NC MEDICAID MANAGEMENT INFORMATION SYSTEM+ (NCMMIS+) PROGRAM

Quarterly Report
to the
North Carolina General Assembly
August – October 2012

State of North Carolina
Department of Health and Human Services

January 1, 2013

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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 August 1, 2012 through October 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 $105.3 million in drug rebates from participating pharmaceutical companies for placing their drugs on the PDL. Additionally, Health Choice Drug Rebates were implemented during the quarter and a total of $123,326 has been collected by the State thus far.
  - 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 46,800 total provider enrollments have been completed.
- A monthly average of 1,664 new enrollment applications has been processed during the quarter, of which 51% were submitted electronically.
- The average processing time to complete all application types was 20.7 business days.
- CSC completed a monthly average of approximately 3,500 on-going provider licensure verifications and a total to date of approximately 70,600; 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 approximately 11,200 provider calls per month, which is a 49% increase over the previous quarter, due mostly to higher call volumes related to provider re-credentialing.
- Provider enrollment fees ($100 per enrollment) in the amount of $2,828,925 have been collected through October 31, 2012.

- o 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.

- o Supplemental Drug Rebate/Preferred Drug List (PDL)
  As noted under *NC Tax Payer Benefits* above, the State has already collected $105.3 million in drug rebates from participating pharmaceutical companies for the Preferred Drug List Program.

- o Health Choice Drug Rebates
  As noted under *NC Tax Payer Benefits* above, the State has collected a total of $123,326 in Health Choice drug rebates.

- **Health Care Provider Benefits**
  - o 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;
  - o 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)
  - AIDs Drug Assistance
  - Early Hearing Detection and Intervention
  - Sickle Cell
  - Infant Toddler Early Intervention

- 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:

CSC completed the Final System Integration Test (FSIT), as scheduled, on August 27, 2012. FSIT consists of a subset of the Final Integration Testing (FIT) and end-to-end test cases that demonstrate NCTracks build integration for the State. CSC executed thirty-seven test case scenarios that focused on functionality surrounding claims and financial processing. The State reviewed the FSIT test case results to validate the NCTracks build

integration and to better determine whether the system was ready for the State to begin User Acceptance Testing (UAT).

Medical Claims User Build Acceptance Testing (UBAT) was completed on August 24, 2012. CSC submitted the test results on September 19, 2012, indicating that 321 test cases passed out of a total of 366. This was the first time that a UBAT process has been used for an MMIS project. Many defects were discovered during the six UBAT testing periods, without which, these defects could not have been discovered until after the beginning of User Acceptance Testing (UAT).

CSC provided streamlined training for NCTracks' UAT to the OMMISS Team. The training consisted of a system demonstration and a walkthrough of documentation. SLI, the Test Management Services vendor, provided training on September 12, 2012, to the OMMISS Team regarding the use of the SILK test management tool, the protocols for HIPAA adherence during testing, and test processes to be followed while in the test lab.

The State began NCTracks' UAT on September 12, 2012, following several days of initial review of the test environment. Testing is scheduled for ninety calendar days and will continue through January 16, 2013. UAT has been divided into four distinct components consisting of:

- OMMISS functional area testing;
- Division business component testing;
- End-to-End testing (multiple test cases strung together to follow a business process from start to finish across multiple functional areas); and
- Provider participation testing.

The State began UAT "smoke" testing—i.e., testing to verify that nothing major was missed—on August 27, 2012, and completed this stage of testing on September 12, 2012. During smoke testing, the Test Team validated the configuration of the testing environment through the execution of selected test cases from each build. Round One of test case execution began on September 12, 2012, and ended, as planned, on October 5, 2012. As of October 5, 2012, the State executed 355 test cases, which was 73% of the test cases planned. Many of the Round One test cases that were not executed had been impacted by unresolved defects. As Round One defects are resolved, the test cases associated with these defects will be executed. It is expected that each of the four rounds of testing will conclude with some defects that need to be resolved.

The State conducted an open call on October 3, 2012, for providers who will participate in the system's "early look" during State UAT. The purpose of this call was to review the options for advance claims submission, using Legacy Transaction Control Numbers (TCNs) or submitting original paper claims. Providers had questions about submissions of claims such as those with other insurance coverage (Medicare and private payers), prior authorization information, etc. Conference call participation was light, although all of the provider associations were represented by at least one provider.

