



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

DEC 28 2009

The Honorable Ulysses Currie
Chairman
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Norman H. Conway
Chairman
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

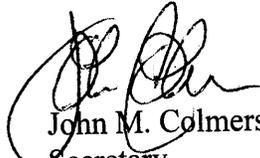
**RE: 2009 Joint Chairmen's Report (P. 94) – Report on Scope of Work for Updating
MMIS and All Medicaid Eligibility Systems**

Dear Chairmen Currie and Conway:

In keeping with the requirements of the 2009 Joint Chairmen's Report (p. 94), the Department of Health and Mental Hygiene and the Department of Human Resources are submitting the enclosed report on the determined scope of work for updating the Medicaid Management Information System and the medical care programs' eligibility systems. The Joint Chairmen's Report specifies that \$100,000 of the appropriation made for the purpose of provider reimbursements in FY2010 may not be expended until the Department of Health and Mental Hygiene and the Department of Human Resources submit this report to the budget committees.

If you have questions or need more information on this subject, please contact Shawn Cain, Assistant Director of Governmental Affairs, at (410) 767-6509.

Sincerely,


John M. Colmers
Secretary

Enclosure

cc: The Honorable Thomas M. Middleton
The Honorable Peter A. Hammen
John Folkemer
Charles Lehman

Susan Tucker
Tricia Roddy
Shawn Cain
Tammy Bresnahan



MMIS and Eligibility Systems Joint Chairman's Report

December 2009

The 2009 Joint Chairmen's Report specifies that \$100,000 of the appropriation made for the purpose of provider reimbursements in FY2010 may not be expended until the Department of Health and Mental Hygiene and the Department of Human Resources submit a report to the budget committees on the determined scope of work for updating the Medicaid Management Information System and the medical care programs' eligibility systems. In addition, the report shall include the rationale for updating the eligibility systems to the determined level. The report shall be submitted by December 1, 2009, and the budget committees shall have 45 days to review and comment.

In 2009, the Department of Health and Mental Hygiene (DHMH) consulted with the Department of Human Resources (DHR) in the planning process for upgrading the Medicaid Management Information System (MMIS) and the Client Automated Resources Eligibility System (CARES). The MMIS is operated by DHMH and CARES is operated by DHR. The CARES system is the primary source of eligibility determination information to support claims processing in the MMIS. Both systems have been in operation since the mid-1990s.

This report will provide an update on the key milestones that have been accomplished so far and outline the proposed scope of the upgrades to be implemented.

MMIS AND ELIGIBILITY SYSTEMS UPGRADE ACCOMPLISHMENTS

The following key milestones have been met to date in upgrading the MMIS and Eligibility systems upgrade process:

1. Completed the MMIS State Self Assessment for the Medicaid Information Technology Architecture (MITA).
2. Completed the Analysis of Alternatives and Preparation of an Advanced Planning Document to the Centers for Medicaid and Medicare Services (CMS) for enhanced Federal Funding for the replacement of the MMIS.
3. Submitted an Information Technology Planning Resource (ITPR) for the MMIS replacement project by DHMH.
4. Submitted an ITPR for CARES enhancements by DHR.
5. Obtained approval of enhanced Federal Funding by CMS for the replacement of the MMIS representing an average of 86% Federal funding for the project.
6. Currently finalizing an RFP for the Design, Development, Implementation and Operations of the new MMIS, with expected release early in 2010.

SCOPE AND RATIONALE FOR UPDATING MMIS AND ELIGIBILITY SYSTEMS

The State of Maryland currently owns and operates the existing MMIS. Maryland's current MMIS was bid as a transfer system in 1992. It was based upon the system then in use in the State of Florida. The system is a direct descendant of the original MMIS

applications based upon the Federal “Blue Book” specifications and technical architecture of the 1970s.

The results of the MITA State Self-Assessment indicate that the current MMIS is incapable of meeting expectations and future needs such as flexible design, document imaging, automated workflow, web portal functionality and improvements to eligibility processing.

