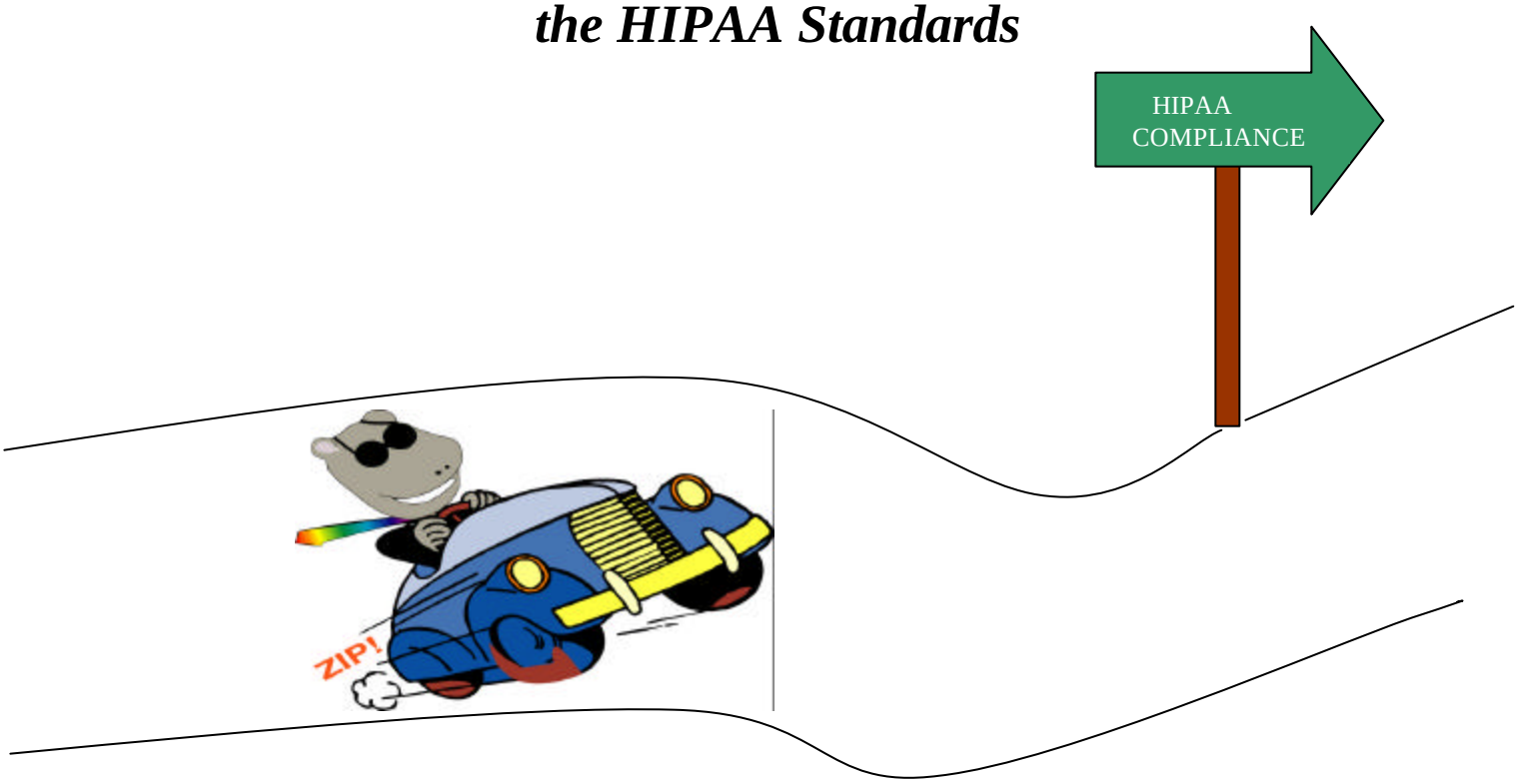
Health Care Financing Administration

PREVIEW of the MEDICAID HIPAA-COMPLIANT CONCEPT MODEL

A Model for States on their Journey to Implementing the HIPAA Standards



ROAD MAPS TO HIPAA COMPLIANCE
VOLUME 1, MAP 2
September 25, 2000

PREVIEW of the MEDICAID HIPAA-COMPLIANT CONCEPT MODEL

A MODEL for STATES on their JOURNEY to IMPLEMENTING the HIPAA STANDARDS

INTRODUCTION

The 26-month countdown has begun for implementation of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Administrative Simplification (AS) Rules. Whether you are a State in the avant-garde of HIPAA implementation, or are just beginning the long journey, you and your data exchange partners are facing challenges and significant benefits ahead. This paper describes how HCFA's Medicaid HIPAA-Compliant Concept Model (MHCCM) can help your State stay on the road to success. The MHCCM demonstrates how HIPAA impacts the Medicaid Enterprise and provides practical tools to help you determine the best course of action based on your circumstance. Whether you are wondering how to get started, analyzing the HIPAA impact, questioning implementation strategies, looking for best practices, or trying to validate what you have accomplished, the MHCCM will help. The MHCCM is a one-stop shop that provides tools and guides, or links and pointers to useful guides available to the HIPAA implementation community.

The theme of a Road Map is used to illustrate the phases of the journey toward compliance. This is the second white paper in a series of five HIPAA-related white papers issued by HCFA. The first paper addressed the benefits and challenges of implementing the AS standards. This paper addresses: What is the Model, What's in the Model, How will it help the States in their efforts to become compliant, and the current status and evolution of the Model. A listing of useful HIPAA related web sites is included, and a survey for States to complete and return to HCFA is attached. Subsequent papers will focus on specific implementation issues and offer suggestions for resolution.

WHAT IS THE MHCCM, ANYWAY?

The Model is being designed and built by HCFA's Center for Medicaid State Operations (CMSO) to assist the States in their efforts to become HIPAA-compliant. The following sections describe the Model in terms of the concept behind the Model, the toolkit to be included with the Model, the ways to use the Model, and the implementation and development status of the Model.

The MHCCM is to be used in the evaluation of the impact of HIPAA across three critical dimensions of the Medicaid environment:

- Enterprise relationships
- Business processes
- Data interchange

These three evaluation dimensions enable a State, starting from a high-level view of their process, to rapidly focus on the processes affected by the HIPAA standards, identify the modifications required to support the new EDI transaction requirements, and to trace those impacts back to components of

the MMIS. Once the set of modifications to processes and systems is known, risk, cost, and schedule can be estimated.