A conference call kickoff meeting with providers was held on October 12, 2012, to review all UAT activities to include: selection and processing of test claim submissions, provider expectations regarding travel and logistics for overnight stays, and answering any remaining

provider questions. Attendance for the call was good and providers raised questions about the testing location/environment and the testing plans.

CSC began Production Simulation Testing (PST) for NCTracks on August 29, 2012. PST is conducted to validate the operational characteristics of the system. During this test, CSC will validate the system configuration, production taljob control language, system schedules, and operational procedures, as well as measure the system performance to identify and remediate anomalies that may jeopardize Service Level Agreements. PST will conclude in January 2014.

The State and CSC presented an NCTracks Overview at the North Carolina Association of Long Term Care Facilities Conference in Winston-Salem on September 18, 2012. The presentation was received well with approximately two hundred people in attendance. The State and CSC also presented the NCTracks Overview at the North Carolina Healthcare Financial Management Association Conference in Myrtle Beach, South Carolina on September 20, 2012. Amelia Bryant, from the North Carolina Hospital Association, hosted the event, which was attended by approximately fifty people.

CSC conducted training for the division testers in preparation for their participation in UAT, which began on October 22, 2012. The UAT training was well attended by the divisions and the overall feedback was good. CSC presented the “Life Cycle of a Claim” on October 15, 2012 to a standing-room-only crowd.

Work In Progress

Discussions continue on the NCTracks changes needed to interface with NCFAST. CSC, OMMISS , Division and NCFAST staff discussed the data requirements for the various Eligibility Information System (EIS) file segments, eliminating fields that were not needed. CSC has identified the items they consider significant changes for NCTracks. Work is in progress to identify alternative solutions to reduce the anticipated change impacts.

OMMISS and DIRM Management met August 8, 2012, to begin planning a strategy to minimize the impact on other systems, including the Replacement MMIS, which will result from switching from EIS to NCFAST. DIRM and DMA have yet to discuss a resolution to the open business issues related to a Managed Care segment, Mass Change, and Auto Assignments. OMMISS provided the updated list of issues, the proposed resolutions and the draft NCFAST record layout that has been discussed. DIRM staff will work with NCFAST staff to produce the expected interface file.

Additionally, NCFAST staff is evaluating alternate strategies for the 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.

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

The installation of new workstations in the Wycliff State test lab was completed ahead of schedule. CSC successfully replaced all twenty-five workstations, and testers report that the new equipment is improving efficiency due to faster PC processing speeds.

OMMISS has developed a list of interfaces to be tested during UAT, and prioritized the list of test cases planned for UAT execution. OMMISS and CSC staff met to evaluate the testing sequence and map the interfaces to the associated test cases for the four planned rounds of UAT testing. OMMISS conducted informal training to various team members to familiarize them with the testing environment and tools. This provided team members with an early opportunity to use the tools before UAT begins.

Meetings were also held with CSC staff to further review State UAT test cases, the interfaces proposed for UAT, and the strategy for UAT execution. CSC provided documentation on the steps required for a financial cycle run and also reviewed their PST plans for interface testing. CSC has identified resources that will be available to assist the State in the UAT readiness.

CSC and OMMISS staff met to discuss the draft of the “Medicaid Lite” Benefit Plan by which the State intends to support the Affordable Care Act. CSC did not note any major issues and agreed to conduct a high-level analysis and provided a written assessment to the State.

The State is working on provider communication regarding the new release date of ICD-10 and helpful tools for the codes mapping review.

Testing Status

As noted in the “Accomplishments” section above, CSC completed the Final System Integration Test, as scheduled, on August 27, 2012.

The following are metrics from the Medical Claims (Build 10) UBAT at the conclusion of the test period in August 2012:

Description	Value	Notes
Test Cases Execution Target	350	Revised target for execution (initial target was 300)
Test Cases Executed	368	105% of revised test cases target
Test Cases Passed	322	88% of test cases executed
Test Cases Failed	46	12% of test cases executed
Defects reported	249	
Closed (Fixed) Defects	205	82% of defects reported
Open Defects	44	18% of defects reported

Several significant defects were left open at the end of the Medical Claims UBAT. These defects affected testing for DMH claims and corrections were delivered early in UAT.