1. **Outdated Technology:** Maryland’s MMIS has outlived most other states’ Medicaid Management Information Systems. The current MMIS uses outdated technology and an older, inflexible technical design. The staff has worked hard to maintain the functionality of the MMIS; however, it is an extremely tenuous system often requiring patchwork solutions. Upcoming legislative mandates such as the new coding requirements (International Statistical Classification of Diseases and Related Health Problems 10th Revision) and HIPAA standards (X-12 5010) will be difficult if not impossible to implement in the current system prior to the immovable implementation deadline.
2. **Lack of Flexibility:** The design and technology constraints make it difficult to make changes quickly to support rapidly changing program requirements and to add or change benefit plans. States require the flexibility of a user-friendly rules engine in order to quickly react to legislative and regulatory changes and to support flexible benefit plans for their clients.
3. **Costly to Maintain:** The MMIS is based on outdated technology and older, inflexible programming that is costly to maintain, operate and enhance. The current system will require extensive and expensive modifications in order to comply with the upcoming ICD-10 and X12 5010 changes. In addition, the lack of an automated workflow management solution with document imaging capability adds significant cost through business process inefficiencies and excessive handling of paper claims and attachments.
4. **Needs Outgrew System:** The Medicaid program has become increasingly complex, with service changes eligibility changes, and new Federal requirements (e.g., HIPAA). New program needs are difficult to address with the existing system. Labor-intensive “workarounds” are used to address these changes in the short-term, but do not represent a long-term solution.
 - **Deficiencies with Client Automated Resources Eligibility System (CARES):** Years of programmatic and legislative changes to the Medicaid program has exposed the inability of the State-wide eligibility system to: a) capture all recipient eligibility data necessary to properly pay claims (instead, work-arounds are required); b) maintain synchronized data between systems due to a one-way interface; and c) handle eligibility determination for all Medicaid programs. CARES does not store eligibility data on the following Medicaid programs:
 - Primary Adult Care (PAC)
 - Kidney Disease Program (KDP)
 - Women’s Breast and Cervical Cancer Health Program
 - Maryland Children’s Health Program (MCHP) Premium
 - Employed Individuals with Disabilities (EID)

- Family Planning
- 5. **Service Levels:** Current contracts and personnel agreements make it impossible to implement service level agreements consistent with industry best practices.
- 6. **Reporting Capability:** Current MMIS system does not provide Decision Support and Management reporting to support Executive and program reporting needs.

Summary of Systems Alternatives Evaluation

The following outlines the approach to addressing the systems needs of the Medicaid Program:

CARES Eligibility

The DHMH and DHR considered multiple alternatives to addressing the requirements for both replacing the MMIS and replacing the Client Automated Resources Eligibility System (CARES – Maryland’s integrated eligibility determination system). The cost and risk associated with this simultaneous replacement of both large systems makes it impractical. In addition, our discussions with DHR regarding CARES indicated that it does not have the resources for a replacement system at this time.

DHMH and DHR determined that the best alternative at this time was to replace the MMIS and enhance CARES to provide a two-way real-time interface with DHMH MMIS system, enhancements to CARES Medical Assistance eligibility determination, and modification of current CARES system to fix deficiencies to support the DHMH MMIS system. An ITPR was developed to address this project in the following manner

- Phase 1 – Two-way real-time interface with DHMH will allow the DHR and DHMH to have access to the latest client information. A new DHMH MMIS Member Management system will have a real-time access through middleware to query CARES system and retrieve the required information to assist in determining Medicaid eligibility. A new system would be the consolidated point of determining eligibility, thus creating a ‘one-stop’ application for all Medicaid eligibility to be determined.

Phase 2 – Enhancements to CARES Medical Assistance eligibility determination include the task associate with reevaluating and fixing citizenship, and modifying the system related to LTC issues as well as creating the ability to generate alerts from DHMH/MMIS to DHR case workers. Currently, all Medicaid programs and coverage groups are not in CARES.

