion, presents unusual challenges, ensuring that adequate infrastructure is able to support technology in communities. Four priorities are offered and aimed at encouraging infrastructure investments in the state.

- **Creating Useable and Accessible Statewide Data:** The adoption of technology allows for strategic use of data for planning and improvement of health care services. Seven priorities are presented and aimed at ensuring that data are readily available for decision support. This includes strategies for encouraging voluntary reporting and transparency of data.

- **Develop the Work Force:** The acceleration of adoption of technology will present challenges to the work force. As a result, four priorities are offered for the purpose of ensuring that the work force is trained and available to support efficient use of technology. This plan also presents a vision where West Virginia plays a role as a national resource for the training of professionals in health information technology.

- **Ensuring Financial Viability and Sustainability:** Finally, the plan recognizes that West Virginia will need strong partners in order to ensure that the financing of this vision, plan and its priorities is viable and sustainable. The plan recognizes that the financing strategies cannot be a burden assumed entirely by any single stakeholder, but will need to be a collaborative effort shared across the health care system.

Acknowledgements

This strategic plan was developed through a collaborative process engaging stakeholders representing the governmental and non-governmental health care system in West Virginia. The work group that assumed the lead for drafting the first iteration of the plan included:

Pat Miller Bureau for Medical Services	Sallie Milam West Virginia Health Information Network (WVHIN) and Health Care Authority	Jim Comerci, M.D. Private Physician Former Chair, Select D Work Group on HIT
Peter Groen Shepherd University Research Corporation (SURC)	Jack Shaffer Medicaid Transformation Grants Community Health Network of West Virginia	Larry Malone West Virginia Telehealth Alliance
John Wiesendanger West Virginia Medical Institute	Sue Ann Lipinski West Virginia Governor's Office of Technology	Laurel Harris Arnold BDMP
Helen Matheny West Virginia Medical Foundation	Robert Coffield Flaherty, Sensabaugh and Bonasso, LLC Chair Health Improvement Institute HIT Work Group	Roger Chaufournier West Virginia Health Improvement Institute

Contributors to the Development of the Strategic Plan Included:

Governor's Office of Information Technology	West Virginia State Medical Association	Shepherd University
Department of Health and Human Resources	West Virginia Medical Foundation	West Virginia University
Bureau for Medical Services	West Virginia Academy of Family Practice	Marshall University
West Virginia Health Care Authority	West Virginia Academy of Pediatrics	West Virginia School of Osteopathic Medicine
West Virginia Health Information Network	West Virginia Hospital Association	Mountain State Blue Cross and Blue Shield
West Virginia Telehealth Alliance	West Virginians for Affordable Health Care	Public Employees Insurance Agency
West Virginia Medical Institute		

APPENDIX G

Preventive and Primary Care Pilot Program

Created by HB 4021 (2006 Legislative Regular Session)

Developed and Implemented by:
WV Health Care Authority and WV Insurance Commissioner

Provider	Number of Enrollees
Monroe Health Center	**13**
PrimaryCare*One*	**336**
New River Health Association	**434** ***9 employers**
Valley Health	**16**
WomenCare, d/b/a FamilyCare	**0**
Manchin Clinic	**3**
TOTAL	**802**