NC MEDICAID MANAGEMENT INFORMATION SYSTEM+ (NCMMIS+) PROGRAM

Quarterly Report to the North Carolina General Assembly

State of North Carolina

Department of Health and Human Services

January 1, 2010

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INTRODUCTION

In June 2008, the NC General Assembly passed Session Law 2008-107, House Bill 2436, of which Sections 10.9.(c), (d)and (e) required quarterly reporting in regard to the Replacement Medicaid Management Information System (MMIS). In accordance with this law, the Department of Health and Human Services began submitting quarterly reports on March 1, 2009. Session Law 2009-451, Section 10.41 continued the quarterly reporting requirements beginning July 1, 2009.

Appendix B–Replacement MMIS Schedule of this report reflects the high-level design, development and installation (DDI) schedule with the major milestones for the 32-month schedule. Details about the schedule are noted in this report's "Schedule" section.

BACKGROUND

For background information on the MMIS Replacement Project, please see *Appendix C–Background.*

STATUS

As previously reported, the Vendor, CSC, is implementing a Multi-Payer conceptual design which reflects the significant business interactions across the Replacement MMIS. This design is maturing throughout the Project as "Builds" that contain applicable multi-payer functionality are completed. The DDI tasks associated with Builds 1 through 3 have been completed. These activities include the set up of an operational NCTracks portal (Build 1), Training/Demo Environments (Build 2) and Imaging, Retrieval and Printing Equipment (Build 3).

Enhancements to the NCTracks Portal login process were implemented promoting a self-service environment for users. CSC also delivered a Joint–Office of Medicaid Management Information System Services (OMMISS) and CSC–Contract Site on the NCTracks portal providing initial dashboards that support program performance monitoring and Web logs that provide the number of "hits" the SharePoint and portal is getting. NCTracks is the single point of entry (portal) to access all Replacement MMIS functionality; it is also the website where all project-related documentation is stored and accessible.

The Provider Early Implementation phase is complete with the approval of the final deliverables for Build 4.1. CSC is producing operational reports for the Enrollment, Verification, and Credentialing (EVC) to monitor provider application inventory and enrollment status. Call Center statistics are provided weekly to monitor service levels, weekly call abandon rates and utilization call types.

Web-based provider enrollment was implemented as planned on August 31 after a successful pilot test with NC Medicaid providers. Provider's feedback was positive with suggestions for minor enhancements. Web-based provider enrollment enables the State to consolidate approximately 60 old forms into 10 new forms that are dynamically generated based on the provider selections via the Web.

Provider EVC Operations implemented a new functionality to collect the newly mandated $100 provider application fee. This will provide the status of a provider's enrollment application and offer a Web-based self-help feature to the provider community.

Retroactive Drug Utilization Review (RetroDUR) Intervention meetings continue with reviews for possible interventions for drug over-utilizations, dose optimization and drug interaction scenarios. Several reports for these interventions have been presented to the Division of Medical Assistance (DMA) Drug Utilization Review (DUR) Coordinator. The Quarterly DUR Board Meeting was held on October 22 with recommendations for intervention letters to be sent to physicians.

CSC completed its initial draft of the Multi-Payer Logical Data Model and a High-Level Benefit Plan conceptual model. The design for these models will mature with the ongoing technical design work and will serve as a guide for each of the builds. Code analysis continues on the edits and audits of the legacy MMIS with the goal of ensuring current policy is addressed in the MMIS Replacement Project. The results of this effort along with the Proof of Concept model for externalization of claim adjudication edits and audits will be incorporated into a Multi-Payer Adjudication Edits and Audits Inventory deliverable.

Preliminary plans for a Joint review of the Integrated Edit and Audit Inventory deliverable are under development. Multi-Payer Team members are active in build meetings to ensure alignment with the approved structure for benefit plans and coverage rules.

Kickoff meetings have been conducted to initiate Requirement Review activities for Managed Care & Third Party Liability (Build 13) and Call Center Services (Build 17). Business System Design activities continue for Financial Management & Accounting (Build 11), Prior Authorization (Build 12), Financial Transactions (Build 15), Health Check and Drug Rebate (Build 16).

CSC presented the Technical Design Document (TDD) Prototype to OMMISS and other project stakeholders providing a framework for the technical design session. Technical Design meetings have begun for Provider (Build 5), Recipient (Build 6), Eligibility Verification (Build 7), Non-Electronic Submissions (Build 8), Pend Resolution & Reference (Build 14) and Automated Voice Response (Build 18).