Medicaid Management Information System (MMIS)

DHMH identified the following options for replacement the MMIS:

1. Procure a contractor to develop, design, and implement (DDI) a state-of-the-art MMIS. Maryland resources would then operate the MMIS after a specified turnover period.
2. Procure a facilities management contractor (FM) for DDI and for operation and maintenance of a state-of-the-art MMIS on state hardware. Maryland resources perform all other MMIS related tasks.

3. Procure a Fiscal Agent (FA) for DDI and operation of a state-of-the-art MMIS on contractor hardware. FA would perform specified Medicaid operations and MMIS system maintenance and enhancement for the contract period.
4. Continue to operate the current MMIS-II and add the federally required enhancements for ICD-10 and ANSI X-12 5010. Years of changes to the MMIS-II have led to numerous patches and creative workaround fixes to support the Maryland Medicaid Program and keep the system operational and support program modifications. The latest business driven change is the Health Insurance Portability and Accountability Act (HIPAA), which required a complete revision of the data acceptance input conversion functionality of the MMIS-II. The need to implement ICD-10 codes as well as future - HIPAA requirements for concurrent support of multiple versions of the ANSI X-12 transactions and medical code sets, will be extremely difficult, time consuming, and expensive to implement under the current system design. As a result, it was determined that the current system would not meet the needs of DHMH that were specified in the MITA State Self-Assessment.

DHMH determined that to reduce project risk the implementation of a replacement Pharmacy Benefit Manager (PBM) would be delayed until 2014. In the interim, the current PBM would be enhanced in 2011 to include the capabilities listed in the *MMIS Operational Alternatives Analysis* section below. The PBM enhancements will be implemented via an amendment to the existing contract.

DHMH identified that the MMIS procurement should also include a state-of-the-art data warehouse and decision support system (DSS) to support Executive and Management reporting, Ad-hoc reporting, enhanced MARS and SURS functionality, and financial “what-if” modeling capability.

MMIS Operational Alternatives Analysis

As part of the decision to replace the MMIS, DHMH also considered the alternatives for how the new system would be operated, including; State-Run, Facilities Management of the MMIS only, and full Fiscal Agent operations.

The major factors in determination of the recommended operational approach are the following existing staffing constraints:

- *Loss of Operational Staff Positions* – The DHMH Operational areas have lost a total of 25.3 full-time equivalent (FTE) positions over the past several years. The loss of staff is primarily budget-related and not driven by business needs. In order for Maryland to continue to self-administer their Medicaid program, the State would need to make a commitment to properly staff the operational areas by increasing the staffing to the appropriate levels. Without that commitment, the program cannot operate at required minimum levels to maintain the Federal Matching Funds for Medicaid Operations and would be in jeopardy of failing to meet the requirements of the Prompt Payment Act.
- *Ability to Meet Technical Staffing Demands* – The current technical staff is proficient at operating the COBOL based legacy MMIS-II system. A replacement

system would require the re-training of the existing staff. While possible, it does pose a barrier in the administration of a current generation system.

The State also has a difficult time attracting and retaining technical staff in the Baltimore-Washington metropolitan area job market. In addition, a significant portion of the State's technical team is approaching retirement and the sudden loss of technical knowledge is a possibility in the near future.

- *Ability to Operate at Industry Standard Service Levels* – Due to the staffing issues in the operational and technical areas, the Maryland Medicaid program has struggled to operate the program at adequate levels of service. Below are some of the programs current service delivery problems that can be attributed to the lack of adequate staffing.
 - Average wait times of over 4 minutes in the Provider Relations call center
 - 19% abandonment rate in the Provider Relations call center
 - Over 250 open system change requests
 - 3,500 claims that have been waiting to be scanned for over 30 days
 - 5,500 written inquiries pending for over 60 days
 - 388 provider applications that have been in process for over 60 days

Due to the current poor economy and the new administration in Washington, it is highly likely that the Medicaid program will see an increase in the member population and/or program expansion in the next few years. The Medicaid programs typically are the busiest when the economy is struggling due to the increased enrollments.

