Department of Human Services

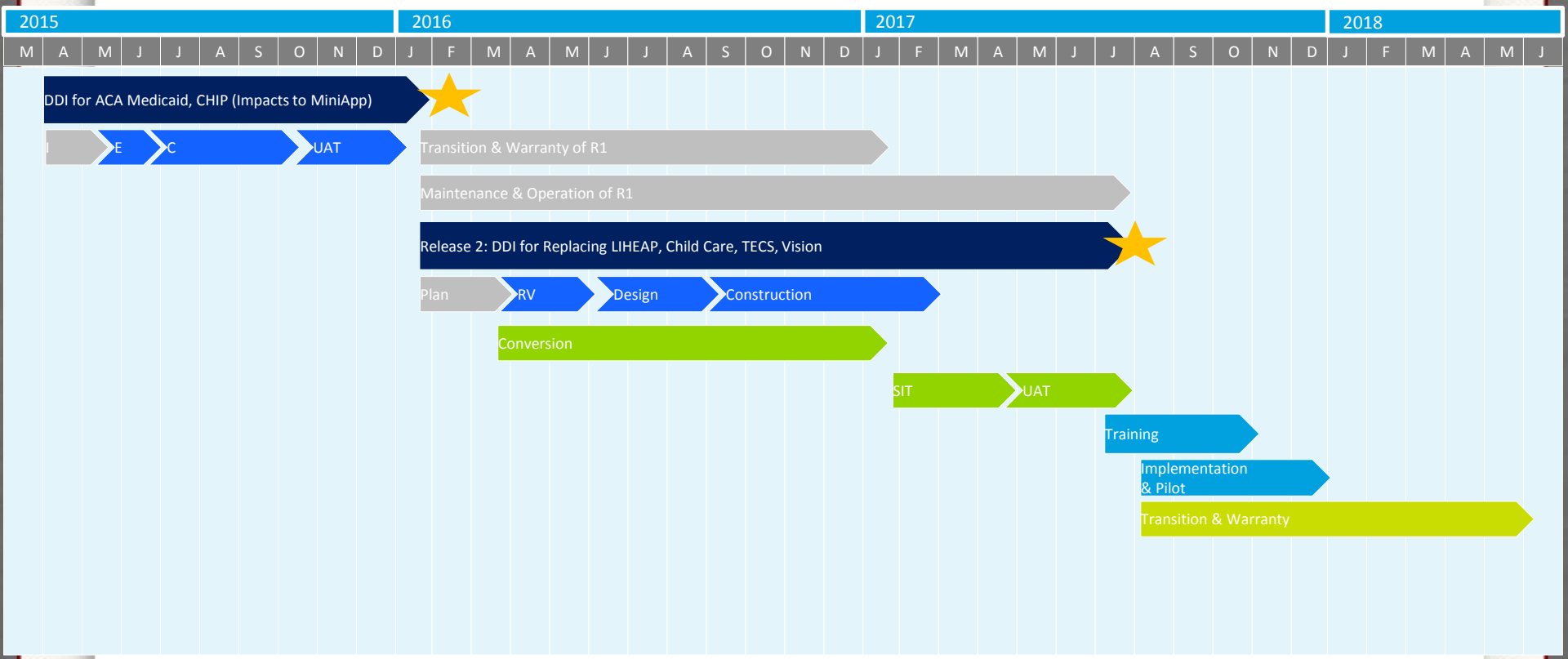
Program Background/Business Need

- Create a single integrated eligibility determination system for the following programs:
  - Medical Assistance (Medicaid)
  - Children's Health Insurance Program
  - Temporary Assistance for Needy Families
  - Supplemental Nutrition Assistance Program
  - Child Care Assistance
  - Basic Care Assistance Program
  - Low Income Home Energy Assistance Program
- All Medicaid related and common functionality costs qualify for Federal Financial Participation of 90%; state match of 10%
  - approximately 80% of the system build leverages these federal matching funds

Program Overview – Format/Roadmap

- Phase I
  - This phase included the functionality to support the Affordable Care Act and is scheduled to run through March 2016.
  - This phase also includes many of the common system components
  - Cost = approximately $45,000,000
- Phase II
  - This phase represents the planning for the remaining components of the system
  - It is inclusive of the planning, requirements and design life cycles
  - Cost = approximately $25,000,000
- Future Phases
  - Includes remaining program areas
  - Life cycle components to be covered includes system configuration and development, system integration testing, user acceptance testing, training, transition and implementation
  - The number of phases is to be determined based on outcome of Phase II
  - Cost = approximately $40,000,000

Proposed Project Phases



Key Objectives

- *A client portal to allow for* a "no wrong door" access to apply for services, create an option for clients to view enrollment status, benefit information and view and update case information, and submit electronic correspondence and verifications.
- *A worker portal to allow for* an integrated eligibility worker workflow for case assignments, integrate referrals, notices, alerts and case narratives within the current eligibility systems as appropriate.
- *A provider portal to allow for* the providers to update demographic information and submit payment requests (LIHEAP, Child Care), creation of an option for employment contractors to update demographic information and submit client work activities (TANF, SNAP).