THE CONCEPTUAL MODEL (MHCCM)

The conceptual Model begins with an Entity Relationship Diagram (ERD) representing a basic configuration of a Medicaid Enterprise. Enterprise views from several States were merged to create the ERD. The ERD decomposes into six major Business Processes:

1. Medicaid Administration
2. Claims Management
3. Reference Data Management
4. Recipient Administration
5. Program Management
6. Provider Administration.

Appendix A, The Basic Business Process Outline, provides a draft outline of the detailed structure of the complete set of business processes defined for the Model. All business processes defined below each of the six major business process are organized into "tiers." Figure 1 provides an illustration of three tiers of business processes from the Claims Management section of the outline in Appendix A.

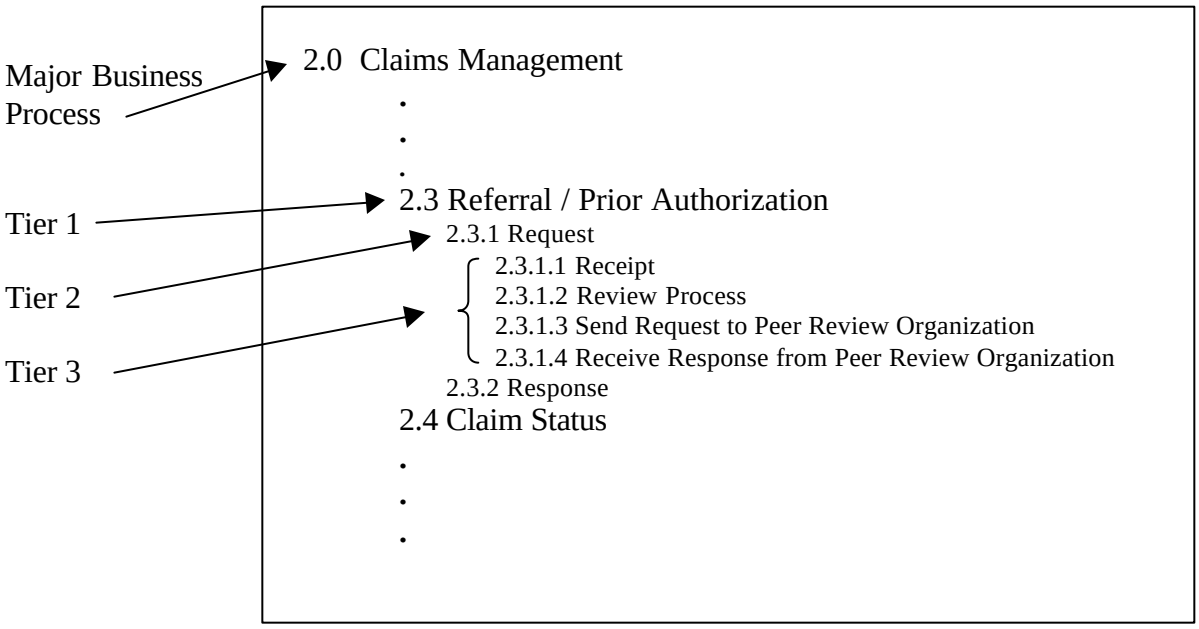


Figure 1

In a graphical representation of the Model, each of these six processes decomposes into detailed views of more specific Medicaid processes. The views of the Medicaid processes show the Entities involved and the data passed within the processes. The Model first of all provides a graphical overview of all Medicaid functions and data. Color-coding shows which functions and data flows are affected by HIPAA. From the business process views, the user will be able to link to various data sources (e.g., the X12N data segments, tables, papers, and external data bases) which help to explain the importance and considerations associated with the specific business process. These data sources, which are both internal and external to the Model, are the components of the Model's "toolkit." Security, Privacy, and National Provider Identifier (NPI) requirements are also included in the Model at all levels.

Figure 2 shows an example of the Batch Receipt Process (a Claims Management business process) represented in the Model.