MMIS Operational Recommendation

With a fiscal agent contract the state can set performance measures and service level agreements, and impose damages for failure to meet those agreements. A Fiscal Agent contractor would provide the flexibility to respond more timely to operational demands to continually meet its goals and its commitments to stakeholders.

Based on a detailed cost benefit analysis and careful review of the assumptions and constraints placed on the Maryland Medicaid program, DHMH intends to proceed with acquiring a Fiscal Agent to replace the MMIS to meet new Federal requirements and takeover a significant portion of the claims business operations.

The transition to a fiscal agent addresses the State's two main needs, the need to improve customer service and the need for a flexible and current technological solution that allows the Medicaid program to meet the increasing demands placed on the Program by Providers, Members and Federal and State legislation.

A primary driver for the transition of business operations to a fiscal agent is the question of whether the State could commit the resources necessary to operate a Medicaid Program in line with the expectations of its customers and consistent with industry standards. In addition, the move to a Fiscal Agent operation will help DHMH address the following issues:

- Consolidation of 14+ contracts to support the operations and technical support functions of the Program
- Loss of Programmatic Institutional Knowledge: Currently nearly 25% of staff supporting the Medicaid program is eligible for retirement. The ability to hire skilled resources in the Maryland market is hampered by competition from County, Federal and private entities with better salary and benefit packages.
- Inefficient use of Taxpayer Dollars: The MMIS is a legacy MMIS written in COBOL that was installed in 1995. The system would require extensive and expensive changes to meet the upcoming Federal mandates for ICD-10 and X-12 5010. It would not be wise to invest so heavily in an aged system that currently does not meet the State's needs in many other areas. The current MMIS is also expensive and cumbersome to maintain and difficult to modify to rapidly meet the State's need to implement flexible benefit plans and additional programs.

The primary reasons to select the fiscal agency model are as follows:

- Provide a performance based contract that with a focus on customer service through service levels:
 1. Improved provider relations
 2. Improved eligibility determination and recipient interaction
 3. Faster claims payment
- Address Staffing Issues
 1. Aging Workforce/Staff Retention
 2. Ability to staff to workload peaks and valleys
 3. Ability to quickly hire and fire based on workload and performance
 4. Access to best talent in operations and IT management
- Address Service Delivery Issues
 1. Ability to meet legislative mandates
 2. Support HIT initiatives
 3. Financial liability attached to the Fiscal Agent meeting service level commitments
 4. Access to best talent in operations and IT management
- Efficient use of Taxpayer dollars by not investing millions in an old, inflexible solution that does not position the Medicaid program for future needs
- Access to innovation and efficiencies based on experience in the industry and other states; best practices implementation

MMIS Systems Request for Proposal

DHMH is currently in the finalization of a Request for Proposals to replace the current MMIS and include operations by a Fiscal Agent contractor. The RFP will require approval by the Department of Budget and Management (DBM), the Department of Information Technology (DOIT) and the federal Centers for Medicaid and Medicare Services (CMS) prior to release.

The RFP has been prepared with the assistance of our planning contractor DK/Fox. The consulting staffs on the project have successfully developed similar MMIS RFPs for multiple states and our RFP has taken the best elements of the most recent MMIS procurements and tailored them to Maryland's requirements.

A corresponding Proposal Evaluation Plan has been developed that provides a detailed methodology to effectively and unambiguously evaluate the vendor responses and give proper weight to those elements that Maryland believes are essential to selection of the best combination of MMIS system and operational experience.

Maryland intends to modify our business practices to be consistent with the selected Vendor IT solution and industry best practices. This will enable us to hold the vendor accountable for service level performance under the operational phase of the contract using their proposed MMIS, configured for Maryland's policies and payment methods.

Upon selection of a successful vendor it will take approximately 30 months to implement the new MMIS, sometime in early 2013.