Medicaid Information Technology Replacement

Medicaid Management Information System (MMIS): Information technology system that supports Medicaid claims processing and other health plan operations – claims processing, management of enrolled providers, managed care assignment and processing, prior authorization, member eligibility, payment rates, etc.

- Mainframe system that is over 35 years old. Original system from the 1970s. Maintained and upgraded over time.
- Supports processing of over 23 million claims per year, 450,000 members, and over 38,000 providers.
- System constraints:
  - Batch, nightly processing (not real time)
  - Implementing changes is costly and time consuming
  - Structure is inflexible and it is difficult to implement needed changes efficiently and to process accurately
  - Structure is not set up to support the complexity of today's claims processing requirements
  - All changes require COBOL programmers
  - Claims processing changes/policy changes take many hours of programming to implement and often cannot be implemented in a way that precisely meets regulations, or may cause processing errors for providers that regularly require providers to resubmit claims multiple times in order to be paid.

System cannot meet new mandates

**The Health Care Reform law is a contributor, but the need to replace is driven more by other factors.*

- **5010/ICD-10 –** new world-wide HIPAA claims transaction/coding requirements
  - International Classification of Diseases (ICD-10) – New coding scheme for diagnosis. Federal mandate for all payors and all providers to implement October 1, 2013.
  - Number of codes increasing from 14,000 codes to 69,000
  - Procedure coding system increase from 3,800 to 72,000
  - Impact is tremendous change in all of the underlying codes and rules for claims processing
  - Pros: huge increase in health care data that can be used for utilization and health management of members, if you can take advantage of it
  - Cons: Not possible to implement in cost-effective manner in current system
- **New proposed federal regulations issued in November 2010**
  - CMS established new requirements for MMIS systems – system architecture and functionality
  - States required to meet new requirements within set timeframes or risk losing enhanced federal match for MMIS
- **Health Care Reform Activities**
  - Affordable Care Act - Medicaid enrollment increase of 25%

- Affordable Care Act - Design and payment of new benefit structure
- Other "health care reform" opportunities for strategies such as Health Information Technology, Medical Home, payment reform, health quality and transparency reporting, and Accountable Care Organizations.
- Current MMIS will be huge barrier to being able to implementing these strategies that have potential to contain costs.

Iowa can no longer delay replacement

- Federal match rate of 90% for new system implementation costs.
- Iowa contracts with a private-sector vendor for MMIS operations and claims processing – will issue competitive procurement for a vendor to bring a new system that meets requirements
- Contract with MMIS consulting firm to assist in analysis of options, cost estimates and analysis of other states' activities, and RFP development
- Total Estimated cost: $100.9 million over multi-year time frame. State share 10%. Includes costs for new system ($77 million) and for 5010/ICD-10 ($23.9 million).

	Estimated State Share	Total Funds (State & Federal)
FY 2012	$2,494,200	$24.0M
FY 2013	$3,667,600	$36.0M
FY 2014	$3,267,600	$32.0M
FY 2015	$1,945,700	$19.0 M

- *One-time funds set aside for health care transformation activities are available for the entire multi-year project*. *Good use of one-time funds for one-time costs*.
- Project is funded in Governor's FY 2012 budget recommendation

Benefits to Medicaid members: Access to explanation of benefits for each claim, wellness information, personalized alerts and reminders for healthier outcomes, management of patient centered care management and medical home assignments.

Benefits to Medicaid providers: Real-time claim processing to get immediate feedback on payment, more transparency in claims processing rules to improve payment accuracy, connection to the Health Information Exchange to avoid the need for faxing and mailing copious information to Medicaid, expanded functionality to support on-line/web-based tasks for providers to reduce paperwork and improve communication.

Benefits to Policymakers and the State of Iowa: Rapid, accurate implementation of policy changes, increased granularity to ensure best pricing decisions, compliance with federal requirements, improved security to comply with HIPAA, improved data for population health management, quality outcomes, predictive modeling and program integrity.

Eligibility System Replacement

Iowa Automated Benefits Calculation (IABC) System: Medicaid eligibility is performed as part of DHS's comprehensive eligibility system, known as the Iowa Automated Benefits Calculation (IABC) system. IABC supports eligibility determination for multiple DHS programs, including Medicaid, Family Investment Program (FIP), Food Assistance, and Child Care.

- Mainframe system that is over 35 years old. Original system from the 1970s. Maintained and upgraded over time.
- For the month of November 2010, IABC determined eligibility for and issued the following benefits:
  - FIP: 17,056 households, 44,541 recipients - $5,780,411 in payments
  - Food Assistance : 163,055 households, 351,898 recipients - $45,669,864 in allotments
  - Medicaid: 459,879 Medicaid recipients determined eligible for November
- System constraints:
  - Implementing changes is costly and time consuming
  - Structure is inflexible and it is difficult to implement needed changes efficiently and to process accurately
  - All changes require COBOL programmers
  - All policy changes take many hours of programming to implement and often cannot be implemented in a way that precisely meets regulations, or to allow workers to do their jobs efficiently.
  - Much of the work remains manual and labor intensive

System cannot meet new mandates -- Federal Health Care Reform

- The changes mandated by the Affordable Care Act cannot be met with the current system.
  - The system and processes are too labor intensive to accommodate the 80,000-100,000 new Medicaid members that will need to be enrolled in a time span of a few months.
  - Changes to income standards and processes are too significant for the old system to be modified to comply.
  - Expectation for integration with the Health Benefits Exchange and web-based functionality cannot be met in the current system.
  - DHS will likely need to not only replace eligibility IT, but also dramatically restructure how eligibility is processed to meet the new requirements and volume.

Tax credit eligibility in the Health Benefits Exchange and Medicaid eligibility must be aligned so that Iowans will be able to move 'seamlessly' between Medicaid, CHIP, and the tax credits

- Eligibility functions in ACA:
  - Medicaid agency – Medicaid and CHIP eligibility
  - Exchange - Eligibility for tax credits that will subsidize purchase of insurance
- Eligibility Gateway: ACA requires integration of eligibility and enrollment between Medicaid and the Exchange
  - Common web-based application for Medicaid, CHIP, tax credits

    - Exchange must screen applicants for Medicaid and CHIP and Medicaid/CHIP must accept referral without further review
    - Medicaid must ensure referral to exchange for those found ineligible for Medicaid and CHIP
    - Many people will move back and forth between Medicaid and tax credits
    - Requirement for 'seamlessness' in moving among programs
- Need for high degree of coordination and collaboration in operational planning between Medicaid and Exchange
- System planning needs to address:
    - IT solutions for Medicaid/CHIP eligibility
    - IT solutions for tax credit eligibility
    - The income standards are intended to be the same – tax credits will follow directly above Medicaid
    - Must be "seamless"
- Strategy: Implement new eligibility system that will be able to support Medicaid, CHIP and the tax credit eligibility

Total Estimated Cost (ballpark): $30 million over three years.

- Federal match rate may be 90% for Medicaid related costs. We know some costs will be at the 50% match rate.
- Currently researching the best strategy for how and how much to replace, and over what time period.
- Estimated state funds need of between $3 million and $8 million.
- Request for FY 12, $1 million state funds.
- One-time funds available for the state share. $1 million is included in the Governor's FY 2012 budget recommendation.