Testimony

Senate Bill 2024 – Department of Human Services

Senate and House Appropriations Committees

Senator Holmberg and Representative Svedjan, Chairmen

January 4, 2007

Chairman Holmberg and Chairman Svedjan, members of the Senate and House Appropriations committees, I am Maggie Anderson, Director of Medical Services for the Department of Human Services. I appear before you to provide information regarding the replacement of the current Medicaid Management Information System (MMIS). Replacement of the MMIS is one component in the Medicaid Systems Project. In addition to my testimony, Sterling McCullough from MTG Management Consultants, L.L.C. will be presenting information on the Independent Analysis and Jennifer Witham, Director of Information Technology Services will be presenting information on the 2005-2007 Preliminary Project Work, and the 2007-2009 Executive Budget Request.

Medicaid Management Information System (MMIS) Background

The MMIS is a claims payment and reporting system that ensures payments for medical services are processed timely and accurately. It ensures the provider claiming reimbursement is enrolled and ensures the service for which reimbursement is requested is within program guidelines. It prices claims, accounts for payments, and maintains a history file of all claims. It is designed to detect problems such as duplicate claims and services beyond program limits.

If MMIS detects a problem, it will either automatically deny the claim, or suspend it for processing by a claims auditor. Even though each of these functions is common of a claims payment system, an MMIS is unique, just like each Medicaid program is unique. Some Medicaid programs cover all optional services, some none or very few. Each Medicaid program covers a variety of eligibility categories, at different income levels. MMIS, through it's interactions with the eligibility systems, MUST be able to determine who is eligible and for what level of benefit. An example of this type of uniqueness is the Medically Needy population. North Dakota is one of the states that cover this eligibility group, and we are unique in how their eligibility is established.

The MMIS also produces a variety of reports. Many of the reports are required by the Centers for Medicare and Medicaid Services (CMS) to report service and payment information. The ongoing receipt of Federal Funds is contingent upon the Department being able to supply accurate reports to CMS within the timeframes they prescribe. Other reports are used to manage the program and identify potential fraud and abuse issues.

Medicaid providers rely on MMIS for accurate and timely payment. These providers include Nursing Facilities, Hospitals, Physicians, Counties, Pharmacies and Clinics. In addition, the Qualified Service Providers (QSPs) rely on the MMIS for the equivalent of their paycheck.

What MMIS is not, is easy to envision. It is not a computer on a desk top, or a pre-packaged software product that can be purchased at a retail store; nor is it software that can be downloaded from the internet. It is literally millions of lines of computer programming code, which requires

the sophistication to interface with numerous other systems and programs to ensure all Federal Medicaid payment rules and State laws are followed. **It must be custom-modified for each state's unique Medicaid program rules**. This is no small undertaking. When complete, the new MMIS would reside on 48 servers and will be maintained by information technology experts. MMIS is a very complex technology, clearly exhibited by the limited number of vendors who have developed systems in this market. Having such a small pool of vendors also drives the cost up.

Why MMIS Needs to be Replaced

North Dakota implemented the current MMIS in the fall of 1978. At that time it was a state-of-the-art system. The system is now 29-years old and it has been modified and enhanced countless times. The current software architecture is not flexible and has made it difficult to meet the business needs of the Department and providers for quite some time. For example, recent Federal changes to the Medicare Crossover claims process has complicated payments to hospitals and physicians. Minor policy changes often involve prolonged and complicated "hard coding" that requires extensive resources, and often leads to additional problems because of all the patches that have previously been made to the system. The current system does not meet current business needs, let alone the ongoing needs of providers.

In addition the fraud and abuse detection tools in the current MMIS are not sophisticated and manual review is often required because of system limitations.

In short, a new MMIS will allow the Department to be more responsive to changes, and in fact, will allow more proactive program management. In addition, it will allow for more efficient, accurate and timely payments to providers.

Medicaid Systems Project Events during the 2005-2007 Interim

The 2005 Legislature authorized an appropriation of $29.2 million to design, develop and implement the replacement Medicaid Systems. The Department released a Request for Proposal (RFP) on June 1, 2005, with proposals due September 1, 2005. The Department received one proposal for MMIS, three proposals for Pharmacy Point of Sale (POS), and two proposals for the Decision Support System (DSS), which are all components of the Medicaid Systems Project. After the proposals were reviewed and scored, the Department held oral presentations with all vendors to further refine the vendors proposals and to ensure the proposals met the business and technology requirements set forth in the RFP. The oral presentations were completed in mid-November 2005 and vendors were asked for best and final offers, which were due December 5, 2005. The Department then notified the Budget Section that the estimated cost of the Medicaid Systems Project had significantly increased.