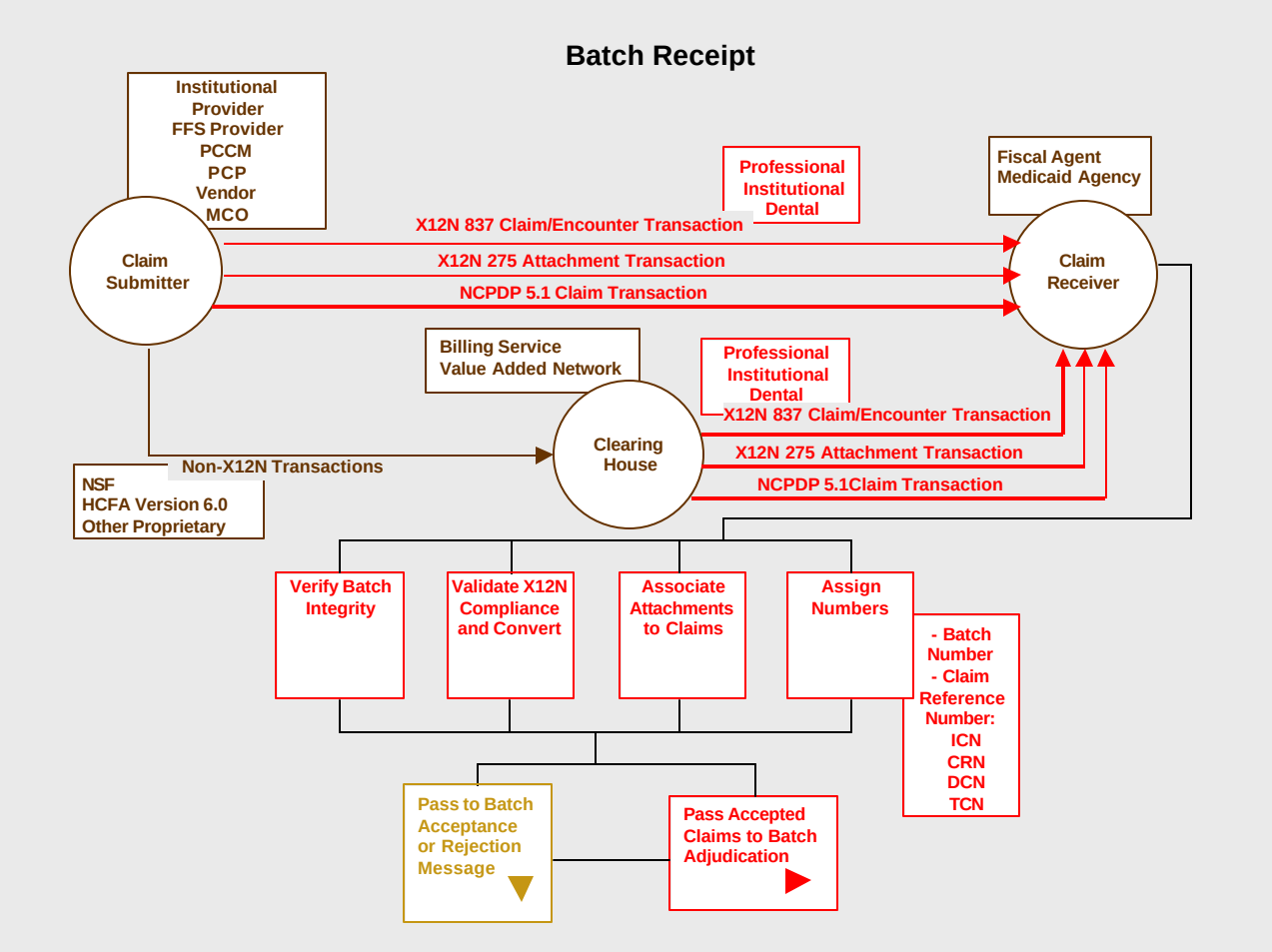


Figure 2

Figure 3 illustrates the levels of decomposition available in the Model, shown in the form of a pyramid. The various representations of the 6 levels, or layers, of the pyramid are listed below. The 6 levels of the pyramid are also referenced in this figure according to the tiered structure of the Basic Business Process Outline (BPO), (see Appendix A), mentioned earlier in the paper.

LEVELS *vs*. TIERS

The *levels* of the pyramid represent the different aspects and areas of the Model as a whole. The *tiers* in the Basic Business Process Outline represent the different decompositions of business processes defined for the portion of the Model that deals with the graphical representation of those business processes.

- Level 1 represents the high-level ERD, at the top of the pyramid.
- Level 2 represents the six major business processes.
- Level 3 represents the next level of business processes defined at Tier 1 of the BPO.
- Level 4 represents the business processes defined at Tier 2 of the BPO.
- Level 5 represents the business processes defined at Tiers 3 and beyond of the BPO.
- Level 6 represents the data repository, which houses the details of the data and information linkages for all levels of business processes, including access to all items in the MHCCM toolkit. The MHCCM toolkit is further described in the next section.

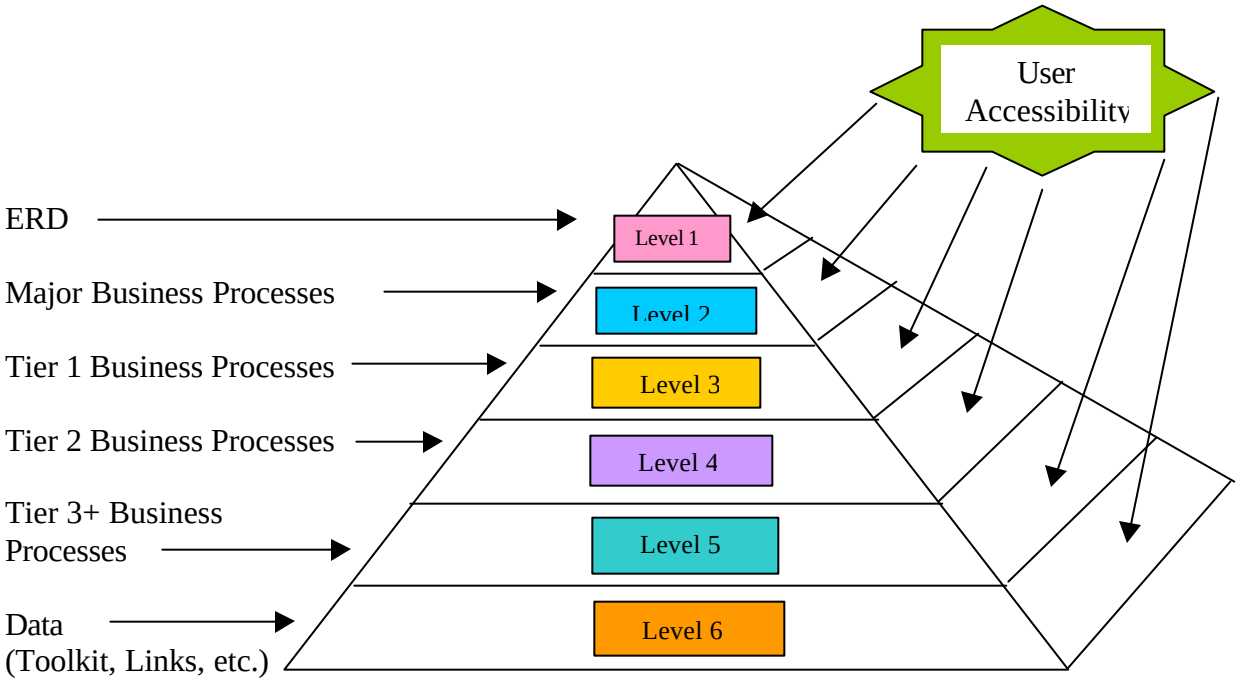


Figure 3

Levels 2 through 5 in the pyramid represent all the basic business processes in a Medicaid Enterprise. These pyramid levels correspond to the Major Business Processes and the subsequent tiers of decomposed business processes. There are 49 business processes defined in Tier 1 as follows:

- 8 processes are defined for Medicaid Administration
- 5 processes are defined for Claims Management
- 4 processes are defined for Reference Data Management
- 7 processes are defined for Recipient Administration
- 18 processes are defined for Program Management
- 7 processes are defined for Provider Administration

Some of the processes in Tier 1 are basic enough to be completely represented in the model from that tier. Other processes in Tier 1 are broken down into further levels of detail, which are identified in Tier 2. Similarly, some of the processes in Tier 2 are then basic enough to be completely represented in the model from that tier, but other processes in Tier 2 are broken down into further levels of detail, which are then identified in Tier 3, and so on.

In addition to the 49 business processes defined in Tier 1, there are approximately 100 business process defined in Tier 2, and approximately 42 business processes defined in Tier 3. See Appendix A (The Basic Business Process Outline) for the specific business processes defined in each tier.

The various levels within the Model are accessible from any other level in the Model. There is no need to go through all successive levels to get to a lower level, or start at the top, or from the beginning, if the destination is somewhere in the middle. Entry options into the Model are available to the user at every level. A State may choose to perform an analysis, or a correlation to its own processes, or perform a data mapping, or go directly to any of the tools in the toolkit, or preview any HIPAA related information by accessing different areas of the Model at the different levels.

