A basic shift in Medicaid payment models requires a shift in the MMIS focus.

States share similar objectives for moving away from the traditional fee-for-service payment model:

- Evolving MMIS Systems to support
  - Improve Health Outcomes
  - Provide Quality Health Care
  - Control Medicaid Program Costs

MMIS

- Improve Health
- Control Costs
- Quality Care
MMIS Background

- Most MMIS need to change to support payment models made possible or required by the Affordable Care Act.
- The MMIS and related components is often the most costly IT project in many state government budgets.
- The MMIS traditionally has a very long, expensive and high risk development process, yet with these changes has or may soon have incomplete program support functionality and data reporting components.
- The System infrastructure for the most part is not contemporary technology and is very expensive to modify.
- Therefore time, money and change risk make many of the present MMIS unsustainable in the future because as payment models change many systems may become largely irrelevant in supporting Medicaid Program operations.
What is going on with the MMIS Today

- In the past 18 months 453 MMIS (includes some multiple iterations) change actions have been received by CMS
- Requests are from all 50 states, the DC and two Territories, VI and PR.
- Project costs are estimated at $3.9B
- Project completion dates range from today to 6/30/2021
- Therefore - 100% is estimated percentage of MMIS which are missing necessary/required functionality to support management e.g. of missing functions/data - encounters, program data for program management and oversight
MMIS Today

- National expenditures for the MMIS are approximately $2.4B
- 116 MMIS funding requests Q1+Q2 FY12
- 172 MMIS Funding requests Q1+Q2 FY13
- Average cost per MMIS action Q1+Q2 FY12 was $12.8 M
- Average cost per MMIS action Q1+Q2 FY 13 was $12.5M

Trend is a 33% increase in activity with a 2% decrease in average costs. More, but smaller incremental changes.
Why concern ourselves with the MMIS?

• In 2010, Medicaid covered nearly 53 million people and accounted for 16% of all health care spending. Single largest coverage source for nursing home care, childbirth, and people with HIV/AIDS. *And ACA expands coverage.*
  o Children – currently 1 out of 4 covered by Medicaid. They comprise most beneficiaries, but only 20% of spending.
  o Elderly and people with disabilities – 18% of beneficiaries, but 66% of spending.

• What does the MMIS have to do with Medicaid?
  o The MMIS is the key system for processing Medicaid claims from providers for the medical care and services furnished to beneficiaries; also produces service utilization & management information required for program administration & auditing.
  o *The MMIS is vital* to provider payment streams, beneficiary access to services, and program management by states and feds.
Future Vision for Development
-Innovation is Key-

• To you, the audience: In the MMIS life cycle, what are the barriers to innovation?

• During which MMIS stages can we incorporate innovation - development, implementation, approval, maintenance, or re-procurement? What would be some key features of innovation?

• CMS is making equal investments in E&E, and even more in HITECH to try to achieve greater efficiencies in the system overall through better information exchange. We are looking to ourselves, states and vendors to innovate in managing all of these IT investments, as well as more effectively manage program needs and project risks.
- Innovation is **Necessary** -

• MMIS replacement projects are too often **over budget** and **behind schedule**.

• Other potential consequences of underperforming MMIS projects include:
  - Technology that’s no longer “state-of-the-art” by the time it’s operational
  - CMS certification reviews get complicated / enhanced funding gets delayed
  - Medicaid Agency’s business user needs not met
  - Harm to provider relations; disruption to beneficiary services

• Recent Federal and state health care and health IT initiatives can further challenge MMIS project efficiency
  - MMIS projects compete with other IT projects for state dollars and resources
## MITA 3.0 and 7 Standards and Conditions – Frameworks to Facilitate Innovation

<table>
<thead>
<tr>
<th>Legacy MMIS</th>
<th>MMIS under MITA 3.0 / 7 S&amp;Cs</th>
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<tbody>
<tr>
<td>Designed to <em>last</em></td>
<td>Designed to <em>change</em></td>
</tr>
<tr>
<td><em>Tightly</em> coupled</td>
<td><em>Loosely</em> coupled, agile and adaptive</td>
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<tr>
<td>Integrated <em>silos</em></td>
<td>Composed of <em>services</em></td>
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<tr>
<td><em>Code</em> oriented</td>
<td><em>Process</em> oriented</td>
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<td><em>Long</em> development cycle</td>
<td><em>Interactive &amp; iterative</em> development</td>
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<tr>
<td><em>Cost</em> centered</td>
<td><em>Business</em> centered</td>
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<tr>
<td>Favor <em>homogeneous</em> technology</td>
<td>Favors <em>heterogeneous</em> technology</td>
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</tbody>
</table>
There is no Big Bang method to achieve the solution

