NC MEDICAID MANAGEMENT INFORMATION SYSTEM+ (NCMMIS+) PROGRAM

Quarterly Report
to the
North Carolina General Assembly
February – April 2011

State of North Carolina
Department of Health and Human Services

July 1, 2011

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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, Section 10.41 continued the quarterly reporting requirements beginning July 1, 2009.

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

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

This report covers the period February 1, 2011 through April 30, 2011.

STATUS

Replacement MMIS PROJECT

System Implementation Date Status

The DHHS Office of Medicaid Management Information Services (OMMISS) and DHHS executives completed negotiations in early March 2011 with Computer Sciences Corporation (CSC) for Amendment #2 of the Fiscal Agent Contract. Final execution of the document is pending approval from the NC Information Technology Services (ITS), the NC Office of Budget and Management (OSBM) and the Centers for Medicare and Medicaid Services (CMS). Contract Amendment approval and announcement of the revised implementation date is anticipated in the first quarter of SFY 11-12. (see *Recent Updates* section on page 10 of this report).

Design, Development and Implementation – Execution and Build Phase

Accomplishments:

- CSC presented an all-day workshop on April 11, 2011, on the multi-payer detailed design, focusing on the fourth and final level of the multi-payer system. OMMISS requested the workshop specifically for the multi-division workgroup for a detailed presentation of the most complex level of the design, the Benefit Service Group (BSG), with the goal of facilitating technical decisions necessary for CSC to complete coding. The workshop effectively explained the interaction of reference, claims, prior approval, edits and audits and other components of the claims processing environment that affect configuration. There are more detailed meetings scheduled to focus on specific topics targeting the completion of all design decisions by the end of May 2011.

- The State reviewed the first version of 12 Functional Area Master Technical Design Documents (FAM TDD) that will serve as ongoing NCTracks system documentation for the life of the System. These documents will be refreshed and delivered quarterly to ensure the State is informed about report design changes, screen changes, system configuration changes, automated workflow and any other changes that are identified through the CSR or testing activities.

- OMMISS hosted a meeting with CSC to discuss the status of the Pharmacy Claims (Build 9) System Integrated Testing (SIT). The State addressed concerns regarding the use of Pro-DUR EMedNY baseline edits, incomplete configuration of the NC pharmacy Point of Sale (POS) edits, and the use of pharmacy codes that are not covered under the NC Medicaid Program. Several of the resulting action items were quickly resolved and others are currently being addressed. Another meeting is planned to determine if any changes to the existing Pharmacy SIT schedule or processes are needed.
- Encounter processing business rules have been documented and will be reviewed with State representatives in May 2011.

Design and Configuration Tasks:

CSC, OMMISS and Division representatives are currently working on the following high-priority design issues:

- Electronic Signature – CSC has provided a draft business design document that is undergoing State review. This new functionality will be available to providers for on-line enrollment, claims submission and prior authorization requests–using the electronic signature as an authorized replacement for the current "wet signature" requirement.
- E-Prescribing – New technology that enables web-based transmission of a prescription from a doctor's office to a patient-specified pharmacy. This process includes access to large commercial databases to check for other insurance information, patient history and prescription history and reduces the risk of fraud associated with paper prescription requests.
- Managed Care Referral Accumulator Logic – Method for the claims system to increment and track recipient visits (units of service) against the total approved referrals to a specific provider within a defined time period. This information will be available through the web-based Provider Portal for providers and recipients to check on the remaining unused referral units before authorizing additional services.
- Multi-Payer Benefit Service Groups (MP BSG) – Finalizing the detailed business rules for storing covered and non-covered medical and pharmacy procedure codes, modifiers, and unique coverage for each payer, health plan and benefit plan.
- Prior Authorization (PA) – CSC is revising the original design to include provider taxonomy and provider locator number (place of service indicator) into the data collected and reviewed for provider eligibility to furnish requested services before a PA is issued. New web-based prior authorization capability will be available under the new multi-payer system.

