



Oregon

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May 3, 2010

The Honorable Peter Courtney, Co-Chair
The Honorable Dave Hunt, Co-Chair
State Emergency Board
900 Court Street NE
H-178 State Capitol
Salem, OR 97301-4048

Re: Medicaid Management Information System (MMIS) Update

Dear Co-Chairpersons:

The purpose of this letter is to provide a status update for the Medicaid Management Information System (MMIS) that was implemented December 9, 2008.

Background

Implemented in 1982, DHS' previous MMIS was designed to handle paper claims submitted by healthcare providers and to track the medical eligibility of Oregon's Medicaid clients. Since that time, the healthcare field has evolved from a primarily fee-for-service system to a system that increasingly relies on sophisticated managed healthcare approaches.

DHS' previous MMIS was unable to efficiently and effectively process the nearly 1.7 million claims, encounters, and capitation payments received each month. As the client needs for providing long-term care and medical services to low income Oregonians continued to evolve, the previous MMIS no longer met the increasingly complex demands. In addition, compliance with the federal Health Insurance Portability and Accountability Act (HIPAA) emerged as a major challenge for Oregon's previous MMIS.

DHS began planning for a new MMIS system in 2001. Work progressed on planning, development and testing for the next 8 years until the system was implemented on December 9, 2008. The new MMIS is more technically capable and functionally superior to the previous MMIS and meets State of Oregon and federal government functional and business requirements, including HIPAA. The design, development and implementation phases of the MMIS project had an approved budget of \$80,762,791 with 90% of those costs funded by the federal government and 10% funding through State certificates of participation (COPs) and the General Fund.

Benefits of the New MMIS

The new MMIS enables DHS to improve and further develop local partnerships, so that human services are provided seamlessly, addressing the full range of client and community needs. The new MMIS benefits MMIS stakeholders in the following ways:

- For Providers, the new MMIS provides a more responsive payment processing through the use of a Provider Web Portal.
- For Policy Makers, the new MMIS provides the flexibility to support state/federal Medicaid legislation and enables improved Medicaid financial decision-making.
- For DHS, the new MMIS provides a federally certified system for DHS-wide Medicaid administration that will result in DHS operating efficiencies and stronger business processes to support Managed Care Organizations (MCO) and Medicaid providers.

Major Accomplishments

- Since implementation on December 9, 2008, the system has been available in excess of 99% of the time.
- When the system went live, it automatically processed 54% of all fee-for-service claim types, the remainder of claims were paid using a manual, transitional payment strategy. The system now processes in excess of 95% of all claim types within 30 days and all claims within 90 days, as required by Federal Prompt Pay requirements.
- When the system went live, the claim denial rate was 50%. This denial rate has fallen to 17%, which is almost half of the previous MMIS's rate.
- Cost Avoidance activities associated with Third Party Liabilities are functioning and have been in place since go-live.
- The Provider Web Portal has performed as expected since implementation and usage continues to increase.

- System response times have indicated 97.5% of information being returned to users within 10 seconds of request submission.
- MCOs are receiving both daily and monthly client enrollment files.
- Claim suspense rates are lower than the previous MMIS. In the previous system, staff would often be weeks behind in reviewing suspended claims. In the new system, claims get paid or denied more quickly because there is no backlog for reviewing suspended claims.
- Pharmacy Benefits Management processes have been operational since system implementation.
- Client coverage letters and semi-permanent medical identification cards are automatically generated from the system.
- Medicaid clients who do not choose a plan are now automatically assigned by the system through an auto-assignment process that uses equal distribution among the MCOs.
- MCO encounter claims are being received and collected within the system.
- The following accomplishments have been realized since the last MMIS update letter dated January 10th, 2010.
 - Co-insurance claims for nursing facilities are now processing through the system. Co-insurance claims are those where a nursing facility client is dually eligible for both Medicaid and Medicare. This functionality was made ready for testing on October 31, 2009. The Department made the co-insurance claim processing available to Nursing Facilities over the last three months. On 4/12/2010, the co-insurance claim functionality was fully implemented.
 - System issues pertaining to improper disenrollment of clients from managed care plans have been resolved. The final resolutions were implemented and clients are being automatically and accurately disenrolled from their plans.

Summary of Delays and Challenges

Although the planning team felt additional testing was necessary to ensure the least amount of disruption to services, CMS would not allow a further delay in beginning the use of the new system and ceased funding on September 1, 2008. In order to resume the federal funding, the MMIS was implemented on December 9, 2008 with significant outstanding issues in the Managed Care, Recipient and TPL sub-systems. DHS implemented manual work around processes to ensure clients received services and providers received payment for services rendered. However, a very small number of clients experienced delays in accessing services, providers struggled to determine

accurate client enrollment information, and field staff experienced increased workload due to manual processes at go-live of the new system.

The presumed period of stabilization was 90 days from implementation (March 1, 2009). On July 21, 2009 DHS sent the MMIS contractor, Hewlett Packard (formally Electronic Data Systems, EDS) a "Notice of Failure of System to Materially Perform, and Demand for Cure" letter. Upon receipt of the letter, Hewlett Packard (HP) devoted additional resources to the project, making progress, but did not fully stabilize the system to the Department's satisfaction. The Department responded by issuing a letter on February 3rd, 2010 giving HP thirty days to deliver a formal system resolution plan. HP delivered a system acceptance plan as well as a fully resourced project schedule to accomplish the acceptance plan to meet deadlines. As of the date of this letter, HP has accomplished 70% of the acceptance plan with the remaining outstanding issues occurring in the TPL subsystem.