The increase is related to several factors. First, there have been changes in technology. Medicaid Information Technology Architecture (MITA) was a concept on the drawing board within the Centers for Medicare and Medicaid Services (CMS) when the Cost Benefit Analysis was prepared. Today, MITA is required and, as a result, cost proposals for all new Medicaid Systems are landing higher than two – three years ago. The

newer technology will enable Medicaid systems to be more effective and efficient and will help ensure seamless health care payments between payers. The new technology also results in a "plug and play" approach to maintaining the system, which allows components to be upgraded or replaced rather than an entire system, as a portion becomes obsolete. For example, if CMS requires a significant program change, this "plug and play" technology will allow North Dakota to be more responsive, in less time and at lesser expense than with the current technology. This is intended to reduce long-term replacement costs. Unfortunately, this has increased the initial development costs, as vendors are making system changes to ensure they can be competitive within the MITA requirements.

When the Cost Benefit Analysis was prepared in the 2003-2005 interim, it was based on estimates for North Dakota transferring a system in from another state. In the meantime, MITA became required, and a transfer was no longer appropriate. Therefore, we are experiencing a cost increase because of a shift in the technology currently under development. The costs for this new technology are not expected to decrease in future years; in fact, costs are likely to increase.

At the March 8, 2006 meeting of the Budget Section, a motion passed that encouraged the Department of Human Services to begin preliminary work on the Medicaid Systems Project. The preliminary work was to include deliverables that would be required, regardless of the option selected during the 2007 Legislative Session.

In addition, the motion encouraged the Department to contract for an independent analysis of the following options:

1. Acceptance of the current ACS Bid

2. Rebidding of the MMIS project
3. Joint development with another state
4. Use of a fiscal agent
5. Outsourcing the billing and payment components

In March 2006, the Department submitted the proposed MMIS contract to the Centers for Medicare and Medicaid Services (CMS) for approval, which is part of the oversight required by CMS. The contract was approved June 6, 2006 by CMS.

Currently, **CMS provides 90 percent federal funding** for the design, development and installation of a new MMIS. In order to receive the enhanced funding, we are required to submit for approval an Implementation Advance Planning Document (IAPD). The IAPD has been approved by CMS, based on acceptance of the current Affiliated Computer Systems (ACS) bid. If a decision is made to pursue a different alternative, an Update to the IAPD would need to be submitted and approved by CMS. In the March 30, 2006 IAPD approval received from CMS, they stated:

"*CMS wants the State to be aware that should the project deviate from the CMS approved IAPD Update, FFP for the new MMIS project will be suspended and disallowed as provided for in federal regulations at 45 CFR 95.611(c)(3) and 95.612. In any event, authorization of federal funding for this project will expire on April 24, 2008* (i.e., the scheduled date for completion of the Operation Acceptance Test and full operation of the new MMIS, POS, and DW/DSS). Also, please be advised that should funding for the full project not be authorized or the system not become*

operational, that the FFP authorized for this project will be subject to disallowance by CMS (see 45 CFR 95.612).”

* This date has subsequently been approved by CMS at July 31, 2009.

Because the Federal Government, through CMS, provides 90 percent federal funding for this project, we requested CMS input for this testimony. Representatives from the CMS Denver Regional Office were unable to be here today; however, they have provided a letter regarding the North Dakota Medicaid Systems Project. Please see attached letter.

Jennifer Witham, Director, Information and Technology Services, will now cover the Sections on the 2005-2007 Preliminary Project Work, and the 2007-2009 Executive Budget Request.

2005-2007 Preliminary Project Work – Phase I

As Maggie stated, in September 2005 the Department received one proposal for MMIS, three proposals for Pharmacy Point of Sale (POS), and two proposals for the Decision Support System (DSS), which are all components of the Medicaid Systems Project. Based on best and final offers received in December 2005, the Department estimated the total cost of the project to be $56.8 million.

The Budget Section found that it did not possess the authority to approve increased funding for the Medicaid System Project beyond the 2005 appropriation of $29.2 million. However, on March 8, 2006 the Budget Section did support a plan for the Department to begin preliminary project work under its existing authority. This preliminary work, Phase I, will not exceed $10 million in 2005-2007. Execution of Phase II of the

project will be dependent on the outcome of this bill based on the action of the 2007 legislative assembly.