- Pay Point – Meetings are ongoing among CSC, the Pay Point vendor, OMMISS and the State Controller's Office to define the business rules for Pay Point configuration to permit payment submission by providers and recipients via web, check and call center authorization.
- Edit and Audit Review – CSC is anticipating release of a June 2011 comprehensive document for review by all payers to define edits and audits as configured in the NCTracks system. This includes Legacy audit logic translated into NCTracks nomenclature, and new audits defined by business rules and CSRs approved for NCTracks.
- File Maintenance – Refining the process during development and operational periods for the Fiscal Agent to maintain changes for edits, audits, Legacy System to NCTracks cross-walks (i.e., provider type/specialty to taxonomy; claim type) and an annual DMA update for CMS revisions.
- Interface Specifications – Interface specifications from the original RFP are being reviewed, clarified and updated as needed. Contact with these vendors has begun to ensure all current business rules and data elements for data exchange are identified and captured.
- Master Report Review – Master report review for all Builds across all Divisions is underway and approximately 75% complete. Report specifications are being detailed and mock report designs created for State review and approval.

OMMISS and CSC Team Leads meet weekly regarding build-specific tasks and action items, and to and coordinate "touch point" meetings with other builds to ensure cross-functional information is communicated timely and efficiently.

Testing Activity

- Call Center – CSC initiated Call Center SIT testing on February 9, 2011. Testing for this build includes new "screen pop" technology that launches the caller's record on the Customer Service Agent's screen when the caller enters specific identifying information and then exits the automated voice response system to speak with a live agent. The Call Center testing also includes new automatic workflow procedures designed to quickly route caller requests to the correct servicing entity for task completion. Testing for this build is scheduled to last through April 25, 2011. As of April 29, 2011, OMMISS had reviewed 92% of the CSC "passed" test cases with an overall pass rate of 83%.

- Health Check – CSC completed the Health Check SIT on February 21, 2011. This is the first build that utilized actual converted claims and recipient data for testing purposes. Prior builds have utilized pre-engineered data created specifically for testing. OMMISS staff reviewed the test cases passed by CSC as a second level of quality review, and initiated additional analysis steps for those cases with testing artifacts that did not support the recorded test result. This process has proven to be helpful in improving communication between the design and test groups, as well as enhancing testing documentation precision. This new process has led to improved testing procedures and documentation through dialogue between the State and Fiscal Agent based upon test

case review. CSC supplemented the testing results validation process by adding QA staff who report to CSC leadership external to the Project. This is being incorporated into future SIT test result reviews as a "best practice."

- Managed Care – CSC initiated Managed Care SIT testing on March 24, 2011. This test phase is scheduled through June 24, 2011, and does not have a State User Build Acceptance Testing (UBAT) test period. As of April 29, 2011, 103 cases out of a total 189 planned cases had been executed, with an overall pass rate of 91%. The State review of passed test cases lags about two weeks behind CSC, with a pass rate of 26% for cases reviewed to date.
- Pharmacy Claims – CSC initiated Provider SIT testing on March 24, 2011. This test phase is scheduled through June 21, 2011 and will be followed by OMMISS UBAT through September 9, 2011. As of April 29, 2011, 262 cases out of a total 612 planned cases had been executed, with an overall pass rate of 83%. The State review of passed test cases lags about two weeks behind CSC, with a pass rate of 34% for cases reviewed to date.
- Prior Authorization (PA) – Prior Authorization started SIT testing on February 10, 2011. This test phase is scheduled through June 15, 2011, and does not have a State UBAT test period. As of April 29, 2011, 449 cases out of a total 627 planned cases had been executed, with an overall pass rate of 85%. The State review of passed test cases lags about two weeks behind CSC, with a pass rate of 68% for cases reviewed to date.
- Provider – CSC initiated Provider SIT testing on February 9, 2011. This test phase is scheduled through June 15, 2011, and will be followed by OMMISS UBAT through September 9, 2011. As of April 29, 2011, 547 cases out of a total 880 planned cases had been executed, with an overall pass rate of 98%. The State review of passed test cases lags about two weeks behind CSC, with a pass rate of 76% for cases reviewed to date.