THE TOOLKIT

The conceptual Model is supported by a toolkit – a collection of informational and practical items related to HIPAA implementation tasks. The toolkit, which is embedded in the lowest level (the data repository level) of the Model, is accessible from any other level in the Model. It may also be accessed directly by the user who may simply want to retrieve specific information. States can access any item in the toolkit to address their own needs from anywhere in the Model. A sample of the items in the toolkit is:

- X12N Data Element Dictionary (DED) – definitions for all data elements of the X12N transaction format.
- Crosswalks – documents linking X12N format and data segments to other widely used formats, e.g., UB92, HCFA 1500, and National Standard Format (NSF). A crosswalk from the X12N standard format and data segments to the State's format and data segments (fill in the blanks) is included.
- Translators – a list of available commercial-off-the-shelf (COTS) software. Translators are products that accept one format and set of data values and convert them into another format and set of data values.
- Checklists – Check off lists to ensure all activities pertaining to HIPAA renovations are complete, e.g., Security Rule checklist.
- General Implementation Plan – A roadmap to assist States with their HIPAA project implementations.

Figure 4 contains a graphic illustration of the toolkit.

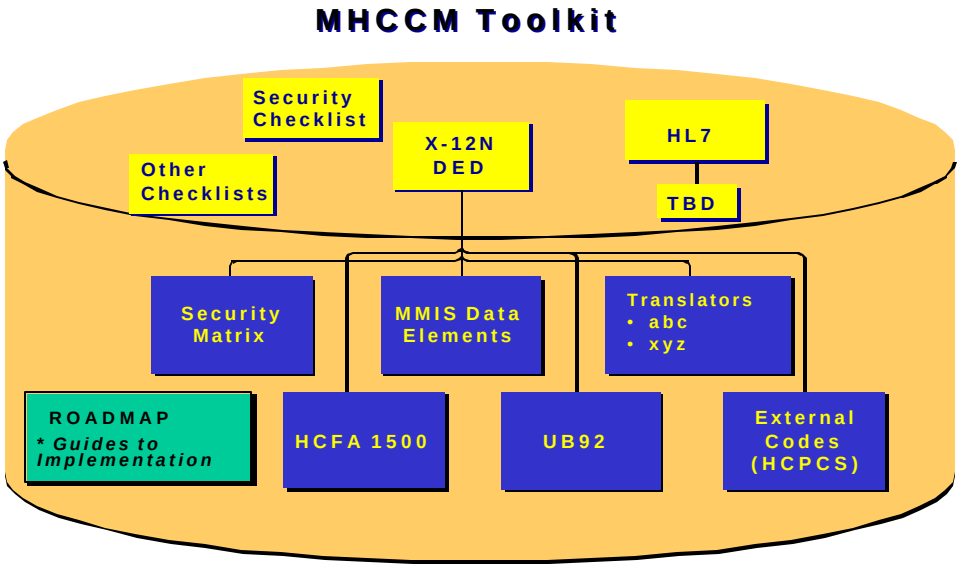


Figure 4

HOW CAN THE MHCCM HELP YOU?

At whatever mile-marker you've reached, the MHCCM can help in your journey along the road to HIPAA compliance. The areas where the MHCCM can offer assistance and guidance include:

- PLANNING - If you're just starting out and are still learning about HIPAA, the MHCCM offers many avenues to explore to help you plan your project.
- IDENTIFYING CHANGES - For those further along, it assists in performing and analyzing your gap analysis, and it helps you identify what changes need to be made to your business processes, systems, and data interchanges.
- STRATEGIZING - Since there are many alternatives, the MHCCM can help you strategize your software solution, whether it's renovate, replace, translate, or a combination of these.
- ASSESSING RISK - Assessing the risk to your current operations is necessary in making the right choices for a successful HIPAA implementation.

No two State Medicaid programs are the same, and no two HIPAA implementations will be exactly alike. The MHCCM is broad enough, with significant depth in the tools and information it contains, to be of use to States facing their individual HIPAA challenges.

Functionality

As a software application, the MHCCM provides the following general functionality:

- Review and analysis of the business processes that all Medicaid enterprises engage in
- Identification of Processes, Transactions, and Data Elements affected by HIPAA
- Indication where Security and Privacy requirements will impact various processes, transactions, and data elements
- Breakdown of Business Processes to Transaction and Data Element levels of detail.
- Support in data mapping of non-standard transaction formats to X12N
- Assistance with performing a Gap Analysis and a Risk Analysis
- Assistance in analysis of the impact to Business Processes and Information Systems
- Guidance in determining renovation strategy and software solutions
- Connectivity to other HIPAA related information (legislation, other models, standards, etc.)

Impact of HIPAA Across Three Critical Dimensions

- Enterprise Relationships

Evaluation and analysis of an Agency's enterprise relationships defines the many individual business entity relationships and identifies those that are impacted by HIPAA.

- Business Processes

From a business perspective, the business process model is used to evaluate the individual business processes and functions that are associated with a given business relationship identified at the

enterprise level. The objective is to identify the impacted business processes and the HIPAA standards area(s) that impact them.

- Data Interchange

The final dimension for evaluation is the data interchange level, where the MHCCM provides an effective mechanism for identifying data-related issues between State systems and HIPAA requirements.

Risk Assessment

Risk assessment is all about making the right choices for your organization given your particular set of options and circumstances. It is a logical component of your organization's decision making process. The difficult part is documenting those decisions and options, and educating your staff members and project team members to raise awareness of the risks inherent to any project.

A risk assessment helps determine where the vulnerabilities are, what the biggest obstacles might be, and helps in deciding what choices to make regarding HIPAA implementation. The MHCCM can provide a great deal of useful information to an organization in its efforts to perform a risk assessment by aiding in the identification of the changes to data and transactions and business processes that need to be made, and of the potential areas of impact to the systems and current operations. Armed with such information, sound decisions can be made regarding the strategy for software solutions and modifications to business practices.

WHICH MILE-MARKER HAVE WE REACHED?

The Model began development in July 2000. The following sections describe the completed portions of the Model and what portions of the Model are still under development.

Completed Portions of the Model

The following components of the MHCCM have been completed:

The Entity Relationship Diagram (ERD) is developed. The ERD is a graphical representation of a basic configuration of a Medicaid enterprise showing the principal entities: beneficiaries, providers, payers, clearinghouses, and business associates. The ERD provides a high level view of activities which bind the entities together within the enterprise.

