

State Agency – Project Status Report



Reporting Period Ending on September 30, 2015

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	0.1	08/30/2013	John Evans	Initial Version.

Projects Status

The projects depicted below represent changes that potentially impact State Agencies:

1. **Project/Change Order:** Affordable Care Act (ACA) Operating Rules – Phase III

1.1 Overview: Phase III Operating Rules apply to Claim Payment/Advice (835) transactions, Electronic Funds Transfer (EFT), and Electronic Remittance Advice (ERA) data. Phase III continues to build on the Phase I and II rules. Phase III is made up of the following rules:

Rule 350 – 835 Retrieval

Enhances Phase II by adding an additional transaction for 835 data file retrieval and addresses dual delivery of 835 and Proprietary Paper Claim Remittance Advices.

An additional requirement added by the Agency will require 835s (Electronic Remittance Advice – ERA) to be generated for every provider. Therefore, every provider, or their designated representative, will need to register for a trading partner ID so that ERAs can be produced and distributed appropriately.

Rule 360 - Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC)

Dictates the combination of codes that can be used for certain business scenarios. Working with their members and other large healthcare systems, CAQH CORE defined four common business scenarios that impact claim payment and processing. For each of these scenarios, CAQH CORE defined specific code combinations that **MUST** be used by Healthcare Systems on the v5010 X12 835 electronic RA. Business scenarios that are encountered beyond these four are left to the discretion of the Healthcare System to determine the code combination to use.

Rule 370 – EFT and ERA Re-association Rule (CCD+/835)

Standardizes the Re-association Data by specifying the location where the data should be stored in both the CCD+ EFT transaction and the 835 ERA transaction. Specifically, Re-association Data is to be placed in the:

- Addenda Record for the CCD+ transaction
- BPR and TRN Segments of the 835 Transaction

Rule 370 additionally specifies:

- The maximum allowed lag time between receipt of an ERA and its corresponding EFT
- Requirements for elapsed time auditing
- Requirements for resolving late or missing EFTs and/or ERAs

Rule 380-382 - ERA/EFT Enrollment

- Rule specifies the maximum data that may be collected to enroll a provider or trading partner for receiving an Electronic RA (ERA/835) or payments via EFT
- Only data elements specified by the rule may be collected.
- The rule specifies the names of the all data elements. These names must be used exactly on paper or electronic enrollment forms.
- The data elements must be presented in a specific order on paper or electronic forms.
- The rules specify which data elements are mandatory and which are optional.
- Related data elements are put into Data Element Groups. The groups must also be presented in a specific order and may be either mandatory or optional.
- The data elements and data element groups are similar, but not identical, for the two rules.

- **Current Status:**

The project is fully implemented. One VAN has not yet moved to Safe Harbor for 270/271 (eligibility) and 276/277 (claims status) transaction processing. Once this VAN completes testing, HPES will finalize the closure of VAN ports and they will all be submitting these transactions purely via Safe Harbor. All Phase III Safe Harbor changes have been completed and verified – including archive processing.

1.2 Potential Impact:

- **Rule 350:** As part of project implementation in July, an automated process ran to associate all providers to trading partners – identifying only those who were not already assigned. A special 2-sided letter was sent with additional explanation and instruction. Since that time two additional automatic assignment processes have run. The last process ran September 30.
- **Rule 360:** Following the mid-July implementation there have been concerns about the removal of '45' as an accepted claim adjustment reason code. While this is still a valid code, it was removed from the possible code combinations that could be associated to EOBs by CAQH CORE. The Agency has decided to allow the use of this code at this time based on provider, vendor and State Agency feedback. The first round of system changes occurred August 7 prior to the checkwrite cycle. The last planned system changes are scheduled to be in place prior to the October 16 checkwrite cycle.
- **Rule 370:** A maximum lag time of 3 business days between receipt of an ERA and its corresponding EFT is allowed. Therefore, system changes were made to hold the ERA until funding is approved and EFTs are released to the Agency's bank. ERAs are now potentially released throughout the week as funds are released. There is no change in the schedule of proprietary RAs. This has been a change for providers, vendors and State Agencies which may require changes to systems and business processes as a result.
- **Rule 380:** ERA enrollment is now required and must occur during enrollment. The Provider Enrollment Portal has been heavily modified to meet this requirement and standardize field and page presentation according to the rules. Additional information has been provided on the portal to assist providers with reassociating ERAs to EFTs and researching late/missing ERAs and/or EFTs.

1.3 Anticipated Implementation Date:

Production implementation occurred July 15. Phase III certification was received from CAQH CORE July 30. Two months of post-implementation support was completed. The project closedown report is being created. The closedown report, final implementation plan, and final project schedule will be delivered to the Agency early October.

2. Project/Change Order: Regional Care Organization (RCO)

2.1 Overview: The RCO project creates a new capability whereby a Third Party Administrator (TPA) will be procured by an RCO to perform claims processing and back office function similar to what the Medicaid Management Information System (MMIS) currently performs for Fee for Service (FFS) claims processing. Pharmacy claims will continue to be processed through the MMIS rather than through the TPA; therefore nightly pharmacy data will be extracted from the MMIS and made available to the RCOs. Enrollment Brokers will be utilized to enable recipients to pre-select their RCOs. Data from the Enrollment Broker will interface to HPES to be processed by the MMIS.

The following additional items have been included in this project:

- Automated Software Quality Control (ASQC) – a review and modification of all batch and user interface (UI) system objects to identify and resolve potential defects, and
- FEITH hardware and software upgrades to support increased functionality to reduce the volumes of paper documentation currently manually scanned into FEITH by providing a mechanism whereby providers may submit documents in PDF format or generate fax barcode coversheets via the web portal.

The project was signed, and startup began, April 1, 2015. A project kickoff occurred May 4, 2015.

Current Status

All subsystems have been working on business and technical designs. All but eight design walkthroughs were completed with the Agency by the end of September, with remaining walkthroughs scheduled in October. Construction is starting.

Joint Application Design (JAD) action items and parking lot items are being worked and reviewed with project stakeholders on a regular basis. Project scope is being documented and estimated. Three Change Control Board scope reviews have occurred, with one remaining to be scheduled upon completion of final scope estimates. The final requirements review meeting is scheduled to occur in October.

2.2 Potential Impact:

Many scope items have been identified and estimated, and many risks are being managed. The Enrollment Broker has not yet been selected. Interfaces between HPES/MMIS and RCOs, Enrollment Broker, and other external entities have not been fully defined. Requirements have not been finalized. A second baselined project schedule is required following completion of estimates for each subsystem being completed to incorporate scope and final design approvals. Formal implementation planning has not yet started, but is critical to ensuring the correct processes are available at required times for Enrollment Broker and RCO testing as well as early implementations to Production to begin auto assignment processing. There is a lot of volatility and risk with no potential to change the final implementation date.

2.3 Anticipated Implementation Date:

Required implementation date is October 1, 2016 with six months post-implementation support. Additional implementations are expected to occur along the way, including a Phase 1 implementation for data model changes, the Automated Software Quality Control (ASQC) implementation, and the implementation of Feith changes to support modified and new reports identified for the other subsystems. Previously early implementation for Diagnosis Related Group (DRG) pricing solution is no longer required, but other subsystems and processes may be required early to support RCO and Enrollment Broker readiness activities and early processes such as auto assignment. Additional information will be forthcoming as the RCO project stakeholders continue to finalize plans.



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