Reporting & Analytics (R&A) Project

Thomson Reuters (TR) continues work on the Design, Development and Implementation (DDI) portion of the R&A Project, while working with the State on a revised schedule to reflect delays in the Replacement MMIS implementation date, as well as an expanded development scope resulting from an increase in the number of tables to be incorporated into the data warehouse.

The R&A Project is under review by the NC Enterprise Project Management Office (EPMO) for the Execution and Build (E&B) Phase approval. A Communication Plan, Quality Assurance Plan and a Technical Architecture Design Document (TASD) have been completed by TR as required for E&B approval. The R&A Project has been classified as "Needs Agency Attention" until resolution of proposed schedule changes.

The State reviewed and accepted a number of deliverables to include the Business Requirements document, Integrated Master Schedule (IMS), Extract Specifications document, Data Accession List and a Commercial Off-the-Shelf (COTS) Software document. TR provided an estimate for R&A Disaster Recovery based on the NC ITS decision to provide only floor hosting.

TR and CSC have identified primary linkages between the seven key R&A touch-point tasks and their dependent tasks in the Replacement MMIS IMS. TR and CSC are planning to meet weekly to ensure that the touch points remain aligned with the respective IMSs.

A meeting was held with representatives from OMMISS, TR and the testing vendor, SLI Global Solutions, to review R&A's Test Management Plan. SLI sent several follow-up documents and checklists to TR as a result of the meeting to assist TR in creating the R&A Test Plan Documents. TR also met with OMMISS to review the setup of the Rally Software that will be used for requirements traceability and as a repository for test cases and defects for the R&A Project.

TR has completed the initial submission of the Application Integration Requirements to NCID (AIRN) document which will define which of the three NCID approaches will be used for the R&A Project. TR began its preliminary work on the design of the R&A interface to NCID pending the final version of the AIRN.

TR and OMMISS met with DMA to determine whether reports for the past three years will be required for the Healthcare Effectiveness Data and Information Set (HEDIS). TR met with several of the DMH SAS power users to gather information on their current SAS usage and the types of reports they create using the software. The DMH users were very responsive and gave good feedback to TR.

Members of the R&A project and OMMISS Contracts Office are developing an evaluation survey for the six-month vendor assessments required by the R&A RFP. Also, the vendor portion of the MITA State Self Assessment was reviewed.

DMA wishes to move forward with an optional training program focused on business analytical skills utilizing TR business consultants. DMA will define the pilot group for this training program whose goal is to promote more analytical philosophy for DMA as they prepare to use the new R&A tools. Once the group skills are assessed, they will be defined and the Basis of Estimates will be submitted. TR will provide DMA with sample curriculum reports using legacy data.

TR conducted a Kick-Off meeting for representatives from the State Health Plan (SHP), Blue Cross-Blue Shield and OMMIS. The agenda for the meeting included Project Overview, Data Acquisition, SHP Business Needs, Database Design and Eligibility Fields. Blue Cross Blue Shield sent representatives for the working data mapping session on the Eligibility Fields. Weekly meetings have been scheduled by TR with OMMISS and SHP about the SHP Project

Members of the R&A team are working with TR to revise the draft SHP deliverables list and to review the Design Solution options for SHP. Several of the R&A project management deliverables will be used for SHP (e.g., R&A Risk Management Plan, Project Management Plan and Change Management Plan). SHP will have its own version of the technical documents specific to SHP.

DHSR Business Process Automation System (BPAS) Project

The Division of Health Service Regulation (DHSR) Business Process Automation System (BPAS) Project has completed the Discovery Phase, ending February 2011, as a part of Planning and Design. On March 1, 2011, the Project moved into the Execution and Build

phase during which GL Solutions arrived on site for a series of Joint Application Design (JAD) sessions with State agency stakeholders and business analysts. During this series of meetings, the contract business requirements and business process details for Stage 1 were reviewed, validated and revised in preparation for development.