Key Objectives

- A single eligibility system for all economic assistance programs will provide sharing of information regarding clients interactively amongst its service programs resulting in increased efficiency, ease of use, mobility of the application, and effective reporting for decision making.

Department of Human Services
Information Technology Committee
Representative Mark Owens, Chairman
December 15, 2015

Chairman Owens, members of the Information Technology Committee, I am Jenny Witham, Director of Information Technology Services for the Department of Human Services (DHS). I appear before you to provide the startup report related to the Eligibility Systems Modernization Project and the status of the implementation of the Medicaid Management Information System replacement.

Eligibility Systems Modernization Project Start-Up Report

Please see attached report.

Medicaid Systems Project – Post Production Update

The ND Health Enterprise Medicaid Management Information System (MMIS) implementation has generally gone well and DHS is completing an anticipated three month operations stabilization period. Eleven provider payment cycles have been completed with $178.3 million being paid to ND Medicaid providers, Children's Health Insurance Plan providers and Health Plans and $43.4 million paid for the regular monthly Medicaid Expansion premium payments.

As expected with an implementation of this magnitude, there have been system issues. The Medicaid providers have been very understanding and the Department is working to correct all issues as quickly as possible.

The state has also contracted with Xerox for a provider call center. The call center is working through high call volume and state staff is

continuing to provide education and training to call center staff so they can best serve Medicaid providers and reduce wait time associated with these high call volumes.

If you have any questions, I would be happy to address them at this time.

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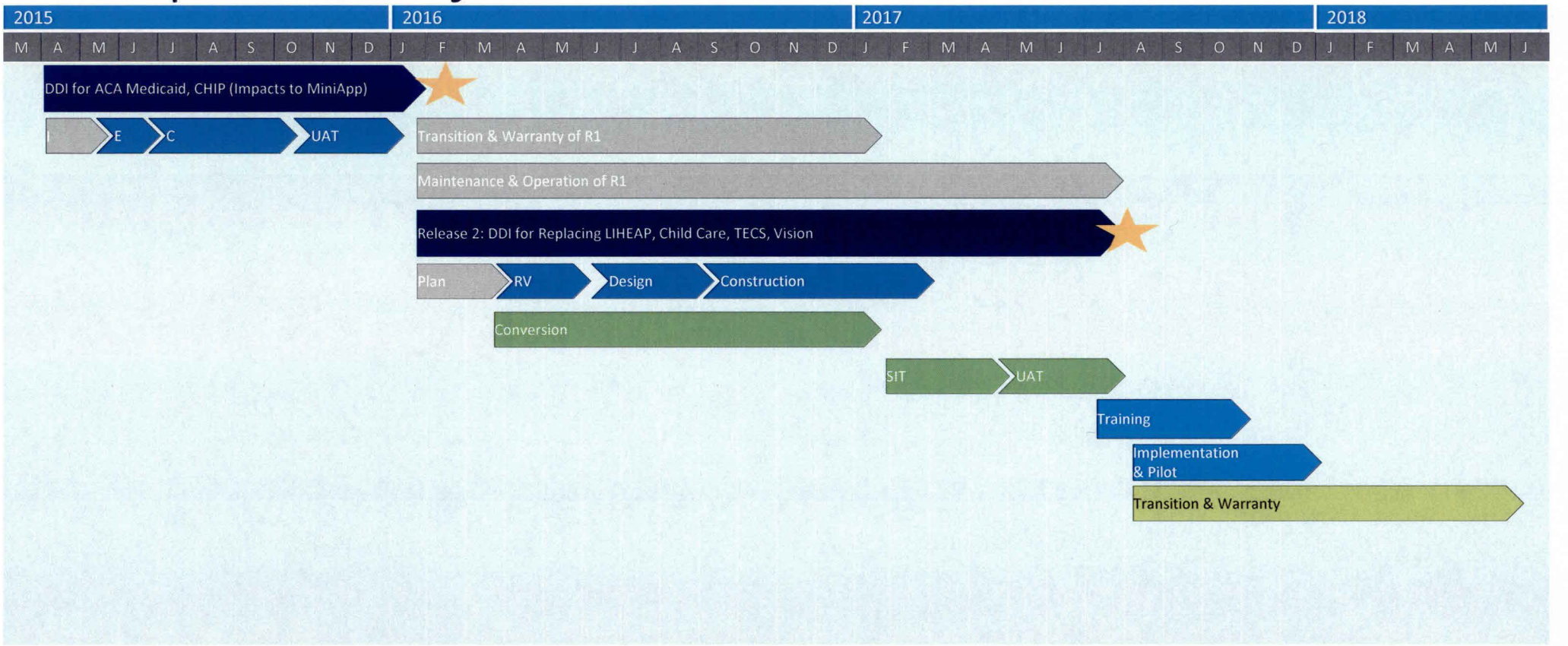
Proposed Project Phases



