PROJECT CLOSEOUT REPORT

Submitted to Large Project Oversight on 11/15/2017

GENERAL INFORMATION

Program/Project Name: CORE Operating Rules-Enterprise (HOPR)
Agency Name: North Dakota Department of Human Services
Project Sponsor: Jenny Witham
Project Manager: Darin Anderson

PROJECT BASELINES

Original And Final	Project Start Date	Baseline Execution Start Date	Baseline End Date	Baseline Budget	Actual Finish Date	Schedule Variance	Actual Cost	Cost Variance
Original Baseline	08/29/2015	10/10/2016	05/04/2017	$4,630,781	11/08/17	91.6% Behind	$4,528,621	4.1% Under
Final Baseline		10/10/2016	05/04/2017	$4,630,781	11/08/17	91.6% Behind	$4,528,621	4.1% Under

Notes: 3 Defects were tied to non-project Edifecs changes. Those included security certificate issues, DB translation items and dash board items. As a lesson learned from the MMIS project, the project team chose to not close the project until all defects were resolved. This is what cause the project to run late. Final project deployment was June 2017. To date, all defects have been resolved and final payments have been made.

MAJOR SCOPE CHANGES

None.

PROJECT OBJECTIVES

Business Objective	Measurement Description	Met/ Not Met	Measurement Outcome
The goal is to adhere to the principles of EDI in assuring that transactions sent are accurately received and to facilitate health plan correction of errors in their outbound responses	Eligibility and Benefit Batch Acknowledgement Rule v. 1.1.0	Met	Compliance with the standards below serves as objective measurement
Addresses acknowledgments for receivers of the ASC X12 005010X279A1 270/271 for Real Time	Eligibility and Benefit Real Time Acknowledgment Rule v. 1.1.0	Met	Compliance with the standards below serves as objective measurement

Business Objective	**Measurement Description**	**Met/ Not Met**	**Measurement Outcome**
Transactions must follow the format/flow as defined in the CORE v5010 Master Companion Guide Template	Eligibility and Benefit Real Time Companion Guide Rule v. 1.1.0	Met	Compliance with the standards below serves as objective measurement
This rule is to address proposed usage patterns for both batch and real-time transactions, the exchange of security identifiers and communication level error and acknowledgments	Eligibility and Benefits Connectivity Rule	Met	Compliance with the standards below serves as objective measurement
The v5010 270 is to inquire about health plan insurance coverage and to respond to such an inquiry using the v5010 271.	Eligibility and Benefits 270/271 Date Content Rule v 1.1.0	Met	Compliance with the standards below serves as objective measurement
This rule is to set a maximum response time when processing in batch mode for the receipt of a v5010 271 to a v5010 270 submitted by a provider or on a provider's behalf by a clearinghouse/switch	Eligibility and Benefits Batch Response Time Rule v 1.1.0	Met	Compliance with the standards below serves as objective measurement
This rule is to set a maximum response time when processing in real time mode for the receipt of a v5010 270/271 or in case of error v5010 999	Eligibility and Benefits Real Time Response Time Rule	Met	Compliance with the standards below serves as objective measurement
System availability must be no less than 86 percent per calendar week for both real time and batch processing modes. This will allow for health plan, clearing house/switch or other intermediary system updates to take place within a maximum of 24 hours per calendar week for regularly scheduled downtime.	Eligibility and Benefits System Availability Rule v 1.1.0	Met	Compliance with the standards below serves as objective measurement

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Business Objective	Measurement Description	Met/ Not Met	Measurement Outcome
This rule includes the Status Request and Response 276/277 TR3 implementation guide and associated errata	Claim Status	Met	Compliance with the standards below serves as objective measurement
This rule covers identity management which includes authentication, authorization, transaction control and audit. Rule applies to v5010 270/271 transactions and specifies the requirement for CORE-certified health plan to normalize a person's last name during any name validation matching process by the health plan or information source.	Eligibility and Benefits 270/271 Normalizing Patient Last Name Rule v 2.1.0	Met	Compliance with the standards below serves as objective measurement
This rule defines a standard way to report errors that cause a health plan not to be able to respond to v5010 271. The goal is to use a unique error code whenever possible for a given error condition. If this is not possible the goal is to return a unique combination of one or more AAA segments along with one or more of the identifying data elements.	Eligibility and Benefits 270/271 AAA Error Code Reporting Rule v 2.1.0	Met	Compliance with the standards below serves as objective measurement
Extends and enhances the Phase I v 5010 271 transactions by requiring the provision of remaining deductible amounts for both the Phase 1 required 12 Service Type Codes and additional set of 39 other Service Type Codes	Eligibility & Benefits Data Content 270/271 Rule v 2.1.0	Met	Compliance with the standards below serves as objective measurement