The Project is organized as a staged delivery comprised of 8 stages. Each stage maps to a business area or a collection or related business functionality. Many of these stages are occurring in parallel. Stages 1, 2, 3 and 4 have begun. These stages are focused primarily on the database and the business area workflow functionality. The business areas addressed in these stages are: Medical Facilities Planning, Certificate of Need, Construction, and Licensure and Certification. Additionally, work on various other aspects of the project has begun. These Project components include data conversion, interfaces, web component, pilot planning, financial components, ordering of the hardware, testing planning, NCID configuration and the legacy system synchronization. Note that the hardware configuration including physical and virtual servers for Production, Testing and Disaster Recovery have been finalized and approved. The hardware will be hosted at the North Carolina Data Center managed by NC ITS.

RECENT UPDATES

As noted in the previous quarterly report, DHHS and CSC have negotiated Contract Amendment #2, which will impact both the cost and schedule of the Replacement MMIS Project. This Amendment incorporates several major changes into the Replacement MMIS, including the federally mandated HIPAA code set 5010 and procedure code ICD-10. On June 24, 2011, the NC OSBM approved the MMIS funding plan for SFY 2011-2013, which includes Amendment #2. On June 27, 2011, the Statewide IT Procurement Office approved DHHS' recommendation to approve the negotiated Contract Amendment. Federal, i.e. CMS, approval of Amendment #2 was received on July 6, 2011. Upon the execution of this Contract Amendment, it will be released to the public. Negotiations with the R&A Project's vendor, Thomson Reuters, as well as with the Independent Validation and Verification (IV&V) and Testing vendors are ongoing and are expected to be completed in the second quarter of SFY 11-12.

These major changes render the current Replacement MMIS and R&A projects' schedules irrelevant. For this reason, these schedules are not included in this report. Once the contract amendments are executed, DHHS will issue a report that will include new schedules and revised budgets. This subsequent report is expected to be delivered in August 2011.

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, and documents the multiple levels of reviews and approvals that are required before a change is enacted. The final review within DHHS is the multi-divisional Change Control Body (CCB). If the change has an associated cost, the Statewide IT Procurement Chief also approves the change. During the procurement process, Offerors were required to

propose the anticipated cost for changes during the DDI phase. CSC proposed $22 million which was approved by CMS and subsequently budgeted by the Agency.

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. The same $22 million change pool identified above is used to fund HIT activities. For that reason, changes are separated in tables below to distinguish changes to the Replacement MMIS and HIT.

Replacement MMIS

	Prior to February 2011	Feb. 2011 - April 2011	Total
No Cost CSRs	143	7	150
Cost CSRs	82	12	94
Number of Approved CSRs	225	19	244
Cost of Approved CSRs	$5,426,458	$189,246	$5,615,704

HIT

	Prior to February 2011	Feb. 2011 - April 2011	Total
No Cost CSRs	0	0	0
Cost CSRs	2	6	8
Number of Approved CSRs	2	6	8
Cost of Approved CSRs	$1,143,723	$3,287,783	$4,431,506

By volume, most of the Customer Service Requests (CSRs) to date have been business rule changes related to the early implementation of the provider Enrollment, Verification and Credentialing functionality.

A summary of the CSRs' costs approved to-date is:

HIT Planning and Medicaid Incentive Payments	$ 4,431,506
Preferred Drug List (3/15/10 – 8/31/16)	$ 3,673,233
HIPAA Code Set 5010, Design	$ 639,105
$100 Provider Enrollment Fee	$ 449,806
All other CSRs	$ 853,560

FINANCIAL UPDATE

CMS funds most DDI activities for the Replacement MMIS and R&A Projects at a 90/10 federal match. Some 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%.

Due to slower-than-planned invoicing from CSC (payments are based on approval of deliverables), combined with longer than expected procurement timelines for the R&A and DHSR projects, it is anticipated that the appropriation carry forward amount from SFY 10-11 into SFY 11-12 will be $14,653,164. Note that this carry forward amount reflects a delay in vendor payments rather than a reduction in overall Program costs.