CSC completed work to 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 identified defect 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.

The following are CSC's plans for Production Simulation Testing:

		Start	End	PST Testing Operations	Status
1	**Environment Validation**	8/29/2012	9/12/2012	Technical Infrastructure Inventory	Complete
				Smoke Testing	Complete
				Technical / Failover - Phase 2	Complete
				Operational Procedures (Asset Inventory)	Complete
2	**Operational Readiness**	9/13/2012	10/25/2012	Regression Testing	In Process
				Batch Job Shakedown	In Process
				Comparative Testing (initial)	In Process
				Report Validation	In Process
				Inbound Interfaces	In Process
				Restart Recovery	In Process
				Security - Penetration Testing	Complete
				Performance Measurement	In Process
				Operational Procedures Testing	In Process
3	**Comparative Testing**	10/26/2012	12/21/2012	Comparative Testing (continued)	
				Batch Job Validation (continued)	
				Report Validation (continued)	
				POS Testing	
				Inbound / Outbound Interfaces (continued)	
				Performance Measurement	
				Operational Procedures Testing	
				Trading Partner Certification	
4	**Final Wrap-Up**	1/2/2013	1/16/2013	Environment Clean-up	
				Final Review	

The 5010 (Build 19), Phase 2, Part 1 SIT ended, as scheduled, on September 20, 2012. CSC executed 475 test cases and passed 413. The State review includes 353 of the passed test cases, with a state acceptance rate of 74% of the reviewed cases.

Provider Testing Status

As stated above, planning for provider testing began several months ago as OMMISS began working with eighteen diverse North Carolina medical professional associations. The groups were asked to nominate up to five members of their association, currently enrolled as DHHS providers, to participate in the UAT testing experience. The final participant selections were made by OMMISS in collaboration with the Divisions. The participants consist of seventeen individual providers divided into six unique provider groups that are representative of NC Medicaid and other DHHS healthcare programs. Each group is scheduled to travel to Raleigh for a specific week between November 12, 2012 and January 11, 2013, when they

will take part in a variety of tests using the new NCTracks Provider web portal including, but not limited to:

- Entering a new claim;
- Entering a claim adjustment;
- Requesting and verifying a prior authorization;
- Verifying recipient eligibility;
- Reviewing the claim payment Remittance Advice; and
- Viewing computer-based training (CBT) modules designed for NCTracks learning.

The initial provider group of four dentists is anticipated to arrive in Raleigh November 13, 2012. OMMISS and CSC are working closely together to prepare for the dental providers with customized training and advance processing of eight of the ten claims submitted by each provider. The claims will be fully processed and a Remittance Advice will be prepared for each dentist. During the scheduled UAT training and testing experience, providers will have the opportunity to enter the two remaining claims directly into NCTracks with assistance from project team members.

Following each weekly event, face-to-face exit interviews will be conducted with participants to learn what went well, areas for improvement, suggestions for the next group of providers, and "lessons learned" for OMMISS and CSC. This information will be used to continue to refine the weekly testing experience for successive provider groups that include DPH local health departments, DMH Local Management Entities (LMEs), pediatricians, and hospitals.

Selected participants for the NCTracks early system are encouraged to also participate in the Provider Operational Preparedness (POP) Phase.

Lastly, OMMISS 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

Project Overview

The purpose of the R&A project is to design, develop, and launch into operation a centralized integrated claims payment data repository for improved decision support analytics capability by a broader spectrum of DHHS staff. The R&A system will satisfy all DHHS requirements for monitoring and assessing trends in the delivery of health care, expenditures, and outcomes for improved policy decisions for programs that DHHS administers.

