Project Startup Report

Presented to the IT Committee April 15, 2011

Project Name: 5010 Legacy

Agency: Department of Human Services (DHS)

Business Unit/Program Area: Medical Services

Project Sponsor: Doug McCrory

Project Manager: Beverly Maitland

Project Description

The Centers for Medicare and Medicaid Services (CMS) is underway with implementation activities to convert from Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12 version 4010A1 to ASC X12 version 5010 and National Council for Prescription Drug Programs (NCPDP) version 5.1 to NCPDP version D.0.

The Secretary of the Department of Health and Human Services (HHS) has adopted ASC X12 version 5010 and NCPDP version D.0 as the next HIPAA standard for HIPAA covered transactions. The final rule was published on January 16, 2009. Some of the important dates in the implementation process are:

Effective Date of the regulation: March 17, 2009
Level I Compliance by: December 31, 2010
Level II Compliance by: December 31, 2011
All covered entities have to be fully compliant on: January 1, 2012

Level I compliance means "that a covered entity can demonstrably create and receive compliant transactions, resulting from the compliance of all design/build activities and internal testing."

Level II compliance means "that a covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards."

HHS permits dual use of existing standards (4010A1 and 5.1) and the new standards (5010 and D.0) from the March 17, 2009, effective date until the January 1, 2012 compliance date to facilitate testing subject to trading partner agreement.

The CMS Medicare Fee-for-Service schedule is:
Level I April 1, 2010 through December 31, 2010
Level II January 1, 2011 through December 31, 2011
Fully compliant on January 1, 2012

- Centers for Medicare and Medicaid Services, Electronic Billing & EDI Transactions, 5010-D.0, Retrieved August 1, 2010, from the World Wide Web:http://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp

The Department of Human Services Medicaid Management Information System (MMIS) is currently unable to successfully create and submit a HIPAA Health Care Claim Payment / Advice, an 835 transaction.

This project is for the North Dakota Department of Human Services, Medical Services Division's Medicaid Management Information System (MMIS) and the Point of Sale System to be enhanced to meet CMS's Level I compliancy.

Level II compliance will be achieved utilizing the existing processes for adding a new trading partner or updating an existing trading partner agreement.

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Business Needs and Problems
The North Dakota Department of Human Services Medicaid Management Information System and the pharmacy Point of Sale System currently are not 5010 and D.0 compliant, respectively. MMIS is also not HIPAA compliant, in that it cannot successfully create the 835 transaction.

Key Metrics		
Project Start Date	Project End Date	Original Baseline Budget
07/06/2010	07/11/2011	$1,232,462

Objectives	
Project Objectives	**Measurement Description**
To meet the CMS Level II compliancy date of 12/31/2011 for the 837P – Health Care Claim Professional Transaction.	**Measurement:** Able to receive the 837P – Health Care Claim Professional Transaction in the CMS 5010 format by 12/31/2011.
To meet the CMS Level II compliancy date of 12/31/2011 for the 837I – Health Care Claim Institutional Transaction.	**Measurement:** Able to receive the 837I – Health Care Claim Institutional Transaction in the CMS 5010 format by 12/31/2011.
To meet the CMS Level II compliancy date of 12/31/2011 for the 837D – Health Care Claim Dental Transaction.	**Measurement:** Able to receive the 837D – Health Care Claim Dental Transaction in the CMS 5010 format by 12/31/2011.
To meet the CMS Level II compliancy date of 12/31/2011 for the 270 – Health Care Eligibility Benefit Inquiry Transaction.	**Measurement:** Able to receive the 270 – Health Care Eligibility Benefit Inquiry Transaction in the CMS 5010 format 12/31/2011.
To meet the CMS Level II compliancy date of 12/31/2011 for the 271 – Health Care Eligibility Benefit Response Transaction.	**Measurement:** Able to send the 271 – Health Care Eligibility Benefit Response Transaction in the CMS 5010 format by 12/31/2011.
To be CMS Level II compliant by the date of 12/31/2011 for the 276 – Health Care Claim Status Request Transaction.	**Measurement:** Able to receive the 276 – Health Care Claim Status Request Transaction in the CMS 5010 format by 12/31/2011.
To be CMS Level II compliant by the date of 4/30/2011 for the 277 – Health Care Claim Status Response Transaction.	**Measurement:** Able to send the 277 – Health Care Claim Status Response Transaction in the CMS 5010 format by 12/31/2011.
To be CMS Level II compliant by the date of 12/31/2011 for the 278(I) – HealthCare Services Review Request for Review Transaction.	**Measurement:** Able to receive the 278(I) – Health Care Services Review Request for Review Transaction in the CMS 5010 format by 12/31/2011.
To be CMS Level II compliant by the date of 12/31/2011 for the 278(O) – HealthCare Services Review Request for Response Transaction.	**Measurement:** Able to receive the 278(O) – Health Care Services Review Request for Response Transaction in the CMS 5010 format by 12/31/2011.
To be CMS Level II compliant by the date of 12/31/2011 for the 834 – Benefit Enrollment and Maintenance Transaction.	**Measurement:** Able to receive the 834 – Benefit Enrollment and Maintenance Transaction in the CMS 5010 format by 12/31/2011.
To be CMS Level II compliant by the date of 12/31/2011 for the 835(I) – Health Care Claim Payment Transaction.	**Measurement:** Able to receive the 835(I) – Health Care Claim Payment Transaction in the CMS 5010 format by 12/31/2011.

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Cost/Benefit Analysis

The anticipated benefit is to meet federal compliancy.

There is no direct anticipated cost benefits associated with this project; it must be completed to maintain the CMS mandated Electronic Data Interchange compliancy. Implementing 5010- and the ability to create an 835 transaction will keep the State in compliance with federal regulations and keep the State from being at risk for loss of federal funding.

An Implementation Advanced Planning Document has been verbally approved by CMS with most of the funding at a 90% FFP. A formal written approval is expected within the next few weeks.

Key Constraints or Risks

The project has the following constraints:

1. The CMS Medicare Fee-for-Service schedule for Level II compliancy by December 31, 2011.
2. Cost, Schedule, Scope and Quality are often in conflict during projects. The Sponsor elected to prioritize as follows:
    - Schedule
    - Scope
    - Quality
    - Cost