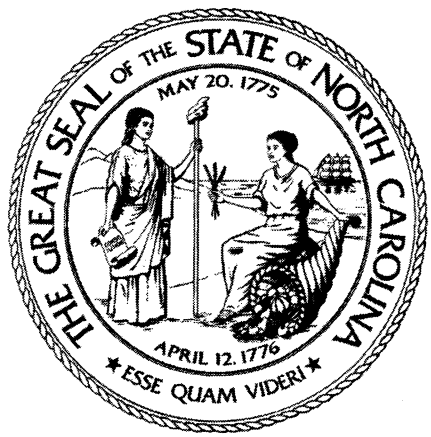
NC MEDICAID MANAGEMENT INFORMATION SYSTEM+ (NCMMIS+) PROGRAM

Quarterly Report
to the
North Carolina General Assembly
May – July 2012



State of North Carolina
Department of Health and Human Services

October 1, 2012

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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 North Carolina Department of Health and Human Services (NC DHHS) began submitting quarterly reports on March 1, 2009. Session Law 2009-451 and Session Law 2011-145, Section 10.29.(h) continued the quarterly reporting requirements.

Appendix D–NCGA 2010 AND 2011 Session Legislative Mandates provides a reference to all of the legislative mandates from the 2010 and 2011 Sessions of the North Carolina General Assembly that potentially affect the NCMMIS+ Program during this reporting period and a brief description of the potential impact.

Appendix E-Background provides background information on the MMIS Replacement Project.

This report covers the period May 1, 2012 through July 31, 2012.

REPLACEMENT MMIS BENEFITS SUMMARY

The NCMMIS+ Program manages the implementation of comprehensive, DHHS enterprise-wide automated Medicaid systems with benefits that greatly exceed the capabilities of the current Legacy MMIS and ancillary systems, such as the Decision Support System (DSS), the Surveillance, Utilization Review System (SURS), the Purchase of Medical Care Services (POMCS), etc. The NCMMIS+ Program includes the Replacement MMIS (the multi-payer claims processing system that will replace the Legacy MMIS), the Reporting and Analytics (R&A) system, and the Division of Health Service Regulation (DHSR) Business Process Automated System (BPAS).

The **Replacement MMIS** will have numerous advanced features to maximize the administrative efficiency and ease of use for NC taxpayers, recipients, agency staff, and healthcare providers. Some of the new systems' benefits are listed for the stakeholders below:

- **NC Taxpayer Benefits**
  - An estimated $165 million in systems' operating costs savings during the first five years for the Replacement MMIS;
  - Lower net Medicaid drug costs through the Supplemental Drug Rebate/Preferred Drug List (PDL) program. PDL is a list of preferred prescription medications based on clinical efficacy and safety, as well as costs to the Medicaid program. To date, the State has collected a total of $92.2 million in drug rebates from participating pharmaceutical companies for placing their drugs on the PDL.
  - Cost avoidance for the Division of Prevention, Access and Public Health Services through the elimination of the largely manual POMCS system as a result of the improved sequencing/processing/payments of claims.

- **Medicaid Recipient Benefits**
  - Ability to realize more transparency for information about health care services and outcomes and facilitate a self-service model for access to information;
  - Improved healthcare access—including improved online communications;
  - Improved healthcare service; and
  - Improved healthcare outcomes for the most vulnerable citizens.

- **DHHS Benefits**

Cost Savings

  - Redirected State staffing costs through automated business functions and efficiencies gained through the consolidation of functions/resources/systems and business process streamlining;
  - Increased State purchasing cost-reduction opportunities through a single integrated multi-payer system for State-sponsored health programs;
  - Reduced claims payment errors;
  - Improved accuracy in dispensing services, equipment, and drugs to program recipients;
  - Easier, more timely and cost-effective system changes;
  - Reduced operating and drug costs, and cost avoidance (as noted under NC Taxpayer Benefits above); and
  - Improved waste, fraud, and abuse detection across programs since administrators can analyze multiple healthcare programs' utilization, billing, and coding patterns.

Functionality

  - Automated business functions;
  - Consolidated business functions, resources, systems, and processes;
  - Increased the future ease of system growth and alignment with the Medicaid Information Technology Architecture (MITA) and the National Provider Identification (NPI) taxonomy frameworks, as well as industry standard code sets;
  - Improved information access and coordination of benefits across multiple agencies;
  - Improved program administration while improving services to providers; and
  - Improved confidentiality protection while providing information to those who need to know.

Early Implementation Operations

  - <u>Enrollment, Verification and Credentialing (EVC)</u>
    In April 2009, CSC implemented a sub-contracted proprietary EVC software system for the enrollment of Medicaid providers. This implementation lifted the burden of provider enrollment from a totally manual system in the Division of Medical Assistance (DMA) Provider Services Unit to the fully-automated system run by CSC. Now, Provider Services staff is able to focus on policy and program oversight issues. The EVC system, a temporary solution within the Replacement MMIS Project, will be replaced with a more robust provider enrollment subsystem that will be integrated with *NCTracks*, aka the Replacement MMIS, at Go-Live and realize the benefits of the new claims payment system.

Statistics to date:

- Approximately 41,800 total provider enrollments have been completed.
- A monthly average of 1,521 new enrollment applications has been processed during the quarter, of which 53% were submitted electronically.
- The average processing time to complete all application types was 14.4 business days.
- CSC has completed approximately 60,600 on-going provider licensure verifications; this was a function that DMA's Provider Services was previously unable to address. The EVC Call Center is currently responding to an average of 7,500 provider calls per month.
- Provider enrollment fees ($100 per enrollment) in the amount of $2,180,850 have been collected through July 31, 2012.

- RetroDUR (Drug Utilization Review)
  Under the RetroDUR program, Medicaid paid claims data is used to identify patterns of behavior involving physicians, pharmacists, and individual Medicaid recipients, or patterns associated with specific drugs or groups of drugs and patterns of fraud and abuse. RetroDUR activities have been moved from DMA, with collaboration from ACS and HP, to CSC's subcontractor, including recipient/provider profiling and ad hoc reporting. The outcomes from this program have improved the quality of care for Medicaid recipients, improved compliance and adherence concerns, educated providers on the latest prescribing standards, and helped conserve program funds.

- Supplemental Drug Rebate/Preferred Drug List (PDL)
  As noted under *NC Tax Payer Benefits* above, the State has already collected $92.2 million in drug rebates from participating pharmaceutical companies for the Preferred Drug List Program.

- **Health Care Provider Benefits**
  - The Provider Web Portal will provide a secure and convenient mechanism to complete, electronically sign, and submit initial provider enrollment applications, retrieve/view/update enrollment information, and check the status of a new application, re-credentialing application, or enrollment change request;
  - Providers will be able to inquire about recipient eligibility for a single date or a span of dates, and can submit an online "mini-batch" to obtain eligibility information for up to 25 recipients in a single transaction;
  - The new system will allow the electronic submission of all claim types, including pharmacy claims for the Sickle Cell Program in the Division of Public Health;
  - Providers will receive electronic Remittance Advices;
  - The automated pharmacy prior approval function will enable an immediate response to a prior approval request submitted via secure website or fax/paper;
  - The new system will fully support Electronic Fund Transfers (EFT) of claims payments for the Division of Public Health;
  - The Automated Voice Response System (AVRS) will provide an enhanced and redesigned AVRS to more efficiently direct callers through the various options to obtain desired information;

- 24/7 Internet access and self-service features will allow providers access to information without a Provider Relations Agent;
- Providers will have online access to the Enhanced Pharmacy Program which includes NC Medicaid and Health Choice PDLs; and
- Other Benefits include:
  - Improved access to online provider training—including access to online provider manuals;
  - Reduced payment errors;
  - Reduced administrative burden through paperless commerce;
  - E-Prescribing;
  - Improved cash flow; and
  - Improved communications and timelier responses to inquiries.

Provider Operational Preparedness (POP)

The Department will work with various types of providers to educate and train them on the new Remittance Advice (RA) reports created by the Replacement MMIS. *POP* will execute RAs in NCTracks based on claims processed by the Legacy MMIS. Additionally, DHHS will conduct a *POP* period beginning March 1, 2013, and may continue through June 30, 2013. During this time, the same claims will be processed through both the Legacy MMIS and the Replacement MMIS so that providers can compare payments from the two systems. A help desk staffed by the DHHS and CSC will answer payment and/or processing questions throughout the *POP*. This extra level of provider education will confirm that the new system is processing claims according to the appropriate State policies, prior to the Replacement MMIS Go-Live.

International Statistical Classification of Diseases – 10th Revision (ICD-10)

The transition from *ICD-9* to *ICD-10*, a prerequisite for the electronic health record (EHR) in the Replacement MMIS, will provide the following benefits:

- Detailed information about *ICD-10* codes will help providers improve the quality of patient care;
- Detailed code sets make it easy for patients to understand the disease. This, coupled with improved information in the EHR and public health record (PHR), ultimately results in greater patient safety and better provider-patient relationships;
- Accurate payments, lower rejection rates, reduced administration cost, and improved revenue cycles directly link to better financials—a key success factor for evaluating investments made for *ICD-10*;
- *ICD-10* can also act as a catalyst for achieving "meaningful use" of EHR, a Centers for Medicare and Medicaid Services (CMS) requirement for Medicaid Incentive Payment System (MIPS) funding to the provider, through more detailed patient information.

The **R&A** system will be closely linked with the Replacement MMIS, and will provide the following benefits not achievable through the Legacy MMIS, Decision Support System (DSS), and Surveillance Utilization and Review Subsystem (SURS):

- Improved waste, fraud, and abuse detection across programs, as noted under "DHHS Benefits" above;

- A centralized claims payment data repository with six years, rather than the current three years, of claims history;
- Access to claims payment data to a broader spectrum and number of DHHS staff in a secure environment that meets State and federal Personal Health Information (PHI) rules;
- User-friendly tools for monitoring and assessing trends in the delivery of health care, expenditures, and outcomes;
- More informed policy decisions about the programs DHHS administers;
- Improved guidance for prevention and intervention programs;
- Information for community and program planning;
- Access to market scan data from various sources for comparison of utilization trends for Medicaid and commercial programs; and
- Functionality to support the State Health Plan in a user-friendly and secure environment.

The **DHSR BPAS** Project will reengineer business processes and provide the means for integrating workflows and data among the DMA, Division of Medical Health, Developmental Disabilities, and Substance Abuse Services (DMH), and DHSR. The following are some of the benefits of the DHSR BPAS implementation:

- DHSR data will be incorporated within the Replacement MMIS to enable optimal decisions and actions in a timely manner by the Medicaid Program;
- Information regarding the status of facility or program registration, license, and/or Medicare/Medicaid participation will be electronically available to appropriate entities;
- Organizational knowledge loss due to attrition and other factors will be prevented through a documented, repeatable, standardized, maintained, and automated business process system;
- A flexible system will accommodate frequent legislative changes;
- Existing data from multiple sources will be converted to a common and unified data source;
- Current business reporting needs will be satisfied;
- Manual analysis, routing, redundant operations, and process cycles time will be reduced;
- Online help and training facilities will be provided;
- Support will be provided for existing, new, or changed business models; and
- The need for increases in temporary staffing will be mitigated through standardized processes.