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

SCHEDULE

The Key Milestone schedule for DHSR's BPAS project is being presented for the first time in Appendix B.

Major changes have been negotiated with CSC for the Replacement MMIS; and changes are being negotiated with the R&A vendor, Thomson Reuters, as well as with the Independent Validation and Verification (IV&V) and Testing vendors. Negotiations for these contracts are expected to be completed in the second quarter of SFY 11-12.

These major changes render the current Replacement MMIS and R&A projects' schedules irrelevant. For this reason, these schedules are not included in this report. Once the contract amendments are executed, DHHS will issue a report that will include new schedules and revised budgets. This subsequent report is expected to be delivered in August 2011.

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 April 2011. 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 0.77% below the ITS-approved budget.

Table 1: Program Costs from September 2006 – January 2011 & Estimates through CMS Certification (August 2012)

Project	Start Date	End Date	Expenditures to Date	ITS Approved Budget	Required State Funds	Current Estimated Costs	Variance
MMIS DDI	11/01/08	11/30/11	$39,657,437	$92,704,823	$10,661,055	$92,704,823	0
[1]MMIS DDI Changes	01/05/09	08/23/11	1,938,780	N/A	2,695,000	22,000,000	N/A
MMIS Early Operations	04/20/09	08/23/11	9,164,497	N/A	3,109,173	10,363,909	N/A
R&A	11/01/08	08/31/11	2,554,622	10,590,927	1,217,957	10,406,045	-184,882
DHSR	07/01/08	06/30/11	2,596,531	7,097,296	2,993,439	5,833,808	-1,263,488
Program-Level	02/01/07	08/31/12	9,700,976	11,151,565	2,007,282	11,665,529	513,964
Business Initiatives							
Health Choice	12/01/08	03/31/11	1,182,994	1,238,546	123,855	1,195,127	-43,419
HIT Planning	02/01/10	12/31/11	860,853	N/A	86,085	860,853	N/A
HIT Incentive Payments	01/01/11	09/30/13	1,973,715	N/A	1,743,178	17,431,779	N/A
Medicaid Forecast.	11/01/09	01/31/11	1,316,851	1,739,914	173,991	1,739,914	0
Completed Projects			9,384,802	9,436,139	1,029,109	9,384,802	-51,337
Total Projects			$80,332,058		$25,840,123	$183,586,589	
[2]Total ITS-Approved	09/16/06	08/31/12	$66,394,213	$133,959,210	$18,206,687	$132,930,048	-1,029,162
Variance							-0.77%

Footnotes:

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

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

Table 2 below represents State funds required for SFY 10-11.

State appropriations of $8,630,571 were moved from SFY 09-10 to SFY 10-11. This movement maintains the $18,829,281 biennium amount included in Section 10.41.(a) of the Session Law 2009-451 Senate Bill 202.

Table 2: State Funds Required for SFY 2010-2011

Project	Estimated Expenditures	Estimated State Funds
MMIS DDI	$15,050,157	$1,956,520
[1]MMIS DDI Changes	2,000,000	260,000
MMIS Early Operations	5,541,727	1,769,883
R&A	1,542,352	192,794
DHSR	1,687,149	759,217
Program-Level	2,194,420	274,303
Business Initiatives		
Health Choice	221,372	22,137
HIT Planning	640,820	64,082
HIT Provider Incentive Payments	4,158,851	415,885
Program Total	$33,036,848	$5,714,821
State Appropriation Balance 7/1/10		$8,630,571
Appropriations SFY 10-11		**$11,737,414**
Estimated Carry Forward Appropriations 6/30/11		$14,653,164

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 11-12.

This table addresses only the MMIS requirements. HIT/HIE requirements are noted in Table 5.

Table 3: State MMIS Funds Required for SFY 2011-2012

Project	Estimated Expenditures	Estimated State Funds
MMIS DDI	$97,061,359	$11,353,479
[1]MMIS DDI Changes	10,000,000	1,217,581
MMIS Early Operations	7,681,057	2,139,291
R&A	6,035,573	633,735
DHSR	3,504,726	1,529,161
Program-Level	2,813,544	295,422
MMIS Total	**$127,096,259**	**$17,168,669**
State Appropriation Balance 7/1/11		$14,653,164
Appropriations SFY 11-12		**$3,232,304**
Estimated Carry Forward Appropriations 6/30/12		$716,799

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 funds required for SFY 12-13.