To lower cost, reduce risk and speed development - some ideas for an incremental path to change

- Multi-state collaboration to share costs
- Re-use of components
- COTS products
- Open source software
- Common components
- Modularity in design
- Plug and play framework
- Out-sourcing
- Incremental development
- Predictive Analytics Projects
- MMIS solutions which serve multiple state health and human services programs
One Approach

Michigan and Illinois reuse/collaboration
a case study – in the works

Stephen DePooter, CIO IL Medicaid

Karen Parker, Director of the Bureau of Medicaid
Financial Management & Administrative Services within
the Michigan Medicaid Agency.

Presentation - audience Q&A
Another Wrinkle: The Move to Managed Care-Centric Medicaid Programs

- Current MMIS projects built around a Fee-For-Service focus underperform (*we get that*)
- But what happens when States move to managed care-centric Medicaid Programs?
  - Many States are making or have made this transition (74% of covered Medicaid lives in some form of managed care in 2011)
  - The MMIS must make the transition, too - from a system built around claims adjudication to one that performs analytics and can be used to manage Medicaid population health outcomes
  - How should this MMIS transformation occur?
A New Tool for Guidance
A collaborative approach between CMS, States and the private sector

States share similar objectives for moving away from the traditional fee-for-service payment model:

• Evolving MMIS Systems
• Improve Health Outcomes
• Provide Quality Health Care
• Control Medicaid Program Costs
Summary of Considerations when Evolving Systems to Support a Managed Care Payment Model

*Basis for Considerations:*

- Are there better ways to implement solutions on time and on budget, while at the same time improving the “time to market”?
- What essential functionality that states need to support MCO programs to manage them effectively?
- What are the lessons learned – what are the “gotcha’s” from vendor’s perspectives in working with states?
- What follows is what the PSTG thinks.
Summary of Considerations for Transitioning to Managed Care

Private Sector Technology Group (PSTG) is an organization comprised of vendors serving federal and state governments.

**MMIS Questions for the FFS to Managed Care Transition:**

- Are there better ways of doing procurements?
- Are there better ways to implement solutions on time and on budget, while at the same time improving the “time to market” for new/innovative solutions?
- What are the components or modules (available in the market) that need to be considered by the state to support a move to managed care? What is essential functionality that states need to support MCO/ACO programs to manage them effectively?
- What are the lessons learned – what are the gotcha’s; from the PSTG perspective in working with states?
- How can CMS modernize the procurement process to align with current technology initiatives, improve speed to market, and control project costs?
Eligibility and Enrollment:

- Centralize Enrollment Broker Services – Manage recipient selection and enrollment in MCOs through a centralized Enrollment Broker who manages:
  - Communications and notices to recipients,
  - MCO selections,
  - Auto-enrollments and dis-enrollments, and
  - Call center services.
Program Administration:

• Require MCOs to use national standards and billing procedures to submit encounter claims data.

• Consider deploying modules and mobile applications.

• Centralize administrative services – provider enrollment, provider credentialing, and claims clearing houses.

• Establish Service Level Agreements (SLAs) metrics to manage performance outcomes

• Utilize national standards to measure quality of MCOs and report performance information publicly

• Promote and implement payment reform for Managed Care / By Model (MCO, ACO, Patient Centered Medical Home)
PSTG Recommendations for Transitioning to Managed Care

Business Intelligence and Data Analytics:

• Develop monitoring reports for all SLAs to measure actual performance against performance targets
• Use national quality metrics to measure program performance against regional and national benchmarks
• Establish a robust Program Integrity Review process
• Evaluate and monitor network sufficiency and health plan performance using geospatial and geographical data
• Consider All Payer Claims Database analysis and functionality through integration with State’s Health Insurance Marketplaces and Health Information Exchanges
PSTG White Paper and Managed Care Toolkit:

• *Modernizing Medicaid: Technology Considerations for Moving from Fee for Service to a Managed Care Payment Model*
  - Includes recommendations for CMS and states to improve the procurement process for Technology and Services
• *Modernizing Medicaid: Medicaid Managed Care Program and Technology Toolkit*
  - Provides a detailed checklist by business process of policy and technology considerations to assist states in implementing technology to support a Managed Care payment model

*Both are available at [www.PSTG.org](http://www.PSTG.org)*
Recommendations for the MMIS Transition to Managed Care

• Your thoughts and considerations?
Discussion

Panel and Audience

Ideas? Comments!