STATUS

Replacement MMIS Project

Project Overview

The purpose of the MMIS Replacement System Project is to design, develop, and install a componentized, integrated, multi-payer Replacement MMIS claims processing system (to include Fiscal Agent operations) with business and technical processes that will satisfy all DHHS requirements; and to provide training for all users prior to implementation of the system. Replacement of the legacy Medicaid Management Information System with a multi-payer claims processing system will include the following State-operated programs:

- Division of Medical Assistance (DMA)
  - Title XIX Medicaid – all programs
  - Title XXI NC Health Choice (State Children's Health Insurance Program)
  - Kids Care (NOTE: pending State legislative funding to implement program – not currently active)

- Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS)
  - Adult Mental Health Crisis Services
  - Criminal Justice Offender
  - Adult Developmental Disability Crisis Services
  - Additional Division sponsored programs

- Division of Public Health (DPH)
  - Kidney Program
  - Cancer & Diagnostic Treatment
  - Sickle Cell
  - HIV Services
  - Additional Division-sponsored programs

- Office of Rural Health and Community Care (ORHCC)
  - Migrant Health (NOTE: State legislation eliminated funding for this program in July 2011; however, historical claims and eligibility information will be carried forward into *NCTracks*)
  - Rural Health
  - Community Care of NC for Unemployed Parents (CCNC-Up; new program)
  - Health Net (new program)

Project Phase: Execution and Build

Accomplishments:

The State completed its review of the Audit Translation document and requested changes were given to CSC for updating the first week of June. Changes to HP code through February 14, 2012, were applied to bring the Audit Translation document into alignment with

test data planned for User Business Acceptance Test (UBAT). Additional audit updates will occur in concert with future testing cycles.

The OMMISS Pharmacy Claims Team completed UBAT for Pharmacy Claim Adjudication on June 6, 2012, executing 101 of the planned test cases. CSC delivered defect fixes to the State, enabling re-testing of failed test cases. As of mid-June, the State had successfully passed 86 test cases with an overall pass rate of 83%. These results reflect progress in clarifying pharmacy business rules for the Preferred Drug List (PDL), First Data Bank covered/non-covered drug data, and for the application of the new automated approach to Benefit Service Groups (BSG) for DMA and DMH Pharmacy Programs.

All ICD-10 Phase 1 deliverables have been approved, including the Integrated Project Plan, Enterprise Maps, and Trading Partner Strategy. The ICD-10 Webpage was launched to the divisions and the OMMISS Communication Team on June 20, and includes an option for email list serve and question submission. As of June 29, two questions and twenty-seven listserv requests have been received. The requests and questions came from a variety of provider roles including clinicians, physicians, dentists, psychotherapists, and office/billing managers.

The ICD-10 Phase 2 system Technical Code Level Analysis deliverable was submitted and an orientation of this deliverable was presented to the State. CSC conducted Mapping and Remediation sessions with the State to review and discuss the Claims Edit/Audit changes that will be required for ICD-10.

The NCTracks code merge for 5010 Phase 2 Part 1 System Integration Test (SIT) was successfully completed and the normal pace of SIT testing resumed. The 5010 Phase 2 Part 2 Statement of Work (SOW) and Basis of Estimate (BOE) options have been submitted and are currently being reviewed by the State.

The SIT for Third Party Liability (TPL), Medial Claims, Medicaid Management and Administrative Reports (MAR), and Finance are complete and the State approved the SIT results. A number of rejected test cases were resolved by CSC as part of the cycle 2 reviews. Some of the outstanding issues included reaching agreement on the plans for completion of the Online Edit and Audit Manual, and the Tables Manual.

OMMISS held a number of meetings with representatives from DMA, DPH, DMH, and the Controller's Office to solicit their input on NCTracks' test scenarios needed to support the divisions' testing efforts. These sessions were well attended and received by divisional staff.

CSC completed Final Integration Testing (FIT) on July 27. CSC describes FIT as the initial end-to-end testing of system modules that have successfully completed Unit Test with the appropriate hardware/software environment. The final testing metrics reported by CSC are:

	Test Cases		
Cycle	**Executed**	**Passed**	**Failed**
1	67	67 (100%)	0 (0%)
2	94	94 (100%)	0 (0%)
3	212	208 (98%)	4 (2%)
4	131	128 (97%)	3 (2%)
TOTALS	505	497 (98%)	7 (2%)

During FIT, CSC discovered 307 defects. Resolution of 34 of these defects was in progress at the end of FIT.

SLI, OMMISS' test management services vendor, conducted a Test Readiness Review on July 26, as the entrance gateway for CSC to commence Final System Integration Testing (FSIT) on July 27. FSIT consists of a subset of the FIT end-to-end test cases to demonstrate NCTracks build integration for the State.

Work In Progress

Representatives of OMMISS, CSC, DMA, NCFAST, and DIRM met weekly to discuss the changes to the field definitions and data structures that are planned for the interface from NCFAST to the Replacement MMIS. The planned changes to the NCFAST interface include differences in field lengths and field content, as well as the introduction of an integrated "family" case identifier that compliments the Legacy individual "recipient" case identifier. An approach has been defined for most of the business issues to determine how to bridge the gaps to achieve both programs' implementation dates.

CSC has identified the change items it considers significant for NCTracks. Work is in progress to identify alternative solutions to reduce the potential impact. Additionally, NCFast is evaluating alternate strategies for the Eligibility Information System (EIS) rollout to minimize the county impact by reducing the number of recipients processed in the initial cutover. These discussions may have an impact on the proposal to use the NCFAST "Bridge" logic as a means for accepting data updates from EIS. OMMISS and DIRM Management met on August 8 to begin planning a strategy to minimize the impact of the switch from EIS to NCFAST on other systems, including the Replacement MMIS.

The OMMISS build teams continue to build test scenarios for handoff to the Test Team for completion of test cases for UAT. The OMMISS team has established a SWAT Team to assist with the UAT planning and execution. The members will mine data for test case scenarios, run queries against the converted data for test data validation, as well as assist with testing environment needs and reporting. This team began meeting the second week of June and will continue through the UAT process.

The State identified the need to increase test scenarios for multi-payer, multi-service claims. The State testers' learning process has been challenging as they learn to convert provider type and specialty into taxonomy, and to perform the required research to create a claim that passes the hundreds of system edits. Identifying valid data for successful test execution also continues to be a challenge for efficient test execution.

Review of the operational manuals, training outlines and storyboards continues. The strategy for the development and presentation of the storyboards for Groups 5-9 has been revamped to foster early collaboration between State and Vendor staff and to consolidate related topics into one concise document. Training components for Groups 1-4 have been submitted for State review and a number of them have been approved.

In preparation for a seamless transition to business operations OMMISS has been meeting with key division stakeholders to present high level overviews of relevant components of the replacement solution, NCTracks. For example, a meeting was held with DMA representatives from Program Integrity, Rate Setting, Audit, Medical Policy, and TPL to provide an overview of the claims processing logic that will change with the implementation

of the replacement solution. The OMMISS Team left the meeting with a better understanding of how to meet the needs of the business unit during the transition. A follow-up session on the NCTracks adjudication process is anticipated before UAT begins.

A draft communication to the various provider associations regarding their role in UAT has been completed and is under review by the OMMISS Provider Communications Team, with a targeted release date of August 10. Providers participating in UAT will be nominated by selected provider associations, with final selections by OMMISS in collaboration with the divisions. Participants selected from the associations will be scheduled for testing in a specific one-week period during State UAT, which begins on November 12, and continues through January 11, 2013. During testing, providers will use the new NCTracks Provider Portal to perform typical daily administrative activities, such as provider enrollment and related maintenance functions, confirming recipient eligibility, requesting and verifying the existence of prior authorizations, and new claims/adjustments submission. Selected participants for the NCTracks "early system look" are encouraged to also participate in the Provider Operation Preparedness (POP) phase.

State reviews of the 4010 and 5010 Companion Guides are in progress. Once approved, companion guides for HIPAA transactions will be released to providers so they can become familiar with the provider system(s) changes necessary to support the NCTracks claims submission process. The State plans to distribute applicable companion guides by the end of August in support of the providers participating in the early system look at NCTracks.

Analysis continues on Legacy CSRs that have been submitted since January 2010 to ensure that all are accounted for in the Replacement MMIS. Activities are focused on creating the Replacement MMIS CSRs to reflect the implemented Legacy MMIS CSRs. CSC is working to estimate the effort required to implement each of these CSRs and to understand their impact on CSR capacity. Additionally, the process of assigning Replacement MMIS CSRs to the various releases, i.e. new versions of the system, continues. Meetings with the Division Program Executives (DPEs) began on June 18 to prioritize the CSRs to aid in the assignment to the various releases and determine which could be implemented after the operational start date.

The installation of new workstations in the State test lab in CSC's Wycliff location was completed ahead of schedule. CSC successfully replaced all twenty-five workstations. Testers reported that the new equipment has been improving efficiency due to faster PC processing speeds.

Testing Status

CSC began the FSIT testing phase on July 27, 2012. As stated previously, FSIT consists of a subset of the FIT end-to-end test cases to demonstrate NCTracks build integration for the State. CSC plans to execute 192 test cases across various builds within the first three weeks, and to complete testing and defect resolution by August 24, 2012. OMMISS will review the test case results from FSIT to better understand whether the system is ready to begin UAT on August 29, 2012.

UBAT for Medical Claims began on May 7, 2012. Medical Claims UBAT has now completed twelve of the sixteen scheduled test weeks. During the remaining weeks, testers plan to incorporate inpatient facility claims and DPH medical claims. To date, the majority of single-

payer claims submitted have been from DMA. Multi-payer claims have mostly involved DMA and DMH. All of the DPH claims require a prior authorization (PA) to adjudicate correctly. It has been challenging during UBAT to locate existing PAs for recipients with DPH eligibility. The X.12 tool, necessary for the creation and submission of test X.12 batch claims, is anticipated to be ready for State use during the week of July 30.

CSC is trying to understand and resolve a defect in the two-cycle claims payment process used for DMH and DPH claims. The first cycle adjudicates the claim and places it in a pending status until the weekly check-write process begins. During the check-write, claims are processed based on the availability of funds. The defect identified usually involves claims not being processed in the same order in which they were received—an important consideration if funds are not available to pay all claims.