This table addresses only the MMIS requirements. HIT/HIE requirements are noted in Table 5.

Table 4: State MMIS Funds Required for SFY 2012-2013

Project	Estimated Expenditures	Estimated State Funds
MMIS DDI	$79,526,199	$9,592,818
[1]MMIS DDI Changes	10,000,000	1,217,581
MMIS Early Operations	7,688,116	2,143,482
R&A	6,286,364	660,068
DHSR	2,859,686	1,221,600
Program-Level	2,829,940	297,144
MMIS Total	**$109,190,305**	**$15,132,693**
State Appropriation Balance 7/1/12		$716,799
Appropriations SFY 11-12		**$12,000,000**
[2]Estimated Cash Balance on 6/30/13		-$2,415,894

Footnotes:

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

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

Table 5 below represents State funds required for HIT/HIE for the Biennium.

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

Table 5: Funds Required for HIT/HIE for the Biennium

Project	Estimated Expenditures	Estimated State Funds
SFY 11-12: HIT/HIE Requirements	$8,459,135	$845,914
SFY 11-12: HIT/HIE Requirements	10,350,603	1,035,060
HIT / HIE Biennium Needs	**$18,809,738**	**$1,880,974**

End of Appendix A

APPENDIX B – NCMMIS+ PROGRAM PROJECT SCHEDULES

The Key Milestone schedule for DHSR's BPAS project is being presented for the first time in Appendix B.

Major changes in the Replacement MMIS have been negotiated with CSC, and changes are being negotiated with the R&A vendor, Thomson Reuters, as well as with the Independent Validation and Verification (IV&V) and Testing vendors. These negotiations are expected to be completed in the second quarter of SFY 11-12.

These major changes render the current Replacement MMIS and R&A projects' schedules irrelevant. For this reason, these schedules are not included in this report. Once the contract amendments are executed, DHHS will issue a report that will include new schedules and revised budgets. This subsequent report is expected to be delivered in August 2011.

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	April 29, 2011		May 4, 2011
6901	Stage 1 Limited Medical Facilities Planning and Unified Data Source Testing Plan Complete	May 25, 2011		
9989	NCID Interface Specification Complete	June 16, 2011		
10768	Stage 3 Construction Workflow Diagrams Complete	June 28, 2011		
10767	Stage 2 Certificate of Need Data Conversion Specification Complete	July 8, 2011		
7206	Stage 2 Certificate of Need Interface Specifications Complete	July 19, 2011		
10782	Stage 4 Licensure and Certification - Phase 4 Search, Query & Reporting Complete	August 17, 2011		
10790	Stage 4 Licensure and Certification User Guide and Reference Guide Complete	August 25, 2011		
10786	Stage 4 Licensure and Certification EIS Interface Specification Complete	September 27, 2011		
10791	Stage 5 Center for Aide Regulation and Education Workflow Diagrams Complete	October 21, 2011		
10792	Stage 5 Health Care Personnel Registry Workflow Diagrams Complete	November 14, 2011		
10795	Stage 5 Health Care Personnel Registry Output Specifications Complete	December 16, 2011		
10797	Stage 5 Center for Aide Regulation and Education/Health Care Personnel Registry Board of Nursing Interface Specification Complete	January 30, 2012		
7725	Stage 6 Pilot Renewal Site Specification Complete	February 13, 2012		
7057	Stage 6 License Verification Website Development Complete	March 15, 2012		
7063	Stage 6 Online Applications Website Development Complete	April 17, 2012		
10807	Stage 6 License verification Website Implementation	May 24, 2012		
7442	Reconcile State Models and Configured System	June 1, 2012		