Accomplishments

The R&A Project's overall status, classified by the NC Enterprise Project Management Office (EPMO), is "Green", meaning the project's monitoring metrics are on target following CMS' approval of R&A Contract Amendment 2 on September 24, 2012. This Amendment addressed all changes to scope and extended the project schedule, hours, and budget to

align with the Replacement MMIS. The Planned Dates from the previous R&A Project schedule have been updated accordingly. The System Release for Production Date has been revised from July 18, 2013 to September 2, 2013. The July 18, 2013 date had been predicated on the assumption that Truven Health Analytics, Inc. (Truven) would receive converted history from CSC on May 31, 2013. The realignment effort between Truven and CSC revealed that the May 31, 2013 date was not attainable. The schedule adjustment first appeared in the August 2012 R&A Integrated Master Schedule (IMS) following the Data Dependency Plan of Action. The schedule and project milestone changes are reflected in Appendix B.

The project is currently under review by the EPMO for SCIO Gate approval for the Execution of Build phase of the R&A system.

The transition from the previous R&A Vendor, Thomson Reuters, to Truven has been executed seamlessly. Some changes are occurring at the account management level and Truven is keeping the State engaged on any additional changes. The sale to Veritas Capital has prompted Truven's acquisition of data center hosting space to implement the R&A system at no additional cost.

A new OMMISS R&A Project Manager was hired on September 25, 2012.

The results of the DHHS Semi-annual Performance Assessment of the R&A Vendor (covering the period of January—June 2012) were presented to representatives from Truven on September 13, 2012. The overall performance assessment for this time period was "satisfactory" for the Average Six-Month Status Report and Evaluation Team Scores.

Design and Configuration Tasks

CSC, OMMISS, and Truven, continue discussions on the exchange of data needed between R&A and NCTracks. The delayed data for System Integration Test 2 (SIT2) was provided on August 15, 2012. CSC has developed a method to provide incremental data updates from NCTracks to the R&A system with the planned SIT3 cycle on November 15, 2012.

Work continues on planning the interfacing methods and design for data exchange between NCTracks and the R&A system for User Acceptance Testing (UAT) and for the Production updates from NCTracks after July 1, 2013. CSC provided a deployment plan to OMMISS which includes engaging Truven in operations planning, currently pending approval by the State. Truven and OMMISS continue to meet weekly regarding specific tasks, action items, and to coordinate "touch point" meetings with CSC to ensure information is communicated in a timely and efficient manner.

Truven continues to enhance the design of the R&A system and has drafted a Change Request (CSR), at no cost to the State, for modifications to the originally proposed model for user security and access roles for DPH and DMH. These enhancements allow sharing of report templates and data within the system separately for each division. It also builds upon the R&A project objectives of providing claims payment data to a broader spectrum of DHHS staff in a secure environment that meets State and Federal Protected Health Information (PHI) rules, thus proving for more informed DHHS program policy decisions. Truven also continues development of the NC Identity Management solution interface.

The R&A Team, Truven, and representatives from the divisions held discussions regarding "Dashboard" reporting methodology and specifications. Dashboards are utilized by Program

Managers and Administrators to monitor Key Performance Indicators (KPIs) specific to programs that DHHS administers in an automated manner. Truven provided an overview of the method by which Dashboards are handled within the R&A software platform. These should provide improved guidance capabilities for prevention and intervention programs within Medicaid and, potentially, other areas within DMH and DPH.

OMMISS is drafting the documentation to execute a Final Security Assessment for R&A prior to the July 1, 2013 implementation date. Truven and OMMISS are working together to ensure that State and Federal requirements are met. The R&A Team also provided assessment details of the Data Analysis Processes for the State of NC Government Business Intelligence Competency Center survey in support of Session Law 2012-142 (HB 950), Part VI-A. Information Technology, Section 6A.7A., which established the "Business Intelligence Initiative" coordinated by the Office of the State Controller (OSC).

The R&A Team and Division Subject Matter Experts (SMEs) completed the review and acceptance of a number of deliverables, including the Deployment and Rollout Plan, and associated Turnover documentation including the Turnover Plan, Statement of Work (SOW), and Integrated Master Schedule (IMS). Updates were submitted for the Data Extract Specification document to better define the interface specifications between NCTracks and the R&A system.

Testing Activity

As noted above, CSC provided an initial extract of the converted MMIS history utilized for the R&A SIT2, which Truven successfully completed on October 29, 2012. Truven is scheduled to begin SIT3 on November 15, 2012. OMMISS is working with Truven and CSC to address challenges regarding delivery of test data from NCTracks to R&A.