ACS Government Healthcare Solutions, the successful MMIS and POS contractor, agreed to sign a fixed-price contract identifying both phases, with the second phase contingent on the outcome of this bill based on the action of the 2007 Legislative Assembly. The first phase will not exceed $8 million, with the total contract price of $37.6 million, for both phases. Approval for this contract was received from CMS on June 6, 2006, and executed with ACS on June 8, 2006. ACS is ready to begin Phase II project work under this contract.

This two phased approach protects the State's interest in retaining the original bid from ACS while focusing on reusable components during the first phase of the project. Specifically, Phase I primary deliverables from ACS include Requirement Analysis Documents for each of the Medicaid functional areas and an overall Medicaid Information Technology Architecture (MITA) assessment.

The Information Technology Department (ITD) staff is augmenting ACS in Phase I. Their software development costs in Phase I will not exceed $1.6 million and represent research into data conversion issues, current edit and audit rules and documentation of current system interfaces. Their work product will also be reusable.

Thomson Medstat, the successful DSS contractor, agreed to keep their price of $3.1 million firm until Phase II of the project could be executed. The Department published a notice of intent to award the DSS contract to

Thomson Medstat on March 31, 2006. No DSS implementation costs will be incurred in Phase I.

At this time, Phase I project work is on time and on budget in accordance with the detailed work plan for both ACS and ITD.

2007-2009 Executive Budget Request – Phase II

The following table represents the current budget request for 2007 – 2009, the anticipated carryover of unexpended 2005-2007 project funds, Phase I project costs, and the total project cost for both bienniums.

	2007-2009 Current Request	2005-2007 Carryover	2005-2007 Phase I Costs	Total Cost*
Total Project	31,072,641	21,456,730	10,000,000	62,529,371
General Funds	3,643,133	0	0	3,643,133
Federal Funds	27,429,508	18,941,021	8,847,889	55,218,418
Other Funds	0	2,515,709	1,152,111	3,667,820
**Total Cost includes a 10% contingency of $5,680,000. Without contingency, the project cost is $56,849,371.*				

- The Executive Budget request in Senate Bill 2024 for Phase II of the project is $31,072,641 of which 3,643,133 are general funds.
- This request, in addition to the unexpended funds from the 2005-2007 project appropriation of $21,456,730 of which $2,515,709 is other funds, brings the total project cost for 2007-2009 to $52,529,371.
- With the $10,000,000 that will be expended in 2005-2007, the total project cost including contingency for both bienniums will be $62,529,371.

- Project costs less the 10% contingency is $56,849,371.
- The 2007-2009 project costs of $52,529,371 includes:
    - $29,606,950 for the continuation of the current ACS contract for the replacement of the MMIS and the POS (with the $8 million expended on Phase I; the total contract is $37.6 million);
    - $9,502,798 for the continuation of ITD labor, hardware and software costs;
    - $3,100,000 for the Decision Support System replacement;
    - $3,869,152 for Independent Validation and Verification services;
    - $5,680,000 in contingency funds;
    - $569,254 for DHS temporary staff; and
    - $201,217 for rent, supplies and other miscellaneous project costs.

Next, Sterling McCullough from MTG Management Consultants, L.L.C. will be presenting information on the Independent Analysis that was requested by the Budget Section in March 2006. We are providing a separate handout for his testimony (Presentation) (Handout: Independent Assessment Report). After Sterling completes his presentation, Maggie Anderson will complete the Department's testimony.

Option 5 – Outsource the Billing and Payment Activities

Based on the motion from the March 2006 Budget Section meeting, the Department released a Request for Information (RFI) seeking responses from potential vendors on the possibility of outsourcing the billing and payment activities. The Department received three responses to the RFI: Electronic Data Systems (EDS), Noridian Administrative Services (NAS), and Affiliated Computer Systems (ACS).

All three potential vendors provided information on the services they could provide under an outsourcing arrangement. Only NAS provided estimated cost information, as it is not the practice of EDS or ACS to provide cost information, unless there is a formal Request for Proposal.

After the RFI responses were received, the Medicaid Systems Project Management Team met with Noridian Administrative Services staff to discuss the proposal and request clarifications.

NAS provided the following quote in their response:

"Based on information in the DHS RFP for an MMIS in 2005, and information provided in this RFI (e.g., number of recipients, claim volumes, call center volumes), NAS estimates the cost to the DHS to outsource claims processing and related services to a fiscal agent would be in the range of $3,500,000 to $5,000,000 per fiscal year. This estimate is inclusive of personnel and facilities only. Hardware and software costs for the MMIS, POS and all other technologies are not included in this estimate. This estimate also excludes the development or

support of the MMIS system or equipment required to process the MMIS. The MMIS system to be utilized would either be the current or future MMIS supported by ITD. A more accurate estimate can be developed when additional details are developed in regards to the scope of work."