Metrics for the Medical Claims \ UBAT as the end of July 2012:

Description	Value	Notes
Test Cases Written	412	Exceeds target of 300
Test Cases Executed	310	75% of test cases written
Test Cases Passed	262	85% of test cases executed
Test Cases Failed	48	15% of test cases executed
Defects reported	212	
Closed (Fixed) Defects	155	73% of defects reported
Open Defects	57	27% of defects reported

OMMISS Team Leads and CSC Team Leads meet weekly to address Build-specific tasks and action items, and to coordinate "touch point" meetings with other Builds to ensure that cross-functional information is communicated in a timely and efficient manner.

Reporting & Analytics (R&A) Project

Thomson Reuters Healthcare has been acquired by Veritas Capital. The new business is a standalone entity referred to as Truven Health Analytics, aka Truven.

On April 13, 2012, Change Request R&A CR-007 was approved, which extends the project schedule, hours and budget to align the R&A Project with the Replacement MMIS schedule.

The R&A Contract Amendment 2, which supports the current Integrated Master Schedule (IMS) alignment with the Replacement MMIS Project schedule, is in the final stages of the approval cycle.

The unavailability of CSC data for the System Integration Testing #2 (SIT2) caused a delay in the R&A Project schedule. Truven and CSC have now agreed on a mid-August 2012 target date for the delivery of R&A SIT2 data, and have reached agreement on subsequent data delivery dates for SIT3, UAT, and production commencement. Truven is in the process of updating the R&A IMS accordingly. OMMISS recently sent CSC and Truven a Data

Requirements document to acknowledge the agreed upon terms for R&A data deliveries and the related schedule realignment. This schedule delay may necessitate a third amendment to the R&A Contract.

The R&A Team reviewed and approved a number of deliverables during this quarter, including the Change Management Plan (Update), Early JSURS Training Plan, Deployment Plan, Turnover Plan, Turnover Statement of Work, Turnover IMS, Data Dictionary, Analytic Test Plan, System Test Plan, and State Health Plan System and Analytic Test Plan.

DMA staff will query the new R&A data warehouse using SAS Enterprise Guide software. The decision to use this software was the first step of a proof-of-concept (POC) to explore options for migrating existing DRIVE parameterized queries that were not identified in the R&A RFP to the new R&A environment. Ongoing POC work with SAS Enterprise Guide continues to increase DMA staff SAS core competencies prior to the R&A Project implementation.

Truven is currently updating the Data Requirements document to reflect items which could potentially impact the types and volumes of test cases planned for the NCTracks UAT. Truven is also performing an analysis on UAT test cases which will enable them to determine if additional repetitions or new scenarios may be required from the NCTracks UAT.

Early Java Surveillance Utilization Review System (EJSURS)

EJSURS Training and UAT is planned to start on July 30, 2012, and continue through August 10, 2012. Truven will conduct onsite training. A total of six EJSURS "Power Users" and sixteen general EJSURs users will be trained during this time period. Various cross-checks have been performed to mitigate risks to the Training/UAT. Expectations have been set with the DMA participants; escalation protocols have been established; and sufficient resources are in place to manage challenges.

North Carolina State Health Plan (SHP)

The SHP UAT was suspended due to the a number of challenges encountered including tester access and login, custom reports running significantly longer than anticipated, and confusion on report results stemming from misinterpretation of terminology between Truven and SHP. Truven extended an apology to the SHP Team for the challenges. Subsequently, a Lessons Learned session was conducted with all parties (SHP, Truven and OMMISS) and a corrective action plan was implemented. Once all corrective actions are in place, the UAT will resume.

DHSR Business Process Automation System (BPAS) Project

The Division of Health Service Regulation (DHSR) is responsible for the allocation, approval, licensing, and inspection of regulated facilities, services, and medical equipment in the State of North Carolina. DHSR decisions are essential to managing North Carolina's Medicaid

Program. The DHSR BPAS Project will provide the means for integrating essential business processes and data among DMA, DMH, and DHSR.

The BPAS Project has completed to full production status the implementation of Stage 1, Unified Data Source, Stage 2, Certificate of Need, and Stage 3, Construction.

All previous UAT issues and structural concerns regarding Stage 2 and Stage 3 have been addressed and they have transitioned to Go-Live status. During the Go-Live period, the operations support agreement went into effect and the business users conducted functional testing and enhancements of the BPAS system to bring it to Production-ready cutover status. On July 9, 2012, both Stage 2 and Stage 3 cutover to full Production. All Certificate of Need and Construction personnel have attended user training at State training facilities. From this time forward, the BPAS System is the system of record for these business areas.

Stage 4, Licensure and Certification (L&C), has completed all design and data conversion work and passed both System Integration Testing (SIT) and User Acceptance Testing (UAT). Stage 4 is expected to enter the Go-Live period in mid-August 2012 and remain in that status for approximately thirteen weeks. As described above, during the Go-Live period the operations support agreement goes into effect and the business users conduct functional testing and enhancement of the BPAS System to bring it to Production-ready cutover status. Stage 4 is much larger and more complex than previously implemented business areas and the project team is working to incorporate all previous lessons learned into this Go-Live period. The project team expects to engage up to two hundred Agency staff in Stage 4 Go-Live and cutover activities.

The project team continues to work on system and output designs for Stage 5, Health Care Personnel Registry (HCPR) and Center for Aide Registration & Education (CARE). The screen designs and the correspondence specifications have been accepted by the State and the data conversion specification development has begun. This process will include onsite vendor visits to work directly with the DHSR business staff to produce a high quality conversion to be used for testing. As previously reported, both of these sections have encountered delays in the system design specification review process, but the transition from technical documentation review to an iterative system screen and functional review has been accomplished and has resulted in higher customer satisfaction.

Stage 6, Web Site, design specifications have been completed and a Stage 6 draft implementation plan has been developed. Once approved, public-facing Web pages can be developed and tested and the Web Pilot can be scheduled and executed.

To date, the DHSR BPAS Team and the DHSR agency have reviewed 770 deliverables, of which 768 have been accepted.

RECENT UPDATES

The R&A Project's Early JSURS production release, scheduled to go live on September 13, 2012, went live on September 24, 2012, due to data conversion issues. The R&A Contract

Amendment 2, which supports the current Integrated Master Schedule (IMS) alignment with the Replacement MMIS Project schedule, is in the final stages of the approval cycle.

The State met with GL Solutions (GLS), the DHSR BPAS Project vendor, on September 6, 2012 to discuss a "going forward" approach. A general agreement was reached and the details are being worked out. The final Go-Live date for the DHSR BPAS Project is expected to be delayed; however, at this time, the extent of the delay is uncertain.

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 executed. The final review within DHHS is the multi-divisional Change Control Body (CCB).

After execution of the initial CSC Contract, Congress passed the American Recovery and Reinvestment Act (ARRA), which included funds for Health Information Technology (HIT). Incentive payments to Medicaid providers for investing in HIT infrastructure are a component of ARRA. DHHS is leveraging its existing contract with CSC to implement the incentive payments. For that reason, changes are separated in tables below to distinguish changes to the Replacement MMIS versus HIT.

Contract amendment #2 with CSC identified several pools for changes:

1) Changes approved at the time of contract negotiations equaled $6,720,749
2) Modification pool for future DDI changes equaled $20,100,000
3) Health Information Technology (HIT) modifications, non-MMIS, modification pool equaled $15,277,760

Replacement MMIS

Amendment 2 approved CSR statistics are reported below. These statistics reflect CSRs reported against the $20,100,000 CSR Capacity Pool. Pre-Amendment 2 CSR statistics are no longer being reported.

Amendment # 2 CSR Statistics for MMIS

	Prior to May2012	May 2012– July 2012	Total
No Cost CSRs	67	3	70
Cost CSRs	167	59	226
Number of Approved CSRs	234	62	296
Cost of Approved CSRs	$8,104,962	$1,464,782	$9,569,744

CSR Capacity Pool $ 20,100,000
CSRs Approved through 07/31/2012 $ 9,569,744

Balance Remaining until 06/30/2013 $ 10,530,256

HIT

The approved CSR statistics for HIT are shown below:

CSR Statistics for HIT (Non-MMIS)

	Prior to May 2012	May – July 2012	Total
No Cost CSRs	0	2	2
Cost CSRs	13	2	15
Number of Approved CSRs	13	4	17
Cost of Approved CSRs	$6,576,849	$507,861	$7,084,710

HIT CSR Capacity Pool $ 15,277,760
CSRs Approved through 07/31/2012 $ 7,084,710
Balance Remaining until 06/30/2013 $ 8,193,050

FINANCIAL UPDATE

Most development, design and implementation activities for the Replacement MMIS and R&A Projects are funded by CMS at a 90/10 federal match. Exceptions to the 90/10 match include funding for training, furniture, indirect costs (overhead) and travel for non-project specific purposes; these activities receive 50/50 federal match. Additionally, 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 financial details are provided in *Appendix A–Financial Update*.

SCHEDULE

There have been changes in the Replacement MMIS schedule to reflect the completion of MAR, SIT, TPL SIT, 5010 Phase 1 SIT, Financial Claims Processing SIT, Medical/Pend Reso Claims SIT, and Financial Claims Processing SIT, as well as a planned date revision for completion of OMMISS Development of UAT Scenarios, as noted on the schedule in Appendix B – NCMMIS+ Program Project Schedules. The DHSR Business Process Automation System Schedule has been changed to reflect the completion of Stage 5 Health Care Personnel Registry Output Specifications, as well as planned date revisions for the completion of Reconcile State Models and Configured System and Stage 7 Specification Walkthrough.

The R&A Contract Amendment 2 negotiations are still in progress with Truven; therefore, there is no update to the January 1, 2011 version of the R&A Project schedule, and it is not included in this report. After the R&A Contract amendment is executed and a new schedule is finalized, that schedule will be included in the subsequent Quarterly 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 of July 2012. It also includes estimated costs through the implementation of the Replacement MMIS plus one year of CMS-certification activities ending on June 30, 2014. Post-implementation maintenance and operational costs are not included in these costs.

The Program's overall estimated costs are running 1.64% under the ITS-approved budget.

Table 1: Program Costs from September 2006 – July 2012 & Estimates through CMS Certification (June 2014)

Project	Start Date	End Date	Expenditures to Date	ITS Approved Budget	Required State Funds	Current Estimated Costs	Variance
MMIS DDI	11/01/08	10/31/13	$134,060,796	$229,847,418	$28,730,927	$229,847,418	0
MMIS Early Operations	04/20/09	06/30/13	16,713,373				N/A
R&A	11/01/08	06/30/13	6,335,228	15,549,664	1,788,211	10,515,257	-5,034,407
DHSR	07/01/08	05/31/12	7,250,562	7,565,102	3,026,041	8,071,980	506,878
Program-Level	02/01/07	06/30/14	13,576,910	18,244,536	2,280,567	18,466,963	222,427
Business Initiatives							
HIT Incentive Payments	01/01/11	09/30/13	8,345,819	N/A	1,023,797	10,237,969	N/A
Medicaid Forecast.	11/01/09	01/31/11	1,523,010	1,739,914	173,991	1,543,010	-196,904
Completed Projects			11,133,002	11,535,538	1,239,049	11,440,782	-94,756
Total Projects			$198,938,700		$38,262,584	$290,123,379	
[1]Total ITS-Approved	09/16/06	06/30/14	$173,879,508	$284,482,172	$37,238,787	$279,885,410	-4,596,762
Variance							-1.64%

Footnotes:

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

Table 2 below represents State funds required for SFY 2011-12.

