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DHHS OIT Initiatives Overview

Health & Human Services Committee

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DHHS OIT Initiatives

- There are three DHHS-sponsored OIT initiatives that are active. Each is associated with a federal mandate with a specific compliance delivery date:
 1. **ICD-10 (International Classification of Diseases)** compliance by 10/1/14
 2. **Affordable Care Act (ACA)** compliance by 10/1/13
 3. **Electronic Claims Transactions** compliance sequenced progressively through early 2016
- The following slides will provide a summary for each of the initiatives to include:
 - Driver for initiative
 - Compliance Date
 - Key high level deliverable(s)
 - Criticality of the initiative
 - Status of the work
- Supporting DHHS Governance Model

ICD-10

- Initiative Driver:
 - ICD-10 is a federal mandate under the Health Insurance Portability and Accountability Act (HIPAA) requiring the health care industry at large to upgrade health care transactions from the current ICD-9 code set to a broader, more detailed set of medical diagnosis/treatment codes associated with the ICD-10 code set
- Compliance Date:
 - Readiness to pass and receive health care transactions utilizing the ICD-10 code set must be accomplished by 10/1/14
- Key high-level changes represented in transitioning from the current ICD-9 to the ICD-10 code set:
 - Expansion of medical diagnosis/treatment codes from approximately 40,000 to 170,000
 - Expanding the ICD code value from a 5 digit numeric value to a 7 digit mixed alpha numeric value
 - Strategic opportunity to leverage the richer health care data reflected in the ICD-10 code set (details on next slide)

ICD-10 (cont.)

- ICD-10 initiative criticality:
 - To ensure accurate and timely claims processing (as well as general health care transmission of information) between the State of Maine and other health care entities, we must be ready to pass and receive health care transactions utilizing the ICD-10 codes
 - Additionally, we are positioned to benefit from the more detailed, richer data associated with the ICD-10 code set in the following ways:
 - Enhanced precision in claims adjudication
 - Enhanced opportunity to assess provider effectiveness
 - Improved ability to detect fraud and abuse
 - Stronger environment for effective claims analytics
- Status of the work:
 - Key high-level accomplishments to date:
 - Working under a defined initiative structure (defined teams, clear roles/responsibilities & governance)
 - Selected key initiative partners –Deloitte (initiative leadership) and Molina (systems development work)
 - Mapped the current ICD-9 codes to the ICD-10 codes
 - Enhanced the claims application (MIHMS) infrastructure to align with the ICD-10 seven character alpha numeric value
 - Developed initial implementation work plans
 - Currently active in early phases of implementation

Affordable Care Act (ACA)

- Initiative Driver:
 - Federal mandate based on the Affordable Care Act requiring states to assess and design the changes necessary to modernize our IT infrastructure for the interface connections and adoption of the new Monthly Adjusted Gross Income (MAGI) rules needed to utilize the Federally Facilitated Exchange (FFE) and Data Services Hub (DSH)
- Compliance Date:
 - The State must be ready to engage with the Federal Facilitated Exchange (FFE) and Data Services Hub (DSH), including operating under the new MAGI rules, by 10/1/13
 - 90/10 CMS Funding available through 12/31/15 for modernization work
- Key high-level initiative deliverable(s):
 - Establish business processes and State connectivity to the FFE and DSH
 - Adopt the federally mandated Modified Adjusted Gross income (MAGI) rules as part of eligibility determination
 - Collapse current Medicaid eligibility categories to the four CMS-defined categories
 - Align State eligibility infrastructure with CMS-defined seven architectural Conditions and Standards
 - Prepare staff to manage operations under an FFE model

Affordable Care Act (ACA) cont.

- ACA initiative criticality:
 - Positions the State to ensure citizens have an avenue to apply for health insurance benefits in alignment with the ACA legislation
 - By aligning with the CMS-defined seven architectural Conditions & Standards, the State has an opportunity to leverage a 90/10 CMS enhanced matching funding to modernize its eligibility applications which will position the State to realize the following longer-term benefits:
 - Enhanced agility to react to legislative and policy changes
 - Enhanced data integrity
 - Enhanced reporting environment
 - Greater access to electronic data to support eligibility verification
- Where are we in the work?
 - Initiative structure has been established including overall governance which crosses disciplines (DHHS, OIT, BOI, Governor's Office)
 - Analysis/Design vendor (KPMG) commenced work the week of 3/4/13
 - Anticipate a May'13 delivery of the analysis/design deliverables
 - Need to secure an implementation partner to take the design and build/execute the implementation
 - Actively establishing an operational readiness plan component

Electronic Claims Transactions

- Initiative Driver:
 - Federal mandate (CMS) to ensure providers have the ability to efficiently exchange health coverage information electronically with consistent and predictable data included regardless of health plan
- Compliance date:
 - There are multiple specific deliverables across compliance dates from 2013 through Jan 2016
- High-level initiative deliverable(s):
 - Enhance existing electronic files exchanged with providers to include specific features and data elements:
 - 2013:
 - Eligibility and Claims Status files
 - Rules and reporting requirements for “real-time” availability
 - 2014 – Claims payment/advice and electronic funds transfer
 - 2016 – Enrollment and referral authorization

Electronic Claims Transactions (cont.)

- Electronic claims initiative criticality:
 - Ensure compliance to avoid specific non-compliance penalties
 - Support provider information needs as defined in the mandate
- Where are we in the work?
 - Actively working with our partner, Molina, to ensure work plans are established and executed to deliver iteratively in alignment with the compliance dates
 - In that we are already operating in an electronic exchange (EDI) model based on our existing MIHMS functionality, the work is enhancing those files as needed
 - On track with the first delivery associated with the exchange of Eligibility and Claims Status electronic files

DHHS Governance High-Level Overview

- Establishing an overall DHHS Governance model that will govern the following:
 - Iterative planning and prioritization
 - Investment decision-making
 - Health of major capabilities, operations and initiatives
 - Risk/Issue identification and management
- Governance Board responsibilities include:
 - Ensure alignment of efforts and investments with Department strategy and roadmap to accomplish
 - Ensure consistent methodology followed to execute on defined priorities
 - Removing roadblocks from major operations and major initiative successful execution
 - Risk awareness and management
 - Resolution of escalated issues