The master list of basic Medicaid business processes has been defined. These have been grouped under six major business areas: 1. Medicaid Administration, 2. Claims Management, 3. Reference Data Management, 4. Recipient Administration, 5. Program Management, and 6. Provider Administration. The major business processes are decomposed into lower levels of detailed business processes. See Appendix A (the Basic Business Process Outline) for a complete listing of the business processes identified for inclusion in the Model.

A subset of the master list of processes is currently included in the Model. The examples provided in the MHCCM software application prototype (to be demonstrated at the MMIS Conference in September 2000) show two business processes and their associated data exchange paths within the Claims Management business process group. One example is the Receipt, Adjudication and Pricing of an Institutional Hospital Claim being received via batch electronic transmission. The other example is the Referral / Prior Authorization Request process.

The methodology for the graphical representation of the business process diagrams is complete. The screen formatting conventions (shapes, colors, etc.) give the user an indication as to the impact of HIPAA compliance (change required, change optional or no impact) to particular objects or to information exchanges between objects.

The set of X12N standard transaction types to be included in the MHCCM software application has been defined (a list of the X12N transaction types appears on page 11). Only the Transaction and Code Set Final Rule has been officially released at the time of this publication. As other HIPAA Rules (NPI, Security, Privacy) are released, the Model will be updated. A functional subset of the X12N standard transaction set (837 and 278) is currently included in the MHCCM software application prototype. The Institutional Claim type (837) is the transaction example that is fully implemented and available in the MHCCM software application prototype for demonstration at this time. The Referral / Prior Authorization Request (278) is a transaction example that is partially implemented in the Model, and time permitting, will be included in the MHCCM software application prototype demonstrated at the National MMIS Conference in Utah in September 2000 as well.

A subset of the data repository (pyramid level 6) is currently defined. The data elements relative to the 837 institutional claim are currently included in the MHCCM software application prototype. A subset of the toolkit has also been included in the MHCCM software application prototype. Two HCFA directed White Papers on HIPAA, several links to informative web sites, and a sample crosswalk are among the tools currently available.

Portions of the Model Still Under Development

The majority of the screens in the MHCCM software application will represent the Medicaid business processes (from the conceptual Model), and will be displayed in a main image pane, or window, as a graphical diagram. MS Windows conventional toolbars and drop-down menus will appear across the top portion of the screen, providing various options to the user.

A Windows “frame” (a narrow vertical window section used for Model navigation) on the left side of the screen will contain the Basic Business Process Outline (BPO) in expandable outline format. This will work much like the MS Windows Explorer, where top level items are listed in a hierarchical directory arrangement, and subordinate items appear in the list when the higher level item is clicked with the mouse. An indicator (plus sign or arrowhead) before each business process denotes whether there are sub-processes for that particular business process or not. Any level of detail of the BPO may be represented in the frame via the expandable outline.

Any business process in the outline may be accessed directly (for viewing in the main image pane) simply by clicking on it from the navigation frame. Alternatively, a business process may be accessed in the main image pane by navigating through the MHCCM's software application graphical structure, by clicking on a basic business process, and then working down through the subsequent levels of images until the desired business process or transaction or data link is reached. Different shapes and different colors are used in the graphic image to represent various steps in the business process, or statuses of transactions or data, or whether an item is affected by HIPAA, or whether an item is affected by security or privacy implications, etc.

Figure 5 illustrates a sample screen display of the MHCCM software application.