Since MMIS resides in a special fund within a 2-type budget code, it maintains a fund balance. Pursuant to G.S. 143C-1-2(b)(iii), the unexpended, unencumbered balance of an appropriation for the implementation of information technology projects shall not revert until the project is implemented. The fund balance on the 2011-12 fiscal year-end budget report was $5,306,911; $4,352,989 for MMIS and $953,922 for HIT/HIE. In addition to earned Federal funds, receipts include transfers from other DHHS divisions. Specifically, a portion of the receipts in each year of the biennium is a prior-year earned revenue transferred as outlined in House Bill 200–Appropriations Act of 2011. The Department may use $3,232,304 in prior-year earned revenue in SFY 2011-12, and $12,000,000 in prior-year earned revenue

in SFY 2012-13 for the procurement, design, development, and implementation of the replacement MMIS.

This table addresses only the Replacement MMIS requirements. HIT/HIE requirements are noted in Table 4.

Table 2: State Funds Required for SFY 2011-2012

Project	Estimated Total Expenditures	Estimated State Funds
MMIS DDI	$82,147,223	$9,820,601
[1]MMIS DDI Changes	3,014,237	367,008
MMIS Early Operations	6,001,428	1,650,230
R&A	$2,950,616	295,062
DHSR	3,751,766	1,733,705
Program-Level	2,504,716	225,897
MMIS Total	**$100,369,986**	**$14,092,503**
State Appropriation Balance 7/1/11		$15,213,188
Appropriations SFY 11-12		**$3,232,304**
Estimated Carry Forward Appropriations 6/30/12		$4,352,989

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.

Table 3 below represents State funds required for SFY 2012-13.

Since MMIS resides in a special fund within a 2-type budget code, it maintains a fund balance. Pursuant to G.S. 143C-1-2(b)(iii), the unexpended, unencumbered balance of an appropriation for the implementation of information technology projects shall not revert until the project is implemented. The fund balance on 2011-12 fiscal year-end budget report was $4,352,989 for MMIS and $953,922 for HIT/HIE. In addition to earned Federal funds, receipts include transfers from other DHHS divisions. Specifically, a portion of the receipts in each year of the biennium is prior-year earned revenue transferred as outlined in House Bill 200 - Appropriations Act of 2011. The Department may use $12,000,000 in prior-year earned revenue in SFY 2012-13 for the procurement, design, development, and implementation of the replacement MMIS.

This table addresses only the Replacement MMIS requirements. HIT/HIE requirements are noted in Table 4.

Table 3: State MMIS Funds Required for SFY 2012-2013

Project	Estimated Total Expenditures	Estimated State Funds
MMIS DDI	$73,548,109	$9,370,182
[1]MMIS DDI Changes	10,000,000	1,217,581
MMIS Early Operations	5,836,566	1,806,641
R&A	6,098,233	879,823
DHSR	3,881,531	1,640,467
Program-Level	3,243,853	586,917
MMIS Total	**$102,608,292**	**$15,501,611**
State Appropriation Balance 7/1/12		$4,352,989
Appropriations SFY 11-12		**$12,000,000**
[2]Estimated Cash Balance on 6/30/13		$851,379

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]- The projected negative cash balance will be addressed per the OSBM-approved MMIS Funding Plan.

Table 4 below represents State expenditures for HIT/HIE during SFY 11 and SFY 12 and estimated requirements for SFY 13.

This table addresses only the HIT/HIE requirements. Funding for these needs is expected through internal DHHS transfers.

Table 4: Funds Required for HIT/HIE for the Biennium

Project	Estimated Expenditures	Estimated State Funds
SFY 10-11: HIT/HIE Expenditures	$5,113,682	$511,368
SFY 11-12: HIT/HIE Expenditures	$3,896,675	$389,668
SFY 12-13: HIT/HIE Requirements	$984,577	$98,458

End of Appendix A

APPENDIX B – NCMMIS+ PROGRAM PROJECT SCHEDULES

As indicated previously in this report to the North Carolina General Assembly, negotiations are still in progress with the R&A vendor, Truven; therefore, there is no update to the January 1, 2011 version of its schedule, and it is not included in this report. After the R&A Contract Amendment 2 is executed and a new schedule is finalized, that schedule will be included in the subsequent Quarterly Report.

Design, Development and Implementation (DDI) Replacement MMIS Schedule

Build Number	UID	Key Milestone	Planned Date	Planned Dates Revised this Report Period	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		March 22, 2010
6		Recipient SIT Complete	August 13, 2010		August 17, 2010
7		Eligibility Verification SIT Complete	August 20, 2010		August 17, 2010
7		Eligibility Verification UBAT Complete	September 9, 2010		September 21, 2010
8		Non-Electronic Submissions SIT Complete	October 25, 2010		November 11, 2010
6	106	Recipient UBAT Complete	January 17, 2011		January 17, 2011
8	86	Non-Electronic Submissions UBAT Complete	February 11, 2011		February 11, 2011
16.1	2703	Health Check (EPSDT) SIT Complete	April 8, 2011		April 5, 2011
17	1221	Call Center SIT Complete	May 24, 2011		May 24, 2011
12	2059	Prior Authorization SIT Complete	June 15, 2011		June 15, 2011
5	1115	Provider SIT Complete	June 7, 2011		July 7, 2011
13.1	1661	Managed Care SIT Complete	July 1, 2011		July 1, 2011
9	2275	Pharmacy Claim Adjudication SIT Complete	July 6, 2011		July 6, 2011
5	1126	Provider UBAT Complete*	October 7, 2011		October 7, 2011
16.2	1389	Drug Rebate SIT Complete**	October 31, 2011		October 31, 2011
18	1468	Automated Voice Response System/Subsystem Reporting SIT Complete	October 4, 2011		October 4, 2011
9	2299	Pharmacy Claim Adjudication UBAT Complete	June 25, 2012		June 25, 2012

14.1	2577	Reference SIT Complete	December 8, 2011		December 8, 2011
FIT/SIT	1223	Data Conversion for FIT/SIT Complete	April 12, 2012		April 12, 2012
EA	1102	Cycle 1 Final Security Roles Deliverable Complete	March 27, 2012		March 27, 2012
15.2	1832	MAR SIT Complete	May 24, 2012		May 25, 2012
13.2	2055	TPL SIT Complete	May 30, 2012		May 25, 2012
19	5234	5010 Phase 1 SIT Complete	June 8, 2012		May 29, 2012
11/15.1	2631	Financial Claims Processing SIT Complete	June 1, 2012		June 1, 2012
10/14.2	1464	Medical/Pend Reso Claims SIT Complete	May 25, 2012		June 4, 2012
Final UAT	1159	OMMISS Completes Development of UAT Scenarios	July 9, 2012	August 7, 2012	
FIT/SIT	1195	Final Integration Test Complete	July 27, 2012		July 27, 2012
Ops Manuals	1084	Operations Manual Complete	February 14, 2013		
FIT/SIT	1187	Final Performance Engineering Complete	September 4, 2012		
10	1454	Medical Claims UBAT Complete	September 25, 2012		
19	5351	5010 Phase 2 SIT Complete	October 11,2012		
FIT/SIT	1189	Final SIT Complete	December 10, 2012		
Final UAT	1224	User Acceptance Test (UAT) Completed	January 16, 2013		
19	5123	5010 Phase 1 Complete	January 14, 2013		
PST	1425	Production Simulation Test (PST) Complete	February 13, 2013		
Deployment	1177	Final Data Conversion for Cutover Complete	February 19, 2013		
Deployment	1133	Site Cutover Go/No Go Decision	February 19, 2013		
Training	4036	Training Complete	February 25, 2013		
Deployment	1144	Replacement MMIS Operational	February 25, 2013		

DHSR Business Process Automation System Schedule

UID	Key Milestone	Planned Date	Planned Dates Revised this Report Period	Actual Date
	Award Announcement /Contract Signed			October 29, 2010
6145	Discovery Phase Begins	October 29, 2010		October 29, 2010
7572	Deliver CDRL1-5 templates	November 12, 2010		November 12, 2010
2796	Project on site kickoff meetings	December 10, 2010		December 10, 2010
7785	Revised IMS submitted	January 14, 2011		January 14, 2011
9375	CDRL 4 Data Conversion and Migration Plan Complete	February 16, 2011		February 16, 2011
7560	CDRL 9 Joint Security Plan Complete	March 15,2011		March 24, 2011
10106	Stage 1 Limited Medical Facilities Planning and Unified Data Source Business Process Definitions, Use Case Analyses, Workflow Diagrams Complete	May 4, 2011		May 4, 2011
6901	Stage 1 Limited Medical Facilities Planning and Unified Data Source Testing Plan Complete	June 6, 2011		June 6, 2011
9989	NCID Interface Specification Complete	July 8, 2011		July 8, 2011
10768	Stage 3 Construction Workflow Diagrams Complete	June 28, 2011		June 28, 2011
10767	Stage 2 Certificate of Need Data Conversion Specification Complete	July 13, 2011		July 13, 2011
7206	Stage 2 Certificate of Need Interface Specifications Complete	June 30		June 30, 2011
10782	Stage 4 Licensure and Certification - Phase 4 Search, Query & Reporting Complete	January 25, 2012		February 8, 2012
10790	Stage 4 Licensure and Certification User Guide and Reference Guide Complete	August 25, 2011		August 25, 2011
10786	Stage 4 Licensure and Certification EIS Interface Specification Complete	April 24, 2012		April 24, 2012

10791	Stage 5 Center for Aide Regulation and Education Workflow Diagrams Complete	February 3, 2012		February 3, 2012
10792	Stage 5 Health Care Personnel Registry Workflow Diagrams Complete	November 18, 2011		November 18, 2011
10795	Stage 5 Health Care Personnel Registry Output Specifications Complete	May 22, 2012		May 4, 2012
10797	Stage 5 Center for Aide Regulation and Education/Health Care Personnel Registry Board of Nursing Interface Specification Complete	August 6, 2012		
7725	Stage 6 Pilot Renewal Site Specification Complete	February 13, 2012		March 13, 2012
7057	Stage 6 License Verification Website Development Complete	October 3, 2012		
7063	Stage 6 Online Applications Website Development Complete	October 5, 2012		
10807	Stage 6 License verification Website Implementation	August 27, 2012		
7442	Reconcile State Models and Configured System Complete	January 7, 2013	March 5, 2013	
7446	Stage 7 Specification Walkthrough Complete	January 11, 2013	January 22, 2013	
10016	Stage 7 AVRS Interface Complete	February 25, 2013		
10009	Stage 7 MMIS Replacement Interface Complete	January 7, 2013		
7466	Stage System Testing Complete	May 10, 2013		
7477	Stage 7 Deliverables Cycle 1 Client Review Complete	March 12, 2013		
10819	Stage 7 Construction Output Specifications Complete	March 28, 2013		
7490	Stage 8 Deliverables Cycle 1 Client Review Complete	April 24, 2013		
7493	Stage 8 Transition to Operations Administrator Guide Complete	May 8, 2013		

