

## Medicaid Management Information System (MMIS) Program

The Medicaid Management Information System (MMIS) Program is a core solution under the HSE. The MMIS Program, with resulting solutions, will align with new Federal and State regulations stemming from the Federal Affordable Care Act and Vermont's Act 48. Vermont has undertaken an aggressive initiative to overhaul health care; dramatically changing health care facilitation, funding, and processes. The current MMIS relies on data that is inefficiently stored and retrieved, and is unable to establish a member-centric view across the range of services provided; this lack of interoperability allows for a silo approach to Medicaid programs and member management. Shortcomings in data management create limitations to for staff when it comes to managing Fraud, Waste, and Abuse cases. The new MMIS will rely on a Service Oriented Architecture (SOA), creating a configurable, interoperable system that will be compliant with the Centers for Medicare and Medicaid Services (CMS) Seven Standards and Conditions.

The new MMIS will be a contemporary SOA-based system that efficiently and securely shares appropriate data with Vermont agencies, providers, and other stakeholders involved in a members' case/care. Vermont's new MMIS solution will:

- Align with the Triple Aim
  - Improving the patient experience of care (including quality and satisfaction)
  - Improving the health of populations, and
  - Reducing the per capita cost of health care
- Improve the customer service experience for Vermonters
- Improve the customer service experience for health and human services providers
- Improve efficiency and effectiveness of Medicaid operations

Multiple procurements comprise the MMIS Program:

- Pharmacy Benefit Management Solution (PBM)
  - The new PBM contract with Goold Health Systems (GHS) was effective May 2014; the design, development and implementation (DDI) period is expected to end December 31, 2014. The new PBM will:
    - Have an improved Point of Sale Processing functionality
    - Provide rebate management with one source of data
    - Maintain the lowest cost possible on pharmaceuticals
- Care Management Solution
  - The Care Management Solution will replace the current vendor contract and will support the work of the Vermont Chronic Care Initiative (VCCI) clinicians in the field and lead to expanded care management efforts across the AHS. It is envisioned that the solution will ultimately have the ability to:
    - Identify members who will benefit from care management intervention and education across AHS programs
    - Track member progress over time and focus on prevention, health and wellness
    - Use data for quality improvement efforts and manage chronic conditions and service delivery

- Core and Contact Center Solution(s)
  - The Core and the Contact Center Solution(s) have different implementation schedules.
  - The new Solution will be CMS certified and MITA compliant, and will provide:
    - Member inquiry support
    - Contact Center functionality for both members and providers
    - The ability to accept requests for grievances and appeals
    - The ability to capture member inquiries and activities
    - Member and Provider outreach and education materials
    - Enhanced Provider Enrollment functionality
    - Support for Members with utilization of benefits
    - Support with non-emergent transportation
  
- Specialized Program Projects
  - The AHS is committed to developing uniform reporting requirements, funding streams, reimbursement rates, provider qualifications, and business processes for specialized programs via the HSE that supports state and federal reform initiatives. Currently, several different specialized systems of care operate with different state and federal reporting requirements, funding streams, reimbursement rates, provider qualifications and data systems; this is costly and inefficient, and detracts from the person-centric model of practice. This initiative provides an opportunity to streamline and standardize reporting requirements, funding streams, reimbursement rates, and provider qualifications.
  
- Independent Verification and Validation (IV&V)
  - The Vendor must provide an independent, detailed review of MMIS deliverables to assess the quality, alignment with objectives, fidelity to State and Federal requirements, adherence to the plan and other criteria yet to be defined. Assessment of compliance to CMS certification criteria documented in the Medicaid Enterprise Certification Toolkit (MECT) checklists is a critical component of the deliverable review process.