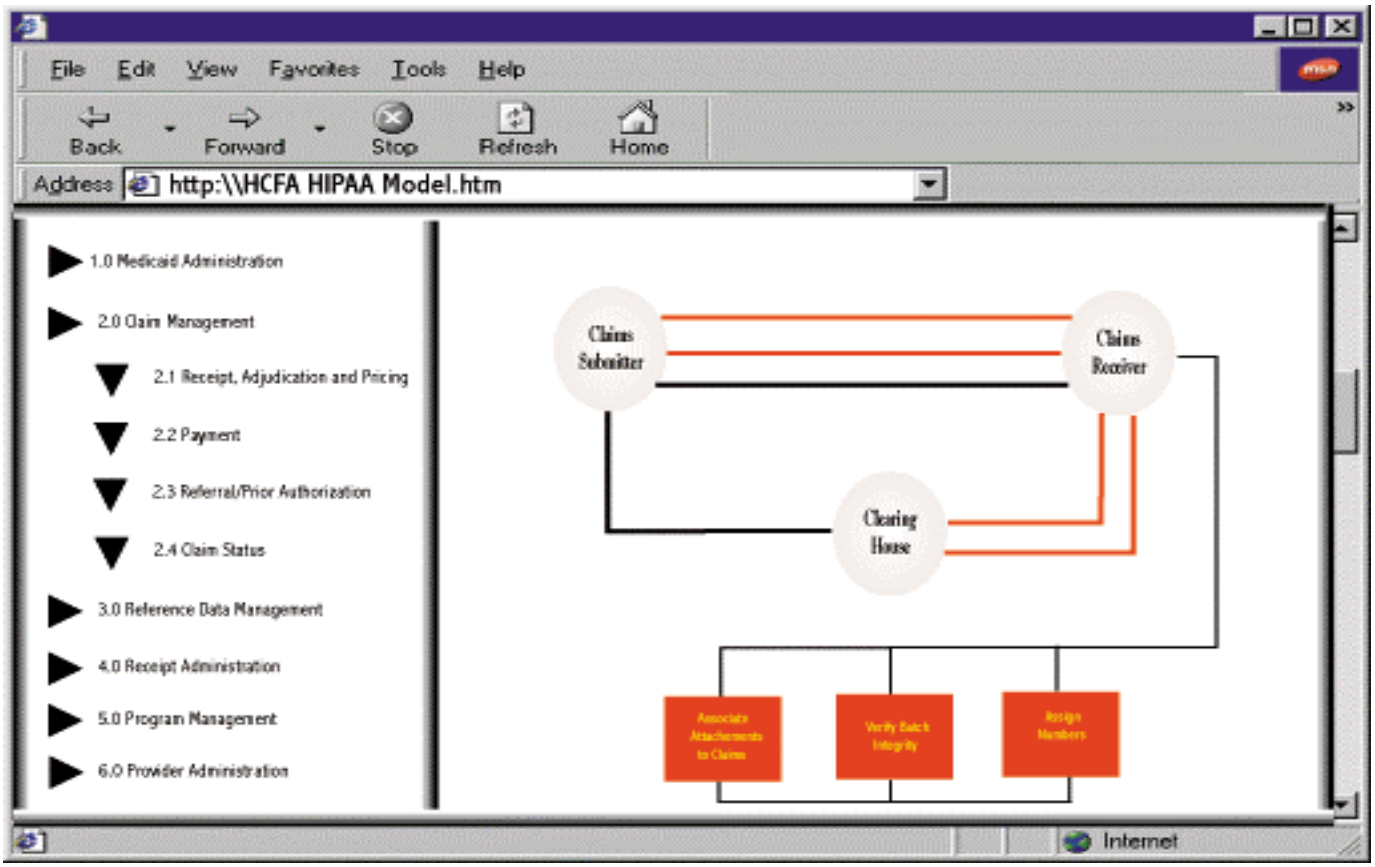


Figure 5

More detailed information (including links to other web-based information) related to objects in an image is available via a pop-up menu. At the lowest level of detail are the data element definitions and synonyms, types or examples of what data may belong in a particular data field on a transaction, references to NPRM or Final Rules, background information on a particular subject, crosswalk or translation references, and links to other web-based information.

All other X12N transaction types in the HIPAA Standard Transaction Set are under development for the MHCCM software application. These include:

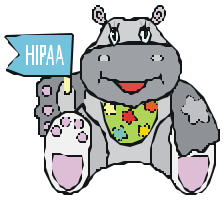
- 837 claim for Professional and Dental
- NCPDP claim for Retail Drugs
- 837 claim for COB of Professional, Institutional and Dental
- 835 Remittance
- 276 Claim Status Inquiry
- 277 Claim Status Response
- 834 Enrollment
- 270 Eligibility Request
- 271 Eligibility Response
- 820 Premium Payment
- 278 Referral Response
- 275 Attachments

Note: There is no published rule regarding the First Report of Injury transaction type. Since there is no definitive status as to its applicability to Medicaid, the First Report of Injury is not currently included in the MHCCM.

All other processes defined in the BPO are rapidly being completed. These include the 49 Tier One Business Processes, the 100 Tier Two Business Processes, and the 42 Tier Three Business Processes, as listed in the Basic Business Process Outline. Additional business processes defined at subsequently lower levels (e.g., Tiers Four and beyond) are listed accordingly in the BPO. Although these are not depicted in the pyramid representation, they are defined and will be fully implemented in the actual MHCCM software application. See the BPO listing in Appendix A for the specific business processes and activities under each of the six Major Business Processes.

The complete Level 6 data repository, which is accessible directly when the user knows which specific data definition they wish to access, or via navigation through the various business process pathways within the graphical Model, is also under development.

Formal development of the Model and the MHCCM software application will be completed over the winter of 2000-2001. It will be validated in a pilot program with a few States during December 2000 and January 2001. Enhancements and/or adjustments to the Model are likely to occur during February 2000 and March 2000, following the pilot program. The Model's formal introduction will occur at a national conference sponsored by HCFA in the spring of 2001.



APPENDIX A

Basic Business Process Outline (DRAFT)

1.0 Medicaid Administration

1.1 Security
- 1.1.1 Security Policy Maintenance
- 1.1.2 Security Audits
- 1.1.3 Security Training
- 1.1.4 Certificate Authority Maintenance
- 1.1.5 Chain of Trust Contract Maintenance

1.2 Privacy
- 1.2.1 Privacy Policy Maintenance
- 1.2.2 Privacy Audits
- 1.2.3 Privacy Training
- 1.2.4 Chain of Trust Contract Maintenance

1.3 Service Coverage Determination

1.4 Administrative Rules and Regulations

1.5 Budget Plan and Monitoring

1.6 Policy Determination

1.7 Rate Setting
- 1.7.1 DRG/Per Diem/Percent of Cost Calculations
- 1.7.2 Drug Pricing
- 1.7.3 Medical Code Rates
- 1.7.4 Co-payment
- 1.7.5 Deductible
- 1.7.6 Practitioner Fee Schedule
- 1.7.7 Clinical Lab Fee Schedule
- 1.7.8 LTC Rates (Case mix, Federal MDS)
- 1.7.9 Managed Care Rates
  - 1.7.9.1 Capitation
  - 1.7.9.2 Case Management
  - 1.7.9.3 Administration
- 1.7.10 Special Contract
- 1.7.11 Waiver

1.8 Other

2.0 Claims Management

2.1 Receipt, Adjudication and Pricing

- 2.1.1 Batch Electronic Claim/Encounter Transactions
  - 2.1.1.1 Receipt
  - 2.1.1.2 Acceptance or Rejection Message
  - 2.1.1.3 Adjudication
  - 2.1.1.4 Pricing
  - 2.1.1.5 Suspense/Pend Resolution
  - 2.1.1.6 Denial Notice
  - 2.1.1.7 Request for More Information
- 2.1.2 Point of Sale Electronic Transactions
  - 2.1.2.1 Receipt
  - 2.1.2.2 Adjudication
  - 2.1.2.3 Pricing
  - 2.1.2.4 Response
- 2.1.3 Paper Claims / Encounters
  - 2.1.3.1 Receipt
    - 2.1.3.1.1 Data Entry
    - 2.1.3.1.2 Online Adjudication
  - 2.1.3.2 Communications

2.2 Payment

- 2.2.1 Claims
  - 2.2.1.1 Calculations
  - 2.2.1.2 Remittance Advice Processing
  - 2.2.1.3 Paper Communications
- 2.2.2 Disbursement
- 2.2.3 Generated LTC Claims
- 2.2.3 Capitation
- 2.2.4 Case Management Fees
- 2.2.5 Managed Care Administration Fees
- 2.2.6 Premium Payments
  - 2.2.6.1 Medicare Part B/Buy-in
  - 2.2.6.2 Private Health Insurance

2.3 Referral / Prior Authorization

- 2.3.1 Request
  - 2.3.1.1 Receipt
  - 2.3.1.2 Review Process
  - 2.3.1.3 Send Request to Peer Review Organization
  - 2.3.1.4 Receive Response from Peer Review Organization
- 2.3.2 Response

2.4 Claim Status

- 2.4.1 Request
- 2.4.2 Response

2.5 Other

3.0 Reference Data Management

3.1 Batch Update Process

3.2 Interactive Update Process

3.3 Rate Maintenance

3.4 Other

4.0 Recipient Administration

4.1 Eligibility Determination

- 4.1.1 Medicaid Eligibility (post TANF)