OMMISS continues the planning effort for UAT. The R&A Team and Division SMEs began joint UAT planning on October 22, 2012, and draft entrance criteria will be developed and discussed with Truven. The proposed entrance criteria will consider open defect resolution levels and passed test cases in determining UAT readiness. Work continues on the development of test scenarios to be used in creating the associated UAT cases. The Team will review the processes with sections of each DHHS division to determine the functionality to be tested. Truven has scheduled training on the R&A system data warehouse and the Advantage Suite Decision Support System (DSS) during the period of November 13 - 15, 2012, for the R&A Team and select Division SMEs.

Early Java Surveillance Utilization Review System (EJSURS)

The EJSURS early-value R&A project has been successfully delivered. This now provides the DMA Program Integrity Unit with a centralized claims data repository to improve fraud, waste, and abuse detection capabilities. UAT was completed on August 2, 2012; and the production system was delivered and certified by CMS on September 24, 2012. Additional training sessions were completed on October 19, 2012. All design and testing documentation submitted to date has been approved, and OMMISS is currently working to formally add the Service Level Agreements (SLAs) for the contractual monitoring of the production system and operations processes.

North Carolina State Health Plan (SHP)

Truven has delivered functionality that allows the R&A system to comply with Session Law 2009-451, Section 10.41.(f), which requires DHHS to ensure that the initial implementation of the R&A Project's solution support the capability to interface with the North Carolina Teachers' and State Employees' Health Plan (SHP). This initial implementation UAT was completed on August 14, 2012, and the solution was delivered for formal evaluation by the SHP staff on September 7, 2012. OMMISS and Truven continue to support SHP staff by providing tools education, contract, and pricing information during the evaluation period, which is scheduled to end on November 29, 2012. Upon completion of the evaluation, SHP management will notify OMMISS if it desires to continue with operational support of the solution beyond this initial implementation.

DHSR Business Process Automation System (BPAS) Project

PROJECT OVERVIEW

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.

Accomplishments:

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

Even though Stage 3, Construction, is in Production and is operating using BPAS in all critical areas, as a safeguard, it continues to perform double data entry until all BPAS component enhancements are complete.

Stage 4, Licensure and Certification, has transitioned to a Go Live status, having addressed all previous UAT issues and structural concerns. During the Go Live period, the Operations Support Agreement is in effect. The business users will conduct functional testing and enhancements of the BPAS system to bring it to Ready for Production Cutover status. Stage 4 Interface Testing is well underway and a Testing Environment is being configured to address specific DIRM testing needs.

Stage 5, Health Care Personnel Registry (HCPR) and Center for Aide Registration & Education (CARE), has transitioned to a Go Live status, having addressed all previous UAT issues. During the Go Live period, the Operations Support Agreement is in effect. The business users will conduct functional testing and enhancements of the BPAS system to bring it to Ready for Production Cutover status. Stage 5 Interface Testing is in the planning

stages and this activity is also expected to use the forthcoming Interface Testing Environment.

Under Stage 6, the Web, a revised plan for the Web is under development due to the expansion of the Online License Renewal requirements. The Business Requirements have been accepted by DHSR and the planning and scheduling documents are currently under review. Once these documents have been approved, public-facing Web pages can be developed and tested and the Web Pilot can be scheduled and executed.

Stage 7, Areas of Commonality, has completed the Business Requirements and the Planning and Scheduling documents are currently under review.

RECENT UPDATES

DHHS is currently in contract amendment negotiations with all three major vendors, CSC (Replacement MMIS), Truven (R&A) and GLS (DHSR BPAS).

DHHS and CSC are discussing the details about addressing the CSRs generated after the system freeze date, while maintaining the scheduled implementation date of July 1, 2013. In addition to designing, coding, and unit testing the changes, these late CSRs will also require additional Final Integration Testing, Performance System Testing, and User Acceptance Testing. The goal of this contract amendment is to apply underutilized funds for CSRs and 5010s toward these additional project activities in a manner that affords a July 1, 2013 go-live date without increasing the total contract price. Contract Amendment #3 is expected to be completed in early January 2013.

Truven and DHHS are negotiating a no-cost contract amendment that will realign interim milestone dates during the January to July 2013 timeframe while maintaining the July 1, 2013 date that the R&A system and Replacement MMIS will be ready to accept data. The contract amendment is expected to be completed in early January 2013.