The preliminary mapping of Operations (Build 100) requirements to business units within the Fiscal Agent Operations Organization is complete and plans for the production of an Operational Requirements Traceability Matrix (RTM) are in progress. A review of the Centers for Medicare & Medicaid Services (CMS) Certification Checklist mappings has begun and checklist mappings are complete for Provider Management, Claims Receipt and Pharmacy POS Claims Processing. NCTracks baseline target field information was extracted and loaded into a conversion rules database. Work to relate legacy fields to their corresponding NCTracks fields for Provider, Recipient, Claims, Pend Resolution and Reference is underway.

The CSC Delivery Assurance Review (DAR) team conducted its second assessment of the Project's performance. OMMISS, CSC and subcontractor staff participated with onsite interviews which were concluded the week of October 2, 2009. The assessment was generally favorable, noting strengths in the Multi-Payer architecture, quality of State subject matter experts, rigor of Project processes and the partnership of the joint team. CSC DAR rating remains yellow in their green/yellow/red ranking system; meaning minor issues remain and should be monitored, but no negative impact to Project is anticipated.

CSC staffing increased from 215 to 239.

RECENT UPDATES

To receive system certification from the CMS, the State must also concurrently replace the existing Decision Support System (DSS) aka Data Retrieval and Information Validation Engine (DRIVE) and the Surveillance Utilization Review System (SURS) aka NC Fraud and Abuse Detection system (FADS). The Reporting & Analytics (R&A) Project was established to address this requirement. This Project will satisfy the mandated CMS requirements to replace the Legacy MMIS+–along with the data warehouse used for reporting–with new technology that will maximize efficiencies, improve flexibility and provide a centralized repository for the Replacement MMIS claims.

The R&A Request for Proposal (RFP) was published on November 23, 2009. The R&A project status will be included in future quarterly reports.

CHANGE REQUESTS

The Replacement MMIS has developed a Change Management Plan (CMP) to ensure changes in the size, scope, complexity and length of the Project are appropriately planned and managed. The CMP documents the multiple levels of reviews and approvals that are required before a change is enacted. The final review within DHHS is the multi-divisional Change Control Body (CCB); then, if the change has an associated cost, the Statewide IT Procurement Chief also approves the change. During the procurement process, Offerors were required to propose the cost anticipated to be needed for changes during the DDI phase. CSC proposed $22 million which was approved by CMS and subsequently budgeted by the Agency. The following table summarizes change requests approval during this reporting period.

	Prior to Aug 2009	Aug-Oct 2009	Total
No Cost CSRs	0	62	62
Cost CSRs	0	5	5
Number of Approved CSRs	0	67	67
Cost of Approved CSRs	$0	$27,622	$27,622

Most of the Customer Service Requests (CSRs) to date have been business rule changes related to the early implementation of the provider Enrollment, Verification and Credentialing functionality which are typically no-cost CSRs. The highest priced approved CSRs to date are:

- $18,362 for the data entry into the EVC system of provider files that are not going through re-credentialing
- $8,482 for the manual maintenance of Community Intervention Services Tracking Worksheet

DHHS and CSC were very active in implementing the legislatively mandated $100 Provider Fee. This function was implemented on schedule in September; however, CSC has not yet submitted a cost or level of effort document to DHHS.

FINANCIAL UPDATE

The current estimated cost of MMIS Design, Development and Installation (DDI) is $114,704,822 of which $13,717,683 is the necessary State matching funds. CMS funds most DDI activities at a 90/10 federal match. Some exceptions to the 90/10 include funding for training, furniture, indirect costs (overhead), and travel for non-project specific purposes; these activities receive 50/50 federal match. It should also be noted that non-Medicaid functionality, such as Public Health and Mental Health are not funded by CMS. In consideration of these factors, the "effective" federal funding rate for the MMIS DDI effort is approximately 88%. The $114,704,822 total MMIS DDI cost includes $22,000,000 in possible change orders approved by CMS (which will require contract amendments should DHHS decide to spend any part of the $22 million) and approval by the Statewide IT Procurement Office.

Program expenditures for SFY 09-10 are estimated to be $64,240,989, which includes $11,556,200 of State matching funds. With a carry forward of $3,775,615 from SFY 08-09, $7,780,585 in new State funds are required in SFY 09-10.

The Reporting and Analytics (R&A) and the Division of Health Service Regulations (DHSR) projects are currently conducting procurement activities; therefore, cost projections from these projects have been redacted from the attached financial tables.

The financial details are provided in *Appendix A–Financial Update*.