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Key Objectives

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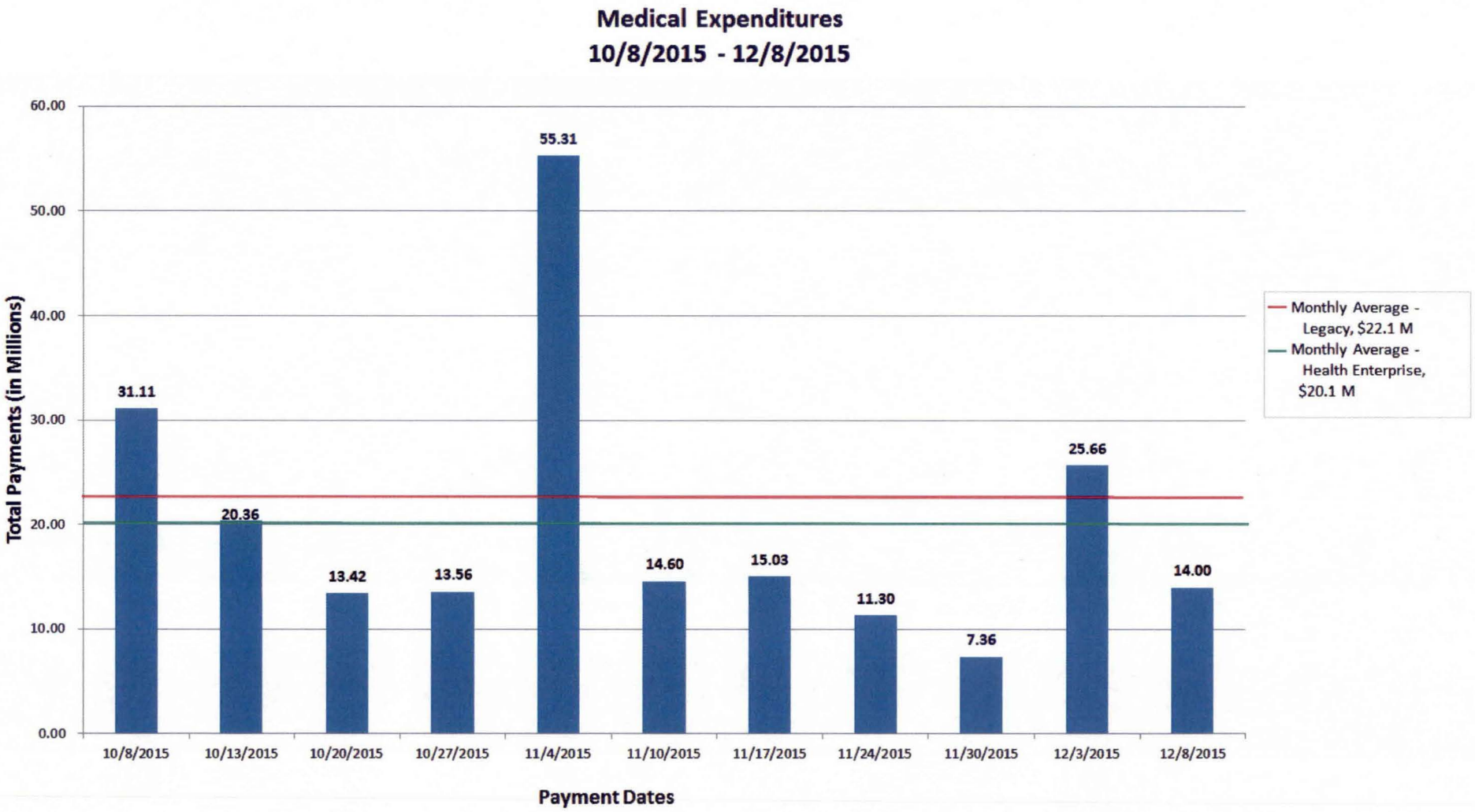
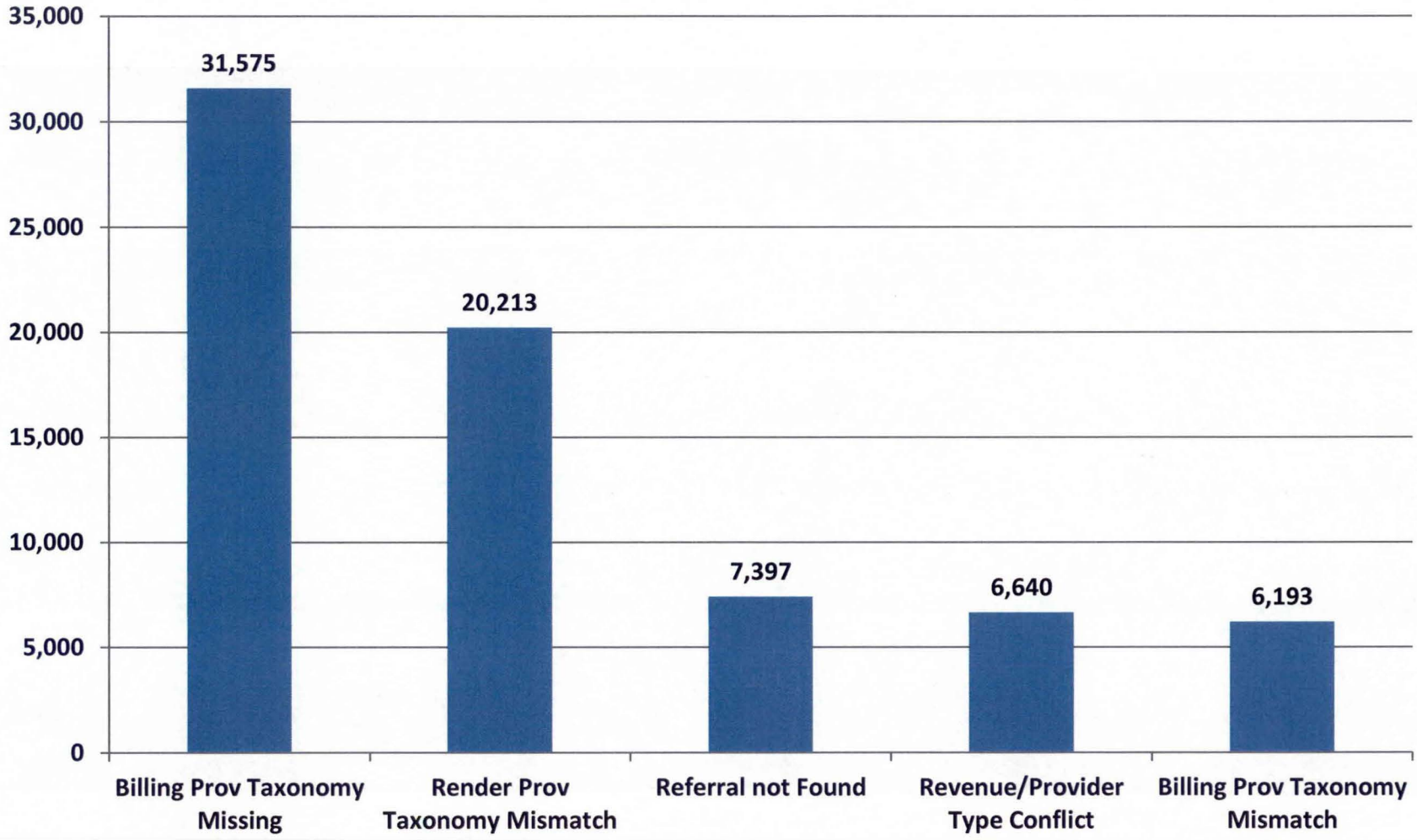
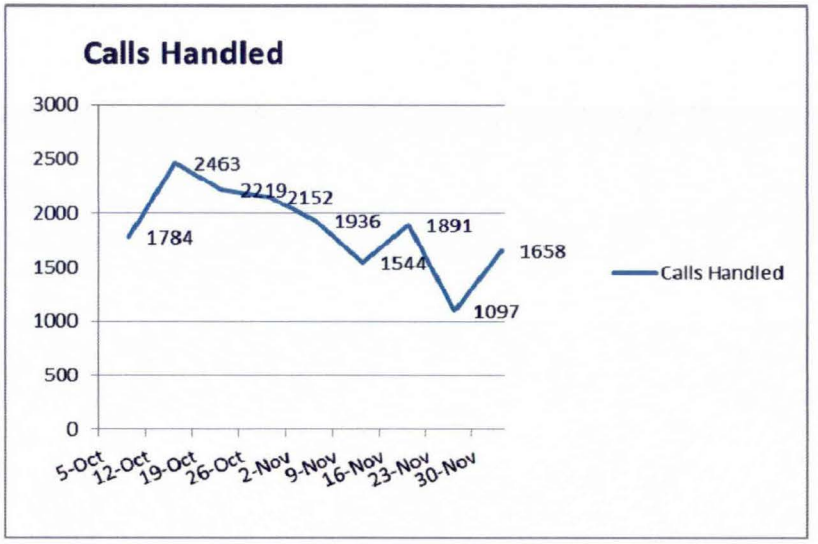
Payment Summary