4.2 Receipt of Eligibility

- 4.2.1 TANF
- 4.2.2 SSI
- 4.2.3 CHIP
- 4.2.4 Disability
- 4.2.5 Spend-down
- 4.2.6 Share of Cost
- 4.2.7 LTC
- 4.2.8 Update Third Party Coverage Information
- 4.3.9 Insurance Information Verification Process

4.3 Enrollment

- 4.3.1 HIPP Determination
  - 4.3.1.1 Medicaid vs. Private Insurance Premium Determination
  - 4.3.1.2 Private Health Insurance Payment
- 4.3.2 MCO
- 4.3.3.PCP, PCCM, Case Manager
- 4.3.4 Lock-in
- 4.3.5 Waiver

4.4 Eligibility Verification

- 4.4.1 Request
- 4.4.2 Response

4.5 Client Outreach

- 4.5.1 Inquiries
- 4.5.2 EPSDT
- 4.5.3 CHIP
- 4.5.4 Complaints

4.6 Maintenance

- 4.6.1 ID Documents
- 4.6.2 Eligibility Data Exchange
  - 4.6.2.1 Enrollment Rosters to MCO
  - 4.6.2.2 Part-B buy-in Rosters
- 4.5.3 Rate Maintenance

4.7 Other

5.0 Program Management

5.1 MARS

5.2 MSIS

5.3 EPSDT

5.4 HEDIS

5.5 Management Reporting

5.6 Financials

- 5.14.1 Accounts Receivable
- 5.14.2 Accounts Payable
- 5.14.3 Cost Settlement/Accounting

5.7 Policy Compliance

5.8 Decision Support

- 5.8.1 Claims History Inquiry
- 5.8.2 Ad Hoc Reporting
- 5.8.3 Management Reporting
- 5.8.4 Other

5.9 Post Payment Review

- 5.9.1 Retro DUR
- 5.9.2 SUR
- 5.9.3 QA
  - 5.9.3.1 Medicaid
  - 5.9.3.2 Managed Care
  - 5.9.3.3 Enrollment Broker
  - 5.9.3.4 Other

5.10 Fraud Detection

- 5.10.1 Pattern Recognition

5.11 Drug Rebate

- 5.11.1 Determination
- 5.11.2 Invoicing
- 5.11.3 Manufacturer Response
- 5.11.4 Accounts Receivable

5.12 Auditing

- 5.12.1 Desk Review
- 5.12.2 State Audit
- 5.12.3 Pharmacy Fill Fee Audit
- 5.12.4 Rate Setting Audits for Providers
- 5.12.5 Other

5.0 Program Management – continued

- 5.13 EOMB
  - 5.13.1 Generate Random Sample
  - 5.13.2 Generate and Distribute EOMBs
  - 5.13.3 Receive Completed EOMBs
  - 5.13.4 Process EOMBs
- 5.14 MQC
  - 5.14.1 Generate Random Sample
- 5.15 Catastrophic Case Management
- 5.16 Documentation Maintenance
- 5.17 Third Party Liability
  - 5.17.1 Cost Avoidance
    - 5.17.1.1 Receipt of Response to Denial for TPL Reasons
  - 5.17.2 Recovery
    - 5.17.2.1 Claims Selection and Coverage Determination
    - 5.17.2.2 Message Processing
    - 5.17.2.3 Receive Response to Recovery Messages
    - 5.17.2.4 Accounts Receivable
  - 5.17.3 Casualty
  - 5.17.4 Estate
- 5.18 Other

6.0 Provider Administration

6.1 Provider Enrollment

- 6.1.1 Enroll Provider
- 6.1.2 Establish Provider Parameters
  - 6.1.3.1 Associate Provider with Program (PCP, PCCM)
  - 6.1.3.2 Associate Provider with MCO
  - 6.1.3.3 Determine Provider Specialty
- 6.1.3 Setup Provider as Electronic Submitter
- 6.1.4 Clearing House Registration
- 6.1.5 Assignment of NPI

6.2 MCO Contracting

- 6.2.1 Establish Contract
- 6.2.2 Contract Management
  - 6.2.2.1 MCO
  - 6.2.2.2 Reinsurance
  - 6.2.2.3 Special Contracts

6.3 Provider Notification

6.4 Provider Relations

- 6.3.1 Research
- 6.3.2 Training

6.5 Provider Maintenance

- 6.4.1 Involuntary Disenrollment
- 6.4.2 Voluntary Disenrollment
- 6.4.3 Change
- 6.4.4 Recertification
- 6.4.5 Reenrollment

6.6 Rate Maintenance

6.7 Other

APPENDIX B

WEB SITES of INTEREST

The following table presents a collection of useful links and web sites pertaining to various aspects of HIPAA. Additional useful web sites will be provided in subsequent papers.

Useful HIPAA Links and Web Sites	
http://aspe.os.dhhs.gov/admnsimppl 104191.htm	1996 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY
http://aspe.os.dhhs.gov/admnsip	Link to the Department of Health and Human Services web site regarding information dealing with the Administrative Simplification Provisions of HIPAA of 1996. This site contains general information about the Administrative Simplification portion of the HIPAA law, an explanation of the Notice of Proposed Rulemaking (NPRM) process, update on when HIPAA standards may be implemented, and presentations made by parties regarding HIPAA.
http://www.hcfa.gov/medicaid/HIPAA	Health Care Financing Administration (HCFA) information on HIPAA insurance portability requirements.
http://www.wpc-edi.com/hipaa	Link to the Washington Publishing Company web site. This site contains all the X12 Implementation Guides, data conditions, and the data dictionary (except for retail pharmacy).
http://www.x12.org	Data Interchange Standards Association web site. The site contains information on ASC X12, information on X12 subcommittees, task groups and workgroups, including their meeting minutes. This site will contain the test conditions and results of HIPAA transactions tested at the workgroup level.
http://www.listserv@list.nih.gov	To receive email notification on publication of documents related to HIPAA regulations, send an email to listserv@list.nih.gov and include "subscribe HIPAA-REGS your name" in the body of the message.
http://www.afehct.org	A health care association dedicated to supporting the use of EDI to improve and reduce the cost of health care.
http://www.disa.org/x12	Data Interchange Standards Association web site. This site contains information on ASC X12, information on X12N and subcommittees, task groups, and workgroups, including their meeting minutes. This site will contain the test conditions and results of HIPAA transactions tested at the workgroup level.