Summary of Outstanding Problems

The majority of problems with the MMIS have been eliminated over the last 17 months. However, there are still outstanding system issues for which the Department is aggressively pursuing resolution:

- 1. MCOs do not have a completely accurate accounting or classification of clients enrolled in their plans due to system data issues with client eligibility history and data issues caused by inaccurate Payment Eligibility Reporting Codes (PERCs). PERCs are assigned by age and other demographic data and are the basis for calculation of client benefits. The Managed Care sub-system has been corrected since go live, but many historic data issues remain.**
 - a. **Impact:** It is unknown how accurate historical client rosters are for their plans during the period when defects were still being worked.
 - b. **Objective:** Correct historical data issues by October, 2010, to ensure accurate client rosters
 - c. **Solutions**
 - i. Fully reconcile the MMIS with MCO data systems
 1. Retroactive re-PERCing for months 2/09 to current - Complete 3/1/10
 2. Eligibility data fix - 6/18/10
 3. Retroactive re-PERCing for months 12/08-1/09 – TBD - Dependent upon eligibility data fix

4. Creation of enrollment validation data – TBD – Dependent upon Eligibility Data Fix.
 5. MCO enrollment catch up files for December, 2008 & January, 2009
 - ii. Implement a system enhancement to provide plans with a prospective report of disenrolled clients to allow plans to execute business processes prior to the end of the month so that they do not pay for services for clients who are no longer on plan rosters. – Initial rough order of magnitude Estimate, July 1st, 2010.
 - iii. Adjustment of capitation payments when retroactive Medicare enrollment is added to a client's coverage. – Estimation process in progress, date to be determined.
- 2. The Department is not receiving full federal match or fully recovering payments made to providers where Medicaid is the last payer of resort.**
- a. **Impact:** The Department is not fully maximizing Federal Funding Participation (FFP) because the system has not been certified. Specifically, upon certification the State will receive 75% enhanced FFP on system operations and maintenance activities instead of the standard 50% FFP for Medicaid program operations. Upon System Certification, the State can be reimbursed by Medicaid for approximately \$6.4 million. In addition, the Department is not collecting on Third Party Payment Recovery also known as Pay and Chase recoveries.
 - b. **Objective:** Maximize Federal matching funds and payment recoveries where Medicaid was the payer of last resort.
 - c. **Solutions:**
 - i. Cost Recovery activities (Pay and Chase) are in progress and scheduled for completion mid June.
 - ii. DHS is working with HP to complete system acceptance activities including the completion of defects identified prior to January 1, 2009, as well as TPL Cost Recovery activities.
 - iii. Complete system certification activities and achieve system certification. - 12/31/10
- 3. The System still requires some manual workarounds to deliver Medicaid Services.**
- a. **Impact:** System Defects and system changes make it necessary for State employees, MCO employees and others to use manual workarounds to deliver Medicaid services.
 - b. **Objective:** Review and eliminate all the workarounds and ensure data clean up activities have been performed.

- i. Eliminate the remaining known defects in the MMIS by system certification.
- ii. Implement critical change requests that help the MMIS better meet current business processes.

Management Actions and Next Steps

Since the December 2008 implementation of the MMIS, the Department has taken many management actions to accomplish three objectives:

1. Accelerate the rate of system stabilization,
2. Improve both internal and external communication and issue management processes,
3. Identify lessons learned, and implement improvements to ensure successful delivery of future Information Technology Projects.

Below is a summary of current and planned management actions to achieve the above objectives:

- The Department hired Point B Solutions, Inc. on November 23, 2009 to expedite MMIS stabilization efforts, resolve the MCO issues related to MMIS stabilization, and improve internal and external communication processes. Point B performed internal Department discussions, interviewed selected MCO representatives, identified themes pertaining to communication and issue management and is building an improvement roadmap to continue improving how the MMIS is managed. In addition, the Department has contracted with Point B to help create better implementation processes for system fixes and changes made to the system.
- Since implementation, the Department has issued several formal breach of contract letters to HP, our MMIS vendor. The latest letter, delivered February 3rd, 2010, gave HP thirty days to deliver a formal system resolution plan. HP responded as requested with a plan to conclude by 4/2/10. Due to identified defects, the plan date was rebaselined to 6/08/10. With consideration to the outstanding issues, the Department has not yet accepted the system.
- The Department has continued working closely with our Federal Partners through status reports and onsite meetings. Our Federal partners were onsite November 23, 2009 to receive an update and to provide guidance and consulting as we work to further stabilize the system and plan for certification. Since that time, the Department has hosted several conference calls and provided twice-per-month status reports to apprise CMS on our progress.
- Once the MMIS is certified, the Department plans to acquire the services of an independent, third party vendor to conduct an end-to-end analysis of the

MMIS project. Project planning, governance, implementation, risk management and other functions will be evaluated as part of the engagement. The Department intends to use the lessons learned to implement improvements that ensure successful delivery of current and future Information Technology projects.

Sincerely,

A handwritten signature in black ink, appearing to read 'JS', with a stylized flourish at the end.

Jim Scherzinger

Deputy Director of Finance

CC: Linda Ames, Legislative Fiscal Office
Bob Cummings, Legislative Fiscal Office
Sheila Baker, Legislative Fiscal Office
Blake Johnson, Department of Administrative Services