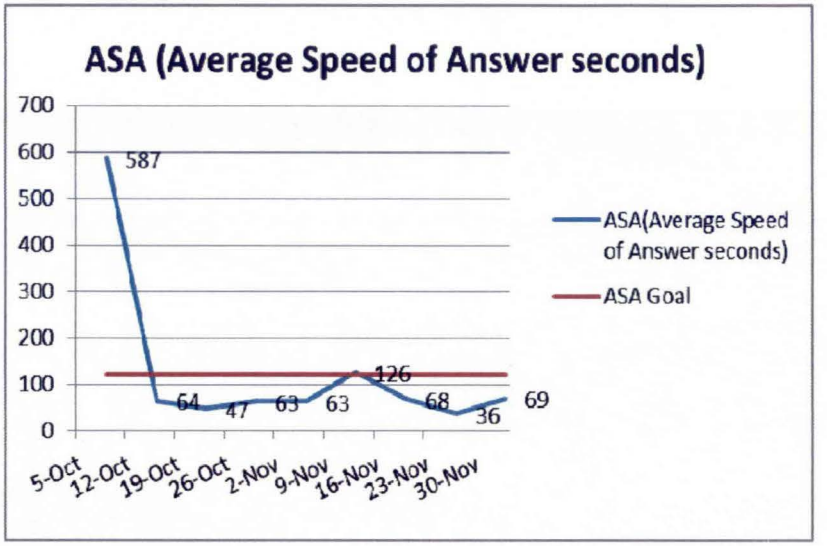


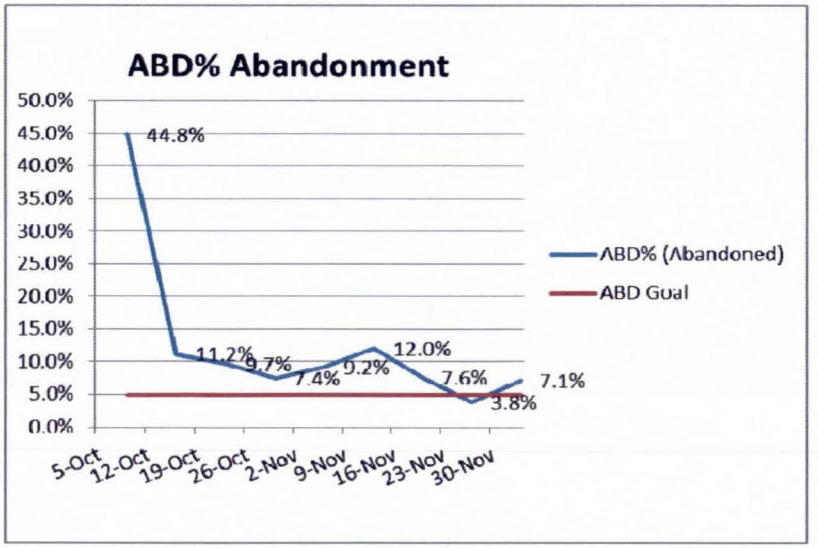
Top 5 Reasons for Denial



Call Center Service Levels







Plan in place to improve overall call Center performance

- State approved call scripts
- Focus on accuracy and quality of responses
- Additional training of call center agents

ITERATIVE PROJECT REPORT FOR PROGRAMS & MULTI-YEAR PHASED PROJECTS

Submitted to Large Project Oversight on 12/14/2015

GENERAL INFORMATION

Program/Project Name: Eligibility System Modernization/SPACES
Agency Name: Department of Human Services (DHS)
Project Sponsor: Carol Cartledge, Brenda Petersen, Jenny Witham
Project Manager: Desi Ottmar

PROJECT DESCRIPTION

The Department of Human Services currently determines eligibility for medical assistance, cash assistance, supplemental nutrition, child care assistance and heating assistance in four separate information systems. Two of these systems will be heavily impacted by the modifications required to comply with the 2010 Patient Protection & Affordable Care Act (ACA). The objective of this project is to replace the current eligibility systems with a single system that will meet the requirements of the ACA as well as streamline the application process for constituents.