SCHEDULE

This report includes the most recent high-level DDI schedule which reflects all major milestones during the 32-month schedule. The Replacement MMIS is scheduled to be operational on August 22, 2011. It should be noted that this schedule may be affected by federally mandated changes referred to as 5010 and ICD-10, described in the June 1, 2009 report.

There have been no changes to the schedule affecting the Project's critical path as of the publication of this report.

End of Report

APPENDIX A –

FINANCIAL UPDATE

Table 1 below represents total costs incurred since the inception of the NCMMIS+ Program in September 2006, through the month ending October 31, 2009. It also includes estimated costs through the implementation of the Replacement MMIS, plus one year of CMS certification activities, ending on August 31, 2012. Post-implementation maintenance and operational costs are not included in these costs.

The Program's overall estimated costs are running .01% below the ITS-approved budget.

Table 1: Program Costs from September 2006 - October 2009 & Estimates through CMS Certification (August 2012)

Project	Start Date	End Date	Expenditures to Date	ITS Approved Budget	Required State Funds	Current Estimated Costs	Variance
[4]MMIS DDI	11/01/08	11/30/11	10,376,262	92,704,823	10,661,055	92,704,823	0
[1]MMIS DDI Changes	01/05/09	08/23/11	0	N/A	2,695,000	22,000,000	N/A
MMIS Early Operations	04/20/09	08/23/11	994,162	N/A	5,181,955	10,363,909	N/A
[2]R&A	11/01/08	08/31/11	REDACTED: SEE FOOTNOTE 2				
[2]DHSR	07/01/08	06/30/11					
Program-Level	02/01/07	08/31/12	6,074,165	11,151,565	2,007,282	11,191,275	39,710
Business Initiatives							
Health Choice	12/01/08	02/28/10	577,750	787,638	78,764	767,696	-19,942
Completed Projects			9,384,802	9,436,139	1,029,109	9,384,720	-51,419
Total Current Projects			REDACTED: SEE FOOTNOTE 2				
[3]Total ITS-Approved	09/16/06	08/31/12					
Variance							-0.01%

Footnotes:

[1]- This amount has been designated as a place holder for legislative and/or Federal changes that may be required during the next fiscal year. Federal match is already approved.

[2]- **Source Selection Sensitive**. The Reporting and Analytics (R&A) and the Division of Health Service Regulations (DHSR) projects are currently in the Procurement Phase. Because the State is conducting procurement activities, **these cost projections have been redacted**. Also, since a contract has not been executed, these projected costs are more speculative than the other estimates.

[3]- Total estimated cost of ITS-Approved Projects; (i.e., the place-holder *MMIS DDI Changes* and the *MMIS Early Operations)* costs are not included in this total.

[4]- Includes $16,591 in expenditures for the SAS Budget & Finance project.

Table 2 below represents State funds required for the current State Fiscal Year (SFY) 2009-2010. No changes from last quarter's report.

Table 2: State Funds Required for SFY 2009-2010

Project	Estimated Expenditures	Estimated State Funds
[3]MMIS DDI	36,048,592	4,722,366
[1]MMIS DDI Changes	11,000,000	1,347,500
MMIS Early Operations	4,190,744	2,095,372
[2]R&A	REDACTED: SEE FOOTNOTE 2	
[2]DHSR		
Program-Level	2,654,306	469,812
Business Initiatives		
Health Choice	198,816	19,882
Program Total	REDACTED: SEE FOOTNOTE 2	
State Appropriation Balance 7/1/09		3,775,615
Appropriations Needed SFY 09-10		**7,780,585**
Estimated Carry Forward Appropriations 6/30/10		0

Footnotes:

[1]- This amount has been designated as a place holder for legislative and/or Federal changes that may be required during the next fiscal year. Federal match is already approved.

[2]- **Source Selection Sensitive**. The Reporting and Analytics (R&A) and the Division of Health Service Regulations (DHSR) projects are currently in the Procurement Phase. Because the State is conducting procurement activities, **these cost projections have been redacted**. Also, since a contract has not been executed, these projected costs are more speculative than the other estimates.

[3]- Inclusive of estimated expenditures for the SAS Budget & Finance project.

Table 3 below represents State funds required for the next fiscal year (SFY 10-11). No changes from last quarter's report.