The DHSR BPAS project is running significantly behind schedule and negotiations are underway with GLS to develop a plan to complete the project. Preliminary plans take the project completion date out one year, to February 2014. The contract amendment is expected to be completed in February 2013.

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 Aug 2012	Aug 2012– Oct 2012	Total
No Cost CSRs	70	12	82
Cost CSRs	226	58	284
Number of Approved CSRs	296	70	366
Cost of Approved CSRs	$9,569,744	$3,114,973	$12,684,717

CSR Capacity Pool $ 20,100,000
CSRs Approved through 10/31/2012 $12,684,717
Balance Remaining until 06/30/2013 $ 7,415,283

HIT

The approved CSR statistics for HIT are shown below:

CSR Statistics for HIT (Non-MMIS)

	Prior to Aug 2012	Aug – Oct 2012	Total
No Cost CSRs	2	0	2
Cost CSRs	15	2	17
Number of Approved CSRs	17	2	19
Cost of Approved CSRs	$7,084,710	$3,036	$7,087,746

HIT CSR Capacity Pool $ 15,277,760
CSRs Approved through 04/30/2012 $ 7,087,746
Balance Remaining until 06/30/2013 $ 8,190,014

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 Final Performance Engineering, Medical Claims UBAT, and 1510 Phase 2 SIT, as well as a planned date revision for completion of Final SIT, Final Data Conversion for Cutover, Site Cutover Go/No Go Decision, and Replacement MMIS Operational as reflected in Appendix B.

The DHSR Business Process Automation System Schedule has been changed to reflect planned date revisions for the completion of a number of Key Milestones as indicated in Appendix B.

As mentioned in the R&A Project update section above, the R&A Contract Amendment 2 was signed on September 24, 2012; therefore, the January 1, 2011 version of the R&A Project schedule has been updated in Appendix B.

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 October 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 – October 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	$152,603,179	$229,847,418	$28,730,927	$229,847,418	0
MMIS Early Operations	04/20/09	06/30/13	18,250,544				N/A
R&A	11/01/08	06/30/13	6,918,497	15,549,664	1,788,211	10,515,257	-5,034,407
DHSR	07/01/08	05/31/12	8,051,415	7,565,102	3,026,041	8,071,980	506,878
Program-Level	02/01/07	06/30/14	14,208,173	18,244,536	2,280,567	18,466,963	222,427
Business Initiatives							
HIT Incentive Payments	01/01/11	09/30/13	8,436,258	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			$221,124,078		$38,262,584	$290,123,379	
[1]Total ITS-Approved	09/16/06	06/30/14	$194,437,276	$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 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 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 $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 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 12-13		**$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.

Table 3 below represents State funds required for SFY 2013-14.

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 at the end of SFY 2012-13 is estimated to be $851.379 for 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 2013-2014

Project	Estimated Total Expenditures	Estimated State Funds
MMIS DDI	$13,672,710	$1,709,089
MMIS Operations	2,974,700	1,487,350
R&A	1,094,355	109,436
DHSR	3,409,432	1,235,592
Program-Level	936,126	468,063
MMIS Total	**$22,087,323**	**$5,009,529**
State Appropriation Balance 7/1/13		$851,379
Appropriations SFY 13-14		**$4,158,151**
Estimated Cash Balance on 6/30/14		$0

Footnotes:

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

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

R&A Contract Amendment 2 has been executed and a new schedule has been finalized, which is included below.