BUSINESS NEEDS AND PROBLEMS

A single eligibility system for medical assistance and all economic assistance programs which provides for sharing of information regarding clients interactively amongst its service programs resulting in increased efficiency, ease of use, mobility of the application, and effective reporting for decision making.

- *A client portal to allow for* a "no wrong door" access to apply for services, create an option for clients to view enrollment status, benefit information and view and update case information, and submit electronic correspondence and verifications.
- *A worker portal to allow for* an integrated eligibility worker workflow for case assignments, integrate referrals, notices, alerts and case narratives within the current eligibility systems as appropriate.
- *A provider portal to allow for* the providers to update demographic information and submit payment requests (LIHEAP, Child Care), creation of an option for employment contractors to update demographic information and submit client work activities (TANF, SNAP).

PROJECT FORMAT

Program/Project Start Date: 5/7/2013

Budget Allocation: Phase 1: $45,436,315; Phase 2: $25,000,000; Future Phases: $40,000,000. All Medicaid related and common functionality costs qualify for Federal Financial Participation of 90%; state match of 10%. Approximately 80% of the system build leverages these federal matching funds.

How Many Phases Expected at Time of Initial Start Date: The project will be broken into four or five major iterations, with functionality delivered either into the production environment or a lower level environment where it will be held for final production release.

Phased Approach Description: The ACA functionality will be iteration 1, and will be released immediately upon completion (Release 1). The remaining iterations will include functionality for Medicaid (age, blind, disabled), Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), child care assistance, Basic Care Assistance Program, and Low Income Home Energy Assistance Program (LIHEAP). These subsequent iterations will be released to production at the same time, when all have been completed (Release 2).

ITERATIVE PROJECT REPORT FOR PROGRAMS & MULTI-YEAR PHASED PROJECTS

Submitted to Large Project Oversight on 12/14/2015

Estimated End Date for All Phases Known at Time of Initial Start Date: Between Q4 2017 and Q2 2018

PROJECT ROAD MAP

The project road map shows the high level plan or vision for the program/projects/phases. It is intended to offer a picture of the lifespan of all the effort that is expected to be required to achieve the business objectives.

Project or Phase	Title	Scope Statement	Estimated Duration (months)	Estimated Budget
Iteration 1	ACA/Release 1	This includes business functionality to support the Affordable Care Act.	34.9 months	$45,436,315
Iteration 2	Planning and analysis for Release 2	Requirements Validation for remaining lines of business (that will go into "Release 2"), and finalization of schedules for next iterations.	8 months	$25,000,000
Iterations 3,4,5 …	Release 2	The remaining business functionality for Medicaid (age, blind, disabled), Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), child care assistance, Basic Care Assistance Program, and Low Income Home Energy Assistance Program (LIHEAP) including the construction, system integration testing, user acceptance testing, training, transition and implementation for each. *These iterations will be broken out more specifically in future startup/closeout reports.*	12 to 16 months	$40,000,000

Notes:

PROJECT BASELINES

The baselines below are entered for only those projects or phases that have been planned. At the completion of a project or phase a new planning effort will occur to baseline the next project/phase and any known actual finish dates and costs for completed projects/phases will be recorded. The startup report will be submitted again with the new information.

Project or Phase	Baseline Start Date	Baseline End Date	Baseline Budget	Actual Finish Date	Schedule Variance	Actual Cost	Cost Variance
Iteration 1	5/7/2013	4/4/2016	$45,436,315				