End of Appendix B

APPENDIX C – REPLACEMENT MMIS BUILDS

0.	Multi-payer Foundation
1.	NCTracks Portal
2.	Training/Demo Environment
3.	Imaging/ Retrieval/ Printing Equipment
4.	Early Implementation 4.1 Provider Enrollment, Verification, & Credentialing (EVC) 4.3 Retro DUR
5.	Provider
6.	Recipient
7.	Eligibility Verification/Transaction Services (EVS)
8.	Non-Electronic Submissions
9.	Pharmacy Claim Adjudication
10.	Medical Claim Adjudication
11.	Financial Management & Accounting
12.	Prior Authorization
13.	Managed Care/Third Party Liability 13.1 Managed Care 13.2 Third Party Liability
14.	Pend Resolution/Batch Interfaces/Reference 14.1 Reference 14.2 Pend Resolution
15.	Financial Transactions/MAR Reporting 15.1 Financial Transactions 15.2 MAR Reporting
16.	Health Check/Drug Rebate 16.1 Health Check 16.2 Drug Rebate
17.	Call Center Services
18.	Automated Voice Response System (AVRS)
19.	5010 Claim Format
99.	Architecture
100.	Operations

End of Appendix C

APPENDIX D –
NCGA 2010 AND 2011 SESSION LEGISLATIVE MANDATES

Calendar Year 2010

Sess. Law	Bill #	Short Title	Summary	Impact on NCMMIS+ Projects
2010-002	H 589	State Health Plan Cover/Hearing Aids/Autism	Requires health benefit plans and the State Health Plan to cover hearing aids and replacement hearing aids.	Potential impact on R&A reporting tables if State Health Plan claims data is included in this project.
2010-003	H 1707	SHP/Aged-Out Dependents; Tobacco Use Testing	• Allows already-enrolled dependent children under the age of twenty-six who are not eligible for employer-based health care to remain on the North Carolina State Health Plan for Teachers and State Employees for plan year 2010-2011. • Directs the State Health Plan to consult with the Committee on Hospital and Medical Benefits before implementing any tobacco use testing program.	Potential impact on R&A reporting tables if State Health Plan claims data is included in this project.
2010-031	S 897	Appropriations Act of 2010	Modifies the Current Operations and Capital Improvements Appropriations Act of 2009.	Items that may impact MMIS include: • CAPMR/DD Waiver changes • Repealed by S.L. 2011-102, s.1 • Replaced by the 2011 Appropriations Act changes to reimbursement rates and program benefits. • Add Never Events to as non-covered by Medicaid State Plan • Modify the Medicaid Recipient Appeal Process
2010-068	S 1193	Implement LTC Partnership Program	• Implements the Long-term Care Partnership Program, to ensure that North Carolina's long-term care insurance laws comport with the Long-term Care Partnership Provisions in the federal 2005 DRA • Authorizes the sharing of confidential information between the North Carolina Department of Insurance, entities that contract with the federal government, and other governmental agencies, as recommended by the North Carolina Study Commission on Aging.	• May require collection & storage of new or modified data elements in NCTracks, including changes to system screens to display data element(s) • Potential reporting changes for R&A and NCTracks • Potential changes to inbound and/or outbound interface requirements for NCTracks

Sess. Law	Bill #	Short Title	Summary	Impact on NCMMIS+ Projects
2010-070	H 382	Health Choice Program Review Process	• Creates the Health Choice Program Review Process to continue the current review process for program applicants and recipients appealing enrollment and eligibility decisions. • Creates a new review process for program recipients to appeal health services decisions. • Adds the health services review process to the agencies and proceedings currently exempted from the contested case provisions of the Administrative Procedure Act.	• Potential to add new data fields in NCTracks to document recipient appeal process • Potential for new standard and ad-hoc reports from R&A and NCTracks to monitor adherence to service level agreements for timeliness of appeal process steps. • Changes to existing appeal process letters and creation of new letter to inform NCHC recipients of new appeal process.
2010-088	H 1692	Medicaid Dental/Special Needs Population	Requires the Division of Medical Assistance and the Division of Public Health, in the Department of Health and Human Services, to explore issues related to providing dental services to the special needs population. Report results to be delivered on or before 11-15-11.	• Based on study's final set of recommendations, potential future NCTracks data fields to collect and report on total services and costs of dental care related to special health needs recipients in LTC or group homes. • Potential future impact on provider enrollment requirements/data collection/reporting related to dental services for special needs recipients • Note: Special Needs designation for children enrolled in NCHC will end effective 10-01-11, per pending Title XXI State Plan Amendment. Special Needs designation expanded covered benefits for NCHC children to include Medicaid services not otherwise covered under the Title XXI benefit plan.

Sess. Law	Bill #	Short Title	Summary	Impact on NCMMIS+ Projects
2010-093	H 1703	Adult Day Care Criminal Record Check Process	Directs the Division of Aging and Adult Services, Department of Health and Human Services, to study the issue of criminal history record checks for current and prospective owners, and operators, as well as volunteers of adult day care programs and adult day health services programs, as recommended by the North Carolina Study Commission on Aging. Findings to be reported on or before 11-01-10.	• May affect eligibility and new enrollment requests for specified providers in NCTracks including extended application processing timeline. • May result in disenrollment of existing providers based on expanded credentialing requirements. • Potential new interfaces in NCTracks with professional organizations and criminal history databases. • Increased cost to credential existing providers and new applicants to cover background checks on expanded individuals subject to criteria. • Potential future impact on reporting from R&A and NCTracks related to adult day care services providers
2010-118	S 765	Pooled Trusts/ Medicaid Reimbursement	Amends the General Statutes with respect to community third party trusts and Medicaid pooled trusts, and to provide for Medicaid reimbursement in certain circumstances.	• Potential changes to determining eligibility for certain programs based on assets used to determine family or individual income. • May require collection of new or modified data elements in NCTracks. • Potential reporting changes for R&A and NCTracks. • Potential changes to NCTracks Estate Recovery rules regarding specified trust, impacting State reimbursement of medical expenditures from estate after death of covered recipient.
2010-120	S 1392	State Health Plan/ Court-Ordered Guardianships	Allows state employees to enroll children for which they are court-appointed guardians as dependents in the North Carolina State Health Plan for Teachers and State Employees.	• Potential impact on R&A reporting tables if State Health Plan claims data is included in this project. • Increased potential NC SHP enrollees and claims, resulting in increased costs due to expanded data storage and reporting needs. • Potential new reports from R&A project to track and report data from new enrollee category, service utilization, and costs related to other plan enrolled members.

Sess. Law	Bill #	Short Title	Summary	Impact on NCMMIS+ Projects
2010-121	H 1705	Consumer Guidelines for Hearing Aid Purchases	Requires the Hearing Aid Dealers and Fitters Board to coordinate a task force that will develop guidelines for consumers to use when purchasing a hearing aid, as recommended by the North Carolina Study Commission on Aging. Study findings due 10-15-10.	Has potential impact, but any recommended guidelines or standards should be external to existing NCMMIS + projects. [Update note: S.L. 2011-020 (HB 60) extends this task force activity to November 15, 2011.]
2010-128	S 354	Continuing Care Retirement Community/Home Care	• Permits continuing care retirement communities to provide or arrange for home care services without providing lodging when those services are provided adjunct to a contract for continuing care • Requires Department of Insurance and the Department of Health and Human Services to study issues related to continuing care retirement communities providing home care services without providing lodging.	• Adds new provider type for Home Health Services – and impacts cross-walk from Legacy MMIS to NCTracks taxonomic value. • New application and credentialing criteria required for NCTracks (paper and web-based). • Potential need to collect future new data elements or modification of existing data elements in NCTracks. • Potential reporting changes for R&A project and NCTracks,
2010-152	S 900	Studies Act of 2010	Provides for studies by the Legislative Research Commission, statutory oversight committees and commissions, and other agencies, committees, and commissions.	The following studies could lead to changes in NCMMIS+ projects: • Consolidation of State Agencies & Departments • Expansion of covered services by Certified Nurse Midwives • Efficient E-Commerce via increased automation, EFT and direct deposit, paperwork reduction, and lowered financial transaction costs • Potentially require LTC facilities to carry liability insurance to retain or obtain licensure (would impact NCTracks credentialing and provider enrollment) • Creation of State Diabetes Coordinator position may result in benefits, payment rates, and reporting for diabetes services • Monitor Impact of Revised Requirements for Personal Care Services for elderly and disabled • Study of mental health services provided to recipients, family support, early detection, and new models of treatment • CCNC requirement to collect BMI (Body Mass Index) from all enrolled Medicaid and NCHC recipients and develop preventive and treatment modalities • Cost effectiveness of supportive housing as alternative to institutionalization (MH/DD/SA) • Prescription Drug Abuse

Calendar Year 2011

Sess. Law	Bill #	Short Title	Summary	Impact on NCMMIS+ Projects
2011-011	S 32	Hospital Provider Assessment Act	Adds new Article 7, *Hospital Provider Assessment Act*, to G.S. Chapter 108A. • Imposes assessments on hospitals to provide revenue to improve funding for payments for hospital services provided to Medicaid and uninsured patients. • All assessment proceeds and corresponding matching federal funds must be used to make the payments required under the new G.S. §108A-124. • Requires DHHS to file a State Plan amendment with CMS.	• R&A and NCTracks new data collection and reporting requirements • New NCTracks requirement for invoicing, collecting funds, and tracking assessments paid by designated hospitals • NCTracks development and maintenance of financial criteria to re-determine billing amount calculation annually • Develop new processes for fund distribution to eligible facilities, State Controller, and refunds
2011-012	S 7	Add Controlled Substances	Adds Mephedrone, Methyenedioxyprovalerone and certain derivatives of 2-Amino-1-Phenyl-1-Propanone, and synthetic cannabinoids to the list of controlled substances.	• NCTracks program changes to covered/non-covered drugs under Controlled Substance classes • NCTracks and R&A potential new reporting on requests for Prior Authorization and claims adjudication for named drugs • Changes to Retro-DURUR reporting requirements
2011-090	S 245	Medicaid Billing by Local Health Departments	• Authorizes local public health departments, district health departments, and consolidated human services agencies ["LHDs"] to bill Medicaid through an approved Medicaid clearinghouse or through DHHS, DPH. • Specifies LHD and DPH data collection and reporting requirements. • LHDs may rebill outside of the HIS system any unpaid Medicaid claims submitted to HIS from July 1, 2010, forward.	• New Trading Partner Agreements and interface testing for electronic claims submission and response • Potential for Local HD to submit aggregate billing data for all claims and file detailed patient encounter date with DPH only; New requirements for interface and encounter processing/reporting with DPH • Develop alternate electronic billing process for Local HD bypassing CNDS registration • Impact to security in NCTracks to validate provider identity