Useful HIPAA Links and Web Sites	
http://www.wedi.org	Workgroup for Electronic Data Interchange web site. This site includes information on EDI in the health care industry, lists of conferences, and the availability of resources for standard transactions.
http://www.hcfa.gov/stats/npi/overview.htm	Information about the National Provider Identifier from HCFA.
http://www.jhita.org	The Joint Healthcare Information Technology Alliance includes AHIMA, HIMSS, and other health care information groups. Provides a variety of HIPAA information including advocacy papers and technology resources.
http://www.nucc.org	National Uniform Claims Committee. This web site includes the data content identified by NUCC to be used in a standardized messaging format or "envelope" to transmit data electronically for non-institutional claims and equivalent encounter information, as well as the coordination of benefits transactions to and from all payers.
http://www.hl7.org	Health Level Seven.
http://www.icd-9-cm.org/about.htm	The International Classification of Diseases, Ninth Revision, Clinical Modification. ICD-9-CM is a classification system that groups related disease entities and procedures for the reporting of statistical information.
http://www.hcfa.gov/medicare/edi-edi.htm	Medicare electronic data interchange.
http://www.ncpdp.org	National Council of Prescription Drug Programs. The standards development organization for retail pharmacy.
http://www.ncvhs.hhs.gov	National Committee on Vital and Health Statistics. The Public Advisory Body to the Secretary of Health and Human Services.
http://www.va.gov/publ/standard/health/toc.htm	Current Activities of Selected Healthcare Information Standards Organizations (a compilation) sponsored by the Center for Information Technology Agency for Health Care Policy and Research.
http:///.hcfa.gov/hcfainit.htm	Information about the Payer ID from HCFA.
http://www.healthprivacy.org	Georgetown University's Health Privacy Project's Working Group includes health advocates, health plans, providers, employers, standards and accreditation organizations and information systems experts. Their report, "Best Principles for Health Privacy," plus extensive commentary on the proposed privacy rule, and a current, comprehensive guide to State

Useful HIPAA Links and Web Sites	
	privacy laws are available on the site.
http://aspe.hhs.gov/admnsimp/asmiles.htm	The DHHS HIPAA Milestones and Compliance Schedule.
http://www.ncpdp.org/hipaa.htm	NCPDP Standards are available to any interested parties. The council provides a complementary copy of each standard with an individual paid membership. For more information on membership, visit the Membership Page. Standards documentation can also be purchased. It is possible to obtain an order form from the Download Area, e-mail Sara Cover, or contact the Council office at 602-957-9105. This is the standard for pharmacy claims. Determination of version requirement will have to wait for the final rule.
http://hipaa.wpc-edi.com/HIPAA_40.asp	Washington Publishing Download code lists at no cost: ▪ Provider Taxonomy (Pilot) ▪ Claim Adjustment Reason Codes ▪ Claim Status Codes ▪ Claim Status Category Codes ▪ Remittance Line Level Remark Codes ▪ Remittance Claim Level Remark Codes ▪ Remittance Generic Claim or Line Level Remark Codes Thirty days after the transaction rule is published, there will be spread sheets containing all data elements available for $300.00.
http://www.nchica.org/activities/EarlyView/nchicahipaa_earlyview_tool.htm	HIPAA Early View™ Version 1.0 is a self-assessment tool used to get a first glance at an organization's readiness to comply with the proposed HIPAA Security Regulations contained in the Administrative Simplification provisions of the HIPAA [P.L. 104-191].

APPENDIX C

TELL US WHAT YOU THINK…

Appendix C is a questionnaire intended for you to provide HCFA with feedback, comments and suggestions, and information specific to your State. The MHCCM can be improved or enhanced based on your input. It will be most useful to HCFA if your responses are as specific and honest as possible. Your participation is greatly appreciated!

Please complete both pages (C-2 and C-3) and return the questionnaire to the HCFA Booth (at the MMIS Conference) or send your completed questionnaire via U.S. Mail to:

Mr. Henry Chao
HCFA
Center for Medicaid and State Operations
Mail Stop S3-18-13
7500 Security Boulevard
Baltimore, MD 21244-1850

MEDICAID HIPAA-COMPLIANT MODEL QUESTIONNAIRE

1. After reviewing this paper and/or the Model demo, rank the usefulness of the Model for your State: ___VERY USEFUL ___ MODERATELY USEFUL ___NOT USEFUL

2. How could we make the Model more useful? _____
   _____
   _____
   _____

3. How far along is your State on the road to HIPAA compliance? (Check all that apply).
   ___JUST BEGINNING ___MAPPING X12N TO STATE FORMATS & DATA SETS
   ___BUSINESS PROCESS IMPACT ANALYSIS ___SYSTEM IMPACT ANALYSIS
   ___SECURITY ASSESSMENT ___PRIVACY ASSESSMENT
   ___RISK ANALYSIS ___CODING ___TESTING

4. What aides or tools have been useful to you at your current status in the implementation process? (Examples: crosswalks, rule info, other models) _____
   _____
   _____

5. What aides or tools will you need in the future? How will you use them? _____
   _____
   _____
   _____

6. Have you been able to obtain HIPAA-related information? ___YES ___NO
   (e.g., On the Rules, On the Alternative Implementation Strategies)?
   If YES, was the information useful? ___YES ___NO
   If NO, what are you still lacking? _____
   _____

7. Have the HIPAA web-sites been useful in your planning efforts? ___YES ___NO
   If yes, which ones helped the most? _____
   _____

8. What do you expect the most difficult obstacles to be? _____
   _____
   _____
   _____

MEDICAID HIPAA-COMPLIANT MODEL QUESTIONNAIRE

9. Please identify your perspective. Are you a…?
   ___ STATE GOV'T ___ FEDERAL GOV'T ___ FISCAL AGENT
   ___ VENDOR ___ CONSULTANT ___ PROVIDER
   ___ OTHER _____

10. What is your position relative to the perspective identified in question 9 above?
    ___ EXECUTIVE ___ PROGRAM ADMIN ___POLICY
    ___ OPS ___ INFO TECH or INFO SYS ___SUPPORT
    ___ OTHER _____

11. Would your State be willing to participate in a pilot program for purposes of validating the Model? (Involves one site visit during Dec 2000 – Jan 2001). ___YES ___NO

12. May we contact you for participation in other HIPAA implementation or Model related activities? ___YES ___NO

13. Can you provide any helpful hints for other States (Do's & Don'ts, etc.)? Use the Comment Section below. ___YES ___NO

COMMENTS / SUGGESTIONS:

TODAY'S DATE _____ STATE_____

NAME_____ PHONE_____

DEPT_____ FAX _____

TITLE_____ E-MAIL_____