The six-year total for Department of Human Services Turnkey (In-house claims processing, claims imaging, electronic claims and provider relations) operations is estimated to be $5,504,786, which is based on current salaries, plus a yearly inflation of 4 percent*. The six-year total for Outsourcing (using the minimum provided by NAS) operations is estimated to be $ 23,215,414, which is based on a yearly inflation of 4 percent*.

*The annual inflation, whether at 4 percent or some other percent, is controlled by the Legislature for the in-house billing and payment activities (Turnkey). The annual inflation for an Outsourcing Contract would be under the control of the vendor.

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Six Year Total
Turnkey	$883,720	$853,174	$887,301	$922,793	$959,705	$998,093	$5,504,786
Outsourcing	$3,500,000	$3,640,000	$3,785,600	$3,937,024	$4,094,505	$4,258,285	$23,215,414

If outsourced, the total funds needed to support this estimated increase for six years of operations would be $17.7 million, of which $4.4 million would be general funds. This is based on a 75/25, Federal/State match rate.

The Department understands that this option is likely the result of concerns about the timeliness of the current claims processing activities. Please be assured, the Department shares those concerns and works very hard to ensure timely claims payment. Federal Regulations require that 90 percent of claims be processed in 30 days. Frankly, the Medical Services Division was quite concerned about meeting this standard with

the implementation of Medicare Part D on January 1, 2006. With Part D implementation, we knew that over 40 percent of our prescription drug claims would now be processed by Medicare. Prescription Drug claims, because they are the most easily processed claims, have always assisted us in meeting the 90 percent standard. Because of the dedicated work effort of the staff who scan paper claims, process claims and work through system issues, for State Fiscal Year 2006 we were able to continue to exceed this 90 percent standard (92.24 percent). If given a new, fully functional and fully operational system, these dedicated claims processing staff would easily be able to exceed this standard.

Finally, Option 5 does not remove the need to replace the MMIS, as this option only addresses ongoing billing and payment activities. This is noted in the proposal from Noridian Administrative Services, "*The MMIS system to be utilized would either be the current or future MMIS supported by ITD.*"

Next Steps

The Executive Budget was built based on Option 1, Acceptance of the current ACS Bid. North Dakota will incur the cost of developing a certified MMIS that meets our unique needs regardless of decisions about operations (Option 5, Outsource the Billing and Payment Activities).

The need to replace the existing system has only increased over the past two years. Our claims processing system is antiquated, difficult and expensive to maintain, and it is not efficient – for either state users or local providers. On a daily basis, our office is faced with providers who are frustrated, angry and fed up with our inability to make changes in the

current system to meet their needs. Coupled with the challenges providers have with reimbursement rates, when the providers reach a breaking point, they choose not to provide services, which results in limited access for our recipients.

Finally, there is no guarantee that the final cost of the system would decrease if the project were postponed or rebid. In fact, with inflation, potential Federal match changes, and changing technology, it is likely that the costs would continue to increase, or we may not receive any bids.

The Department is committed to this project and has invested considerable resources in this effort. We do recognize that the projected cost is significantly higher than the 2005-2007 appropriation; however, the Medicaid system processes over four million claims per Biennium, totaling expenditures over $1 billion. It is CRITICAL to the Department and the Medical Services Division that we be able to fulfill our responsibilities to policy makers, providers, and recipients. To ensure the eventual system meets the needs of policy makers, providers and recipients, the Department established a group of stakeholders that has been asked for input and has been kept informed of project milestones. The stakeholder group includes provider associations, Information Technology Department (ITD) representatives, Legislators, the State Auditor's Office and other interested parties. It is the Department's intention to continue and expand this stakeholder group during the design, development and implementation phases of the project.

Medicaid is the fastest growing program in many state budgets, and as such, it is critical that the computerized system that supports nearly

every aspect of daily program administration be able to meet the current and future business needs. The current system does not meet these needs, and it is difficult to plan for the future, while relying on a system that is antiquated and not easily modified and adapted.

We respectfully request your support for Option 1, which will allow the Department to move forward with the momentum of Phase I (work completed in the 2005-2007 interim), and implement MMIS in the shortest period of time.

Sterling McCullough, Jennifer Witham, and I would be happy to answer any questions you may have.