Sess. Law	Bill #	Short Title	Summary	Impact on NCMMIS+ Projects
2011-099	H 474	Protect Adult Care Home Residents	• Strengthens adult care home infection control requirements. • Requires DHHS to develop guidelines prescribing the manner in which an adult care home is to report a suspected communicable disease outbreak to the local health department. • Requires DHSR to annually inspect adult care homes for compliance with safe infection control standards. • Requires DHSR and DHHS to develop mandatory, annual in-service training programs for medication aides and for supervisors on infection control, and to award continuing education credit upon successful completion.	BPAS: • Additional training, examination, and CE credit requirements will require data and business rule development and/or modification • Potential business rule changes after the rules development required by this law is completed • Potential business rule modifications for inspections • NCTracks changes to credentialing process for Adult Care Homes, including web pages, paper enrollment form, and collection/tracking of new data elements related to licensure and enrollment • Potential for new database creation or interface to validate all requirements are met for licensure of each type of sub-provider within Adult Care Home
2011-102	S 316	Additional Section 1915 Medicaid Waiver Sites	Repeals S.L. 2010-31 s.10.24, *Statewide Expansion of Capitated 1915(b)/(c) Behavioral Health Waivers.* • Requires DHHS to implement additional 1915(b) (c) Medicaid waiver sites through a Request for Application (RFA) process for LME applicants who prove readiness. • Allows State facilities to disclose certain information for purposes of collecting payment. • Directs the distribution of a fund balance upon the dissolution of an area authority. • Contingent upon CMS approval of waiver expansion application	• NCTracks business rules needed to accept and process encounter data from multiple entities in standardized format • Changes to existing reports and new reports for NCTracks and R&A projects • Expansion of managed care Fiscal Agent processes to include new entities
2011-103	S 608	Health Care Sharing Organizations	Declares that health care sharing organizations are exempt from health insurance regulation if the organization meets certain criteria, including: "Provides for the financial or medical needs of a participant through contributions from one participant to another in accordance with criteria established by the health care sharing organization."	No direct impact to NCMMIS+ projects. This impacts regulation of such non-profit groups and does not exclude individual from applying for other insurance. This impact is external to NCMMIS+ scope of work as currently defined.

Sess. Law	Bill #	Short Title	Summary	Impact on NCMMIS+ Projects
2011-104	S 512	Authorize Overnight Respite Pilot	Requires DHHS to pilot an overnight respite program in qualified facilities that offer adult day care. • DHHS must adopt rules to ensure the health and safety of the overnight respite participants. • DHSR will enforce the adopted rules. • The pilot adult day care programs must be selected and have received a DHSR initial inspection by January 1, 2012. • DHSR must conduct monitoring visits at least every six months. • DHSR will be responsible for investigating complaints. • Each adult day care program participating in the pilot must periodically report the number of individuals served and the average daily census to DHSR, on a schedule determined by DHSR. • The act is repealed June 1, 2015.	BPAS • New data and process requirements, to be determined after the required rule-making • New interface requirement with DAAS • Not a covered service under DHHS – no impact to benefit plan for this provider type in NCTracks.
2011-117	S 307	Smart Card Biometrics Against Medicaid Fraud	Establishes the NC Smart Card Pilot Program, for a 6 to 12 month period. • The pilot program involves enrollment, distribution, and use of smart cards by designated recipients as replacements for currently used Medicaid assistance cards. • Detailed requirements for the Program are specified in the Act. • Report of pilot results due June 30, 2012.	• Program administered by DMA Provider & Recipient Services – potential that this could be delegated to Fiscal Agent • May involve contract with 3rd party vendor to produce cards. NOTE: NCTracks was to produce NCHC ID cards, but this is being de-scoped for DIRM to produce Medicaid & NC Health Choice cards. • Fiscal agent call center will need new procedures instructing recipients on how to obtain replacement card(s). May require interface with 3rd party vendor to send requests. • Equipment distribution, use, and training needed for all participating providers on recipient eligibility. • Potential alternate "quick-pay" reimbursement for providers • New data sets (4) required for analysis of program success. Data collection and reporting potential impact to NCTracks and R&A. • Interface with DMV for photos and identify verification required.
2011-145	H 200	Appropriations Act of 2011	Note: Provisions of this act are listed in a separate table in this Appendix.	Please see the separate S.L. 2011-145 (HB 200) table.

Sess. Law	Bill #	Short Title	Summary	Impact on NCMMIS+ Projects
2011-185	S 597	Behavioral Health Services for Military	Ensures that the behavioral health needs of members of the military, veterans, and their families are met. • DMH/DD/SAS must collaborate with military agencies and other organizations to determine gaps in the care for traumatic brain injury, and report its recommendations by July 1, 2012. • DMA and others must ensure that MedSolutions, Inc., is using the appropriate evidence-based diagnostic testing for screening and assessment of traumatic brain injury. • DMH/DD/SAS and DMA must explore the possibility of implementing value-based purchasing or grants to provide additional reimbursement for certain providers, and define appropriate process and outcome measures on which to tie performance-based incentive payments. • The Commission for MH/DD/SAS must adopt rules for LME staffing and training requirements. • DMH/DD/SAS, in conjunction with others, must develop a training curriculum for community service organizations, and report on the curriculum by July 1, 2012.	• Potential for future benefits available to expanded group of eligibles specific to head trauma and PTSD. Would require new health plan and benefit plan design under DMH for NCTracks multi-payer system. • Potential to require alternate method of recipient eligibility to receive specific targeted services, • Extensive referral potential from external entities. Issues include whether a referral equals a prior authorization for claims adjudication purposes. • New provider type and type of service potential (new taxonomy and internal modifier in NCTracks) • Services provided through LMEs – unique requirements for claims handling needed • Reimbursement rates to be established for services
2011-189	S 449	Task Force on Fraud Against Older Adults	• Directs the Consumer Protection Division, Dept. of Justice, to coordinate a Task Force on Fraud Against Older Adults, which must include DHHS representation. • Task force must examine, among other things, establishing a statewide system to enable reporting on incidents of fraud and mistreatment of older adults. • Interim report due by November 1, 2011, and final report with recommendations due by October 1, 2012.	• BPAS – Future data interface/sharing and business rule changes, depending on action taken following task force recommendations. • Potential NCTracks and R&A new reporting and data element collection specific to criteria as defined under this Task Force mission.
2011-197	H 331	Allow PAs and NPs to Sign Death Certificates	Authorizes physician assistants and nurse practitioners to complete medical certifications as to the cause of death for death registration.	No direct impact to NCMMIS+ projects. Impact and action is external to project scope of work.

Sess. Law	Bill #	Short Title	Summary	Impact on NCMMIS+ Projects
2011-202	H 509	Exclusions from Licensure: Home Services	Excludes from requirement to seek licensure as a mental health facility consumers living in their own home and receiving services.	• BPAS – Modify monitoring requirements to incorporate this exclusion from licensure requirement • MMIS-Provider – Changes to provider enrollment and credentialing questions for provider type to ensure that no license is required for these situations.
2011-249	H 397	DHHS Penalties and Remedies Revision	Revises licensure penalty classifications, processes, factors to be considered, and remedies pertaining to mental health facilities, adult care homes, and nursing homes.	BPAS – Modify business and data rules, due to the legislative changes.
2011-253	H 618	Streamline Oversight / DHHS Service Providers	Streamlines duplicate oversight of certain DHHS service providers. The DHHS Secretary shall: • Direct that a rate-setting memorandum be prepared for every change or adjustment made in service definition, policy, rule, or provider requirements that impacts services provided in accordance with this act. • Dissolve NC Treatment Outcomes Program Performance System (NC-TOPPS) Advisory Committee and establish a task force to improve the way data is accessible across services by August 1, 2011. • Allow private sector implementation of an Internet-based, secure, and consolidated data warehouse and archive for maintaining corporate, fiscal, and administrative records of providers by September 1, 2011. The regulatory body that conducts administrative monitoring must use the data warehouse for document requests. • Annually review updates to policy made by the certain national accrediting bodies, and take action to ensure that DHHS policy or procedural requirements do not duplicate them.	• MMIS- Provider – data collection and credentialing process changes, with potential for interface to new database • NCTracks – change to reference file maintenance process for pricing (will require rate setting memo) • R&A – Optional creation of new provider administrative database for central access by multiple entities to avoid duplication of unfunded mandates (Internet-based). No recipient data will be stored here. Purpose to avoid duplication of multiple agencies conducting provider credentialing activities. • BPAS – data & process changes

Sess. Law	Bill #	Short Title	Summary	Impact on NCMMIS+ Projects
2011-254	H 629	Substance Abuse Treatment	• Requires chemical dependency screening and assessing of criminal defendants ordered into residential treatment at Dept. of Correction-operated facilities. • If the screening indicates chemical dependency, the court must order an assessment to determine the appropriate level of treatment. • As a condition of probation, the court may require a defendant to undergo available medical or psychiatric treatment and remain in a specified institution if required for that purpose. • Requires the NC Substance Abuse Professional Practice Board to adopt rules related to the approval of substance abuse specialty curricula developed by a school, college, or university.	• Potential to impact facilities licensed by DHSR. • Potential need to coordinate with the Dept. of Correction with respect to these types of services. • See, e.g., S.L. 2011-264, s.1(a): Statewide restructuring of management responsibilities for the delivery of services for individuals with mental illness, DD, and SA disorders through expansion of the 1915(b)/(c) Medicaid Waiver – to result in the establishment of a system that is capable of managing all public resources that may become available for MH/DD/SAS .
2011-258	H 808	Revise Laws on Adult Care Homes	• Authorizes DHSR to waive annual inspections of adult care homes that achieve the highest rating, • Establishes an informal dispute resolution procedure for adult care homes to dispute cited inspection deficiencies.	BPAS – Data and business process modifications
2011-264	H 916	Statewide Expansion of 1915(b)/(c) Waiver	• Directs a statewide restructuring of management responsibilities for the delivery of services for individuals with mental illness, DD, and SA disorders through expansion of the 1915(b)/(c) Medicaid Waiver – to result in the establishment of a system that is capable of managing all public resources that may become available for MH/DD/SAS. • Establishes requirements for DHHS and LMEs with respect to statewide expansion of the 1915(b)/(c) Medicaid waiver. • Revises counties' duties and county area authority standards. DHHS responsibilities include, but are not limited to: • Designating a single entity to assume responsibility for all aspects of waiver management. • Using managed care strategies, including care coordination and utilization management, to reduce the trend of escalating costs in the State Medicaid Program. • Phasing out the current CAP-MR/DD Waiver as well as the utilization management functions	• Phase out of existing CAP MR/DD benefit plan by July 1, 2013 to be replaced by waiver expansions statewide for all LMEs • Potential impact to electronic claims filing procedures if LMEs elect single administration model where a single LME acts as general administrator for all state waiver participants (i.e. large claim files submitted from a single provider for statewide waiver services) • Increased reporting for existing managed care reports to expand to duplication of reports for current Piedmont Waiver Program for each new waiver entity • New reporting and interface/data collection requirements between CCNC, LMEs, and NCTracks