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	August 7, 2012		October 1, 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		August 31, 2012
10	1454	Medical Claims UBAT Complete	September 25, 2012		September 21, 2012
19	5351	5010 Phase 2 SIT Complete	October 11,2012		October 11, 2012
FIT/SIT	1189	Final SIT Complete	December 10, 2012	November 16, 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	March 6, 2013	
Deployment	1133	Site Cutover Go/No Go Decision	February 19, 2013	March 6, 2013	
Training	4036	Training Complete	February 25, 2013		
Deployment	1144	Replacement MMIS Operational	February 25, 2013	March 11, 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		July 26, 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	February 12, 2013	
7063	Stage 6 Online Applications Website Development Complete	October 5, 2012	February 14, 2013	
10807	Cancelled - Stage 6 License verification Website Implementation	August 27, 2012	Cancelled	
7442	Reconcile State Models and Configured System Complete	March 5, 2013	May 6, 2013	
7446	Stage 7 Specification Walkthrough Complete	January 22, 2013	January 9, 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	April 19, 2013	
7477	Stage 7 Deliverables Cycle 1 Client Review Complete	March 12, 2013	January 29, 2013	
10819	Stage 7 Construction Output Specifications Complete	March 28, 2013	February 14, 2013	
7490	Stage 8 Deliverables Cycle 1 Client Review Complete	April 24, 2013	March 8, 2013	
7493	Stage 8 Transition to Operations Administrator Guide Complete	May 8, 2013	March 26, 2013	

Reporting and Analytics Schedule

UID	Key Milestone	Planned Date Per Amendment 2	Planned Dates Revised this Report Period	Actual Date
	Award Announcement /Contract Signed			June 29, 2010
30	Project Kickoff Meeting	July 7, 2010		July 15, 2010
288	Data Summit Complete	July 20, 2010		July 26, 2010
226	Gather and Document Business Requirements	October 13, 2010		October 25, 2010
1214	Initial Test Data Submission Complete	November 2, 2010		November 19, 2010
281	Business Requirements Document Complete	September 24, 2010		March 9, 2011
366	Extract Specification Document Complete	September 23, 2010		March 17, 2011
1781	Software Development and System Engineering Plan Complete	April 6, 2011		April 6, 2011
173	Change Management Plan Complete	May 20, 2011		May 20, 2011
222	Hardware and Software Installation Complete	November 18, 2010		June 1, 2011
204	Joint Security Plan Completed	July 27, 2011		July 27, 2011
4900	DW Design Group 2 Completed	August 31, 2011		August 31, 2011
4903	DSS Design Group 1 Completed	September 30, 2011		September 30, 2011
4912	DW Load Scripts Development Group 1 Completed	October 14, 2011		October 14, 2011
1836	Acceptance Criteria fo Analytic Test Plan Complete	November 9, 2011		November 9, 2011
1791	Acceptance Criteria for R&A Data Dictionary Complete	December 8, 2011		December 8, 2011
4902	DW Design Group 4 Completed	January 20, 2012		January 20, 2012
442	Data Warehouse Design Complete	February 9, 2012		February 9, 2012
523	Detailed System Design Complete	March 14, 2012		March 14, 2012
732	System Integration Test 1 Complete	April 23, 2012		April 23, 2012
6154	SHP SIT Complete	May 16, 2012		May 16, 2012
1021	Training Plan Accepted and Complete	June 12, 2012		June 12, 2012
6171	SHP SIT Results documentation	June 22, 2012		July 2, 2012
7204	E J-SURS Viewer/OLAP Training Complete	July 27, 2012		July 27, 2012
1614	Turnover Plan Complete	August 22, 2012		August 22, 2012
6211	SHP Production Build Release	August 17, 2012		September 10, 2012
7278	E J-SURS UAT Test Results Complete	October 5, 2012		September 10, 2012
7282	E J-SURS Design Model ready for Production	September 13, 2012		September 24, 2012
787	System Integration Test 2 Complete	July 6, 2012	October 29, 2012	October 29, 2012
7307	SHP Go/No Go Decision	November 29, 2012		
652	QSI Development Complete	June 6, 2012	December 5, 2012	
1035	Data Management Plan Complete	December 21, 2012		
589	QSI Extract Development Complete	May 30, 2012	January 3, 2013	
1007	Business Continuity/Disaster Recovery Plan Complete	October 24, 2012	January 17, 2013	
833	System Integration Test 3 Complete	September 30, 2012	February 19, 2013	
1473	SIT3 Results Document Complete	November 27, 2012	April 15, 2013	
1721	UAT Complete	January 8, 2013	June 12, 2013	
1476	Submit CDRL-39 UAT Results Document for State Review	January 31, 2013	July 3, 2013	
891	Execution Phase Close Out Deliverables Complete	March 11, 2013	August 12, 2013	
919	System Release for Production	July 18, 2013	September 2, 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

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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.

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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

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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