ITERATIVE PROJECT REPORT FOR PROGRAMS & MULTI-YEAR PHASED PROJECTS

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OBJECTIVES

Project or Phase	Business Objective	Measurement Description	Met/ Not Met	Measurement Outcome
Iteration 1	Objective 1.1: Meet federally mandated requirements to integrate with the federal HBE.	Measurement 1.1.1: Successful send and receipt of all defined eligibility transactions from the federal hub and completion of the enrollment and/or reenrollment processes by October 1, 2013.	Met	Currently being met with an approved contingency, and will be modified in future iterations
Iteration 1	Objective 1.2: In order to apply the correct Federal Matching Percentage (FMAP) for Medicaid enrollees, the system must be able to determine upon enrollment whether the individual's authorization was based upon existing eligibility criteria or the criteria created by the ACA.	Measurement 1.2.1: Determine methodology the state will deploy for determining the application of FMAP by December 31, 2012. Measurement 1.2.2: The system is able to correctly report claims payment data by FMAP upon go live	1.2.1 is Met, 1.2.2 is Met	Currently being met with an approved contingency, and will be modified in future iterations
Iteration 1	Objective 1.3: Creation of real-time application process.	Measurement 1.3.1: Public facing application in which the client is capable of completing the application for Medicaid and CHIP online upon go live.		
All iterations	Objective 2.1: Meet the system requirements as outlined in the Centers for Medicare and Medicaid (CMS) Enhanced Funding Requirements: Seven Conditions and Standards (MITS-11-01)	*All of the following measurements must be included in the APD submission, be addressed in the Gate Review for concept of operations, and be present upon project completion:* Measurement 2.1.1: Modularity Standard - This condition requires the use of a modular, flexible approach to systems development, including the use of open interfaces and exposed application programming interfaces (API); the separation of business rules from core programming; and the availability of business rules in both human and machine-readable formats. Including: ▪ Use of Systems Development Lifecycle methodologies. States should use a system development lifecycle (SDLC) methodology for improved efficiency and quality of		

		products and services. ▪ Identification and description of open interfaces: States should emphasize the flexibility of open interfaces and exposed APIs as components for the service layer. ▪ Use of business rules engines. States should ensure the use of business rules engines to separate business rules from core programming, and should provide information about the change control process that will manage development and implementation of business rules. ▪ Submission of business rules to a HHS-designated repository. States should be prepared to submit all their business rules in human-readable form to an HHS repository, which will be made available to other states and to the public. <u>Measurement 2.1.2</u>: MITA Condition - This condition requires states to align to and advance increasingly in MITA maturity for business, architecture, and data. Including: ▪ MITA Self Assessments. CMS expects all states to complete a self-assessment and may wait until version 3.0 is published (expected in 2011). ▪ MITA Roadmaps. States will provide to CMS a MITA Maturity Model Roadmap that addresses goals and objectives, as well as key activities and milestones, covering a 5-year outlook for their proposed MMIS solution, as part of the APD process.		

		▪ Concept of Operations (COO) and Business Process Models (BPM). States should develop a concept of operations and business work flows for the different business functions of the state to advance the alignment of the state's capability maturity with the MITA Maturity Model (MMM). <u>Measurement 2.1.3:</u> Industry Standard condition - States must ensure alignment with, and incorporation of, industry standards: the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security, privacy and transaction standards; accessibility standards established under section 508 of the Rehabilitation Act, or standards that provide greater accessibility for individuals with disabilities, and compliance with federal civil rights laws; standards adopted by the Secretary under section 1104 of the Affordable Care Act; and standards and protocols adopted by the Secretary under section 1561 of the Affordable Care Act. Including: ▪ Identification of industry standards. CMS will communicate applicable standards to states. Standards would be updated periodically to ensure conformance with changes in the industry. ▪ Incorporation of industry standards in requirements, development, and testing phases. States must implement practices and procedures for the system development phases such as requirements analysis, system testing, and user acceptance testing (UAT). <u>Measurement 2.1.4:</u> Leverage Condition - State solutions should		

		promote sharing, leverage, and reuse of Medicaid technologies and systems within and among states. Including: ▪ Multi-state efforts. States should identify any components and solutions that are being developed with the participation of or contribution by other states. ▪ Availability for reuse. States should identify any components and solutions that have high applicability for other reuse by other states, how other states will participate in advising and reviewing these artifacts, and the development and testing path for these solutions and components will promote reuse. ▪ Identification of open source, cloud-based and commercial products. States should pursue a service-based and cloud-first strategy for system development. ▪ Customization. States will identify the degree and amount of customization needed for any transfer solutions, and how such customization will be minimized. ▪ Transition and retirement plans. States should identify existing duplicative system services within the state and seek to eliminate duplicative system services if the work is cost effective such as lower total cost of ownership over the long term. <u>Measurement 2.1.5:</u> Business Results Condition - Systems should support accurate and timely processing of claims (including claims of eligibility), adjudications, and effective communications with providers,		

		beneficiaries, and the public. Including: ▪ Degree of automation. The state should be highly automated in systematic processing of claims (including claims of eligibility) and steps to accept, process, and maintain all adjudicated claims/transactions. ▪ Customer service. States should document how they will produce a 21st-century customer and partner experience for all individuals (applicants, beneficiaries, plans, and providers). ▪ Performance standards and testing. CMS intends to provide additional guidance concerning performance standards—both functional and non-functional, and with respect to service level agreements (SLA) and key performance indicators (KPI). <u>Measurement 2.1.6:</u> Reporting Condition - Solutions should produce transaction data, reports, and performance information that would contribute to program evaluation, continuous improvement in business operations, and transparency and accountability. <u>Measurement 2.1.7:</u> Interoperability Condition - Systems must ensure seamless coordination and integration with the Exchange (whether run by the state or federal government), and allow interoperability with health information exchanges, public health agencies, human services programs, and community organizations providing outreach and enrollment assistance services. Including: ▪ Interactions with the Exchange. States should ensure that open interfaces		