Sess. Law	Bill #	Short Title	Summary	Impact on NCMMIS+ Projects
			currently performed by public and private contractors. (LMEs must offer to contract with providers that were previously approved to provide targeted case management under the CAP-MR/DD Waiver, for the provision of Community Guide services.) • Selecting LMEs that have been assessed to meet minimum criteria for waiver operations. Later, requiring other LMEs to merge with or be aligned through an interlocal agreement with an LME that has been approved. • Determining the feasibility of adding habilitation services to the State Medicaid Plan through the 1915(i) Option. • Considering the impact on ICF-MR facilities and minimize potential inconsistencies with the Certificate of Need (CON) law. • Discontinuing the pilot program to administer the Supports Intensity Scale. • Establishing written policies ensuring alignment of objectives and operational coordination. • Submitting, in coordination with others, a strategic plan delineating specific strategies and agency responsibilities by October 1, 2011. • Submitting status reports on the restructuring and expansion.	

Sess. Law	Bill #	Short Title	Summary	Impact on NCMMIS+ Projects
2011-272	H 677	Discharge of Adult Care Home Residents	• Amends the ACH residents' rights law and the associated Medical Care Commission rulemaking standards with respect to protections against transfer or discharge. • Establishes a new process by which adult care homes can initiate the discharge of residents for specified reasons. • Requires the DSS of each county to establish an "ACH resident discharge team" to assist with finding a placement for the resident, if needed. • Establishes a new process for appeals of such discharges, utilizing a Hearing Unit to be designated within DMA. The Hearing Unit's decision is the final agency decision. • Exempts hearings of appeals initiated by adult care homes from G.S. 15B contested case provisions.	BPAS – New data and process requirements
2011-311	S 670	Revise Membership/Hearing Aid Fitters Board	• Allows dispensing by apprentices if supervised by a "Registered Sponsor," who must be *either* a board licensee *or* a licensed doctoral-level audiologist [formerly only board licensees could supervise]. • Requires registration by the board of non-licensee Registered Sponsors.	• This is a non-standard provider, but may require collection of additional data element for enrollment and credentialing process in Medicaid program • Claims processing could be impacted if data regarding supervising provider does not meet criteria
2011-314	S 607	Conform Medical Record Laws	Makes conforming changes to several medical record confidentiality laws: G.S. 90-85.36 G.S. 122C-52(b) G.S. 122C-55 G.S. 130A-12 G.S. 130A-143 G.S. 131D-21 G.S. 131E-144.3	No impact to NCMMIS+ Program.
2011-326	S 148	GSC Technical Corrections / Other Changes	§§14(a)-(e) modify controlled substances lists.	No impact to NCMMIS+ Program

Sess. Law	Bill #	Short Title	Summary	Impact on NCMMIS+ Projects
2011-337	S 375	NC Health Information Exchange Act	Regulates disclosure of protected health information through a voluntary, statewide HIE network. Each covered entity that elects to participate must enter into a business associate contract and a written participation agreement.	• Potential new interfaces for obtaining recipient eligibility and healthcare information (inbound/ outbound) • Potential new business rules and HIPAA agreements to exchange information between NCTracks and other Authorized Business Associates and authorized providers • New scripts for call center and revised letters for recipients to advise them of right to opt out of having personal information shared through HIE • New data elements and reporting to track opt-out and approval for release of protected medical information
2011-346	S 437	Enact First Evaluation Program	• Adds a new waiver process and criteria for the DHHS Secretary to allow certain certified providers to conduct initial (first level) examinations for involuntary commitments of individuals with mental illness. • Requires DMH/DD/SAS to expand its standardized certification training program to include refresher training for all such certified providers.	MMIS-Provider – credentialing data and process
2011-349	S 474	Photo ID for Certain Controlled Substances	Requires pharmacies to require photo identification prior to dispensing certain controlled substances.	Business process needed for POS for specified controlled substance classes to confirm that ID has been confirmed. This could change POS application development ongoing now with SureScripts and NCTracks.
2011-355	S 743	Encourage Volunteer Health Care Providers	Amends physician and physician assistant licensure laws. • Broadens the applicability of "Limited Volunteer" license categories • Adds "Retired Limited Volunteer" license categories	• MMIS-Provider – data and business rules for credentialing MDs and PAs • Services furnished by these providers are not reimbursable – edits needed in claims processing to ensure claims are zero pay to performing provider • New reports and data elements regarding provider enrollment data collection • New provider type may be needed

Sess. Law	Bill #	Short Title	Summary	Impact on NCMMIS+ Projects
2011-375	H 644	Establish Pharmacy Audit Rights	• Establishes pharmacy audit rights and standards for recoupment of claims. • Authorizes a 30-day period to submit a written request for a reconsideration review to DMA.	• MMIS-Pharmacy – audits & recoupments business processes • Impact to Program Integrity audit triggers, audit process, and provider appeal rights under audit • Potential changes to financial module for recoupment of claims if provider appeals results of audit • New edit may be required to identify pharmacy providers who are subject to audit or may have been identified for recoupment after audit. Needs to also identify if they have filed appeal and business rules related to recoupment if appeal is in process.
2011-386	H 809	Model Healthcare-Associated Infections Law	Requires DHHS to establish a statewide surveillance and reporting system for healthcare-associated infections, and to subject hospitals to its requirements.	• DHSR – access to data • MMIS-Provider – access to data • R&A – analysis of data
2011-389	H 678	Pilot Release of Inmates to Adult Care Homes	Requires DHHS, in collaboration with the Dept. of Correction, to establish a pilot program to allow inmates released from confinement to be placed in adult care homes.	• BPAS – accommodation of pilot data and pilot facility business rules • MMIS – potential new eligibility category with specific associated benefit plan • MMIS – new reports and data collection based on this specific pilot claims and recipient data • R&A – pilot data analysis reporting potential

Sess. Law	Bill #	Short Title	Summary	Impact on NCMMIS+ Projects
2011-398	S 781	Regulatory Reform Act of 2011	Makes sweeping changes to the NC Administrative Procedures Act and related statutes that significantly impact our divisions in their rulemaking, contested case, and declaratory ruling responsibilities and will likely impact the NCMMIS+ projects over time. In addition: • Section 1. Requires that all policies, guidelines, and interpretations be in a rule, if they meet the definition of a rule. • Section.2. Establishes a "Rules Modification and Improvement Program" to conduct an annual review of existing rules, which will include public input. Agencies must review the public comments, prepare a report on whether any of the recommendations contained in the comments have potential merit and justify further action, and submit a report of their findings to the OSBM by January 31 each year. • Section 55. Requires DHHS to request a waiver from the federal single Medicaid state agency requirement. • Section 57. Requires every State agency or other body with rule-making powers to deliver a list of all permanent rules adopted by the body – including specific information for each rule – to the legislature by October 1, 2011.	Divisions: • Impact on key staff availability due to new responsibilities imposed by this act. • Future business process changes are likely to be defined as a result of this act. • Potential to change NCTracks File Maintenance Process for entering changes to business rules, edits, etc. based upon State CSRs and federal legislative requirements (i.e. FA may have higher obligation to ensure all requirements are met before change is made to NCTracks system.)

Sess. Law	Bill #	Short Title	Summary	Impact on NCMMIS+ Projects
2011-399	S 496	Medicaid and Health Choice Provider Requirements	• Adds a new G.S. Chapter 108C, "Medicaid and Health Choice Provider Requirements," with requirements for provider enrollment and screening, sanctions, change of ownership/ successor liability, appeals, and other specifics. • Removes an exemption from contested case requirements that had existed with respect to certain appeals by community support services providers. • Modifies procedures for changing medical policy. • Expressly authorizes rulemaking for Medicaid and Health Choice programs.	• MMIS – Provider business rules for credentialing need to be revised based on level of provider risk as "limited, moderate, or high." This applies to NCHC and Medicaid providers. Requires new notification letters to advise provider of their determined risk level and required credentialing procedures. • MMIS – business rules must allow for out of state providers credentialing to be based on credentialing conducted by the other state • Credentialing and enrollment rules impacted by new screening criteria based on criminal history • New rules for provider payment suspension based on credentialing or recertification results obtained and appeal process for providers. This will impact claims processing rules also and new edits or cross-check with specific data elements in provider file need to be created. • Rules required for entity that will be responsible for handling provider appeals that result in withhold of payments. Issues include whether FA or DMA Provider Division will handle these appeals. • New requirements for VANs (billing agents) to enroll and identify with State or their claim submissions will not be recognized and processed (business rules needed to identify and verify the Trading Partner agreement status for electronic claims). • New minimum training requirements for provider enrolling in Medicaid or NCHC program to complete enrollment. Requires changes to application and application review business rules.