Table 3: State Funds Required for SFY 20010-2011

Project	Estimated Expenditures	Estimated State Funds
[3]MMIS DDI	36,139,674	4,734,297
[1]MMIS DDI Changes	6,000,000	735,000
MMIS Early Operations	3,833,219	1,916,610
[2]R&A	REDACTED: SEE FOOTNOTE 2	
[2]DHSR		
Program-Level	2,415,594	427,560
Business Initiatives		
Health Choice	0	0
Program Total	REDACTED: SEE FOOTNOTE 2	
State Appropriation Balance 7/1/10		0
Appropriations Needed SFY 10-11		**10,169,072**
Estimated Carry Forward Appropriations 6/30/11		0

Footnotes:

[1]- This amount has been designated as a place holder for legislative and/or Federal changes that may be required during the next fiscal year. Federal match is already approved.

[2]- **Source Selection Sensitive**. The Reporting and Analytics (R&A) and the Division of Health Service Regulations (DHSR) projects are currently in the Procurement Phase. Because the State is conducting procurement activities, **these cost projections have been redacted**. Also, since a contract has not been executed, these projected costs are more speculative than the other estimates.

[3]- Inclusive of estimated expenditures for the SAS Budget & Finance project.

End of Appendix A

APPENDIX B –

REPLACEMENT MMIS SCHEDULE

This January 1, 2010, Quarterly Report includes the most recent high-level design, development and installation schedule which reflects all major milestones during the 32-month schedule. The *Replacement MMIS* is scheduled to be operational on August 22, 2011.

It should be noted that this schedule may be affected by federally mandated changes. On January 16, 2009, US DHHS published two final rules to adopt updated HIPAA standards to the Electronic Transaction Standards, and adoption of the ICD-10 code set. These legislative changes are commonly referred to as 5010 and ICD-10. A summary of these changes is contained in the June 1, 2009 Quarterly Report document.

Design, Development and Implementation (DDI) Replacement MMIS Schedule

Build Number	Key Milestone	Planned Date	Actual Date
	Award Announcement /Contract Signed	December 22, 2008	December 22, 2008
	Project Kickoff Meeting	January 5, 2009	January 5, 2009
2	Setup Baseline System Replica Environment Complete	March 3, 2009	March 3, 2009
	CSC Permanent Facility Ready for Early Occupancy	March 5, 2009	March 5, 2009
1	Project Management Portal (NCTracks) Complete	March 26, 2009	March 26, 2009
4.3	RetroDUR Early Implementation	April 6, 2009	April 6, 2009
	Final Baseline Integrated Master Schedule Submitted to the State	April 9, 2009	April 9, 2009
4.1	Provider Early Implementation Operational for Enrollment, Verification and Credentialing	April 20, 2009	April 20, 2009
	NCID Framework Complete	April 24, 2009	April 24, 2009
	Final Baseline Integrated Master Schedule Accepted by the State	April 27, 2009	April 24, 2009
	Management Plans Complete	May 7, 2009	May 7, 2009
3	Install Imaging/ Retrieval/ Printing Equipment	June 12, 2009	May 22, 2009
	Configuration Management Plan Complete	June 25, 2009	June 8, 2009
	Master Test and Quality Assurance Plan Complete	October 2, 2009	October 2, 2009
	Business Continuity/Disaster Recovery Plan Complete	October 7, 2009	October 7, 2009
0	Multi-payer Foundation Complete	March 22, 2010	
6	Recipient SIT Complete	July 21, 2010	
5	Provider SIT Complete	August 18, 2010	
7	Eligibility Verification SIT Complete	August 20, 2010	
6	Recipient UBAT Complete	September 13, 2010	
5	Provider UBAT Complete	October 20, 2010	
	OMMISS Completes Development of UAT Scenarios	September 30, 2010	
7	Eligibility Verification UBAT Complete	October 29, 2010	
8	Non-Electronic Submissions SIT Complete	October 25, 2010	
11	Financial Claims Processing SIT Complete	January 13, 2011	
14	Pend Resolution/Batch Interfaces/Reference SIT Complete	January 5, 2011	
17	Call Center SIT Complete	December 9, 2010	
18	Automated Voice Response System/Subsystem Reporting SIT Complete	January 28, 2011	
12	Prior Authorization SIT Complete	February 8, 2011	
8	Non-Electronic Submissions UBAT Complete	November 22, 2010	
9/10	Medical/Pharmacy Claim Adjudication SIT Complete	December 14, 2010	
15	Financial Transactions/MAR SIT Complete	February 2, 2011	
	Final SIT Completed	January 25, 2011	
16	Health Check/Drug Rebate (EPSDT) SIT Complete	February 1, 2011	
13	Managed Care/TPL SIT Complete	February 23, 2011	
9/10	Medical/Pharmacy Claim Adjudication UBAT Complete	March 14, 2011	
	User Acceptance Test (UAT) Completed	June 7, 2011	
	Training and Documentation Complete	March 11, 2011	
	Final Data Conversion Complete	July 20, 2011	
	Production Simulation Test (PST) Complete	August 11, 2011	
	Replacement MMIS Operational	August 22, 2011	