		are established and maintained with any federal data services hub and that requests to the hub are prepared and available for submission immediately after successful completion of the application for eligibility. ▪ Interactions with other entities. States should consult with and discuss how the proposed systems development path will support interoperability with health information exchanges, public health agencies, and human services programs to promote effective customer service and better clinical management and health services to beneficiaries. Measurement 2.1.8: A state self-assessment will be completed after the release of the final MITA 3.0 guidelines.		
All iterations	Objective 3.1: Increase efficiency in application processing for each program.	Measurement 3.1.1: Reduction in the meantime from which an application is received until the application is authorized. The mean time and expected reduction for each program will be identified during the project and met within six months of go live for that program. Measurement 3.1.2: Utilization of online reauthorization at go-live.		
All iterations	Objective 3.2: The system is user friendly.	Measurement 3.2.1: Conduct survey of Eligibility workers within three months of application roll-out with a 90% approval rating. Measurement 3.2.1: Request online customer feedback at end of application process with a 90% approval rating for six months post implementation.		
All iterations	Objective 3.3: Web based application is accessible from any location using multiple devices types	Measurement 3.3.1: Successful application access and interaction through identified devices during acceptance testing.		

	including PCs, smartphones, and tablets.			
All iterations	Objective 3.4: Application will include business intelligence features which allows for tracking in real-time key performance measures as well as long term trending via data warehouse solution.	Measurement 3.4.1: Key performance measures are captured during requirements gathering and demonstration of functionality confirmed during user acceptance testing. Measurement 3.4.2: Project will include data extraction, transfer, and load to external data store with business intelligence functionality which will allow stakeholders to query and generate ad hoc reports.		

POST-IMPLEMENTATION REPORT

Post-Implementation Reports are to be performed after each project or phase is completed. A "PIR" is a process that utilizes surveys and meetings to determine what happened in the project/phase and identify actions for improvement going forward. Typical PIR findings include, "What did we do well?" "What did we learn?" "What should we do differently next time?"

Project or Phase	Lesson learned, success story, idea for next time, etc.

COST BENEFIT ANALYSIS

- Currently DHS utilizes separate eligibility systems for Medicaid/CHIP and the various economic assistance programs (EAP). The EAP programs include Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Basic Care, Child Care and Low Income Heat Assistance Program (LIHEAP). The current systems are based on architecture and technology that are being retired by the Information Technology Department (ITD) due to limited resources available with appropriate knowledge to maintain these systems. The current architecture makes interoperability difficult between eligibility programs.
- The objective of this project is to replace our current eligibility systems with a single system that will meet the requirements of the ACA as well as streamline the application process for our constituents.

KEY CONSTRAINTS AND/OR RISKS

Constraints:

The project has the following constraints:

- Availability of technical standards for ACA requirements, such as specifications for interfacing with the federal data hub and the federal exchange.
- Cost, schedule, scope, and quality are often in conflict during projects. The governing committee elected to prioritize as follows:
    1. Schedule

2. Quality
3. Cost
4. Scope

Risks of Performing the Project:

Risk: Limited resources to complete the project.

Impact: Staff from both DHS and ITD may need to have work reassigned. DHS will need to augment staff by hiring contractors.

Risk: Federal regulation change.

Impact: Additional scope will impact both cost and schedule.

Risk: Interfaces with federal and state systems.

Impact: Dependencies will exist regarding sharing information to and from external systems. The degree that the project team can control the interfaces to these systems is a risk to the project.

Risks of Not Performing the Project:

Risk: DHS would need to incorporate new eligibility rules for Medicaid under ACA into the Legacy eligibility systems. Current systems do not have the capability of a real-time application process.

Impact: Inefficient usage of state resources would be expended on new functionality using an outdated technology platform.

Impact: Lose ability to take advantage of federal 90/10 funding match.

Risk: Legacy Medicaid and CHIP eligibility systems would have limited ability to interact with the federally facilitated exchange due to its outdated technology platform.

Impact: The public would not have access to apply for assistance electronically. The state has the potential to be out of compliance.

Risk: Inefficient county worker operations for eligibility determination.

Impact: Would require the continued use of multiple eligibility determination systems.

Impact: Existing processes and maintenance activities remain antiquated.