S.L. 2011-145 (HB 200) Appropriations Act of 2011

Sess. Law 2011-145	Section Title	Summary	Impact on NCMMIS+ Projects
§6A.7(b)	State Information Technology Consolidation	Requires DHHS, in coordination with the State CIO, to develop a plan to implement a single case management system throughout the Department, beginning in the 2012-2013 fiscal year.	BPAS: • Potential for significant scope change to the extent BPAS in developing "case management system" functionality • New interface/data integration requirement with the single case management system to prevent duplicate or inconsistent data MMIS: • Must determine whether there will be an interface/data integration requirement
§6A.18	Enterprise Electronic Forms and Digital Signatures	The State must: • Implement a coordinated enterprise electronic forms and digital signatures capability; and, • Integrate executive branch agencies already in the process of developing electronic forms and digital signatures projects.	BPAS: • Integrate this functionality into the State system, after it is implemented MMIS: • Integrate this functionality into the State system, after it is implemented for provider and recipient documents filed electronically.
§10.17	DHHS Regulatory Functions Study and Plan	Requires DHHS to: • Examine all regulatory functions performed by each division, and report its findings by January 30, 2012. • Develop a plan to consolidate regulatory functions performed by the various divisions.	MMIS: • To be determined based on results of study and recommendation submitted as part of final report in January 2012. NCTracks is multi-payer system and impact may be less than on other projects.
§10.19	Prohibit Use of All Funds for Planned Parenthood Organization	For fiscal years 2011-2012 and 2012-2013, prohibits DHHS from providing State funds or other funds it administers for contracts or grants to Planned Parenthood, Inc. and affiliated organizations.	MMIS: • Claims business rules and processing edits required to ensure that claims are not paid in error • New reporting for claims with specific procedure or diagnosis or place of service to monitor that regulations have been implemented correctly

Sess. Law 2011-145	Section Title	Summary	Impact on NCMMIS+ Projects
§10.24	Health Information Technology	Directs DHHS, in cooperation with the State CIO, to coordinate health information technology (HIT) policies and programs within the state. The goal is to avoid duplication of efforts and ensure that each State agency, public entity, and private entity that undertakes health information technology activities does so within the area of its greatest expertise and technical capability and in a manner that supports coordinated State and national goals	MMIS – HIT project will be integrated into NCTracks in future, and payments will be issued through new fiscal agent. Details are still being worked out on integration process and timeline.
§10.26	Aids Drug Assistance Program	Directs DHHS to work with the Dept. of Correction (DOC) to use DOC funds to purchase pharmaceuticals for the treatment of inmates with HIV/AIDS in a manner that allows these funds to be accounted for as State matching funds in DHHS' drawdown of federal Ryan White funds.	MMIS – impacts claims processing to ensure that specific drugs covered under Ryan White program are not paid under NCTracks. EOB message should give instructions to provider on how to file claims with unique grant program for these services.
§10.26A	Men's Health	• Directs DPH to delegate to the Chronic Disease Prevention and Control Office the responsibility for ensuring attention to the prevention of disease and improvement in the quality of life for men over their entire lifespan. • Directs DHHS to develop strategies for achieving these goals.	• May result in new benefit plan under DPH for multi-payer system • Will require modifications to covered services for men's health under defined payer and benefit plan • May require creation of new notification to recipients within eligibility criteria to advise of new benefits under covered program.
§10.27	NC Health Choice Medical Policy	• DHHS cannot implement any proposed medical policy change exceeding $1,000,000 for a given fiscal year unless the source of State funding is identified and approved.	• No direct impact to MMIS+ program. This approval is required before change order is entered in maintenance request tracking system for new Fiscal Agent.
§10.28	Community Care of North Carolina	• DHHS and DMA must enter into a three-party contract between NCCCN, Inc. and each of the 14 CCNC networks, which includes certain requirements. • By July 1, 2012, the DHHS, DMA, and NCCCN, Inc. must finalize a comprehensive plan that establishes certain management methodologies.	• May require changes to monthly PMPM for CCNC networks and enrolled recipients. Current rules reimburse PMPM for Medicaid only – no reimbursement for NCHC enrollees. • CCNC may need to be enrolled as a specific provider type to ensure that claims are covered and specific rules applied to this managed care organization and PMPM claims are processed based on systems business rules.

Sess. Law 2011-145	Section Title	Summary	Impact on NCMMIS+ Projects
§10.31A [as amended by S.L. 2011-391, s.24]	Medicaid Provider Assessments	DHHS may implement a Medicaid assessment program for any willing provider category allowed under federal regulations, except for hospital providers subject to the assessments authorized in Session Law 2011-11.	• MMIS-Financial – may impact reimbursement amount calculation on adjudicated claims. Need to determine if there are specific cut-back rules that can be applied to defined providers. • R&A – potential new reports based on provider cut-back payments
§10.33	Medicaid Cost Containment Activities	Appropriates funds to support Medicaid cost containment activities, which may include: • Prospective reimbursement methods • Incentive-based reimbursement methods • Service limits • Prior authorization of services • Periodic medical necessity reviews • Revised medical necessity criteria • Service provision in the least costly settings • Plastic magnetic-stripped Medicaid identification cards for issuance to Medicaid enrollees [*see also*, S.L. 2011-117] • Fraud detection software or other fraud detection activities • Technology that improves clinical decision making • Credit balance recovery and data mining services • Other cost containment activities	• MMIS – impact to be determined based on results of study to determine which provisions will be implemented into NCAC. Potential changes are too broad at this time to determine impact to NCTracks program. • R&A – impact to be determined based on results of study to determine which provisions will be implemented into NCAC.
§10.36(c)	Families Pay Part of the Cost Under the CAP-MR / DD and CAP-Children's Programs	Similar to previous S.L. 2009-451 §10.65. Adds: "Implementation of this provision shall be delayed until the implementation of the new MMIS."	This program may be deleted based on other legislation passed in 2011. No changes will be evaluated until future continuation of this program is determined. NCTracks is scheduled to implement between March 1 2013 and July 1, 2013.
§10.38	Medicaid Waiver for Assisted Living	Requires DHHS to develop and implement a home- and community-based services program under Medicaid State Plan 1915(i) authority in order to continue Medicaid funding of personal care services to individuals living in adult care homes.	NCTracks impact to reporting and business rules related to processing claims and payment rates based on expansion of 1915(i) waiver approval by CMS

Sess. Law 2011-145	Section Title	Summary	Impact on NCMMIS+ Projects
§10.41	NC Health Choice	• Rewrites G.S. 108A-70.21(b); changes program benefits, and requires payment of per member per month fees to CCNC providers. • Repeals G.S. 108A-70.23 (services for children with special needs). • Modifies G.S. 108A-70.27(c) to require DMA to provide to the Department data required under this section that are collected by the Plan. • Gives DHHS additional rule-making authority for the transition and operation of Health Choice.	• NCTracks impact to add claims payment to CCNC for PMPM for NCHC recipients (suspended at this time). Business rule changes needed and potential change to interface from NCTracks to CCNC networks. • Eliminate benefit plan for Special Needs under NCHC program (impacts multi-payer design and Business Rules & Analysis project used to code benefit plans) • Changes NCHC benefits to be Medicaid look-alike program. Significant modification to benefit program and business rules already submitted to NCTracks for Title XXI.
§10.42	Medication Therapy Management Pilot	• Requires DHHS to develop a two-year medication therapy management pilot program to be administered through CCNC. • Funding will be through the Enhanced Federal Funding for Health Homes for the Chronically Ill.	Does not appear to have direct impact to NCTracks at this time, as pilot project will be conducted outside of standard claims processing system.
§10.44	Medicaid Recipient Appeals	Requires DHHS to review the appeals process for adverse Medicaid determinations for Medicaid recipients to examine whether it conforms with, or exceeds, the requirements of federal law.	• Impacts recipient letters and notification of appeal rights based on changes in this legislation • Fiscal Agent must mail letters from local Raleigh location rather than NY Central Processing Center per new regulations. NCTracks working on solution to this, as they do not have capacity for large mailings from local office. Potential 3rd party vendor to be engaged. Changes are still under review.
§10.47(d),(e)	DHHS Savings through CCNC	(d) If savings are not being achieved in the amount required by subsection (a), requires the Secretary, to the extent required in order to achieve savings at the required rate, take whatever actions are necessary, including the following to be effective January 1, 2012: • Reduce Medicaid provider rates by another 2%; and, • Eliminate or reduce the level or duration of optional Medicaid services. (e) Requires DHHS, in collaboration with CCNC and LMEs, to ensure the effective integration of behavioral health and physical health services for Medicaid recipients.	• Impact to NCTracks via new pricing files provided to Reference subsystem. Decision on pricing will be determined and identified by State.

Sess. Law 2011-145	Section Title	Summary	Impact on NCMMIS+ Projects
§10.47	Revise Pharmacy Dispensing Fees for Pharmacists that Dispense High Proportions of Generic Drugs	Requires DHHS to revise Medicaid pharmacy dispensing fees to encourage more generic prescriptions and thereby achieve savings of $15 million dollars in the 2011-2012 fiscal year and $24 million dollars in the 2012-2013 fiscal year.	• NCTracks changes to pricing manual guidelines, reference files, and Build 9 Pharmacy pricing calculation (to include dispensing fees). May require CSR if additional changes are made from current dispensing rates and methodology.
§10.49A [as amended by S.L. 2011-391, s.26A]	Home Care Agency In-Home Aide Services Licensure Moratorium	Imposes a three-year moratorium, beginning July 1, 2011, on licensure of new home care agencies that intend to offer in-home aide services.	BPAS – Modify business rules MMIS-Provider – Modify business rules
§10.53	Repeal State Abortion Fund	Section 93 of Chapter 479 of the 1985 Session Laws, as amended, is repealed.	MMIS – potential impact of coverage for abortion and additional documentation required for any abortion claim submitted to validate that reason is based on one of several approved conditions. Business rule changes and system changes to suspend every abortion claim for manual review.
§13.3(e) [as amended by S.L. 2011-391, s.27(a).]	Abolish, Transfer, or Consolidate DENR Environmental Health Programs	Transfers all DENR Radiation Protection Section functions to DHSR.	BPAS – Expand project scope to incorporate new data and business responsibilities
§13.3(eee) [as amended by S.L. 2011-391, s.27(d)]	Abolish, Transfer, or Consolidate DENR Environmental Health Programs	• DHSR is responsible for developing a training program for tanning equipment operators. • If the training program is provided by the Department, the Department may charge each person trained a reasonable fee to recover the actual cost of the training program.	BPAS – Expand project scope to incorporate new data and business responsibilities
§13.3(ooo)	Abolish, Transfer, or Consolidate DENR Environmental Health Programs	Provides that annual fees collected from certain nuclear facilities by the Dept. of Crime Control and Public Safety are for the use of the Radiation Protection Section of DPH. The fees can be used only for costs of planning and implementing emergency response activities as required by FEMA for the operation of nuclear facilities.	BPAS – If the reference to DPH instead of DHSR is an error, new data and business processes will need to be incorporated into the project.
§23.3 [as added by S.L. 2011-391, s.49.]	Department of Insurance and Affordable Care Act	• Dept. Insurance (DOI) and DHHS may collaborate and plan in furtherance of the requirements of the ACA for establishing and operating a State-based Health Benefits Exchange. • DOI may contract with experts necessary to facilitate preparation for an Information Technology system capable of performing requirements of the ACA.	Impact to be determined as Health Insurance Exchange is further defined by State and requirements for interface/interaction with NCTracks claims processing system. Greatest impact may be to NCFAST project for determining applicant eligibility for specific benefit programs (public and private).

Sess. Law 2011-145	Section Title	Summary	Impact on NCMMIS+ Projects
§29.23	Limit State Abortion Funding/Health Plan/ Insurance	No state funds may be used for the performance of abortions or to support the administration of any governmental health plan or government-offered insurance policy offering abortion, except where (i) the life of the mother would be endangered or (ii) the pregnancy is the result of a rape or incest.	MMIS – potential impact of coverage for abortion and additional documentation required for any abortion claim submitted to validate that reason is based on one of several approved conditions. Business rule changes and system changes to suspend every abortion claim for manual review.

End of Appendix D

APPENDIX E – 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) 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 re-procurement 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. Furthermore, this procurement process will provide 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 DHHS staff members primarily 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 are responsible for overseeing 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 E