End of Appendix B

APPENDIX C –

BACKGROUND

Medicaid is a health insurance program for certain low income and needy people. It serves over one million people in the State, including children, the aged, blind and/or disabled, and people who are eligible to receive federally assisted income maintenance payments. For approximately 31 years, North Carolina has had the same vendor supporting the Medicaid claims processing system and associated outsourced business functions. In 1999, the same vendor was contracted to develop the Division of Mental Health, Developmental Disabilities and Substance Abuse Services' (DMH/DD/SAS) Integrated Payment and Reporting System (IPRS) using the Medicaid claims payment system as a prototype. In addition, the Department operates another claims processing solution to facilitate claims payment for the Division of Public Health (DPH).

DHHS recognized the need to improve business processes and services provided by merging several of its claims payment systems into a *multi-payer* solution. This DHHS plan was modeled from CMS' Medicaid Information Technology Architecture (MITA) and Statewide Enterprise Architecture concepts. The processing of Medicaid and other healthcare claims directly supports DHHS' mission to serve the people of North Carolina by enabling individuals, families and communities to be healthy and secure and to achieve social and economic well being.

The NCMMIS+ Program was initiated in September 2006, to manage the activities related to the reprocurement and implementation of systems and services for a Replacement Medicaid Management Information System (MMIS) as well as systems and services for Reporting and Analytics (R&A) and an information technology (IT) system for the Division of Health Service Regulation (DHSR). The Replacement MMIS will expand claims payment functionality beyond Medicaid to include the Division of Public Health (DPH), the Migrant Health Program in the Office of Rural Health and Community Care (ORHCC), the Division of Medical Assistance (DMA), and the Division of Mental Health, Developmental Disabilities and Substance Abuse (DMH).

In July 2007, the Department of Health and Human Services (DHHS) posted a Request for Proposal (RFP) to fulfill the Centers for Medicare and Medicaid Services' (CMS') mandate that the State conduct an open procurement for a replacement of the Medicaid Management Information System (MMIS) and Fiscal Agent operations contract. Then, in June 2008, pursuant to the requirements of Section 10.40D.(a) (2) of Session Law 2008-107, DHHS amended the RFP to include the following payers: NC Health Choice, NC Kid's Care, Ticket to Work, Families Pay Part of the Cost of Services under the CAP-MR/DD, CAP Children's Program, and all relevant Medicaid waivers and Medicare 646 waiver, a five-year demonstration project that places the state's high-risk Medicare patients and dual eligibles (i.e., patients qualifying for both Medicaid and Medicare) into the primary care program known as Community Care of North Carolina (CCNC).

The NCMMIS+ Program consists of three major functional groups that are to be procured and contracted separately, which will provide the State with flexibility in contracting, and provides for access to the knowledge and skills of multiple vendors, and will broaden the industry experience base in NC DHHS systems by providing opportunities for specialization that might attract new

vendors or partnerships not seen in a monolithic acquisition. The three major functional groups are: 1) Core MMIS Replacement, 2) Reporting & Analytics and 3) DHSR.

There are two other major procurements in addition to the three mentioned above: 1) Test Management Services and 2) Independent Verification and Validation (IV&V). Test management of all three NCMMIS+ Program functional groups is outsourced to a single vendor that specializes in testing. The Test Management Vendor is responsible for managing the testing activities while primarily DHHS staff will perform the tests. Because of the close relationship among the Program's three functional groups, having one testing vendor is more efficient than procuring three different vendors. The Test Management Services contract was awarded to *SysTest Labs* on July 29, 2009.

CMS mandated that the State acquire IV&V services for the Replacement MMIS. The lead IV&V staff members have the responsibility to oversee the Project and report directly to the Project Sponsor and to CMS. The IV&V vendor provides the Lead with supporting staff as needed for specific activities; for example, a DBA (Data Base Administrator) may be called in to review data base layouts, etc. DHHS will also use the IV&V services for the R&A, and DHSR projects. The IV&V contract was awarded to MAXIMUS, Consulting Services, Inc. on September 17, 2009.

End of Appendix C