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The rule addresses the message envelope metadata, the message envelope standards and the submitter authentication standards for both batch and real time transactions and communications-level errors and acknowledgements.	Connectivity Rule	Met	Compliance with the standards below serves as objective measurement
This rule focuses on improving the conduct and exchange of electronic claim advice data as these transactions can have a direct impact on a provider's revenue cycle management process.	Health Care Claim Payment/Advice (835) Infrastructure Rule v 3.0.0	Met	Compliance with the standards below serves as objective measurement
The CORE Rule specifies that health plan or other entity must continue to deliver their proprietary paper claim remittance advices during a parallel implementation testing time periods and use the ASC X12 standard acknowledgments and support the CORE connectivity safe harbor requirements.	Health Care Claim Payment/Advice Infrastructure (835) Rule V3.0.0	Met	Compliance with the standards below serves as objective measurement
The goal of this rule is to establish a foundation for the successful and timely reassociation of the Healthcare EFT Standards transaction being exchanged between a health plan and healthcare provider through the ACH Network and the corresponding v5010 X12 835 being exchanged by a separate mechanism.	EFT and ERA Re-association (CCD+/835) Rule v 3.0.0	Met	Compliance with the standards below serves as objective measurement

Business Objective	Measurement Description	Met/ Not Met	Measurement Outcome
Ensure that the necessary data for reassociation is collected for reassociation. The goal of the rule is to establish a foundation for the successful and timely enrollment of healthcare providers by health plans to engage in the payment of healthcare claims electronically.	EFT Enrollment Data Rule v 3.0.0	Met	Compliance with the standards below serves as objective measurement
A health plan or its agent or vendors offering ERA enrollment will offer an electronic way for providers to complete and submit the ERA enrollment.	ERA Enrollment Data Rule v 3.0.0	Met	Compliance with the standards below serves as objective measurement

POST-IMPLEMENTATION REPORT

Post-Implementation Reports are performed after a project is completed. A "PIR" is a process that utilizes surveys and meetings to determine what happened in the project and identifies actions for improvement going forward. Typical PIR findings include, "What did we do well?" "What did we learn?" "What should we do differently next time?" Notable findings are presented in this closeout report.

Lesson learned, success story, ideas for future projects, etc.
One lesson learned from MMIS was to be sure all defects were resolved prior to final payments. In this project, the project team chose to leave the project open and run late due to the final three defects. The reason for this was to be sure the defects were fixed prior to final payment and project closeout.
Documentation process is vital. It is not an option to treat documentation as an afterthought, and a defined process and adherence to that process is critical. It provides clarity, direction, and saves project time, as there would be higher trust in the process.
Edifecs product issues. Meaning there were bugs found within the Edifecs software that impacted the project
Teamwork always prevails.
The implementation of new CORE channel was a challenge since it involved multiple stake holders and coordinating with multiple teams. And it was new implementation technologically. It was a pleasure working with ITD on setting up firewalls, load balancers, Certificates etc. It was fruitful when state started using the new CORE channels for their real time testing.
This project has satisfied an ACA requirement that gives more stability to the information that we share with our providers and the process that is involved around that information.
One example is the required conformity of our Companion Guides. It has become more and more evident that trading partners are using these guides and have certain expectations for them.
Another example was the review that we needed to give our system on how we were setting the Claim Adjustment Reason Codes and Remark Codes. This will also add conformity across payers which will help providers understand how to process the information we give them.
ND Medicaid is CAQH CORE certified for Operating Rules Phase I, II and III.

Delivery of the dashboards for 270 and 276 are useful to the state for quick reference to check compliance.
Identifying the risks well in advance lead to success.