	Complete			
7446	**Stage 7 Specification Walkthrough Complete**	**July 23, 2012**		
10016	**Stage 7 AVRS Interface Complete**	**August 27, 2012**		
10009	**Stage 7 MMIS Replacement Interface Complete**	**September 26, 2012**		
7466	**Stage System Testing Complete**	**October 23, 2012**		
7477	**Stage 7 Deliverables Cycle 1 Client Review Complete**	**November 14, 2012**		
10819	**Stage 7 Construction Output Specifications Complete**	**December 4, 2012**		
7490	**Stage 8 Deliverables Cycle 1 Client Review Complete**	**January 17, 2013**		
7493	**Stage 8 Transition to Operations Administrator Guide Complete**	**February 5, 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 SESSION LEGISLATIVE MANDATES

NCGA 2010 SESSION LEGISLATIVE MANDATES
IMPACTING the NCMMIS+ PROGRAM

Bill #	Session Law #	Title of Bill	Summary of Legislation	NCMMIS Potential Impacts
H 382	2010-70	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 MMIS to document recipient appeal process & new ad-hoc reports to monitor efficiency of appeal process.
H 589	2010-2	Ins. & 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.
H 1692	2010-88	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.	• Based on study's final set of recommendations, potential future new MMIS data fields for pricing, services, provider info 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
H 589	2010-2	Ins. & 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.

NCGA 2010 SESSION LEGISLATIVE MANDATES

IMPACTING the NCMMIS+ PROGRAM

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H 1703	2010-93	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, operators, and volunteers of adult day care programs and adult day health services programs, as recommended by the North Carolina Study Commission on Aging.	• May affect provider services functionality in MMIS. • Potential future impact on provider enrollment requirements/ data collection/ reporting related to adult day care services providers
H 1705	2010-121	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.	Has potential impact, but any recommended guidelines or standards should be able to be accommodated within existing MMIS projects.
H 1707	2010-3	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.
S 354	2010-128	Continuing Care Retire. 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. • Potential future new data elements or modification of existing data elements in the MMIS.

NCGA 2010 SESSION LEGISLATIVE MANDATES

IMPACTING the NCMMIS+ PROGRAM

Bill #	Session Law #	Title of Bill	Summary of Legislation	NCMMIS Potential Impacts
S 765	2010-118	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.	• May require new or modified data elements in MMIS • Potential reporting changes for R&A
S 897	2010-31	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 • DMA to contract w/ CCNC for Enhanced Primary Care Case Management System • Expand 1915 Waiver • Study Medicaid reimbursement rates & program benefits by 4/2011 • Add Never Events to MSP • Modify the Medicaid Recipient Appeal Process
S 900	2010-152	Studies Act of 2010	Provide 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 MMIS: • Consolidation of State Agencies & Departments • Efficient E-Commerce • Monitor Impact of Revised Requirements for PCS • Cost effectiveness of supportive housing as alternative to institutionalization (MH/DD/SA) • Prescription Drug Abuse
S 1193	2010-68	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 new or modified data elements in MMIS • Potential reporting changes for R&A

NCGA 2010 SESSION LEGISLATIVE MANDATES

IMPACTING the NCMMIS+ PROGRAM

Bill #	Session Law #	Title of Bill	Summary of Legislation	NCMMIS Potential Impacts
S 1392	2010-120	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.
H 1703	2010-93	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, operators, and volunteers of adult day care programs and adult day health services programs, as recommended by the North Carolina Study Commission on Aging.	• May affect provider services functionality in MMIS. • Potential future impact on provider enrollment requirements/ data collection/ reporting related to adult day care services providers
H 1705	2010-121	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.	Has potential impact, but any recommended guidelines or standards should be able to be accommodated within existing MMIS projects.
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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, and provides for access to the knowledge and skills of multiple vendors, and will broaden the

industry experience base in NC DHHS systems by providing opportunities for specialization that might attract new vendors or partnerships not seen in a monolithic acquisition. The three major functional groups are: 1) Core MMIS Replacement, 2) Reporting & Analytics and 3) DHSR.

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

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

End of Appendix E